MAKING HOSPITAL CHAPLAINS IN AN AGE OF BIOMEDICINE

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for Mom

with all my love and admiration

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ABSTRACT

In this dissertation, I explore the training and work of chaplain residents in a large, inner-city university hospital in the eastern United States as a participant in a two-year Clinical Pastoral Education (CPE) program, a culturally unique religious apprenticeship that combines (1) pastoral care on assigned hospital units with patients, family, and medical staff with (2) classroom reflection and analysis in a small student cohort with an experienced supervisor-practitioner. I utilize this experience both as a privileged lens onto issues of suffering, reflexivity, and the body and to introduce a significant yet largely overlooked component of the therapeutic enterprise to scholars of the social and philosophical aspects of medicine.

I set out to accomplish several tasks with this work. **First**, I seek to broaden anthropological depictions of religion in biomedical settings, particularly those that present it as an eccentricity, weakly rational coping mechanism, psychopathology, and/or import from non-Western cultures. **Second**, I challenge interpretations of decision- and meaning-making in clinical settings that focus narrowly on biomedical practitioner/patient relations. I do this by analyzing narrative interactions between chaplains and patients in order to highlight the distinctive role of religious practitioners in reflexive and semiotic aspects of the inpatient experience. **Third**, I attempt to broaden anthropological understandings of the formation of religious leaders by examining processes of role ascription and role attainment in the face of a medical system that is increasingly hegemonic in its scope, both psychologically and morally. I do this through (1) a phenomenological analysis of residents' exposure to clinical difference and strangeness; (2) a thick description of their development of an altruistic, non-judgmental presence and their demarcation of therapeutically appropriate emotional, spiritual, and somatic boundaries; and (3) a typology of the ways in which the doctrine-experience dialectic leads to the gradual emergence of individual philosophies of pastoral care. **Fourth**, this research offers novel insights about solidarity and authority to the growing sub-discipline of the anthropology of Christianity, an emerging specialty which has shed light on social relationships in ecclesiastical and community settings, as well as on symbolic healing rituals, but has had relatively little to say about the role of religious specialists in healing vis-à-vis Western clinical science.

RÉSUMÉ

Dans cette thèse, j'explore la formation et le travail de résidents aumôniers (*chaplain*) dans un hôpital universitaire situé dans un grand centre urbain de l'Est des États-Unis. Je me base ici sur ma participation à un programme d'Éducation pastorale clinique (CPE), un apprentissage religieux unique sur le plan culturel, qui combine (1) un service pastoral sur des unités assignées avec des patients, des familles et le personnel médical, et (2) un travail de réflexion et d'analyse effectué au sein d'une petite cohorte d'étudiants placés sous la direction d'un superviseur-praticien d'expérience. J'utilise cette expérience à la fois comme un point de vue privilégié sur les questions de souffrance, de réflexivité et de corporéité, et comme une manière d'ouvrir sur une composante de l'entreprise thérapeutique encore largement négligée par ceux qui s'intéressent aux aspects sociaux et philosophiques de la médecine.

Ce travail se donne différents objectifs. **D'abord**, je vise à élargir la manière dont l'anthropologie se représente la place de la religion dans des contextes biomédicaux, en interpellant particulièrement les descriptions qui la présentent comme une excentricité, un moyen peu rationnel d'affronter les problèmes, un signe de psychopathologie et/ou quelque chose d'importé à partir de cultures non occidentales. **En deuxième lieu**, je questionne les interprétations des processus de décision et de recherche de sens en contexte clinique, qui se centrent de manière étroite sur les relations entre patients et praticiens biomédicaux. Je le fais à partir d'une analyse des interactions narratives entre aumôniers et patients, en vue de mettre en relief le rôle distinctif des praticiens religieux par rapport aux aspects réflexifs et sémiotiques de l'expérience de l'hospitalisation. **En troisième lieu**, je cherche à élargir les façons dont l'anthropologie approche la formation des leaders religieux, en examinant les processus d'assignation et d'acquisition de rôle face à un système médical qui se révèle de plus en plus hégémonique dans sa visée, à la fois psychologique et morale. Pour y arriver, je procède ici (1) à une analyse phénoménologique de l'exposition des résidents à la différence culturelle et à l'étrangeté; (2) à une description riche de la manière dont ils développent une présence altruiste et dépourvue de jugement et celle dont ils établissent des frontières appropriées sur les plans émotionnel, spirituel et somatique; (3) et à l'élaboration d'une typologie des façons dont la dialectique doctrine - expérience conduit à l'émergence graduelle de philosophies individuelles de service pastoral. **En quatrième lieu**, cette recherche offre de nouveaux éclairages sur les notions de solidarité et d'autonomie et contribue ainsi à un champ en expansion, celui de l'anthropologie de la chrétienté, une spécialité émergente qui a jeté une lumière sur les relations sociales en contexte ecclésial et communautaire, aussi bien que sur les rituels symboliques de guérison, mais qui a encore relativement peu de choses à dire sur le rôle des spécialistes religieux vis-à-vis de la science clinique occidentale.

1

INTRODUCTION

A PARADOX OR TWO

It wasn't supposed to turn out this way.

Or was it?

The 21st century U.S. hospital was supposed to be rational, scientific, objective—secular. Unlike the last hundred years, it wasn't going to be interested in the explanatory power, ideologies, or methods of religion, particularly as manifest in chaplains working within its halls.

The alert historian and anthropologist recognize, however, that religion and medicine have been tightly intertwined in a wide range of settings. In the West, Christianity and Judaism have long manifested concern about the health and welfare of the body and were, for many centuries, key instruments of clinical intervention and scholarly reflection. Outside this milieu, cultures from Siberia to the Amazon continue to emphasize links between the supernatural and the physical, the holy and the profane, and blessing and violence.

With the development of Western medicine, religion was seemingly pushed to the clinical margins by scientific practitioners and researchers throughout much of North America and Europe. I say "seemingly" because the distillation of these disciplines into geographic and ideological moieties has tended to be more a scholarly presumption than a clinical reality, yet even this is changing in some quarters. Scholars from specialties such as neuroscience (e.g., McNamara 2009), evolutionary biology (e.g., Reiss 2009), and the history of science (e.g., Harrington and Zajonc 2008) have expressed keen interest in recent years in the emerging academic field of religion and science[1], but medical anthropology seems—curiously—to have declined the open call to join this large and lively debate, typically ceding such issues to the anthropology of religion (which has its own limitations of

[1] The phrase "religion and science" appears at several points throughout this dissertation and refers specifically to the subfield of religious studies that addresses the historical, philosophical, cultural, and political relationship between these two fields as broadly construed. See e.g., Polkinghorne (1998), Brooke (1991), and Attridge, ed. (2009). There is no tidy or universally-agreed linguistic equivalent for studies at the interface of spirituality/faith/religion and health/medicine/healing, though there exists a growing literature attempting to distinguish various pairings of these terms. See e.g., Barnes and Sered, eds. (2005) and Miller and Thoresen (2003).

engagement with Christianity but has been making promising strides through the work of Cannell (2006) and others). There have been a few exceptions, such as in psychiatry (i.e., when the mind is diseased; see, e.g., Jenkins and Barrett 2003), the analysis of non-Western religions in Western scientific settings (e.g., Fadiman 1997), or studies of Western medicine and religion in non-Western settings (e.g., Inhorn (2003) and Roberts (2006)). Nonetheless, one could be forgiven for seeing in such texts a perpetuation of the science:modernity::religion:pre-modernity outlook rather than viewing the interaction of these two domains as potentially, if not actually, one of symbiosis and ongoing accommodation.

This is so, despite the fact that matters of religion, faith, and spirituality continue to be significant forces throughout the U.S. cultural landscape, from classrooms to courthouses to, yes, hospitals. Prayer, ritual, and pastoral conversation are visible throughout the corridors of medical centers large and small, yet the phenomenological and ideological influence of religion in these spaces has largely been overlooked by anthropology. This leads to a simple yet dramatic question: Why do patients, family members and friends of patients, and other hospital employees interact with religious leaders in a biomedically driven inpatient setting in the 21st century?

This thesis turns to the anthropological practice of fieldwork and participant observation to contribute to religion-science and religion-medicine debates through an ethnographic analysis of a deceptively simple experiment. Take a small group of people with training in religion and expertise in preaching, teaching, and parish administration, and with varying degrees of familiarity with biomedicine (see e.g., Keating and Cambrosio 2004 for a useful elaboration on biomedicine as an analytical social science construct) for many of their own health needs, and insert them as practitioner-trainees into an ideologically unique clinical setting. What happens? What insights can we gain about relationship between science and religion in the U.S. today through the interaction of one particular type of science—biomedicine—and one particular type of religious practice—hospital chaplaincy—through the experience of residents in a Clinical Pastoral Education (CPE) training program? How does this education seek to shape the mindsets, assumptions, personalities of students, and those with whom they interact, in the clinical space? What does the program's structure reveal about the ways in which chaplain residents come into contact with biomedicine, understand it, appreciate it, challenge it, and learn about points of overlap, conflict, and omission? More broadly, what happens when one ideological system goes to work under the auspices of another, ostensibly toward a common goal of patient well-being?

Initially, one might suspect that chaplain residents would undergo the same initiation as other trainees: they would become acclimated to the sights, smells, and political dimensions of the

institution. They would learn the emergency protocols, memorize floor plans, and complete online training for the use of hospital software programs. Gradually, they would develop a sense for the needs, desires, frustrations, hopes, and experiences of patients, family members, and others in the hospital space. Religious specialists are often presented (e.g., Eliade 1964) as closely interrelated with cultural issues of ethics and morality, so it is reasonable to think that students might devise certain codes of behavior, enforce them, and even demonstrate them through their own actions. This may well be the case in some small-scale societies, where there are no other therapists or rival systems of morality from which the afflicted may seek assistance.

But what about the hospital? Are chaplains first and foremost hospital employees, epistemologically consonant with other clinical practitioners, or are they essentially shamans with name badges? The last few decades have witnessed the proliferation of secular ethics committees and the notion that the biomedical clinic itself has become its own moral system, with rules of enforcement and mechanisms that lead patients to internalize particular norms of behavior and self-management (cf. Foucault 1965, Rose 1997). Biomedicine has developed theories about the mind and social behavior, seemingly leaving religious specialists in the U.S. with less and less to say about how people should behave and what—or how—they should feel in response to various therapeutic choices and outcomes. If this is the case, then it seems that chaplains should have no substantial role to play regarding proclamations of guilt, the examination of conscience, or the consolation of affect that stood at the core of their work in previous centuries. What is the function of religious specialists if, more and more, biomedicine can explain all things human at the molecular level? Contrariwise, if chaplains do serve in some capacity as agents of morality, interpretation, and social activism, then what is the content of the ideologies that they seek to embody, and who is served by such work?

That is, we must concern ourselves not only with the where, when, and how of the interactions of religious specialists in the biomedical space, but also the why. It is crucial to understand how this environment affects the cultural formation of the chaplain, but it is equally important to try to get a sense of how the chaplain resident affects the environment in return—how these interactions evolve over the course of the training, and how circumstances affect outcomes. Is there some sort of stable social equilibrium that emerges between biomedical practitioner and religious specialist, or is this mixture inherently volatile? In what sense does suffering act as an emulsifier, a catalyst, or limiting reagent of these two therapeutic systems? Do interactions on some units become relatively efficient and deterministic, while others remain unpredictable, or at least stochastic? Further, how do chaplains influence each other through their reflections and cohort activities?

A central aim of this research is thus to develop a nuanced understanding of how religious beliefs and religious healers, operating under the rubric of biomedical treatment, influence hermeneutic enterprises—meaning facilitation and belief formation, questioning, and revision—within the clinical setting, particularly as seen through narrative interactions between chaplains and patients, their family and friends, and other hospital staff. To the extent that both the body and biomedicine demand (or inhibit) particular forms of interpretation, the work of chaplains with patients may potentially function in a variety of manners: as subversion, resistance, division of labor, mutualism, mediation, or even a co-opted tool of control and compliance.

RELIGION, AFFLICTION, AND HEALTH

The concepts of good and evil, along with their associates order/disorder, health/illness, right/wrong, and equilibrium/disequilibrium have long held the scholarly interest of anthropologists of religion and medicine. Indeed, such dichotomies stand at the core of many systems of thought and serve as endpoints for the delineation of more nuanced, intermediary positions that the afflicted experience as social actors when confronted with various disruptions to their daily lives. Religious and medical frameworks both propose theories for the maintenance of the desirable and theorize human and environmental (including supernatural) factors that can undermine it. Likewise, each espouses mechanisms that can help individuals and groups to regain the favorable when it has been undermined.

This is not in any way to suggest that such theories of good and evil are infallible or sacrosanct. Nor, for that matter, does it market a wily form of neo-structuralism as *the* paradigm of choice for topics at the interface of religion and biomedicine. Rather, one of the central aims of this project is to suggest that individuals and collectives routinely weigh different causal hypotheses and treatment options when confronted with fragmentation and are less concerned with consistency of thought than cohesion of therapeutic method. I argue that such processes seem to reflect strict cultural norms and processes in the clinical space but in fact leave ample room for initiative, negotiation, skepticism, and reframing, particularly when viewed through the lens of pastoral care.

Religion and the Body

Most, if not all, religious traditions devote considerable attention to the use and maintenance of the human body. Topics frequently include the proper role of the body in ritual, reproduction, and everyday interpersonal relations (Louth 1997); maintenance through, for example, dietary restrictions and rest (Jacobs 1997); ways to avoid pollution and protocols for purification (Collins 1997);

connections between individual and collective bodies, especially in relation to the transcendent (Saso 1997); and what could be called spiritual anatomy, or the description of various embodied forces and tendencies within the physical self, including descriptions of what in the West has been described as monism and dualism and what in other areas is described as spirit possession (Nesbitt 1997). Religion thus seems to function as both descriptive and normative with reference to the body, and as such it appears to operate as a key classificatory system for regulating the physical and for explaining its malfunctions.

It is important to recognize, however, that these texts are frequently theoretical or remain largely at the level of doctrine. How do they fare in reality, especially in a setting as ideologically charged as a major teaching hospital—at once cosmopolitan and contentious—where beliefs are routinely open to revision and appear to be challenged at every turn by flexible ontologies? As an anthropologist, it is crucial to consider the dialectic between belief and lived practice when an individual is faced with potentially life-saving interventions that may nonetheless challenge or undermine religious dictates. Fortunately, the activities of hospital chaplains provide just such an opportunity to analyze such conflicts.

Evil and Its Correlates

Misfortune, through whatever means, stands at the heart of both religion and healing. Though the terms *evil* and *sin* appear much more frequently in theological texts than anthropological ones, they serve as useful heuristics for the analysis of forces that engender pain, suffering, and attempts to restore order.

Health and holiness have been important themes in the anthropology of religion since the 19th century. Tylor (1873), for instance, elaborated animism to depict souls that inhabit all living things and interact with humans in ways that may be beneficial or detrimental to the latter according to particular sets of rules and prohibitions. Radcliffe-Brown (1939) described taboo as a tool to help humans recognize and maintain a sense of order in the physical world and to develop clear senses of morality, fear, and interdependence among various components of a person's lived environment. Douglas (1966) reiterated many of these themes in her own reflections on taboo and on the relationship between purity and danger, though she saw taboos more in terms of good social relations than an example of an inferior mentality that conflated events. More recently, anthropologists such as Parkin (1985) and Macfarlane (1985) have analyzed some of the social consequences of the concept of evil in relation to the health of the collective and the relative autonomy of its members. Evil and sin have been largely ignored by anthropologists of biomedicine, however, which is surprising, given its predominance in the mindsets of many in the U.S., particularly following the

9/11 attacks. By analyzing the training and work of hospital chaplains, I hope to demonstrate that evil and sin are still significant concepts in the thought of many patients and indeed the chaplain residents themselves, albeit in ways that reflect close intermingling with scientific modes of thought and repeated exposure to similar cases that challenge dogmatic beliefs.

Meanwhile, philosophers of religion, especially Christianity, have long struggled with theodicy and social manifestations of the unfavorable in light of ontological claims about the divine. Research has focused broadly on the logic of a monotheistic God claimed to be omnipotent, omniscient, and wholly good and manifestations of evil and suffering observed among humans in this world. Some, like Mackie (1990), have argued for a distinction of various types of evil, some of which he argues may be necessary as counterparts to the appreciation and determined propagation of good, yet without placing undue constraints on either humans or God. Adams (1990) continues this theme in light of human epistemological limitations synchronically and diachronically, suggesting that these limits must be taken into account when interpreting social events. Others, including Chisholm (1990), have sought to understand ways in which problems of language and logic relate to the phenomenology of evil, distinguishing various possible and actual states of affairs and their opposites, in order to understand more fully what can and cannot be compared in discussions about the net goodness of the world. Plantinga (1990) reviews the problem and limits of free will in order to understand the extent to which individual culpability may contribute to the evils that humans experience. Writers such as Bousfield (1985) and Inden (1985) explore the cultural, environmental, and cosmological implications of evil for social continuity and rupture. All of these issues bear on issues of belief in U.S. hospital settings, in which violence, poverty, and stress bring significant numbers of individuals to emergency rooms and trauma bays.

Alongside this scholarship, a number of social anthropologists have considered social understandings of and reactions to evil outside the West. These ethnographies explore a range of ideas about supernatural causality and initiative, as well as ways in which human beings struggle to make sense of such acts within their own cultures. Overing (1985), for example, discusses evil in relation to knowledge acquisition among the Piaroa in Venezuela, suggesting the potential for misuse of power that is inherent in the development of skills and insights. Mair (1969) investigates evil as embodied in the work of witches and explains a number of its social functions in small-scale societies. Similarly, Brain (1973) considers the influence of ancestors over the living and argues that this type of human-supernatural interaction can serve as a mechanism through which evil can be made manifest.

In other cases, interpretations of evil are concerned less with specific relationships than as a reflection of social hardship or the responsibility of each individual to guard against the ever-present possibility of succumbing to evil's effects. These belief systems can change over time, as Parkin and others argue, particularly as a consequence of missionary activity and other forms of cross-cultural exchange, often leading to revised cosmologies and social conflicts. How they evolve in light of scientific ideologies in technologically sophisticated settings, however, is another question, one that is receiving increasing attention outside North America but is, apart from a few ethnologists like Luhrmann and Csordas, still largely under-theorized.

Suffering and Death

Suffering, I argue, is ubiquitous. It is conveyed through a wide range of idioms, but there appears to be a growing consensus among ethnographers that it reflects conditions of communal living as well as individual bodily experiences. The fact that suffering is widely regarded as undesirable provides a powerful rationale for the work of both religious and healing systems across a wide range of ethnic groups that attempt to respond productively to its effects on both individuals and collectives. Such processes are particularly important to understand in terms of the limits and possibilities of the narratability of suffering and the relationship between suffering and religious ideologies.

Scholars have investigated these issues from a variety of magnifications. Lock (1997), Asad (1997), and Young (1997) each stress social suffering as a phenomenon that affects the social body, rather than merely the individual person, and they suggest a variety of ways in which the processes of social suffering can reflect both internally- and externally-generated disorders and the ways in which their effects are both legitimated and controlled. Morris (1997) and Das (1997) highlight issues in the relationship between language and suffering, including the ways in which discourse bridges the experience of suffering between social actors and makes claims upon them as a form of strangeness that demands a response from the other. Bowker's (1970) seminal treatise on suffering in religions of the world, and Soelle's (1975) meditation on evil in light of the horrors of 20th century Europe, both discuss normative responses to socially generated misfortune—particularly those events that seem to lack any redemptive value for the individual or the collective—based on various religious ethical frameworks espoused by religious traditions. Given the increasing social individualism and isolation present in many U.S. hospitals, these theories are extremely important considerations in the analysis of both patient and family/friend experiences of hospital-based affliction and loss as cultural phenomena.

Religious Specialists

Anthropology has long been interested in the work of those who assist the diseased and injured, including those who practice the manipulation of the physical to achieve healing, as well as those who demonstrate special connections to the supernatural and who utilize this access on behalf of the afflicted.

Ethnographers have described ways in which apprentices hone particular skills and access a variety of diagnostic and therapeutic techniques for purposes of intervention in individual cases and in situations involving conflicts within the collective. Durkheim (1893) traces the social development of specialization through his notions of mechanical and organic solidarity through technological development, social cohesion, and regulatory practices, suggesting some of the difficulties and opportunities that arise for the collective as individual members of the society develop various types of expertise. Frazer (1911-5) describes magic as a way of introducing human uses of spiritual power for personal gain, protection, and restoration. Hand (1969) depicts a number of "folk" or home remedies similar to Frazer's forms of magic as a way of highlighting both (1) a range of local treatment methodologies that reflect popular understandings about illness processes and (2) some of the ways in which individuals and households attempt to find healing without the use of specialists.

Subsequent writers, including Eliade (1964), Turner (1968), and Von Furer-Haimendorf (1970), characterize the formation and social functions of various religious specialists, while Macquarrie (1996) discusses the role of human mediators who bridge gaps between the mortal and the supernatural worlds in order to fulfill a variety of social needs. Brown (1988) adds to these descriptions some of the dangers associated with shamanism and the social risks that come with access to power. More recent accounts have articulated some of the ways in which medical pluralism contributes to ambivalent beliefs and decisions about which type of practitioner to seek for a given set of symptoms. Atkinson (1992) works within this vein and challenges some common assumptions about shamanism through a description of both the psychological aspects of therapeutic practice and performance that do not necessarily lead to social cohesion.

What is the relationship between these practitioners and biomedicine? Perhaps more to the point, what is the relationship between these practitioners and hospital chaplains? The former question has received considerable attention from anthropologists (e.g., Greene 1998, Adams 2005, and Langwick 2007), whereas the latter has to my knowledge received none. I believe that anthropology has neglected this question far too long and needs to confront the questions of why religious specialists continue to exist as components of biomedical inpatient healing and how these

figures relate to these other practitioners as social figures. Are chaplains anachronisms, exceptions that prove the rule of secular scientific rationality? Or, contrariwise, do they reflect some larger, perhaps more uncomfortable, aspect of Western society that anthropology, and especially British social anthropology, thought that postmodern cultures had long since abandoned?

Cognitive and Psychological Considerations

The overlap between psychological anthropology and the anthropology of religion is significant; both study a wide range of mental states and offer theories about the individual and social ramifications of these mindsets. Although theories regarding the etiology and treatment of altered states of consciousness, possession, trance, and the like vary in their emphases, both subfields have sought to understand the ways in which groups interpret abnormal social behavior, promulgate the supernatural, utilize chemical substances to achieve mental states, and draw upon symbolic aspects of the manifestations of the mind in order to (re-)achieve social stability.

Four topics in particular merit close investigation in relation to the training and work of hospital chaplains in the biomedical setting. The first, social cognitive processing in mental health and religious healing, focuses on practitioners and some of the issues that they face when attempting to provide healing to the mentally afflicted; here researchers focus on issues such as the relationship between alternate states of consciousness (ASCs) and somatic intervention and the place of a healer's own illness experiences in improving care for the afflicted and as a way of understanding the dialectic of affect in healing processes (Greenfield 1991). Second is the phenomenological and socially situated experience of the illness process for patients. Questions here emphasize, for example, the exigencies of competing treatment paradigms (Bass 1994); topics of identity and the maintenance of the self in relation to issues of gender and power (Boddy 1988); and the use of chemical substances such as peyote for ritual, therapeutic, and epistemological purposes (Slotkin 1955-6). Third is the role of semiotics in mental illness and healing. Hermeneutic therapy, as we might call it, includes both spiritual and medicinal components and is closely intertwined with the ways in which cultural norms and ideologies influence mental well-being, both in the patient-practitioner encounter and within the broader social setting (Csordas 1988).

A fourth and related topic is the healing accounts of Jesus of Nazareth. Because hospital chaplaincy in the United States has its roots in Christianity, it is worthwhile to bear in mind the place of healing within the broader work of Jesus of Nazareth before turning our attention to modern inpatient medicine. Research by Davies (1995), for example, is particularly helpful in this regard, for it considers a number of healing accounts from New Testament texts in light of recent work in psychology, including altered states of consciousness and trance/possession. Remus (1997),

meanwhile, takes a more traditional textual-analytic approach to both the Gospels and early healing accounts of the Disciples and suggests a variety of symbolic and political rationales for healing intervention that extend beyond the welfare of the afflicted individual.

Hospital Chaplaincy

Research on hospital chaplaincy has tended to be pedagogical and phenomenological in nature, emphasizing practical elements in ways that parallel best-practices literature in clinical medicine. Holst (1985a), for example, explores links between chaplain-patient discourses and counseling psychology and psychoanalysis to understand how this particular type of religious engagement has evolved in light of scientific advances. Katonah (1985) draws an analogy between hospital admission for patients and social rituals of initiation and suggests ways in which chaplains can serve as important figures in the therapeutic journey, while a second essay by Holst (1985b) comments on some of the social and psychological aspects of initial visits by chaplains to patients as a unique form of cultural interaction. Grundmann (1985), meanwhile, discusses a variety of phenomenological and practical components of spiritual service for hospital patients near death.

Culture, and particularly epistemological and political economic considerations, remains underdeveloped in most discussions of health care chaplaincy, apart from general acknowledgements that hospitals are unique social spaces and that race and ethnicity are important considerations in pastoral interactions. In a critique of Western secularism, Engelhardt Jr. (2003) considers some of the implications of the shift of hospital chaplaincy in the U.S. away from its "traditional" Christian roots. A related article by the same author questions the logic and efficacy of attempts by chaplains to provide succor to patients and others outside Western religious traditions (1998). Delkeskamp-Hayes (2003), meanwhile, highlights a number of the challenges faced by Roman Catholic and so-called "generic" Christian hospital chaplains interacting with patients and others from religious traditions other than their own. Joseph (1998), an Orthodox priest, considers a variety of implications of hospital chaplaincy's focus on the issues of this world versus those of the hereafter, and Kotva (1998) draws attention to a number of the institutional challenges that chaplains face when attempting to minister equitably where tendencies toward relativism are pervasive. In her observational analysis of hospital chaplaincy, Norwood (2006) considers a variety of ways in which religious healers struggle to accommodate the overarching ideological climate of medical centers in order to provide care to the afflicted. Finally, Lee (2002) investigates some of the theories and mechanisms of Clinical Pastoral Education as a pedagogical system.

All of these papers address important aspects of pastoral ministry in hospital settings, yet they neglect a sustained analysis of biomedicine as a cultural system in relation to religious practice.

Apart from the essays by Kotva and Lee, the papers analyze chaplaincy strictly from the perspective of believers, persons whose own religious convictions are more or less sympathetic to the concept of pastoral care. While their descriptions are illuminating, they do not situate their findings in broader social scientific literature on such topics as epistemology, power, temporality, or narrative, topics that stand at the center of this dissertation.

RATIONALITY AND BELIEF

Background

Two of the central ways by which we can conceptualize the social issues and processes in the hospital space are rationality and belief. It is often the case that patients, their family and friends, medical practitioners, and hospital chaplains each approach the human body and its afflictions from very different conceptual and practical perspectives, from matters of etiology and diagnostic methodology to prognostication and therapeutic intervention. It is crucial to understand these different vantage points in order to appreciate the ways in which social actors interact phenomenologically and discursively when confronted with disease, pain, and injury.

This project is concerned not only with the ways in which beliefs are formulated, sharpened, undermined, and re-affirmed within the inpatient healing trajectory, but also with the mechanisms by which the culture of the hospital shapes knowledge exchange and opens spaces for negotiation and understanding. It aims in particular to understand (1) the ways in which biomedicine serves as the benchmark for what can be considered rational and reasonable within the walls of the hospital and (2) how other epistemological and cultural systems of understanding and expression like religion fare when confronted with what appears to be a normalizing structure of discourse, beliefs, and behavior in the face of illness and bodily malfunction.

Biomedicine, particularly within the clinical context of U.S. hospitals, reflects a range of hermeneutical and epistemological positions typically associated with Western science, including rationality, value-free objectivity, and the validity of various types of evidence. Gordon (1988), Young (1982), and Csordas (1988), for example, have questioned the reliability of many of these philosophical assumptions and have underscored the need to analyze individual illness journeys in order to understand how specific cultural variables, influence the ways in which topics such as rationality and empiricism impact therapeutic processes. Hacking (1990), Latour (1993), and Daston and Galison (2007), meanwhile, are prominent among philosophically oriented researchers who have studied the rise of statistics and the concepts of risk and objectivity in social thought and thus

introduce important factors that relate to questions about the robustness and interaction of various beliefs. They have focused important attention in particular on chance and randomness as mechanisms that have both over- and under-determined the meaningfulness of disease and illness phenomena for patients, practitioners, and others.

Belief Formation and Maintenance

A first consideration, and one that is of particular import to the work of hospital chaplains, is the processes by which individuals come to hold beliefs about the events that are unfolding before and within them. There is typically a process of data analysis that precedes an enunciation of a person's position about causal forces and other factors in such social phenomena. Such processes often vary widely, in terms of both the intensity of the scrutiny and the types of devices used to draw conclusions. Second, in addition to the various forms of diagnostic equipment utilized by doctors, Skorupski argues that statistics and probability frequently serve as important sources of persuasion when looking for possible outcomes and future planning (1976). The question "What are her chances, doc?" has become extremely pervasive in critical care situations and underscores the fact that in many cases, the degree to which persons hold opinions has as much to do with memory and the experiences of other patients as it does with the particulars of the case at hand. Third, the work of writers such as Elster (1979) and Wittgenstein (esp. *OC* 343), are likewise important reminders of limits that individuals may face as they attempt to formulate beliefs. Time constraints, perceptions of suffering and discomfort, inconclusive lab results, unanswered prayers—these are but a few examples of the complexities that someone may encounter, synchronically and often diachronically, as he attempts to formulate an opinion in the clinical space.

Consistency is likewise a significant factor by which many philosophers judge the rationality of a person's beliefs, though it is one that is fraught with potential difficulties, especially in contexts in which new data emerge constantly. While in a sense consistency can reflect mastery, it may also connote an inability to incorporate new findings or to strive for common ground with one's interlocutor. Indeed, to return to Wittgenstein, we must recognize that rule following is an insufficient criterion with which to weigh either the status of a person's beliefs about a particular issue or how these beliefs shape the individual's outlook (*PI* 202), but I argue that it is nonetheless a reality with which we must contend in terms of decisions and interventions that are considered normative in hospital treatment.

For this project, I'm interested in particular in how religious specialists learn to conceptualize problems in the clinical space—spiritual, physical, emotional, psychological, and relational. What factors cause them to view particular phenomena as problematic? How do the schemas of illness,

affliction, sin, brokenness, estrangement, disease, injury, and fragmentation that they bring with them to the program from their own previous experiences of illness and biomedicine configure their understanding, and how does the clinical experience subsequently challenge, modulate, or confirm these thoughts? I am similarly interested in understanding how chaplains learn to respond to uncertainty in their work, how this new knowledge modulates their beliefs about what can and cannot be known by humans, and what this ultimately means for epistemological processes in the hospital more broadly. Indeed, I argue that the answers to these questions hold significant import for understanding how religious specialists define themselves as clinical practitioners and how they situate their own work in relation to that of biomedical interventionists. I also suggest that the ways in which chaplains learn to configure the unknown extends to their views of the other, particularly the afflicted stranger, provides important insights into their views of patients as social interlocutors worthy of narrative and emotional hospitality, rather than as problems in need of solutions. Such processes of becoming comfortable with the foreign, the abnormal, and even the pathological can create unique types of social relations that can render both scientific and religious beliefs more therapeutically valuable, and malleable, than they would be in the absence of such patience and mutual vulnerability.

Knowledge Exchange and Negotiation

The question of commensurability has a long history, within both anthropology and philosophy, and it holds particular salience for the interaction of religious and scientific outlooks in situations involving sickness and treatment. In order to understand these interactions, we must try to ascertain first whether the topic under consideration is the same for both parties, or if they are in fact discussing different phenomena. This may appear obvious in the hospital environment, but one of the hypotheses of this project is that assumptions on this most basic of levels can have enormous and negative ramifications for chaplains if they are left unexplored. I suggest that it is crucial for their training to understand the ways in which various actors gauge the credibility and substance of others' beliefs in the hospital in order to appreciate power relations and the manners in which decisions are made.

Likewise, it is important to consider elements of power, notably hierarchical relationships within hospitals, to understand how individuals engage each other regarding aporias of rational belief and practice and how religious training and responses to uncertainty may shape broader cognitive practices throughout the clinical space. I argue that in many therapeutic situations, pastoral dialogues are more speculative than concrete in their orientation, particularly as narratives from patients and practitioners range from synopsis to meaning to application and back again. While it may be easy for

one or more parties to rush to epistemological judgment about a given statement in a pastoral encounter, I contend that the emphasis of such exchanges is guided ultimately to be a patient's recovery and well being, rather than analytical robustness. That is, I shall demonstrate that the highly pragmatic nature of clinical religious narratives largely overrides theoretical concerns about the rational coherence of belief systems or explanatory models. I suggest that this is especially true in treatments involving experimental therapies or when unexpected positive (or, as some might say, *miraculous*) outcomes occur—situations in which uncertainty may be sufficient to warrant counterintuitive or seemingly irrational thinking and in both the patient and practitioner (cf. Horton 1977). In such cases, Weber's *Zweckrational* individual seems likely to remain but an idealization (Sica 1988).

Additionally, to the extent that biomedical practitioners view confident certainty as an aura that they must convey to patients and family, they may feel a correspondingly greater need to demonstrate firm beliefs than persons like chaplains, whom I argue learn to be comfortable with many manifestations of inconsistency or uncertainty and feel less cultural pressure to embody rugged assurance or omniscience in the clinical setting. I suggest that chaplaincy students experience considerable freedom to express sentiments such as religious faith and humility in light of the unknown, especially to the extent that such mindsets represent ambiguity and trust in the supernatural. Crucially, I contend that this openness can in turn have therapeutic and interpersonal benefits for the afflicted as well, who can then express their own fears and perplexities without fear of moral judgment, narrative paternalism, or cognitive pathologization.

It is here and elsewhere that we begin to notice the viability of mediation within the hospital enterprise. If we accept the fact that many persons lack the experience and/or exposure to engage meaningfully in a fraction of the discussions that occur along a healing trajectory, it becomes appropriate to contemplate the possibility of a bridging figure who can introduce new options, recognize biases and behavioral norms, translate conceptual schemes and categories, and search for common ground to build trust and foster dialogue between various actors—whether or not agreement is ultimately achieved. While such a character might not resemble Weber's grand mediator, able to overcome each *hiatus irrationalis* (Sica 1988), the mere presence of this type of person suggests the possibility, if not also the desirability, of inter-group solidarity and ideological flexibility. Indeed, the seemingly endless clinical division of labor within the hospital complex is not only reminiscent of Durkheim's distinction between mechanical and organic solidarity (cf. Lloyd 1990), but it makes the viability—if not necessity—of a bridging figure like a religious specialist that much more real.

NARRATIVE, THE DIALECTIC, AND LINGUISTIC MEDIATION

The stuff of narrative and the dialectic has long captured the attention of anthropologists of both religion and medicine. Theorists have made important advances in our understanding of the dialectical processes by which two or more persons utilize discourse to shape and clarify identities, influence each other through disputation in the search for truth, and adjust their relative proximities and senses of unity. More recent work on issues of hegemony, social norms, and phenomenology (Ricoeur 1984-8)—to name but a few—have afforded increasingly nuanced insights into the ways in which individuals and groups interact discursively, and these insights have been crucial to our understanding of moments of sickness and health.

Despite these advances, there remains a great deal to understand about the mechanics of clinical narrative interrelations, and I suggest that a careful consideration of religious discourse in hospitals can open profound new horizons for theorizing social relations in the hospital space. Narrative, quite simply, is *the* central methodological consideration in the formation and clinical work of hospital chaplains in the 21st century. It serves as their main form of diagnosis, therapeutic intervention, social connection, reflexive apparatus, ritual technology, and temporal bridge. Here again, though, we confront many of the same issues of the previous section, particularly the compatibility of these various types and classes of discourse with others in cultures dominated by biomedical configurations of interpersonal activity. Are religious and biomedical conversations wholly different clinical phenomena lacking any sort of lingua franca, or are there ways in which they can be mutually illuminating—if not also reinforcing?

A quick survey of the anthropological and philosophical literature on the nature of the self, individualism, and self-other relations also makes frequent mention of the concept of mediation as a central component of interaction. The reader is wont to discern a clear understanding of the types and degrees of linguistic mediation that can occur between two or more parties, however, especially in environments like the hospital, where the interaction of religious and scientific narratives often entails competing—or at least differing—temporal horizons and understandings of the relationship between discourse and the body. If mediation is indeed one of the central questions of epistemology and of narrative more broadly, then one of the key tasks of this project must be to articulate the concept of mediation in such a way that descriptions of the narrative components of these processes become crisp; phrases such as "the cultural mediation of *x*" simply will not do.

The Ontology of the Dialectic: Consciousness, Phenomenology, and Mereology

A central thesis of this dissertation is that for chaplains, the hospital experience is closely tied to issues of self-consciousness and personal agency within the context of shared medical experiences.

These topics gain special urgency when we consider them in light of the aforementioned dialectic processes, for however much an individual may be able to learn about herself, by herself, such knowledge is not exhaustive and can be augmented or mediated by the presence of another, and I argue that this is one of the central goals of CPE in the U.S. today.

Issues of reflexivity raise issues of proximity and trajectory in self-other and subject-object relationships that hold significant bearing upon social relations in spaces like university medical centers. Hegel, perhaps more potently than others, argued that recognition frequently implies struggle and surrender but can—at least in theory—lead to greater autonomy through solidarity (Bernstein 1971). Others, like Aboulafia, view the dialectic in terms of an apprenticeship-like process, where "the mediated self, the self that becomes what it is through its relationships with others, becomes the mediating self, the self that can determine the direction of its own life" (xvi). From a narrative standpoint, this may take the form of implicit and explicit questions, life histories, sacred texts, and other devices, in which both the self and the other come into sharper focus as distinct entities. The self in particular may oscillate between subject and object, at times distinguishable from the I and hence a "mediated thing" (115), and at other times unified with it. Likewise, consciousness may be either actor or topic of analysis; here too we may see moments of negation, opposition, and stable and unstable unities, according to the nature of the reflection at a given point in time. This occurs as individuals wrestle with the epistemological and social implications of possible mediated syntheses implied by the presence of an other, even as they struggle with the notion of a limit as mediator and the stability of such a limit in terms of separation across time, circumstance, and commitment (1986).

These issues are particularly important in relation to questions of openness and trust in a space as arguably liminal as the hospital, one in which basic ontological forms are open to manipulation. A key historical theme in these discussions of unity among various dialectical partners is the notion of some sort of overarching being, with whom the various subjects and objects find a common source of identification that influences the nature of the exchanges. Examples range from Kant's reason consisting of finite intuition mediated by finite understanding, where the latter two reflect pure imagination, to Hegel's Absolute, where the mediation of transcendental intuition and the speculative idea together represent a uniting force that "restores sameness through doubling," rather than a device that "unites opposing elements after they have been divided" (Taminiaux 60-1). Merleau-Ponty, meanwhile, sees in the transcendent a vehicle for perception and emphasizes the concept of the *form* when arguing for the predominance of ensembles over atomic units (Taminiaux 157).

In Heidegger, the indelible presence of Being conditions knowledge accumulation and, due to its ontological excess over the sum of individual beings, helps to dictate common ground and interpersonal exchanges. For him, intrapersonal relationships of the sort aspired to by chaplain residents can be seen in terms of sameness and identity. Mediation thus occurs *within* persons as well as *between* them to foster equality among parts—a "unity of a manifold, combined into the unity of a system, mediated by the unifying center of an authoritative synthesis" (29)—where the presence of difference implies a set of clarifying and ordering activities. This can occur through appeal to language and reflective appropriation, within the parameters of being's relationship to Being, in which the concepts of the dialectic and mediation are eventually ceded to the "spring"—a mutual appropriation in which one gifts itself to the other without dissolving ontological difference. This concept of identity implies a "manifold unity mediated by synthesis" (12) that is predicated on the presence of Being, which the individual identity reaches through the *step back* that allows difference to emerge *without turning Being into an object*, where difference can nonetheless imply conciliation. He conceptualizes this relationship between part and whole as a circular equilibrium, both within the individual and between the person and his milieu, thus stressing the organic unity within which particular exchanges occur.

These theories are innovative and original, but they are just that—theories. How do they hold up against lived experience? In this thesis, I seek to hold these and other philosophical concepts up to the work of chaplain residents as mediators and representatives of the supernatural to examine the extent to which concepts such as unity, communitas, and conciliation are legitimate phenomena that occur in the clinical setting, especially in light of apparent trends to see in medicine conflict and animosity. Indeed, these longstanding social concepts ground much of the theory of CPE, which is interesting in its own right. Yet to what extent do they configure the epistemological outlook of religious specialists in hospitals or function as metaphorical themes for chaplains, many patients and family members, or biomedical clinicians? If they do in fact accurately represent the mindsets of chaplains and others in terms of clinical pastoral goals, then what conclusions can we draw about the biomedical setting as a place of reconciliation shaped by the work of religion? Likewise, how do the issues and dilemmas of the biomedical space as workshops of de-fragmentation configure the social identity of clinical religious specialists in 21st-century America?

This is not to suggest that these arguments for the possibility of unity are without their critics or that such unity is long lasting, however. Crapanzano points to a number of theories that are skeptical of the value and possibility of any sort of over-arching oneness in the current age, from post-modernists, who view it as arbitrary and uncompelling, to Kuhnian romantics, who believe that

unity is at best an unstable equilibrium. It is one thing to hope for understanding, he says; it is quite another to envision solidarity (1992). Along these lines, for example, Ginsburg suggests that particularly when mediating technologies disproportionately reflect one side of the debate or are used in a context foreign to both sides, it is easy for them to be co-opted (1995). This topic, I shall argue, is a particular concern for hospital chaplains, who struggle to balance commitment with neutrality in their clinical interactions in ways that allows them to be faithful to their personal religious convictions while open to difference, recognizing that their moral framework may force them at times to take sides and forego facile rapprochements.

A number of philosophers have likewise wrestled with ontological elements of exchange and with mereology, the analysis of the relations of parts and wholes. Here the question is not "Is there a gap?" so much as it is "What is the nature of this gap?" and "Can the gap be overcome?" This project seeks to know how a variety of forces, from the fragmented self/subject, to other actors, and to ideologies, make their presence felt within what is often characterized as dyadic encounters in relation to concepts of a unified whole or wholes vis-à-vis the medium of language. These questions are particularly salient, given the preponderance of conversations that discuss and address the supernatural as a juridical or therapeutic agent in the biomedical setting. This is especially true to the extent that pastoral conversation highlights and facilitates phenomenological aspects of bodily sensations in the hospital and thus attempts to bridge gaps between raw experience and cultural frameworks of affliction proffered by religion and by biomedicine. Hence, considerations of language and healing, even—or perhaps particularly—in the West that neglect the divine element of communication necessarily overlook significant component of the cultural and ideological whole that is the hospital space.

The Materials of the Dialectic: Functional Aspects of Language and Narrative Structures and Devices

At first glance, it may appear obvious to suggest that spoken and written language stand at the heart of both the dialectic and social mereology. Mattingly states bluntly that "actions and narratives are interpretively dependent, locked in the familiar hermeneutic structure of part to whole" (1998a:110). Philosophers from Aristotle to Wittgenstein have reflected on the possibilities and limits of language as a mechanism of exchange, and many anthropologists have embraced the centrality of the dialogic within the activities of the dialectic. An individual's relationship with words, and the meanings contained in these words, can likewise be immediate or mediate, according to both the listener's and the speaker's relative coordinates vis-à-vis an original event or transmission (Wolterstorff 1995).

The analysis of clinical narratives also points to the multiplicity of functions of language in the social encounter. Narrative can serve as a "primary expressive form for the mediation of disruption" (Becker 14). Acts of speaking and listening may stimulate other senses and may thus generate multiple forms of knowledge (Hunter 1991). Speech can be assertoric and manifestational; it may both make and communicate claims (Wolterstorff 1995). As a result, just as language has the potential to illuminate, it can likewise obscure, generating multiple levels of discourse that often tangle the locutionary and the illocutionary. I suggest that such processes can be particularly complicated in settings like hospital ICUs, when a person communicates with both verbal and bodily signs that appear inconsistent or stress one over the other, and when tensions reflect a combination of both immediate and mediate expression, leading persons to interact simultaneously on different levels as they attempt to discern meaning (Bernstein 1971). The fact that chaplaincy residents spend significant amounts of time each day working through these processes with patients and others, and then reflecting upon the interactions alone and with their peers, provides a wealth of data for understanding clinical communication processes that warrants close attention.

Toward a Synthesis? Norms, Hermeneutics, and the Apophatic

There are other potential barriers to healing in conjunction with narrative exchange. For example, individuals in a given setting may face a wide range of complex or unfamiliar interpretive pathways when trying to make sense of an experience. Wolterstorff argues that experiences that are narrated demand interpretation, yet it may not be at all obvious whether one should try to make sense of speech at the level of a given passage of text, chapter, book, canon, human authorship, mediated divine authorship, redaction milieu, historical utilization, or modern-day performance (1995). *Contra* Lévy-Bruhl, Mattingly argues that experiences that are pre-narrated or non-narrated lack coherence, are ungraspable, and illusory, such that no amount of narration can entirely overcome the inherently discontinuous nature of the self and its experiences (1998a), thus rendering the possibility of cognitive or emotional unity impossible at the outset. Likewise, motivations for interpretation can also be diffuse and problematic. While the potential for domination is always present in dialectical encounters, the more salient issue may be the extent to which the medium is used to provide labels or assign phenomena to categories and thus exert power over experience. Similarly, acts of revelation can be a form of double violence, in which the drive to overwhelm the other can lead to under-determination and/or dissimulation of the sense of selfhood (Taminiaux 1985). Thus, any intentional act of change that stems from interpretative dialogue can in a sense be viewed as a decision—albeit often an unconscious one—to undermine the self as it currently exists in the hope that a more

substantive, perhaps even self-sufficient, self will emerge. Such a shift may indeed pose significant cultural, emotional, and spiritual risks in a setting as fraught as a research-intensive hospital.

Nonetheless, a number of authors point to forces in narrative that work to counteract these entropic tendencies, both at the intrapersonal and interpersonal levels. Crapanzano argues that there is always some center that holds together a given dialectical encounter; this may be a single entity or may reflect multiple centers that are nested within each other. Opposition can be viewed in terms of this center and may be associated with the self or may, in psychoanalytic terms, be transferred to the other through symbolic and/or indexical means (1992). True, this polysemy may—intentionally or not—lead to false unions through misunderstanding, but the potential for reconciliation is nonetheless present. Bernstein contends that language use is inherently, if often unconsciously, strategic in terms of a person's determination to initiate and sustain contact with specific persons, a reality that residents soon learned to appreciate in their work. Moreover, he contends the idioms that persons use to highlight idiosyncrasy are less unique to the individual than they are pre-loaded into that culture's repertoire of responses, such that either pathway can be seen as a form of cultural continuity. Mattingly argues that gaps of a certain width can be crucial to narratives if they are to pose interest for parties and thus hold the discussants together (1998a), and Becker challenges the traditional Western assumption that chaos, as the opposite of order, is unequivocally bad and must be fought at all costs (1997). Finally, Ulanov and Ulanov contend that one of speech's key functions is to draw mortal and supernatural parties into close proximity. Beyond a certain point, however, they contend that the unitive effect of love overwhelms language and ultimately leads to silence (1982).

These theories hold significant implications for interactions in hospitals and point to a number of variables that shape the type and success of these encounters. At a most basic level, there is often a gap in the degree of willingness to enter into interpretive dialogue; meaning making simply may not be a high priority for one side (Kleinman 1988). Mattingly argues that patient and practitioner are likely to interact extensively only if they see themselves within the same broad story, one that acknowledges therapeutic prerogatives *and* the individual needs and aspirations of the specific persons in the drama (1998a). Wolterstorff likewise cautions that a person may, for example, be disinterested in the knowledge that a person brings to a given encounter, or she may choose simply to remain silent in light of new evidence. In terms of dialogue with the supernatural, he contends that in the Christian tradition, humans cannot demand a reaction from the divine—God is under no obligation to respond (1995).

I argue that these processes of narrative reasoning have implications for the health of afflicted persons and also for their sense of self as a reconciled entity, whether or not they see themselves as

religious and whether or not they discuss religious topics with the chaplain. These conversational enterprises likewise reflect an important struggle for chaplains who work at the interface of what could be called the *little narratives* of patient lives, memories, and experiences, and *grand narratives* presupposed by the teleology of the Christian tradition. Indeed, I shall suggest that the experience of this dialectic is of critical importance to the formation of chaplains' own therapeutic and social outlooks as religious leaders and, by extension, the amount of power that they seek to wield in the cultures of the hospital. I shall also demonstrate that the non-judgmental moral stance, central to the ideology of clinical pastoral education (CPE), complicates processes of meaning making for some residents and can make it difficult for them to situate particular instances of misfortune within a broader cosmological framework by subverting the soteriological underpinnings of their traditions and practical basis for religious outreach to the afflicted. Residents' own narrative reflections of their clinical interactions are particularly helpful in this regard, for they provide a unique perspective within which to understand how trainees wrestle with the possibility of various types of conciliation and communion and conceptualize the relationship between idiographic and nomothetic across various time spans in light of ideologies that tend toward individualism versus communion.

Relevance of This Project

This research contributes to both medical anthropology and the anthropology of religion in a number of ways. First, the training of hospital chaplains has never been studied in depth by an anthropologist, particularly through participant observation, and so it marks an important addition to the hospital ethnography oeuvre in general. This set of research coordinates offers novel insights into the emotional, psychological, and spiritual experiences of hospital chaplains as practitioners and into their enculturation into a unique social environment, one that shapes the parameters of their work and their outlook on disease, injury, and the human body. Particularly as biomedicine expands its cultural and ideological reach globally, I argue that anthropologists of religion who wish to study the formation and work of religious specialists—or for that matter, topics of suffering, death, embodiment, narrative, consciousness, belief, or temporality—must consider the influence of biomedicine on subjects in general and religious practitioners in particular in order to appreciate their epistemological, and hence social, Sitz im Leben. At the same time, as religion continues to be an extremely potent force in local and global social relations, I argue that medical anthropologists who wish to study the body, cognition, gender, power relations, social difference, violence, and a host of other topics related to the phenomena of biomedicine must consider the influence of religion—and

particularly global, organized, Western religious traditions—to appreciate key factors that contribute to disease, injury, affliction, and the promise and constraints of scientific intervention in the name of healing.

Second, the analysis of the hospital space from the perspective of the chaplain provides a new and significant slant on familiar anthropological topics such as therapeutic technologies, individual and corporate suffering, embodiment, and the facilitation of difference. It highlights some of the ways in which religion and chaplains affect social structures and relations in the hospital hierarchy, in terms of epistemological priorities, personalities, and the relative moral authority of clinical practitioners. Similarly, it describes the extent to which the hospital as a collection of cultures provides space for religion in healing activities and utilizes chaplains as culture brokers to mediate between individuals and groups. It also provides new mechanisms for understanding religion as a social phenomenon and the ways in which social relations take on previously unrecognized forms of significance in the clinical setting.

Third, this dissertation discusses in depth the phenomenology of faith, spirituality, and religion within the hospital setting. It analyzes some of the key ways in which biomedical nosologies facilitate and complicate interactions between religious beliefs and somatic bodies. It also discusses ways in which biomedicine and religion frame death as both rupture and continuity and investigates how these overarching perspectives interact in the not-so-everyday lives of patients and family/friends.

A fourth topic, and one that has also curiously received little attention in medical anthropology, is the relationship between religion and meaning making within Western hospital cultures. Pastoral care students who train in the clinical setting find themselves in a unique position of applying theological training in a highly structured ideological environment, one guided by epistemological, diagnostic, therapeutic, and cosmological tenets that, at first pass, seem to stand at cross-purposes to those of world religious traditions. I suggest that it is crucial to understand the forms and degrees of adaptation that occur in both directions in order to facilitate processes of meaning for patients and family and friends, as well as for practitioners, in order to mitigate sentiments of nihilism that accompanied many biomedical interventions.

Fifth, I revisit current anthropological understandings of confessions and confessional technologies in the clinical space through an analysis of the work of chaplains as religious authorities. I highlight ways in which beliefs and sentiments are expressed and negotiated in hospital, particularly with reference to the concept of pastoral non-judgment. I present an alternative framework for the notion of the hospital as a confessional space through analyses of transcripts

between chaplains and patients in which guilt, shame, and self-judgment are prominent activities and suggest that new diagnostic techniques have led to a re-division of labor in clinical judgment between biomedical practitioners and religious specialists.

Sixth, I seek to expand anthropological understandings of hope, risk, and uncertainty in hospitals through reference to pastoral care, in order to show in concrete terms how statistics and theology intermingle to shape senses of the present and the future. More generally, I discuss the stakes involved in the future as a central factor in the work, values, and presuppositions of hospital culture and argue that interpretations of the unknown that neglect the religious dimension necessarily overlook a key component of clinical reasoning for a great many patients and practitioners and thus provide misleading depictions of senses of the possible among the afflicted.

Finally, I utilize this research and participant observation as a long overdue contribution to science and religion debates in the U.S. This fieldwork was conducted during the second Bush administration, a time of intense popular interest in religion throughout many parts of the U.S. While I do not speak at great length about the political or religious climate outside my hospital site in the thesis, I contend nonetheless that the ethnographic analysis of religion in biomedical settings can contribute in important ways to both popular and scholarly religion-science discourses through reflection on specific examples of ways in which actors both embody and interact with both systems in periods of significant existential stress and uncertainty. This is to say that while figures such as Dawkins (2006) and Hitchens (2007) are fascinating thinkers, they're not ethnographers, and as such, I believe that both medical anthropology and the anthropology of religion have important data and insights to add to these discussions.

METHODOLOGY

In this thesis, I do not focus on the lives of patients *per se*, but rather on phenomenological and interpretive experiences of chaplains and their interlocutors within the culture of biomedicine, in light of its assumptions, rituals, norms, standards, power structures, and biases. These interactions offer crucial insights into factors that delimit discourse and guide reflexive processes, and they also determine what information is deemed amenable to analysis, which issues are given particular focus, and how perceptions of power and status impact therapeutic interventions.

My aim is likewise not to critique of biomedicine but to describe a lived, real-world interaction of science and religion. Hence, I wish to avoid armchair debates between theologians and scientists or psychological/lab-based experiments of cognitive behavior in neo-Victorian fashion in

favor of face-to-face encounters and decisions in a unique cultural and ideological setting. By investigating topics of religion and science in a particular affective setting, this study problematizes and expands understandings of the ontologies of both biomedicine and religion in situations in which individuals face, for example, not speculations about geological records or evolutionary hypotheses about genera but rather culturally conditioned approaches to misfortune in living human beings, when emotions and personal investment in a situation are profound. It thus attempts to shed light on biomedicine through the lens of religion and religion through the lens of biomedicine.

This project investigates the therapeutic enculturation of religious specialists in a setting that is both familiar and foreign. It analyzes the experience-reflection dialectic employed by CPE to understand how practice generates particular epistemological and relational outlooks in the course of exposure to disease, injury, pain, death, and uncertainty. Likewise, it investigates the ways in which trainees present themselves and their clinical work to themselves, their supervisor and fellow students, patients and their families and friends, and biomedical staff members. It pays particular attention to how these presentations in turn become objects of inquiry that shape personalities, clinical techniques, and ways of relating to the other. It analyzes the key role of pastoral analysis at multiple levels: residents' own reflections of their patient interactions, their reflections on their own self-formation, peer group reflections on colleagues' work through classroom didactics, and my reflections on these processes and my own position in these undertakings as an anthropologist.

Synopsis of Fieldwork Activities

The residency program is an nine-month, full-time stipended apprenticeship that includes clinical supervision and patient contact. There are usually five or six students in the residency program each year; about half of the students, like me, typically apply to continue for a second year to explore selected topics in greater depth.

The following is a summary of the components of the residency program:

- *Clinical Activities on Inpatient Units*, including daily visits to each unit to meet patients and their family and friends; weekly multi-disciplinary patient discharge rounds; charting of all patient contacts; leadership of a weekly spirituality discussion group on the psychiatric unit; baptisms, commendations, memorial services, and weddings, as needed; and the occasional facilitation of staff support groups
- *Other Clinical Duties*, including afternoon and overnight on-call duty shifts on rotation, coverage of all trauma alerts and responses (i.e., contact with family members, liaison with

medical and other hospital staff and police, family escort, and pastoral support of patients and others)

- *Pastoral Care Department Duties*, including daily morning rounds; verbatim presentations to the peer group and supervisor for analysis; leadership at daily hospital chapel services; attendance at various didactic and training seminars; weekly, hour-long individual supervision sessions with the director of pastoral care, focusing on the analysis of a clinical interaction, patient care statistics, and written personal reflections on topics of theological, interpersonal, psychological, and practical relevance to the training
- *Various Non-Clinical Duties*, including organization and support of hospital-wide programs (including the Employee Diversity Committee, Black History Month, yearly Cancer Center memorial service, National Pastoral Care Week, and Kosher and Halal meals) and hospital-wide orientation and compliance with codes and standards established for all health system employees

The philosophy of clinical pastoral education focuses on skill development and personal growth. In particular, it emphasizes the ability to

- *Hone interpersonal pastoral skills within the hospital environment*—to become proficient at initiating helping relationships, recognize relational dynamics within group contexts, listen and reflect empathetically, and manage conflict resolution and crisis situations
- *Develop a clear understanding of the ways in which religion and spirituality are manifest and can be utilized positively in the hospital context*—to be able to articulate the central theological tenets that inform the student's pastoral ministry and to provide pastoral ministry to a wide variety of people without imposing one's own perspectives
- *Refine professional workplace skills*—to manage ministerial and administrative functions in terms of accountability, productivity, and clear/accurate clinical communication and to establish collaboration and dialogue with peers, authorities and other professionals

Data Analysis

Data include a combination of pastoral conversations with a variety of persons and reflection on these activities, both individually and with the peer group of residents and the program director. Key considerations are the ways in which dialogues are generated, under what conditions, and by whom, and particularly the ways in which conversations do or do not represent the dialectical processes described in the theoretical section above. In particular, I discuss ways in which chaplains mirror and differ from the descriptions of mediators listed above—the processes by which they come

into contact with various parties, take initiative and respond to requests for assistance bridging gaps, and utilize various resources (linguistic, ritual, symbolic, etc.) to attempt to realize heightened consciousness and social collegiality as aspects of broader therapeutic processes.

This thesis contains no interviews, structured or otherwise. Instead, it utilizes three types of narrative materials:

1. *Anonymous, de-identified "verbatim" accounts of pastoral conversations*. These reports represent the chaplain's recollection of the conversation as it occurred—they are not taped, and notes are not taken during the conversation—and are selected primarily to discuss exchanges that seemed to the resident challenging, frustrating, or unsuccessful and in need of further reflection. For each verbatim, I consider the account itself; the historical, socio-economic, psychological, and spiritual attributes that the various parties (patient, family member, friend, staff, and chaplain) bring to an encounter; the comments that are generated in the discussion of the verbatim; and my own reflections on each case as a whole. At each level, I shall consider broadly the ways in which
    (a) Self and other are made manifest, maintained, and undermined
    (b) Individuals express and reject solidarity, both with themselves and with others
    (c) The chaplain attempts to re-frame impressions and suggest options that can open up beneficial possibilities for participants in a given encounter
    (d) Reactions to religious discourse and imagery
    (e) The extent to which dialogue as a unique form of dialectical exchange can serve to illuminate issues of hope, rationality, and phenomenology discussed above

    In my analysis of these various topics, I pay particular attention to evidence of emplotment and temporal editing; issues of trust, familiarity, and candidness; interruptions and other breaks in the dialogue, such as silence; sentiments of longing and desire that suggest a possible trajectory of relationships; (seemingly) incommensurate beliefs and assumptions; perceived and real power differentials between speakers, e.g., through differences in formality of speech, age and education, and length and tempo of responses to questions; and scriptural quotations and other forms of indirect or borrowed narrative.
2. *Reflection papers* are based on weekly meetings alone with the supervisor as well as classroom sessions with the cohort (see Chapter 3).
3. *A collection of informal conversations and observations* with peers and others, primarily on my own units and secondarily on units to which I am paged during on-call rotations. This diary includes anecdotes, personal frustrations and successes, emotional reactions to events,

notes from various speakers and meetings, and insights into the nature of healing in the hospital environment. Here in particular I am interested in informal ways in which chaplains enter into relationships and difficult situations to attempt to give various actors a greater sense of options, peace, and clarity into the practical, emotional, and spiritual components of the treatment process.

Two points need mention here. First, both as CPE student and as ethnographer, I engage in reflexive analysis of my place in these interactions. It is both a significant requirement of the residency and a widely expected of anthropological fieldwork today. My subjectivity, as well as that of my fellow residents, reflected an absolutely crucial component of my data collection, and it would be impossible to understand the social formation of these practitioners without their gazes at themselves, material which comprises the bulk of Chapters 4 and 5. These reflections are intensely personal, and I ask that the reader approach both the words themselves and my attempts at analysis with this in mind.

Second, I note some common themes and dilemmas in my general discussion in Chapter 7 but elected not to code the documents to attempt to find statistical patterns or frequencies of topics. This is something that I may do at a later date, but for this thesis, I decided to focus on each case as a unique, separate encounter because this is the method that CPE uses. That is, the program did not ask students to compare verbatims or compile all of the narratives together at the end of a quarter to examine trends. One could certainly debate the merits of such an activity, but for now, I attempt to keep my analysis as close as possible to the training activities that residents did.

I am likewise interested in the phenomenological experience of the residency and the consequences it has for how trainees come to view themselves and relate to others through the encounter with affliction. In particular, I investigate how experiencing such phenomena leads to certain mindsets and affects that then contribute to subsequent pastoral interactions.

BACKGROUND ON RESEARCH SITE

This project considers the training and work of hospital chaplains at a large, inner-city university teaching hospital in the eastern United States. It serves patients from the metropolitan area and is a referral hospital for the region, state, and the U.S.

Religious services have been held regularly at the hospital since the 19th century. A chapel was constructed after World War II, and a part-time chaplain was hired in the 1970s to coordinate pastoral services. Growth in the 1980s and 1990s led to the establishment of full-time chaplain

positions and a variety of chaplain training programs. Education is offered at beginning (internship) and advanced (residency) levels to lay and ordained individuals with backgrounds in theology and a sense of call to serve patients, their family and friends, and those who care for them.

I chose this site for a number of reasons. First, the region has a long history of religious and medical innovations and continues to be a social setting influenced by these two cultural systems. Second, the hospital itself has in recent years been interested in research at the interface of religion and medicine, and my supervisor expressed eager support for my project during my interview for the residency. Third, the social and cultural diversity present in the clinical setting gave me the opportunity to explore a solid range of religious, biomedical, and ideological phenomena related to my research questions.

ETHICS APPROVAL

I maintained regular dialogue with my pastoral care supervisor about the scope of this research and received enthusiastic support for the project. I applied for and received institutional approval from the hospital to utilize the patient verbatims for this project, subject to guidelines established by national HIPAA[2] policies regarding the use of patient information for research in U.S. hospitals, so as to protect confidentiality and maintain anonymity. The verbatim reports are a standard component of chaplaincy training at this and other accredited centers throughout North America and, from an ethical standpoint, are equivalent to patient cases presented by physicians and medical students to their peers for training and research purposes. They are not interviews that require consent from patients or other care recipients; they are unrecorded, unstructured clinical conversations with persons that reflect the chaplain's *recollection* of the encounter. Patients are informed upon admission that the nature of the teaching hospital implies that the care they receive may be documented for educational purposes and that every reasonable effort will be made to disguise their identity for studies and projects that involve a broader audience.

I received similar ethics clearance for this project from McGill University.

There are several reasons why I chose to undertake chaplaincy training as my route to data collection for this thesis. First and foremost, I was genuinely interested in this work as an individual and wanted to pursue it in greater depth for personal reasons. Second, it would have been impossible to do this research exclusively as a wall fly, for it would have been entirely unethical and

[2] The Health Insurance Portability and Accountability Act, administered by the Office for Civil Rights of the federal Department of Health and Human Services, is a set of national standards designed to protect the privacy of personal health information (http://www.hhs.gov/ocr/hipaa/).

inappropriate to attempt to sit in on such personal, vulnerable meetings and take notes. Third, I believe that such an outside presence would have generated distorted data and could quite likely have been contraindicated from a clinical standpoint. Participant-observation was thus the best, and only, method that would work for this type of study of immersion, proximity, and trust, especially under such short time spans and under such dramatic situations. Fourth, undertaking the training allowed me to understand the experience of training from the inside and to reflect firsthand upon struggle with such topics as uncertainty, emotional exhaustion, personal relevance, and theological ambivalence.

All proper names in this dissertation are pseudonyms.

Some Limits to This Research

There are a few limits to this study. First, in long-standing anthropological tradition, I shall be participating in as well as observing my research topic, meaning that my interests as a researcher may bias some of my work as a clinician, and vice-versa. This was likewise a potential problem for my peers, who were aware of my dual status as a chaplain resident and doctoral student. Second, the vast majority of pastoral interactions are relatively brief in nature (< 20 minutes) and involve only a single meeting with most persons; while this is the norm for the profession, it does not allow the sort of depth that is often desirable for more traditional ethnographic encounters. Finally, on a conceptual level, the dialectic as a paradigm for the analysis of mediation may not be a conscious component of chaplains' understandings of their duties and hence may introduce a somewhat artificial framework into the research.

Brief Outline of the Dissertation

Chapter 2 outlines signal events in the historical relationship between religion and medicine in hospitals in the New World, focusing on the period from Jamestown until the end of the 20th century. It highlights political relationships between hospitals and organized religions, diagnostic and therapeutic practices, ideological shifts and technological advances, government oversight, comparative views of patienthood, evolving concepts of morality and social worth, debates about causality, and challenges to various forms of clinical authority. It also analyzes the roles of religious specialists within the hospital setting, from early physician-preachers in colonial New England to the consolidation of clinical pastoral education (CPE) training agencies in the 1960s.

Chapter 3 summarizes the structure and pedagogy of CPE. It outlines its educational mission, application and selection processes, mechanisms of supervision, clinical and classroom responsibilities of students, ideological tenets, and modes of assessment. Particularly important here for the dissertation as a whole is the description of the verbatim instrument as a device for analysis in both the training program and for ethnographic purposes.

Chapter 4 begins the first of three ethnographic chapters. Here, I introduce reflections by residents about various aspects of their experience in the program, in particular the transition from parish ministry to hospital chaplaincy and their initial reactions to the sights, sounds, and smells of the hospital culture. Chapter 5 builds upon this information with discussions about additional aspects of clinical training, in particular processes of reflection and the presentation of the self before the peer cohort as methods of both professional formation and clinical skill development. I also introduce dilemmas of power and discuss chaplains' perceptions of biomedical practice in light of their own clinical interventions. I discuss briefly issues of self-care and life outside the hospital at the end of this segment.

Chapter 6 is a meta-chapter consisting of four parts. I selected twelve case studies of chaplain-patient interactions from the data that I collected over the two years of the program and organized them according to four types of hospital settings: the trauma bay; intensive care units; inpatient psychiatry; and "step-down" units, a catch-all grouping that I devised to cover floors and wards that do not fit into the other three categories. Each "verbatim" study presents a narrative account of the clinical interaction, followed by the chaplain's own reflections about the meeting and concludes with commentary from peers to the work.

Chapter 7 is the main analytical segment of the thesis. Here, I return to questions that I raised in this introduction in light of my data and draw conclusions based on the goodness of fit between my fieldwork and corresponding theories about such topics as narrative, hope, phenomenology, rationality, and religious specialists in the ethnographic literature.

Chapter 8 ties up a few residual issues and presents a framework for future research.

2

HISTORICAL BACKGROUND:
RELIGION, MEDICINE, AND THE U.S. HOSPITAL

> The encounter with a chaplain can be profound and spiritual, and sometimes religious in a traditional way. More and more, though, ministering … is likely to be nonsectarian, or even secular.
>
> — *New York Times* (29 October 2008)

INTRODUCTION

This chapter charts the relationship between religion, the human body, and the enterprises of healing in hospitals in the United States from the earliest settlements through the end of the twentieth century. It explores the ways in which people of various walks of life, primarily those of the Christian traditions, have conceptualized and responded to illness and suffering in light of their understandings of God, cosmology, and theological anthropology. It presents accounts of bodily misfortune from the perspectives of the patients, families and communities, physicians, and clergy of the day who experienced the illnesses firsthand.

Central to this discussion is the claim that matters of religion, faith, and spirituality have always been present in the treatment of inpatients. Their manifestation and appropriation changed dramatically over the centuries, primarily the result of the following six factors:

1. Shifts in hospital administration and control over inpatient care
2. Scientific advances in diagnostic equipment and therapeutic regimes
3. Challenges from competing practitioners
4. New theologies and new religious-social movements
5. Specialization
6. The development and popularization of psychiatry

I consider each of these forces en route from the first almshouses of colonial New England to the multi-specialty research hospitals that dominated the landscape of American medicine at the turn of

the millennium, noting in particular their formative effects on the identities and practices of physicians and hospital chaplains.

THE 16TH AND 17TH CENTURIES: DIVINE COVENANTS AND MORAL COMMUNITIES

It is easy to get the impression that every word and deed in 17th century North America was somehow connected to religion. After all, the missionary impulse served as a strong rationale for exploration, conquest, and settlement, and the search for greater religious freedom likewise guided the actions of many prior to the turn of the century. Political affairs, climactic events, and bodily misfortunes were all interpreted through the lens of Christian theology, and attempts to secure safety and prosperity likewise appealed to the God of the Old and New Testaments. Christian ethical exhortations framed interactions with neighbor and stranger, in sickness and in health.

While it is clear that Christianity had a pervasive effect on the lives of Spanish missionaries, Native Americans, and northern European immigrants in the years leading up to 1700, it is equally clear that individuals and communities held a wide variety of postures to their faith and to their God, ranging from strict piety to strict pragmatism to (occasionally) supreme indifference. Whatever the perspective of the individual, however, he recognized that organized religion and the watchful eye of the local minister were social phenomena that he could not conveniently avoid.

Religious Considerations

The mid-1600s were a complex time for European settlers in the New World. Religion was an enormously potent force, both in terms of motivations that brought families across the Atlantic and in terms of the ways in which these actors made sense of their new surroundings. This is not to suggest, however, that expressions of piety were by any means monolithic across society or, for that matter, internally consistent within a given household. On the one hand, Catholic and Protestant alike viewed North America as a breeding ground for conversion, and leaders such as Winthrop viewed the new land as a "city upon a hill" where "ministers would preach every Sunday and all colonists would be required to attend," where "laws banned idleness, drunkenness, gambling, and fancy dress" (Butler 2003:53).

On the other hand, expressions of doubt, indifference, and prejudice were commonplace. Open atheism was uncommon, yet a fair number of people expressed not only criticism of specific groups but also doubt about religion altogether. English anti-Catholicism quickly destroyed public Catholic worship in the colonies, and little Protestant worship supplanted the disappearing Catholic services, particularly in the Chesapeake region, until the 1690s, and as of the 1680s, the Virginia and

Maryland colonies were remarkably indifferent in matters of religion. Even within the supposedly uniform and disciplined Puritan-dominated regions, neighbors disagreed with each other, ignored new settlers, and lost their own religious intensity while becoming increasingly intolerant. As early as 1649 in New England, the religious leadership often failed to sustain adherents, churches fell into disuse, and worship became so uncommon that many colonists observed it only occasionally.

Other ideologies and traditions added to what was, for many, an unsettling and overwhelming spiritual journey. "The survival and surprising strength of magical practices further complicated the British American religious landscape after 1690," argues Butler. "Historians formerly thought that most magical beliefs and practices died out in the colonies after the 1692 Salem witch trials," but this is no longer thought to be the case (2003:91). Part of this heterodoxy stemmed from old European customs, but some of it also continued as a result of exposure to Native American and African traditions. For instance, while huge numbers of Native American religious simply disappeared, because so many of the cultures and societies that sustained them became extinct, the tribes that did survive often change, sometimes adopting and adapting to Christianity in a syncretic fashion, "taking on new elements that also honored traditional concerns" (2003:100). Likewise, while no African religions survived whole in the British colonies of North America, remnants would survive in overt and covert fashions well beyond the Civil War.

What, then, did this flurry of religious sentiments mean in terms of colonial senses of identity, solidarity, and culture? Stated plainly, "many colonists enjoyed the religious freedom that had emerged in America. But not everyone grappled easily with the confusion it produced" (Butler 2003:95). Likewise, slow but steady increases in ethnic and economic diversity undermined any easy sense of uniformity or loyalty to any particular cause. There was never a single, overarching cosmology that organized colonial ways of being in the world and relating to other people and the natural environment. Individuals had a variety of mechanisms for coping and surviving that were often idiosyncratic and varied with the exigencies of the locale, often rendering elusive clear senses of community and unity.

Epistemology and Rationality: European Antecedents and Colonial Advances

If one's own transgressions could cause, or at least engender, bodily misfortune, then it was crucial to reflect upon one's actions to attempt to determine the cause of the problem and, if possible, make amends so as to relieve the suffering. This is not, however, to say that this process was practiced everywhere with the same rigor or with the same understanding of Divine immanence. Even those who did ascribe a strong causal link between human sin and supernatural wrath recognized that such a theology could have its limitations. This was particularly the case in colonial

New England when the afflicted, after careful introspection, could find "no particular sinful cause to justify God's wrath," in which case "the Puritan was to bear humbly both his or her own illnesses and those of loved ones," for it was believed that God often used suffering for spiritual development, and the willingness with which an individual accepted suffering could be seen as a measure of his or her status as a child of God (Watson 1991:18).

At the same time, clergy and laity alike recognized that witches and demons "in league with Satan could be the progenitors of disease … Satan's ability to engender disease was bound not only by God's will, but by the laws of nature," for many Puritans "understood the etiology of disease as a complex interaction of primary and secondary causes: God was the first cause, and Satan operated under a 'commission' from Him" (Watson 1991:23). The laity could also be active participants in the diagnostic process; in one case of bewitchment, "lay men and women often relied upon ancient folk tests to uncover the witch, including the baking of urine cakes and the scalding of the sick child's urine" (1991:27). Likewise, "the use of countermagic by both 'cunning folk' and church members was by no means unusual in seventeenth-century New England" (1991:30).

In fact, the decree of 1691 that "'forever hereafter there shall be a Liberty of Conscience in the Worship of God' in the Provinces of New England" (Watson 1991:60) may have been as effective as any scientific discovery in shifting understandings of illness and etiology prior to 1700. Theological diversity undermined the covenantal worldview that had long guided colonial understandings of their relationship to God, to their own bodies, and to each other. True, many still saw in misfortune the direct hand of God, yet the social implications of such sad events presented an epistemology that largely placed corporate sin in abeyance until the rise of the cholera epidemics in the 19th century.

Gradually—though by no means completely—the growing identification of chemistry with rationality, "separate from the mystical, religious doctrines of the earlier chemical reformers, and separate from the political and social aims of the Puritan iatrochemists of England, the school of iatrochemistry began to lose its appeal for the majority of the minister-physicians of New England" (Watson 1991:118) and for many under their charge. Likewise, the rise of deism and Newtonian physics further undermined the appeal of explanations based on direct Divine intervention in favor of those based on natural law.

"Hospitals" Prior to 1700: A Brief Glance

It is within this context that we turn our attention to healing. While many in the seventeenth century continued to see the chemical arts through the lens of alchemy, steeped in deeply religious significance, "Galenism was not supplanted by the new chemical healing; rather, the mystical,

religious aspects of iatrochemistry were separated form the practical side, and chemical medicines were retained alongside Galenic techniques and remedies" (Watson 1991:6). Houses for the sick likewise bore the stamp of European thought:

> Medieval hospitals were conducted by religious or knightly orders and had a strong communal character; those who worked there were bound together in a common identity and belonged to a common household. "Even when hospitals were taken over from the ecclesiastical authorities by municipalities in the later Middle Ages," writes George Rosen, "they were not secularized. Essentially, the hospital was a religious house in which the nursing personnel had united as a vocational community under a religious rule." In a different way, the almshouses of colonial America, which were the first institutions here to care for the sick, retained a communal character …. Early hospitals had a fundamentally paternalistic social structure; their patients entered at the sufferance of their benefactors and had the moral status of children. [Starr 1982:149]

A Primer on Christian Ministry to the Afflicted

If there is a single theme that runs throughout the history of American hospital medicine and chaplaincy, it is the sense of moral obligation to intervene on behalf of the sick, grounded in a profound sense of integrity needed for such a task (Warner 1997). We can trace such obligations of the Christian believer back to the Apostles, yet we also realize that there have long been divisions of labor within the Christian community that led some to specialize in outreach to the afflicted in mind and body.

Scholars have debated the extent to which the various roles implied distinct persons for distinct roles, or whether a single person might exercise a variety of roles, simultaneously or over the course of his ministry. This issue is particularly salient when we consider ministry to the ill. Prophets, for example, frequently worked at the margins of institutional structures, though some have argued that they held a liturgical role as well (Knox 1956). Teachers and preachers were most active on church grounds, leaving a good deal of the work in the community to other believers. Such work in the administrative and pastoral work of the churches was, particularly in the primitive church, left to women.

While deacons in the Patristic era were frequently viewed as mediators between the bishop and the laymen who often held primary responsibility for the sick and the dying, it is important to

recognize the status of non-liturgical ministrants such as the virgin, the sub-deacon, and the healer (exorcist) frequently had primary contact with the afflicted. Clement distinguished between what he called the "meliorative" and "ministrative" components of ministry; presbyters represented the former as "physicians for the body and philosophers for the soul," whereas the "ministrative deacons corresponded to children in their duties toward parents and to subjects toward rulers" (Knox 1956:43).

Several other influential views of the particular roles and responsibilities toward the sick emerged in the pre-Medieval period. By Chalcedon, bishops had acquired the right of supervision over monasteries, poorhouses, and hospitals in their dioceses, and visitors of the sick gradually emerged as a special class of servants of the church (Knox 1956).

Several centuries later, Luther argued that "every believer in the gospel is a priest, i.e., a *mediator* and intercessor between God and men. He must transmit to others the power of the gospel that has laid hold of him" (Pauck 1956:112, emphasis added), a position that was not entirely inconsistent with the various types of outreach to the sick in the centuries preceding the Reformation. Despite what Pauck considers the far more this-worldly emphasis of Protestant clergy within the immediate social setting, illnesses within the home appear to have been an issue that brought intervention, usually in the form of a pastoral visit, only when requested by the family of the afflicted. In Calvin's Geneva, however, clergy in theory visited the sick in hospitals on a regular basis.

In the Puritan age in England, "priests" who spent the bulk of their energy at the altar were now "ministers," with pastoral care and preaching integrated into their responsibilities (Hudson 1956:180). Pastoral visitation "included visiting the sick, 'helping them prepare either for a fruitful life or a happy death,' but it also had as its objective becoming 'acquainted with the state of all our people as fully as we (ministers) can … for if we know not the temperament or disease, we are likely to prove but unsuccessful physicians'" (1956:194). Around this time, there was an intensification of the role of pastor as counselor, which

> was everywhere regarded as one of the most important as well as the most difficult of all pastoral duties. The age, of course, was one which had intensified personal problems and the changing pattern of society created many new situations in which people felt the need of guidance in making moral decisions. The ministers, in turn, were acutely aware of their responsibility to help those who were beset by perplexity, anxiety, and indecision. [Hudson 1956:196]

I have raised these issues at some length because they crystallize for us a number of important considerations regarding the scope, ownership, and theology of Christianity to affliction–considerations which re-emerged with the development of hospitals and health care in 17th century North America. First, we note that there has never been a single ministry of health within the church. Individuals of varying degrees of education and ecclesiastical approval have engaged in outreach to the poor of health, from what were essentially lay visitors and deacons, who brought companionship and perhaps practical assistance to the ill in their own home, to spirituals, who offered shelter and sustenance to the sick, to primarily parish-based clergy, who might have visited the ailing in their homes and provided a more spiritual sense of health through word and sacrament, to the occasional healer or exorcist, who appealed more directly to supernatural forces in their efforts to cure.

Second, we see that with this proliferation of roles, there is also an implicit–and sometimes very explicit–broadening of Christianity's understanding of what exactly constituted illness. Most often, there was a somatic component that required physical intervention of some sort, but there was also recognition that sickness was intimately related to a person's spiritual well-being. Adherents thus needed a steady diet of instruction and sacramental assistance from the priest in order to remain healthy, thus emphasizing the church's preventative, as well as curative, responsibilities to its members.

A corollary of this distinction between the body and the spirit or soul is that the church in Europe prior to the 1600s came increasingly to have what could be considered inpatient and outpatient responsibilities. That is, priests were primarily responsible for reaching out to the healthy (or not-yet-sick) in body but ostensibly sick in soul, while the other members–deacons, monastics, and others less directly responsible for the oversight of a parish and/or diocese–were more concerned with individuals after they became bodily sick.

THE 18TH CENTURY: HOSPITALS AND ALMSHOUSES IN AN AGE OF RELIGIOUS AND SCIENTIFIC DIVERSITY

If 17th century North America was modest in terms of its religious complexity, the 18th century was unwieldy. Waves of new immigrants, particularly from central Europe, brought new theological and philosophical outlooks and added nuances to those already established in the colonies. Such diversity held important implications for broader senses of community and—particularly in the years following the Revolutionary War—for the maintenance of identity in the fledgling country.

Healing likewise became a more multifaceted phenomenon. It is here that we witness the construction of the first hospitals and the spread of almshouses as both sites for rehabilitation and symbols of social inequality. As Rosenberg suggests with his title, this era became one in which the new society contended with the stranger in its midst, where the care of the afflicted came to be seen more in terms of social policy and moral outreach than divine retribution.

Religion, Theology, and Regionalism: Wither Orthodoxy?

Despite what must have seemed at times like religious fiefdoms, each with its own ethnic culture and theological interpretations, there emerged a number of pan-colonial religious movements that drew the attention, allegiance, and often ire, of individuals from New England to the Carolinas. 18th century revivalism, for example, typically stressed a "new birth" in Christ and encouraged believers to purify their lives and rejuvenate their congregations (Butler 2003:121-2). "Acknowledge your depravity and seek refuge in Christ!" would have been an apt rallying cry for such movements. Critics found them crude, overly emotional, and anti-intellectual, whereas supporters viewed revivals as unparalleled opportunities to refresh denominations that were expanding numerically yet lacked inner conviction and fervor.

Thus, while denominational institutions in the colonies "emphasized effective leadership and thus made an important contribution to the ultimate rise of democracy in America" (Butler 2003:124), the democracy that was beginning to emerge left space for religious dissent and non-denominational movements to shape the theology and application of religion in various spheres of communal life. Importantly, though, the popularity of millennial thinking that emerged around the 1770s frequently linked God with America's cause and promoted a positive, expansionist view of the nation that increasingly emphasized the young nation's sense of responsibility, particularly to the weak and marginalized.

Epistemology and Rationality in Light of the Above

Many physicians and clergymen recognized that Western medicine offered little curative potential in the 18th century, and some were convinced that the hospital in particular could give the worthy poor little beyond palliation. That said, how did practitioners understand causality and intervention in this new century? What was the balance between an activist, interventionist faith and one that favored limited treatment and left healing to the hand of God? What were the responsibilities of the patient for her own welfare?

The predominant model during this period was one of diagnostically active and therapeutically passive physicians, diagnostically and therapeutically active ministers, and patients who were expected to contribute actively to healing through sin logs and moral/character reform.

Prior to such diagnostic aids as the stethoscope and x-ray, the account of the patient's own sensations held significant sway in the epistemological process within the hospital and, with the doctor's own senses, comprised the main data-gathering devices of medicine prior to the 1800s (Rosenberg 1987a). Likewise, practical experience and the sound, rational judgment of the physician were considered at least as reliable as theoretical knowledge for many, even as a growing cohort of ambitious young doctors turned to training in Europe after the Revolutionary War and were exposed to ideas such as French skeptical empiricism (Warner 1997).

Yet the place of rationality within the hospital defies easy categorization for the clergyman as well as the physician, for what was at stake was larger than the issue of the success or failure of one therapeutic regimen over another: it struck at the heart of the concept of a divinely ordered universe and the extent to which humans could measure, predict, and *control* the processes of the human body directly, as opposed to relegating the ebb and flow of a given individual's well being to the realm of prayer and the caprice of God.

Doctors and Doctoring

Just as there was religious diversity in the 18th century, so too was there a range of scientific advances (and practitioners) with which communities would have to contend. Earlier in England, John Wesley railed against what he perceived to be the elitist and unnecessarily complicated theories of physicians, advocating instead an ideology of healing that stressed "personal autonomy and self-direction." Many in America championed such an outlook, particularly after the Revolutionary War, as lay healers "saw the medical profession as a bulwark of privilege, and they adopted a position hostile to both its therapeutic tenets and its social aspirations" (Starr 1982:47).

It is likewise important to recognize that in colonial America, while the Christian religion was a largely organized and structured enterprise, healing practices were not. "All manner of people took up medicine in the colonies and appropriated the title of doctor," Starr explains, for "the physician's role did not exist in a completely separate and independent form. In the seventeenth and eighteenth centuries, it was common for the clergy to combine medical and religious services to their congregations…[and] men and women of lower rank also served as doctors" (1982:39). Such trends continued until the end of the century, though the practice of medicine increasingly became separated from the parish work of the clergy. True, "pastoral practice continued into the nineteenth century," but ministers by and large left the mechanics of bodily intervention to others (1982:40).

Communal Christianity and Moral Outreach: The Colonial Hospital

It is within this context of often-bewildering religious diversity that we turn to the question of clinical healing for the afflicted. Consider the following quotation:

> For centuries, Christian charity had inspired the clergy and wealthy believers to take care of the poor, disabled, and ill. From the sixteenth century onwards, poor relief was expanded. Town councils and societies of citizens established communal alms-houses as a kind of institutional support. From the eighteenth century, groups of "enlightened" middle-class individuals en-gaged in philanthropic support. They were convinced that a large part of the working class suffered from serious social handicaps and would not be able to gain a solid position in society. As the century progressed, relief was increasingly combined with attempts to "educate" and civilize." Support was individualized which meant that a poor individual or family was first scrutinized in order to determine whether they were decent enough to receive help and whether they would be able to support themselves in the future. [Jansz 2004:25-6]

Medicine was practiced in a variety of locations in the 17th century, most frequently in the home, and the healers were as often members of an individual's own family as a medical practitioner. With the exception of the occasional pest-house—which served as much to contain as to provide—the early American hospital, as an institution focused on healing, was characterized primarily by the socioeconomic and moral status of its clientele (Rosenberg 1987a).

Despite considerable rancor about the worthiness and inclusion/exclusion of particular individuals for hospital treatment, the colonial hospital was fundamentally a social institution. A *Christian* social institution. While from a technological/scientific standpoint, there was little that separated the early hospital from other centers of healing, yet the hospital was viewed by many in positive terms as a shelter for those in need of medical assistance. The majority of patients were victims of accident or insanity, and as such they were counted among the "worthy poor," respectable Americans who did not bring their unfortunate fate upon themselves and who thus deserved the charity of their fellow (Protestant) believers (Rosenberg 1987a:18-9). Hospitals could be seen as a source of civic pride, and by providing workplaces for aspiring physicians, they served a number of practical functions as well.

Contrast this rather romantic image with that of the almshouse. In addition to inferior accoutrements and coarser workers, almshouses typically implied a person's abandonment by family, employers, and even church congregations (if he attended). Such institutions frequently also housed Roman Catholics, ethnic minorities and recent immigrants, and others with heterodox religious

beliefs and practices. Crucially, though, almshouses functioned as *de facto* penitentiaries for persons who were afflicted through their own immorality or imprudence, for while "age and disease might on occasion strike even the virtuous…the prostitutes and alcoholics who cluttered the almshouse hospital provided living proof that God chastised sin immediately and inevitably through the body's own mechanisms" in the 1700s (Rosenberg 1987a:17). Inmates might have taken comfort that the contagiously ill would have been sent to a pest-house (Starr 1982), yet almshouse inpatients realized that their lot was as much a sentence as a verdict.

It is nonetheless important to observe a number of commonalities to these two sites of treatment. In part due to the therapeutic limitations of medicine during this period, the hospital and almshouse were both viewed as reform schools. Rosenberg explains that moral encouragement, if not outright indoctrination, was a key element of the healing experience. What better opportunity for spiritual growth and maturation than during a period of suffering and uncertainty? With the superintendent assuming personal responsibility for the physical and moral condition of those under his charge, inmates often experienced charity that was both humiliating and highly regimented (1987a).

Mental hygiene, meanwhile, was soon recognized as a distinct form of medical need in the colonies. While it is true that in the early 1700s, "the mentally ill, along with other classes of dependents, were treated as a local responsibility, primarily within their own or other families" (Starr 1982:72), the growth of cities brought with them an increasing number of those deemed insane, and hence the need for specialized centers away from city centers, both to provide a safe haven for those in need and to maintain order within the downtown cores.

Organized religion was no stranger to the custodial care of such persons. At least as far back as 1409, the Catholic Church oversaw the asylum in Valencia, and religious exercises were usually a component of the inmate's experience—though it is likely that these were primarily ritualistic in orientation. By the late 1700s and early 1800s, researchers in Europe and America—including Benjamin Rush in Philadelphia—began to focus on the possibility of biological underpinnings of madness, yet even here, treatment focused on social discipline and "re-instilling morality in the mental life of the patients." Importantly, though, Abma suggests that such treatment centered on the moral authority of the physician, whereas other practitioners, such as clergy, performed their work outside asylums (2004:96-7). Though the reasons for the decline of moral treatment are too complex to permit discussion here, it is interesting to recall that such care was highly dictatorial and suggestive, a top-down approach that appealed primarily to the social status of medicine for its credibility.

Enter the Minister

It is difficult to get a clear picture of the work of Protestant religious leaders within American hospitals in the 1700s, though we can draw some preliminary conclusions. First, in terms of trained officials in the clinical space, Watson argues that most colonies lacked the financial resources to secure a trained physician. Second, since the local minister was often the most educated member of the community, and because they "served as [God's] special arbitrators, helping both to heal the sick and to avert disease in their communities" (1991:3), villagers often turned to them for assistance in times of individual and corporate misfortune.

One of the key distinctions between medical and ministerial approaches to illness and misfortune was their differing perspective on experience as a gauge for possible futures. Physicians tended to intervene in the present based on educated guesses about the likelihood of future outcomes, guesses that were formulated through analysis of past medical outcomes and always with the understanding that the death of the body represented the outer limit of their ability to intervene on behalf of the patient. Further, willingness to prognosticate was "reinforced when there [was] an *effective* therapy for a disease, because effective therapy further narrows the range of possible outcomes. Once a diagnosis is made and effective therapy initiated, the clinical course of a disease [was] often presumed to be relatively fixed" (Christakis 1999:4).

Clergy, meanwhile, exhibited a variety of different postures toward affliction and death, and these stances were typically the result of their understandings of soteriology and theological anthropology. Particularly in the early 1700s, ministers were keenly concerned with the individual's state of sin as reflected in the person's bodily condition as a presage of judgment and damnation—events that the minister hoped to be able to help the afflicted avoid, and for which the cleric felt keenly responsible.

That said, clerics during this period frequently offered their own physical interventions to counter the effects of sickness. Many relied on both Galenic-inspired herbals propounded by Culpeper and Salmon and such "occult concept as the role of astrology in humoral medicine...into both remedy collections and medical books" well into the 18th century (Christakis 1999:88). Indeed, even Calvin believed that "physicians used their knowledge of the heavens properly when they selected suitable times for bleeding their patients or administering medicines, because, he claimed, there is 'quelque covenance' between the luminaries and our bodies," though with Luther he "strongly opposed judicial or divinatory astrology as diabolical superstition" (1999:90).

Much of their work of clergy in the hospitals and almshouses of the 1700s thus focused on the status of the individual patient and the health of her soul. With the slow but increasing

pathologization of behavior, and particularly with new mental health concepts, the questions of what was normal and what was moral became increasingly hazy. For ministers, the growth of medical scientific techniques for observation and manipulation of the patient by a burgeoning number and type of interventionists, along with the growing number of beds assigned to each of them, made it more and more difficult to exercise continuous oversight of each patient.

How were clergy received within the hospital? While there are a number of patient accounts have been found that detail their hospital experiences in antebellum America, it has been extremely difficult to discern from these documents the specific effect of Protestant ministers on their stays. We know, for example, that American medicine was influenced by the "moral treatment" of Pinel and France and Tuke in England, where physicians (as opposed to clergy) stood at the vanguard of morality-based medicine (Starr 1982:73). At the same time, patients sometimes developed black markets in whisky and tobacco or resorted to suicide as forms of resistance to the near-totalitarian lifestyle under which they tried to recover (Rosenberg 1987a). However much the mores of the institution were inspired by Christian theology, it is unclear the extent to which individual ministers supported or deviated from these customs.

Several elements of Protestant-inspired care can give us clues to this mystery, however. In New York, for example, Catholic priests were routinely barred from visiting patients, and the anti-Romanism of the Great Awakening helped further the push for Catholics and Jews, as well as African-Americans, to found their own hospitals, in part so that their own would not be forced to endure the proselytizations seen in many white Protestant centers but could instead receive spiritual nourishment according to their own tradition (Rosenberg 1987a).

THE 19TH CENTURY: THE MATURATION OF THE AMERICAN HOSPITAL

In many respects, the nineteenth century represented an era of optimism. Images of majestic frontiers, technological innovation, and religious tolerance afforded individuals senses of boundless possibility. Romantic idealism pervaded art and literature, as people from all walks of life began to explore what it meant to be American.

However, this century would not be spared its share of war, inequality, and suffering. Issues of urban pollution and want stood in stark relief to the bucolic images offered by Lewis and Clark. Theologies that provided answers to questions of the previous century often seemed hopelessly inadequate in light of new scientific, economic, and social theories. Authority and its legitimization

were called into question from the statehouse and pulpit to the surgical theatre and boardroom, as competing ideologies sought the allegiance of citizen and immigrant alike.

This was a time of marked change for healers and healing. New theories undermined old nosologies, and new diagnostic and therapeutic procedures offered hope to many who would have been left without recourse in the previous century. Nonetheless, the political and economic exigencies of the era meant that more than ever, the afflicted could exercise choice in treatment, challenging in new ways the paternalistic, if not dictatorial, medical practices seen just a few decades earlier.

Notes on Social Religion

After the Revolutionary War, the main denominations faced a range of possibilities and challenges as they sought to clarify their message and solidify their place within the social fabric of the fledgling country, on matters ranging from government structure and family relations to social welfare and personal spirituality.

Particularly toward the end of the century, most mainline denominations, especially Baptists, Congregationalists, Disciples, Episcopalians, and Presbyterians in the North and West, were defined by liberals, whose ideas were in many ways emblematic of a larger process of rapid change. Urbanization forced people of varying outlooks to live close to each other, and many believers in such environments could no longer assume that their own worldview was the only one that existed. University-based researchers increasingly displaced the clergy as the final judges of what was true or not true (Butler 2003)—a fact that would hold increasing importance in the coming century for persons seeking to become hospital chaplains.

Gradually, these sentiments were fused with elements of historic Christianity and religions and cultures of ancient Greece and Rome coming together to form what became variously known as "Publick" or "civil" religion, reflecting a desire to give religious meaning to the nation itself (Butler 2003:173). These concepts represented more than patriotism: they symbolized a desire to place the US in a larger framework of significance, an attempt to say that America occupied a special or even unique place in God's plan for the world.

These sentiments held concrete implications for views of the human body, individual initiative, and communal outreach. They did not, however, mean the same things to everyone, and the hermeneutical postures that various individuals and groups adopted held important implications for the ways in which they responded to the immediate social needs of their day. Some Christians, particularly Quakers and Puritans in the 18th century, thought in terms of relief, not reform. They

assumed that poverty and pain were here to stay; for the most part, the best one could do was to ease the suffering and protect the vulnerable.

In the early 19th century, however, a new approach to poverty and human suffering began to emerge, as many were persuaded that the world really could be fundamentally improved. The objective was to master the laws of society to make life more just, humane, and enjoyable. Protestant denominations in New England in particular saw in the Bible a sense of responsibility to the whole of society. Members of those groups tended to be well-educated and economically secure, resources which gave them opportunities to help others. Likewise, in their minds the growth of critical methods in the study of history, science, and other cultures had rendered the older notions of religion obsolete. The choice, then, was either to discard faith entirely or rethink and reclaim what was true in light of recent advances in knowledge. Particularly toward the end of the 1800s, such intervention emphasized the care of the human body, easing of poverty in the nation's swelling cities, and the reduction of the suffering caused by alcohol abuse (Butler 2003).

In contrast, a large minority of Christians, including Roman Catholics, Lutherans, and Mennonites, as well as Jews, rarely attempted to reform society as a whole (Butler 2003). This was not because they were selfish but because they were confronted by more pressing problems of taking care of their own families in a forbidding land. Albeit for different reasons, many Biblical literalists likewise placed little emphasis on social reform, focusing instead on the conversion of souls and the life hereafter. Many of the "radical evangelicals" in their midst continued to espouse the view that sin produced physical suffering and were hence less inclined to comfort the afflicted than to chastise them (Butler 2003:312).

Epistemology and Rationality in an Age of Pluralism

While physician and minister could theoretically agree on the possibility of a predictable, scientific underpinning to physiology and illness, it was the physician who felt the increasing onus to incorporate such an understanding *of* the body into a practical therapeutic regimen *for* the body. By contrast, the minister could plausibly point to suffering as a sign of divine displeasure well into the 1800s without overarching concern for the specific nature of the illness. This is not to say that clergy were indifferent to questions of theodicy or ignored the role of unethical behavior in misfortune—quite the opposite—but they were far more concerned with the salvation of the soul, moral instruction, and spiritual growth than they were with the particular mechanism by which the individual was afflicted. Similarly, in the 18th and early 19th centuries, physicians of all pedagogical persuasions left ample room for faith in their work (Warner 1997), yet fideism was clearly a dead end. Prevailing views varyingly reflected larger socio-political norms, from the skepticism of

sweeping theories of illness and illness systems in favor of simple explanations in the Jacksonian era to an emphasis on self-trust and self-reliance that increasingly characterized the pioneer spirit of the new republic. Nonetheless, there was a growing recognition that an epistemology that included standards and norms—however universal or local in scope—would gradually lead to more effective treatments and professional salvation.

Starr theorizes the outlook of religion on illness and the human from 1760-1850 as follows:

> At a time when science had not yet provided adequate explanations of disease, much less means of preventing it, Protestantism nonetheless promoted "the disenchantment of the world" by recognizing only one supernatural force, divine providence. And so, contrary to common opinion, it was the development of religious thought, rather than medical progress, which first brought about the decline of magic and healing and other spheres of life. [1982:35]

These medical questions reflected long-standing philosophical and theological debates about the structure and predictability of the universe, a debate that only intensified with Darwin's *Origin of the Species* in 1859.

It is useful to consider briefly emerging notions of the patient as a unique person, for in many ways, the concepts that emerged during this period—in part as a result of etiological and therapeutic questions—presaged the distinct identity that would emerge with the development of psychoanalysis and pastoral counseling movements a century later.

Prior to the 1900s, the problem was that there appeared to be a tension between the universal and particular that neither science nor religion could resolve. Consider:

1. All were responsible for their own state of being.
2. Individual misbehavior necessarily (i.e., universally) led to illness.
3. A particular misbehavior affected the entire body's equilibrium.
4. The same misbehavior could affect persons differently.
5. The same misbehavior could require different treatments, either when multiple persons were afflicted through this misbehavior, or when the same individual performed the misbehavior at different points in time.

Gradually, scientific knowledge developed to the point that physicians began to look to statistical norms and standards by which to measure the type and magnitude of an individual body's deviation, not so much from itself, but from a large population. "Individual physiological processes [became] meaningful in themselves," and "physicians began to think more in terms of discrete

disease entities and disease-specific causation and less in terms of general destabilizing forces that unbalanced the body's natural equilibrium" (Warner 1997:87). This view became increasingly popular with the spread of Parisian medicine and its surgical emphasis on localized rather than systemic pathologies (Starr 1982).

While it is true that the use of statistics by non-allopathic practitioners caused some to question the reliability of the numerical method as a way to gain therapeutic knowledge, and others remained firm in their belief in divine causality, by the late 19th century it had become a crucial component of diagnostic and therapeutic practice. Likewise, the gradual acceptance of scientific knowledge as a means to undermine the therapeutic value of bloodletting, long a tool in the physician's arsenal, signaled both a new epistemological focus and, consequently, a new moral standard for medical intervention (Warner 1997). Finally, the experience of Civil War doctors had made many realize that "individual volition and social circumstance threatened to have less and less to do with the explanation of sickness … the energetic Christian as well as the drinker and whoremonger might charge into the bullet's path" (Rosenberg 1987a:140).

It is difficult to overstate the importance of this transition. With the increasing use of such intermediary aids as stethoscopes and thermometers, physicians took an enormous leap forward in their diagnostic capabilities, a set of innovations that was never matched by clergy (Warner 1997). Such a transition meant, among other things, that the patient's narrative account of the illness assumed far less importance—and often less credibility—in the search for medical causality than it had in the past. For the physician, such a perspective was nowhere near as objective, as useful, as the account generated by these new scientific devices. For the minister, the physical body had never been the primary source of information about a person's condition, but so long as human pathophysiology had remained a black box to physicians, clergy could arguably claim parity with physicians in diagnostic prowess. No longer. The man of the cloth continued to use the patient's account as his primary source of data, yet he was effectively forced to cede the diagnostic enterprise to the doctors and to the research and pathology labs that were increasingly common components of new hospitals (Rosenberg 1987a).

Orthodoxy and Struggles for Legitimacy

While numerous accounts of philosophical disputes surrounding proper patient treatment exist, a particularly interesting instance of this conflict emerged in the middle and late 1800s, during the rise of such practices as Christian Science, chiropody, and osteopathy. William Holcombe, a homeopath influenced by Swedenborgianism, aimed his criticisms at what he perceived to be antiquated ideologies in both Western medicine and denominational religion:

> As it is impossible for the old bottles to contain our *new wine*, I strongly recommend the immediate demolition of all Orthodox Theological Schools and all apothecary shops …. The present race of Old Church theologians and of Allopathic doctors has to *die out* before the good seed can spring up on the place of those weeds in the garden of the world. [Warner 1997:180]

This diary entry is instructive for a variety of reasons. First, it suggests both the influence of medical and religious elites that held into the 1850s and their attempts to retain the dominance over healing that they had long struggled to maintain. Second, by linking the two fields in his condemnation, Holcombe suggests the possibility of a concerted effort to limit the ascendancy of would-be practitioners. Such a joint enterprise would have made sense for both Protestant (and, to a lesser extent, Roman Catholic) Christianity and what became known as allopathic medicine, for while one could argue that the physicians had little diagnostic or even therapeutic use for religion, a political alliance with the dominant institutional religions could only add moral and numerical strength to their cause.

Third, in the ideological battles of the 18th and 19th centuries, Christianity's status as a source of moral legitimacy and oversight remained largely intact, despite natural science's increasing ability to explain the physical world. Why? Inertia accounts for a good deal of the continued authority. Since the age of Greek medicine, religion had exerted a noticeable presence in centers of healing in the West, and Christian denominations were often the owners, managers, and providers of care in hospitals until well into the 19th century.

In this respect, one could argue that scientific medicine increasingly became a demanding tenant in religion's house. Did it undermine Christianity's status on its own land? Yes and no. Early American hospitals were both notorious and predictable: the afflicted generally avoided them if they could, in large part because they knew that there was often little cause for hope for full and speedy recovery. Somewhat later, scientific progress led to senses of both hope and uncertainty. Patients began—cautiously—to express optimism in new devices and procedures, but neither they nor the physicians were ready to evict religious elements from hospitals. Instead, religion and science realized that the authority of the other could augment their own legitimacy. This increasing specialization and division of labor helped to increase the power of professionals in new occupations and likewise generated new hierarchies that bore marks of familiarity that likewise bolstered legitimacy (Starr 1982).

Such changes did not occur in a social vacuum, however. Just as religion increasingly ceded aspects of medical care to science within the hospital, it developed a complex relationship with civil governance and the propagation of morality within the public realm. With the scientific medical community, Starr argues that a variety of aspects of individual social behavior—particularly those labeled as deviant—became medicalized, and together they were able to use political channels to extend their power and authority into more and more areas of private life (1982).

Communal Christianity, Moral Outreach, and the Individual in the Hospital

Armed with this information, we turn our attention now to the hospital as an intentionally social, scientific, and religious institution, as we seek to understand how it struggled and grew amidst such a bewildering variety of new ideologies and forces. As we begin, it is important to recognize the ways in which individuals from a variety of walks of life—scientists, clergy, parishioners, politicians, the wealthy, the indigent, and others—were forced to contend with an entity that resisted easy definition, one that seemed to redefine its aims and abilities with each new decade.

Recall, however, that whatever the mode of inquiry, physician and chaplain alike acknowledged a rational design to nature in the first decades of the 19th century, in which the desire to be a "missionary to the bedside" (Warner 1997:17) was to be tempered with an acknowledgment that human intervention, of whatever form, was to serve as an aid and not an obstacle to natural processes (19-20, 23), for many held the view that the great majority of ailments cured themselves (Rosenberg 1987b). Edinburgh's influence on medicine in Philadelphia in the 1800s, for example, led to a hybrid state in which physicians were both theoretically orientated and quite active in terms of therapeutic intervention (Warner 1997).

Even as the concept of a stable, internal bodily equilibrium waned, symptomatic healing could still be quite aggressive, though this was tempered by a variety of factors, including a gradual shift to an antiheroic impulse, palliative care, and increased vigilance as a precursor to intervention. While many could still claim that "occasional failure to cure did not necessarily negate the usefulness of a therapy but only emphasized its limitations, [because] death … was a part of Nature's (or God's) order" (Warner 1997:92), this greater shift toward specificity increasingly minimized environmental factors—including divine impulses—that impinged upon a particular case (102).

Toward the end of the 1800s, the pendulum of medical care had shifted partway back toward previously disavowed interventions. As Warner further explains, this shift back to an emphasis on rationality in therapeutics, and not just empirical observation in the clinical setting, presented a signal shift in American medicine. This New Rationalism "would supplant the limitations of therapeutic specificity with the prospect of universalism, fixed laws, systems, and even an approach to certainty"

(1997:244), for while rationality's place in diagnostics had been relatively secure for some time, it was viewed as capable of generating a "science of therapeutics," thus breaking the stalemate that had been generated by empiricism (1997:247).

Far from mobilizing the patient into greater action, Starr argues that this "increased dependence on capital equipment and formal organizations … added a highly persuasive rhetoric to the authority of medicine" (1982:137). To the extent that this statement is correct, the end of the 19th century can be viewed as an inversion of the priorities embraced by Wesley's followers a century earlier. Esoteric practice, a lack of therapeutic transparency, and a mentality that the patient should be expected to understand neither why she was ill nor how treatment worked became the predominant posture among physicians. Gradually, "the American faith in democratic simplicity and common sense yielded to a celebration of science and efficiency," where "legitimate complexity" was an increasingly common component of life as America continued to expand and industrialize (Starr 1982:140).

By the 1870s, the hospital was a reality that the urban poor were effectively forced to accept, despite the fact that it was still viewed by many as "an object of fear and an 'asylum' of the dependent and socially isolate; even a 'wretched and filthy hovel' seemed preferable" to many (Rosenberg 1987a:116). There were a number of important shifts beginning to occur in the role of the hospital as a social institution, however, and they all related to an issue of signal medical and theological importance: proximity. First, hospitals were increasingly found near the heart of population centers, thus diminishing the geographical gap between healthy and afflicted. Second, the development of antiseptic procedures helped to legitimize surgical procedures and increasingly demarcated the hospital as the site of its practice, meaning that even in light of private and public wards, actors of all social statuses began to seek treatment under a common roof. Third, the presence of women's committees and other voluntary groups within hospitals, full of zeal to reach out to patients at the bedside, further blurred the lines between outside and inside, healthy and ill, sinner and saint, and while the hospital never became an established missionary field for lay evangelists, the ongoing presence of volunteerism and charitable fundraising for hospitals among various church groups (Rosenberg 1987a) bespoke a continued social commitment—gospel, some would say—to the afflicted and marginalized, one whose aim was only slightly closer to religious care than proselytization.

As we have seen, the 19th century witnessed a dramatic increase in immigration and growth of religious diversity that was often linked to the expansion of ethnic populations. While these various groups often mixed productively, there was frequently a push to care first for one's own,

whether in the form of ethnic churches, newspapers and other forms of media, or health care. Nonetheless, there are several intriguing consequences of the growth of denominationally sponsored hospitals. First, these hospitals tended to take medical cases that their voluntary counterparts rejected, suggesting that in antebellum America, if not later, ethnic and religious biases were two of the key determinants of the centre at which an individual would be treated—and the type of religious experience it would be. This is not to say that these other hospitals were any less determined in their application of religious principles and practices within their wards. Indeed, they could be equally rigorous in their execution of authority (Rosenberg 1987a), though policies of discrimination against women and ethnic minorities made the field of medicine both homogeneous and biased in favor of the populations they would serve (Starr 1982).

Second, these hospitals may nonetheless have been more pragmatic in their strategies of attracting patients than their Anglo-Protestant counterparts:

> Religious and ethnic hospitals were generally more successful in attracting the elusive paying patient of modest means. Such institutions were often small and seemed to prospective patients very different from the impersonal, alien, and alienating general hospitals. To be treated by a religious woman and to pay a modest sum for one's room and board transformed a hospital stay for Catholics into something less painful and humiliating than it would have been in a large, nonsectarian—that is, Protestant—voluntary hospital. [Rosenberg 1987a:240]

There is an important theological implication here. By receiving services at a Catholic hospital as paying patients, they felt a sense of satisfaction—perhaps even relief or pride—that they would not be exposed to unfavorable religious doctrine. Their payments reflected not a rejection of the religious component within their hospital stay, but a pragmatic choice of the type of religion that they would receive. Gradually, though, religious pluralism in patient populations often submerged the denominational affiliation of many religious hospitals, for "while specific groups sponsored hospitals, they took pride in serving patients of all faiths—though not all races—without prejudice" (Starr 1982:175).

Toward the end of the 1800s, there was a gradual decrease in the number of nonprofit voluntary hospitals in larger areas as more and more fees were introduced. Like their small-town counterparts, voluntaries continued to be viewed in terms of public interest, but the former continued to see widespread community involvement, whereas the large centers were increasingly private and

self-perpetuating (Rosenberg 1987a). Moreover, the expansion of market forces and government intervention, as well as improved transportation methods helped to make the hospital a viable option for the ill, thus prompting a different sort of relationship between the hospital and its immediate environs. Moreover, "the old rhetoric of charitable paternalism was superseded by a new vocabulary of scientific management and efficiency. While much of this may have been more talked about than acted upon, the ideological change was one further signal of the hospital's transition from household to bureaucracy" (Starr 1982:161).

It is difficult to specify precisely when health care practitioners, and particularly chaplains, began to lose interest in inculcating a work ethic within their patients. Several features, however, emerge as likely factors. From a practical standpoint, the gradual decrease in the length of average non-psychiatric patient stays made it increasingly difficult to solidify a new worldview in the inpatient. Second, the increasing place of science, as opposed to morality, as a focus for clinical resources further marginalized behavioral issues that did not bear directly on the presenting illness—this apart from the view among some clergy and mental health workers in the late 19th century that work and physical activity in general can have salubrious effects on the patient's outlook. Third, van Drunen and his colleagues argue that the development of the psychology of work and organization as a professional specialty in such institutions as the military and the university, as well as concomitant legislation aimed at unemployment and health coverage, likewise mitigated the need for the hospital environment to concern itself with such issues. In their opinion, the Protestant ethic "[had] been replaced by the 'psychological ethic'" (2004:161).

This shift marks another key turn in the relationship between religion and medicine throughout the 19th century. "After the proclamation of human rights and individual freedoms of the American and French bourgeois revolutions," writes van Ginneken, "individual citizens were considered sovereign" (2004:222). Concurrent with the growing development of the person as a distinct social individual, with unique abilities, needs, and desires, was the recognition of the need for ways in which to manage, or at least shepherd, such distinctness toward a set of common goals. van Drunen and Jansz argue that "the agency of social management gradually shifted from private organizations, such as guilds, charities, and philanthropic societies, to the public realm. From the second half of the nineteenth century onward, more and more aspects of human conduct became a matter of public policy" and that such social management implied processes of "*professionalization* and *scientification*" (2004:8).

Jansz suggests other broad influences gradually coming together during this period to influence concepts of progress, including the growth in popularity of Cartesian rationality, the

possibility of achieving mastery over one's own mind as a means of controlling the body and the external world; and related secular understandings of the human individual through a scientific worldview. These trends increased in the 19th century, for even in the U.S., "individualism opened up possibilities for those who had been constrained by the traditional frames of church and community," though "it also contributed to feelings of insecurity, in particular in people who felt uprooted and alienated in the course of the rapid social changes" (2004:21). More broadly,

> In the course of the nineteenth century, the new and reconstructed forms of social management were targeted eventually at the entire population. Rather than brute imposition of social order or religiously inspired charity, social management became infused with notions of rational, scientific social planning. From now on, every individual, irrespective of his or her position, could in principle be advised, observed, registered, and compared with other individuals. [Jansz 2004:29]

THE 20TH CENTURY: TECHNOLOGICAL MEDICINE AND THE RISE OF MODERN HOSPITAL CHAPLAINCY

Western medicine came of age in the 20th century. Not only did scientific advances give physicians enormous diagnostic and therapeutic prowess, but government and market forces also contributed legitimacy, and at times enormous power, to the field. Funds became available for research and for hospital construction, bringing the reality of inpatient care into the neighborhoods and communities of millions of Americans—often for the first time.

Yet for a century that witnessed the advent of such miraculous advances as penicillin, CT scans, and organ transplantation, a host of long-standing issues persisted in the realm of patient care. The wonder of new drugs and new equipment, for example, raised profound ontological questions about what it meant to be human in an age when the realities of total war and widespread suffering were stark. The atrocities of genocide and the possibilities of life support forced deep ethical reflection on the range of how much humanity could—or should—responsibly take into its own hands. Access to such power, whether in the battlefield or the hospital, caused many to rethink the degree of control ceded to traditional sources of authority—the physician, the minister, the researcher, and others. This search for insight took a wide variety of forms as the afflicted sifted

through an increasingly dizzying array of philosophies, models, and movements to find explanation and direction in what often seemed an increasingly lonely and fragmented world.

Notes on Social Religion

The 20th century witnessed an expansion of several of the homegrown religions of the previous century and the growing public awareness of a variety of Eastern religions, as long-standing Christian denominations sought once again to define themselves in an increasingly heterogeneous environment.

Churches that identified themselves as charismatic and literalist began to attract large followings, particularly among marginalized ethnic groups. Like their predecessors a century earlier, many evangelicals and fundamentalists who had condemned Charles Darwin's theory of evolution and who espoused the inerrancy of the Bible, grew increasingly suspicious of the cities, seeing them as seedbeds of sin and political corruption. Some revised their eschatological views, insisting that the world would *not* improve before the Second Coming, in some cases adopting a theology of dispensationalism that concentrated on conversion, or regeneration, of individuals rather than society as a whole (Butler 2004).

More intellectually inclined believers did not embrace dispensationalism or charismatic healing but, influenced by such theologians as Reinhold Niebuhr and Karl Barth, found a renewed focus on original sin, human depravity, and the justification of force to restrain evil. This was countered in some circles with Judeo-Christian and feel-good theology, can-do attitudes toward self-improvement, and the rise of the concept of "true" Christians (read: patriotic Americans) and social respectability in light of Communist threats, civil disobedience, and the rise of the death of God theology (Butler 2004:360). Roman Catholics also experienced waves of change, particularly through the Second Vatican Council and the release of the papal encyclical *Humanae vitae*, which caused many adherents to challenge the notion of unswerving obedience to Rome.

Toward the end of the century, the return of evangelicals to politics through the elections of Carter and Reagan, and the formation of such groups as the Moral Majority and Traditional Values Coalition, along with a range of televangelists and the influential prosperity theology of the 1980s (Butler 2004), all contributed to an increasingly acrimonious debate about the nature of creation, human responsibility, and the possibilities of rebirth and regeneration.

The Political Economics of Inpatient Medicine

As we have seen, ambiguity and the unknown have been components of the hospital experience since their founding. In the 20th century in particular, various insurance schemes arose to buffer the financial consequences of health risk for individuals. It is perhaps ironic, then, that the

medical profession, and occasionally Christian denominations, stood opposed to a number of these plans, including various forms of prepayment, contract practice, medical cooperatives, and the like. Why?

> The advent of antibiotics and other advances gave physicians increased mastery of disease and confirmed confidence in their judgment and skill. The chief threat to the sovereignty of the profession was the result of this success. So valuable did medical care appear that to withhold it seemed deeply unjust. Yet as the felt need for medical care rose, so did its cost, beyond what many families could afford. Some agency to spread the cost was unavoidable. It would have to be a third party, and yet this was exactly what physicians feared. [Starr 1982:232]

Further, Starr argues that "social insurance departed from the earlier paternalism … by providing a right to benefits instead of charity. In this sense, it constituted an extension to social warfare of liberal principles of civil and political rights" (1982:238). While almost all agreed that illness represented a burden on the nation's social well-being and productive efficiency, there was disagreement about how best to combat it, with some contending that "direct investment in public health would have a higher return than cash benefits for the sick" (1982:250).

Another important consideration in our analysis of 20th century medicine is the broadening range and degree of illnesses seen in American hospitals. In particular, the move toward outpatient services brought a different type of client to health centers, namely persons who would often only require the services of a single department or a limited range of practitioners. For example, the disappearance of dispensaries as independent institutions, and their incorporation into outpatient departments by many hospitals, not only emphasized the hospital as a business where fees were collected for services rendered, but it also presented an image of the hospital as a place where the afflicted might spend an hour or two and then leave (Starr 1982).

Other factors led to increased utilization in the mid-1900s. The Hill-Burton Act of 1946, and the subsequent decision to provide capital reimbursement through Medicare, directed enormous sums of money to community hospital construction and to the development of technology within new and existing centers. Likewise, third party, fee-for-service payment encouraged hospitals and doctors to maximize their volume of services, thereby increasing their own incomes (Starr 1982). Particularly the first two factors further raised the profile of the hospital as a component of American—and particularly suburban, middle class—life. Perhaps ironically, despite the interest in public health and

preventative medicine that characterized much of the early and mid-20th century, hospitals relied for their livelihood in no small part on those who did not take adequate care of themselves.

It is worth underscoring the attitudes that emerged in response to this legislation. Prior to the 20th century, hospitals remained for many a socially undesirable institution, a sort of holding pen for the economically marginalized that was often seen as scientifically and morally suspect. Most often, they were established by the haves for the have-nots, often at a formidable distance from the latter. It is not too strong to say that the growing recognition of the value of hospitals on the part of the middle and upper classes for their own needs transformed the hospital from a house of charity increasingly to one of greed. Indeed, if these temples of healing were once visible demonstrations of a community's munificence, they were viewed more and more as billboards for self-preservation.

So much so, in fact, that physicians came to be seen not only as sources of cure, but also as aids in prevention. Along with bacteriology's increasing emphasis on isolation and disinfection, medicine increasingly emphasized education in personal hygiene and "'the use of the physician as a real force in prevention' by organizing medical examination of the entire population" (Starr 1982:191). At first glance, it would seem as though the public health official became the scientific equivalent of 18th and early 19th century preachers. With his sermons on specificity and bible of scientific data, his message promoted a quantitative morality that was both persuasive to the individual citizen and a boon for physicians. Now, everyone was supposed to seek the oversight of physicians—not just the already ill—thus making medicine a more pervasive component of the American consciousness.

Toward the last quarter of the 20th century, however, the images of physicians and inpatient medicine began to slip:

> Even the response to rising costs cannot be entirely understood apart from a diminished faith in the efficacy of medicine and increased concern about its relation to other moral values. Many worried—and the courts often agreed—that doctors and hospitals might abuse their power, if patients' rights were not more clearly protected …. For the first time in a century, American physicians faced a serious challenge simultaneously to their political influence, their economic power, and their cultural authority. [Starr 1982:380]

As we have seen, the culture of hospitals is not easily changed, but "the increased tendency of the courts to view the doctor-patient relationship as a partnership in decision making rather than a doctors' monopoly" reflected the fact that an unmediated relationship between physician and patient

was unpalatable for many, and particularly for inpatients (Starr 1982:389). This has been true in therapeutic options and in other aspects of treatment:

> Controlling revelation of information in order to influence patients' thoughts or behaviors is a key aspect of physicians' action with respect to prognosis. The fact that physicians feel the need to control the information they formulate or communicate at all suggests not only the power that they believe is inherent in prognosis, but also their considerable professional duty in this regard. [Christakis 1999:50]

This is a crucial shift in the history of American hospital medicine. Physicians needed authority to maintain legitimacy, but too much oversight could and did lead to a rejection of a system of unchecked oversight in favor of a more egalitarian approach:

> In its commitment to the preservation of life, medical care ironically has come to symbolize a prototypically modern form of torture, combining benevolence, indifference, and technical wizardry. Rather than engendering trust, technological medicine often raises anxieties about the ability of individuals to make choices for themselves. [Starr 1982:390]

Orthodoxy Revisited: Hospital Access, Outpatient Healing, and the Art of Rapprochement

Just as physicians faced challenges from government agencies and insurance corporations, they continued to face opposition from a variety of heterodox practitioners, much as their predecessors had in the previous century. Lay groups such as bonesetters, abortioners, and botanic practitioners did not establish inpatient hospitals, and despite the fact that many sectarian practitioners eventually won licensing privileges in the 20th century, they "were usually unable to win access to hospitals or the right to prescribe drugs" (Starr 1982:127). Indeed, the growth of these centers "was a key precondition for the formation of a sovereign profession" (1982:72), in part because the routine of the hospital helped to delineate the roles and duties of practitioners, and also because the buildings themselves served as visual testaments to the increasing uniqueness and specialization of this particular type of healing.

By the turn of the 20th century, the relationship between what was labeled allopathic medicine and mainline Christian denominations had effectively gelled into what could be called orthodox healing, based on a posture of mutual understanding and an implicit division of labor.

1901, for example, saw passage of the first definitive medical practice act empowering the board of health to act as a board of medical examiners. By then, physicians had finally united behind effective legislation, and they had the support of the Presbyterian and Methodist churches, which were alarmed at the growing popularity of Christian Science and Weltmerism, a local mind-cure cult (Starr 1982).

This is not to say that the borders of orthodox healing were completely impermeable. In some cases, it was strategically easier to incorporate some of the practices of such groups as homeopaths into their own ideologies rather than risk losing patients to the competition. However, given the fact that AMA membership had climbed to 60% by 1920 (Starr 1982), did the medical field need the endorsement of such practitioners—or, for that matter, religion? How did increasing solidarity and standardization among physicians, and later, nurses, affect their relations with chaplains and other staff members in the local hospital?

While physicians as a group were keen on maintaining "a monopoly of competence" within the hospital, Starr argues that "they needed technical assistants who would be sufficiently competent to carry on in their absence and yet not threaten their authority," thus encouraging "a kind of responsible professionalism among the higher ranks of subordinate health workers" (1982:220-1) particularly among the scientific practitioners, but also, I wish to suggest, among the chaplains. In terms of theology and pastoral intervention, medical specialties were beginning to mature to the point that it was increasingly difficult to speak of the relationship between religion and hospital medical practice in monolithic terms. There was no longer any reason to believe that such disparate fields as cardiology, dermatology, and psychiatry would see the same potential benefits—or threats—to their work as did physicians a hundred years prior.

Therapy and Related Clinical Agendas Reconsidered

As the 20th century progressed, it became clearer the extent to which the therapeutic modalities of physicians and chaplains had diverged. While both remained steadfast in their desire to help those in need, several crucial shifts caused the two fields to embrace different priorities. The first, as we have seen, were the increasingly sophisticated diagnostic devices of the physicians, which radically altered their understanding of human physiology and illness etiologies. The second was the increasing embrace by chaplains of theologies that emphasized Divine mercy and availability to all persons, coupled to a far less judgmental hermeneutic of suffering and misfortune. What emerged, then, were diagnostically and therapeutically active physicians, chaplains who relinquished somatic diagnosis and therapy to physicians in favor of psychological reflection and self-awareness, and patients who were primarily passive recipients of medical treatment while active explorers of issues

of religion and spirituality related to their current state in anticipation of future growth and social reconciliation.

A second important consideration is that while any interaction between patient and physician was presumed limited to the two individuals, Cabot and Dicks explain that interactions between patient and chaplain implied also the presence of a third member, God, who was "seen through the obligations of the two persons" (1936:173). For them, this relationship was but one of many that included "husband and wife, teacher and pupil, employer and employed, friend and friend, (who) must choose whether they will face each other or whether both will face a third that is greater than either" (1936:174) when one attempted to reach out to the other in an act of charity.

Third, and perhaps most significantly, the chaplain could serve as an icon for forgiveness as part of the therapeutic enterprise. Reconciliation was not a concern of medicine (though one could argue that it was an implicit goal of public health), but for the minister, it was a key element in the process of healing. Forgiveness had always been present in outreach to the sick from the standpoint of asking God's pardon for wrongs committed, but the chaplain could also encourage the patient to offer forgiveness to others—particularly those who might have contributed to the patient's illness. How much this latter manifestation of forgiveness is a recent emphasis versus a long-standing tradition within American hospitals is difficult to discern, though the emphasis in previous centuries on illness, either stemming from one's own actions or centered on the need to bear it as mysterious and unknowable, suggests that forgiveness of the other was not a primary consideration of either the clergyman or the patient. It would indeed be interesting to know more about how advances in epidemiology, and scientific etiologies in general, have contributed to (1) theological understandings of social forgiveness and (2) the evolution of social practices of forgiveness, topics that, alas, received little attention in Rosenberg's discussion of blame and supernatural reasoning in *The Cholera Years*.

Writing in the early part of the 20th century, Cabot and Dicks believed that while some experienced suffering as a result of their sins, only a small fraction of illness could be explained thus, and if patients did feel some sense of guilt or estrangement from God, these sentiments did not necessarily manifest themselves somatically. Intriguingly, though, they speculated that "suffering which does not test or stimulate the sufferer must be good for some one else" (1936:107). Such a theological posture was certainly not universal then or at the end of the century, yet it is illustrative inasmuch as it suggested a way to find meaning, relieve fears, and to provide a starting point for positive growth for the patient.

Cabot and Dicks point to a number of other ways in which the chaplain could promote growth throughout the hospital experience. Arguing that "people go backwards in their spiritual growth when they are terrified, depressed, bitter, lonely" (1936:55), they suggest that the minister has a key role to play in alleviating fears about the hospital experience, serving as the equivalent of an illuminated compass for inpatient stays. Likewise, they argue that chaplains can be a welcoming presence, a familiar face that could pierce senses of loneliness and isolation that had become increasingly common elements of the hospital experience. For one of their patients, "the minister was *interpreter* not only between the patient and God, but between the patient and her family, bringing them together so that she need not bear alone the majesty and the grimness of death, and so that the family might share the noble courage which she had attained" (1936:59; emphasis added).

Psychiatry, Mental Hospitals, and the Beginnings of Pastoral Counseling

The post-World War II era saw a huge expansion of non-psychiatric mental health workers, such as psychologists, social workers, and clergy. Abma points to the work of Carl Rogers and his belief in the ability of non-physicians to provide useful assistance to afflicted individuals, as well as his conviction that clients could engage successfully in self-therapy, as a key watershed moment in mental health in particular and in the concept of healing more broadly. Specifically, his view of the therapist as "no more than a facilitator of psychological change in the individual" and his emphasis on "ordinary unhappiness and alienation" in addition to the pathological (2004:114) both decreased the image of practitioner as almighty curer and broadened the range of issues suitable for the therapeutic encounter—issues which were not (yet) medicalized and which did not require the scientific expertise of a physician. Such advances were by no means a knell to psychiatry, though by agreeing with psychoanalysis that many mental problems include social (and not exclusively biological) components, psychiatrists further legitimated the place of discourse within the toolkit of clinical practice.

One consequence of this new conception of mental hygiene was a markedly increased reach of psychiatric principles after 1945:

> Liberal-minded people approved of a broad extension of medical authority into the regulation of social life. The consensus of the enlightened favored substituting therapeutic for punitive responses in the social management of delinquency, alcoholism, narcotics use, and sexual deviation. Psychiatry, previously concerned primarily with the care of the insane, had been institutionally marginal before World War II. Now it moved into the "main-stream" of American medicine

> and American society and enormously expanded its claims and its clientele.[3] [Starr 1982:337]

Likewise crucial to this success was the expansion of clinical psychology beyond the realm of description to intervention; it was now a "dynamic" field that could benefit patients in the name of social welfare. The expansion of psychiatry into outpatient, neighborhood-based practice helped to demystify the field and also helped to mitigate the extraordinarily bad press that it had received through texts such as *The Snakepit* and *The Shame of the States* because of its affiliation with mental hospitals. These exposés portrayed the institutions—and psychiatry, by implication—as cruel and incompetent, where "half-starved mental patients [were] herded into filthy, barn-like wards and stripped of every vestige of human decency" (Starr 1982:345).

In many respects, however, psychiatry represented the vanguard of change in the relationship between (hospital and institutional) medical practice and the community. During the post-World War II period, increased hospital construction and insurance signaled a push toward inpatient care as an increasingly large proportion of medical care, but the "rediscovery of community" care, particularly ambulatory medicine, was precipitated in no small part by the introduction of major tranquilizers, meaning that mental patients "who were previously hospitalized could now be safely treated, or at least more safely ignored, on an outpatient basis" (Starr 1982:365). Moreover, Abma suggests that mental health is one, and perhaps the only, area of medicine in which a number of socially legitimate practitioners, including clinical psychologists, psychoanalysts, social workers, and pastoral counselors realistically competed with medical professionals for clientele throughout the 20th century (2004).

Such conclusions held enormous consequence for the work of ministers within the realm of health care. This psychological perspective was taken up by "progressive groups" within the Protestant churches (Nelson 1970:101), culminating, among other things, in the Emmanuel Movement in Boston, in which the Reverend Elwood Worcester and Dr. Richard Cabot advocated "'the Christian religion as a healing power,' aiming at the 'alleviation and arrest of certain disorders of the nervous system which are now generally regarded as involving some weakness or defect of character'" (1970:102).

While popular interest in the Emmanuel movement began to wane after World War I, it is significant for a variety of reasons. It heralded what is arguably the first example of active and egalitarian collaboration between clergy and physicians in patient care, a platform in which medical

[3] Such theories have come under recent and sustained attack by, for example, Wacquant (2009) as misrepresentations of the social goals of penal and other institutions aimed at the poor and otherwise marginal.

specialists and religious specialists linked their respective backgrounds in search of a unified solution to a single illness. This experiment was both an exercise in the division of labor, in which the physician would treat the (primary) biological condition and the pastor the (secondary) emotional and spiritual issues that sprang from the biological complaint, and an acknowledgment of the possibility of the multifaceted nature of human illness, with the aim of revitalizing the "living faith in a person's life" through personal interviews, physical examinations, regular religious instruction, various forms of suggestion, and work (Nelson 1970:55). Such visions of patient care were pivotal, not only because they tacitly acknowledged the social context of suffering, but also because the therapeutic tools of talking and listening were used by both physician and minister, and as such, practitioners could only stand to benefit from each other's insights in the counseling role. As of 1907, Cabot could report that even those patients who were not healed of their physical distress reported that they gained a new outlook on life and saw their lives as worth living.

Thus, while the phenomenon of medicalization was particularly effective in terms of diagnostics and therapeutics, prevention likewise became a part of its agenda. In a very real sense, Christian ethics, with its emphasis on personal responsibility, served as *de facto* preventative medicine before physicians became actively involved in the maintenance—rather than merely the restoration—of good health. Medicine could thus be seen as catching up with religion through its efforts to promote preventative mental health, particularly during the Progressive Movement.

After the Second World War, both public and professional conceptions of the various uses of psychological and psychiatric intervention expanded. It was but a short hop from the use of mental health as a form of prevention to mental health as an aid in the pursuit of happiness. This was true for the religiously inclined as well as for others: "East coast intellectuals in the United States used psychoanalysis in their cultural struggle against New England puritanism, while on the other hand moral conservatives sought support in Freud to conquer the 'internal wilderness' of mankind" (Abma 2004:109).

It is difficult to overstate the implications of this move toward the psychologization, and subsequent medicalization, of human motivations for Christianity in general and for hospital chaplaincy in particular. While the concept of mental defect as a factor in determining accountability in Western legal traditions was hardly new, Weijers argues that the gradual shift toward "moral insanity" persuaded both physicians and courts to view people "less as mental or spiritual subjects who deliberated morally, and more as biological organisms which were subject to physical derangement" (2004:198-9).

In theological terms, we could see this hermeneutical shift as one from guilt and personal responsibility to the pathologization of sin. The Christian tradition has, over the centuries, recognized the possibility of spirit possession and other factors which may contribute to an individual's inability to act rationally and charitably, thus bringing misfortune on himself and/or others. Still, we have seen that the overarching view in American Christianity was one that stressed autonomy and personal accountability and typically interpreted illness in terms of wrongs committed—deliberate acts that widened the gulf between the person and God and hence generated suffering.

Nevertheless, for the hospital chaplain who was sympathetic to the scientific explanations of his medical colleagues, this frequently meant that he was forced to work within their causal framework when discussing illness with patients, despite the fact that such explanations did not in and of themselves undermine the concept of God as prime mover—they did not provide the believer with satisfactory explanations for why a given individual might possess the biological factors in the first place. It is unclear the extent to which the chaplain attempted to convert the patient to this point of view, but as was explained to me in conversation, given the fact that converting and convincing have been accorded very low priority in chaplaincy work in the 20th century (Ciampa 2004), it is conceivable that the patient too accepted whatever explanation the physician gave and then explored the religious implications of these explanations with the chaplain.

Yet how can we reconcile such a position with the argument that "psychoanalysis and other mental health paradigms have in the twentieth century 'secularized' and psychologized our view on a host of other phenomena formerly considered primarily from a moral point of view, from varieties of sexual behavior to delinquency, and from marital problems to juvenile unruliness" (Abma 2004:125)? Is it the case that, when patients seek out chaplains for their ability to provide counsel, they are looking for a doctrinally vague form of spirituality, a sort of generic supernatural, as a component of the illness experience? Are patients seeking transcendence in the midst of misfortune, not so much in terms of guidance for moral behavior but as a way of connecting their experience to something larger than themselves? More research is needed to provide satisfactory answers to these questions.

Cabot, Boisen, Dicks, and the Beginnings of Clinical Pastoral Education

As Holifield suggests, the work of Richard Cabot, Anton Boisen, and Russell Dicks were of signal import for the development of hospital chaplaincy as a unique specialty within the twentieth century (see Appendix B). Though they lament the trend toward specialization in health care and pine for such multi-taskers as Schweitzer (7) and the angelic conjunctionists, they recognized that

such combinations were increasingly the exception rather than the norm and argued for the office of the chaplain as a unique and worthy one. Appealing to the lofty sentiments of Lincoln, they suggest that

> Doctors, nurses, family, friends, and the patient himself are too close to the situation to evaluate it comprehensively. Who can praise the doctor so judiciously, who can admire the patient so discriminatingly, as the minister? Who can weigh complaints so dispassionately? Who is so apt to see what is missing in the total set-up? With malice toward none, with charity for all, he can interpret the efforts of each actor on the stage. None of them can see himself with sufficient detachment, with sufficient humor, nor judge the rest with sufficient charity. [Cabot and Dicks 1936:8]

Richard Cabot trained in philosophy and medicine at Harvard, rising to prominence as a cardiologist in the late 19th century. In addition to his prowess for the natural sciences, he possessed a keen, even visionary, understanding of the needs of patients and of illness. Cabot devoted a substantial amount of his energy in the years prior to the beginning of the Emmanuel Movement to the development of clinical social work for patients, which he understood to be primarily a liaison between the physician, patient, hospital, and wider community (Nelson 1970).

While these achievements were noteworthy in their own right, it was the questions of religion, and the roles of spirituality and the divine in the illness process, which truly captured his imagination. He was convinced that "persons need a reason for being, a foundation, and a motive for living which religion can provide. Qualified ministers can educate people so that religion becomes the foundation of their lives" (Nelson 1970:59).

Cabot readily acknowledged the positive potential of clergy as part of a clinical team, but there was a problem. Theological schools in the early 20th century were well equipped to train their students in such topics as theology, Biblical exegesis, and homiletics, but in his opinion there was no means to train men to understand human nature or interpersonal relationships (Nelson 1970). After careful reflection, he set forth a plea for a clinical year in the course of theological study, in which seminarians would gain first-hand exposure to persons in the midst of concrete suffering and would learn techniques for responding creatively and compassionately to their needs.

In 1924, Anton Boisen, a Protestant minister and sometime student of Cabot who shared many of his mentor's ideas, began what was essentially an apprenticeship at the Worcester State Hospital, a mental health facility west of Boston. It was there that he tested many of these theories

and later took on a number of students of his own for clinical instruction and subsequently attracted a cohort of four students to train under him (Leas 2008). In 1929, Cabot and Boisen had garnered enough interest and resources to formalize their work and chose a board of governors for their new organization, according to the laws of the Commonwealth of Massachusetts, finally agreeing on the title "The Council for the Clinical Training of Theological Students, Inc." (Nelson 1970:122).

In 1933, Russell Dicks was appointed the first full-time Protestant chaplain at the Massachusetts General Hospital, marking the beginning of another highly productive relationship within the nascent chaplaincy movement. For Cabot, Rev. Dicks was ideally suited for the post because of his own experiences as a hospital patient. Nelson argues that Dicks "knew personally the doubts, the fears, the apprehensions, and the struggles that one faces in the medical and surgical hospital. Also he had experienced the various attitudes which medical personnel expressed toward him as a patient and he knew the restrictions of the patient's way of life" (Nelson 1970:133).

The attributes of the individual holding the office were thus considered crucial to his effectiveness. Cabot and Dicks argued that if the chaplain "has never known irritable weakness, dumb misery, disappointed love, remorseful sorrow after the death of a neglected parent, his power to see that another suffers these experiences is slight" (1936:87). They placed far more emphasis on the chaplain's own life experiences, and his ability to draw from his own repository of suffering as a way of identifying with his patients, as crucial components of is ministry to the afflicted. While more recent theories of pastoral care have questioned the appropriateness of extensive self-disclosure within the clergy-patient relationship (Ciampa 2004), the awareness of the need for a sense of authentic solidarity between sufferers increased steadily since that time.

For Cabot and Dicks, the central purpose of this office of benevolent and omniscient servant was growth, particularly the provision of a safe atmosphere in which reflection could occur. The minister could provide such a space by offering love, skills for improved self-reflection, and the conviction that they were indeed valuable as human beings. They likewise offered specific recommendations for optimal care, from chart reading and diagnostic techniques to lengths of stay and the appropriate way to offer sympathy, the proper volume of one's voice, and the need to listen, rather than argue (1936). In this sense, their work represented a unique pedagogy, a particular form of human interaction that emphasized specific mechanisms and a fairly rigid protocol for ministers who were hospital employees and who found themselves allied to a number of potentially competing parties.

Boisen and Cabot gradually grew distant, both personally and pedagogically; though in many respects they shared much common ground on the needs of the patient and the type of background

needed by clergy to be able to respond effectively to those needs. Boisen had his share of apostles in New York and developed a separate school of clinical instruction in the 1940s that was influenced by psychoanalysis and theologies emerging in particular from Union Theological Seminary in New York, ideas that stressed the patient as a "living human document" seeking to find release from the turbulent inner self, leading to greater insight and liberation (Holifield 1983:248). Cabot's cohort, centered in Boston, also emphasized growth but stressed ethical formation over freedom and autonomy. Other strong personalities contributed to discussions and occasionally clashed over the theoretical and pedagogical elements of clinical pastoral training, with some in the New York group (e.g., Hiltner) emphasizing "theological reflection about human experience" and others (e.g., Brinkman) favoring "science and psychology [that] subsumed the importance of pastoral theology" (Leas 2008). All of these camps, however, focused on the need to move the afflicted individual beyond self-deceit and to equip him to respond productively to the continually changing social and natural order as clinical training expanded to the South and the Midwest.

After World War II, the two groups, along with two smaller organizations, the Lutheran Advisory Council (originally based in St. Louis) and the Southern Baptist Association of Clinical Pastoral Education (headquartered in Louisville) found themselves responding to many of the same questions about the state of humanity and its potential for the future in light of the destructive potential that it had displayed just a few years earlier. New theologians rose to prominence, and graduate education in psychology and religion contributed to theories of human intervention in the lives of the afflicted, and many of these ideas found their way into pastoral care. By the 1960s, there was a growing recognition of the need for standardized practices and a common voice in the pastoral care community and, after a number of sometimes contentious meetings, the four groups merged in 1967 to form the Association for Clinical Pastoral Education, thus becoming the main training and accrediting body for hospital chaplains in the United States (Leas 2008).

Though some theological differences remain between members, the group has managed to retain a strong sense of cohesion over the past 42 years. The organization covers the entire U.S. and is headquartered in Decatur, Georgia. Leas explains that for most of the 20th century, certified supervisors were almost exclusively white Protestant men, though today some 140 out of 670 active supervisors are women, and both religious (including Roman Catholic, Jewish, and Muslim) and ethnic (particularly African American and Hispanic) diversity has increased (2008).

The CPE model has been adopted by a number of other countries as well.

3

CLINICAL PASTORAL EDUCATION: THEORETICAL AND PEDAGOGICAL CONSIDERATIONS

INTRODUCTION TO CLINICAL PASTORAL EDUCATION

As the name suggests, CPE is a specific type of instructional methodology. It is a form of hands-on training that emphasizes the practical *application* of theories and doctrines learned in seminary settings in a unique social environment, with individuals experiencing what are often the most profound and challenging moments of their lives. Students in these programs do not simply utilize their book-based learning in hospitals and other health-care settings, however: they analyze their interactions, observations, and emotions—their clinical data—under the tutelage of an experienced chaplain supervisor with a small peer group, both to refine their skills as a health care provider and to develop a critical awareness of their own beliefs, biases, and abilities as distinct persons with unique life histories. Informally known as an "action-reflection-action" pedagogy, CPE is a structured, experience-based approach to adult learning that presupposes mature, insightful initiative on the part of students to identify their own, and others', strengths and weaknesses in the therapeutic enterprise and, more broadly, in social interaction (Standards Committee 2005:1).

Training occurs exclusively in clinical settings, through a combination of work as chaplains on inpatient units and other patient areas throughout a medical center, along with small-group reflection sessions in office space in the hospital specifically set aside for such purposes. These CPE offices typically contain a small library, computers and other office equipment, message boards, handbooks describing the policies of the program and the hospital, various on-call duty calendars, contact numbers for area clergy and parishes, and enough chairs for students and the supervisor to sit in a circle during group sessions. In addition, hospitals offering CPE also have a chapel, an on-call sleeping room for chaplains on overnight duty, and a department of pastoral care office, containing offices of full-time staff chaplains employed by the hospital, and usually a department secretary.

Chaplaincy training follows the quarter system in U.S. higher education. A "unit" (or "quarter") of CPE consists of a minimum of 400 hours, approximately 300 of which involve direct

clinical work and individual reflection and the other 100 of which consist of classroom education with the cohort and one-on-one interaction with the supervisor (Accreditation Commission 2005:54). Students pay very modest tuition to receive instruction. There are two types of programming: training for chaplaincy, and training to be CPE supervisors. At the chaplaincy level, the first, introductory unit is called an "internship." Depending on the center, internships are offered on a full-time basis for 10-11 weeks over the summer; cohorts typically consist of seminary students who have completed one or more years of a Master of Divinity (M.Div.) program and are pursuing CPE training as part of their ordination and/or degree requirements. Occasionally, centers also offer internship training on a part-time basis for seminarians who wish to do their training concurrent with their academic courses. Chaplaincy residencies are offered on a full-time basis and are open to those who completed the first unit of training; they begin in September and continue until the following June. Residency students are salaried employees of the medical center who pursue more in-depth, specialized work over the course of one, or sometimes two, years of training (i.e., between three and six units of what is called "Level II" training); these candidates have typically completed their seminary studies, are ordained, and are contemplating hospital chaplaincy as a vocation. They tend to be somewhat older, may have worked in a parish setting in the past, and are frequently considering a change of career or type of ministry. Supervisory training is offered at a handful of sites throughout the U.S. for individuals who have completed Level II training; it typically includes a minimum of three additional years of training. Only a very small fraction of those who complete training to work as chaplains decide to pursue supervisory education.

PROGRAM ADMINISTRATION, STRUCTURE, AND OVERSIGHT

The CPE program is a central component of the medical center's department of pastoral care.[4] Depending on the size of the department and the hospital, there may be a single ACPE supervisor who doubles as the head of the department, or there may be several supervisors who head multiple training programs throughout the facility. The supervisor(s) is usually a full-time employee of the hospital and is a chaplain; he or she may occasionally also have clinical assignments in addition to the educational responsibilities. Departments may also have staff chaplains who work as paid, full-time hospital employees; they have typically completed at least one year of CPE training and a theology degree and are usually ordained by their specific religious tradition (e.g., Methodist,

[4] Each institution determines its own name for the chaplaincy department. References to "religion and health," "spiritual care," "pastoral services," and "pastoral care and education" are common and may be used more or less interchangeably for the purposes of this thesis.

Catholic, Jewish, Buddhist); they spend the bulk of their time ministering to patients and family members on assigned units and provide only informal support and advice to CPE students. Larger hospitals typically include at least one Protestant, Roman Catholic, and Jewish chaplain and may include other religious traditions, depending on resources and patient demographics.

Each CPE program is part of a national network of training centers, sponsored by the Association for Clinical Pastoral Education, Incorporated (ACPE), headquartered in Decatur, Georgia. Since 1967, it has established and maintained national standards for curriculum and training of supervisors and students, as well as the accreditation clinical training centers. Through its national office and regional chapters, it works with local health care institutions to authorize supervisors and students to provide ministry to patients and others as part of the latter's training for future work as ministers and as others in which the care of persons is a central component. All who offer instruction in hospital chaplaincy must be members of the ACPE and comprise the bulk of its members and leadership; students, seminaries/divinity schools, and others may also join the organization to support the institution by paying a yearly subscription.

Centers derive much, but not all, of their organizational and pedagogical structure from the national guidelines. They have mission and values statements that describe the range of spiritual services offered. For students, there is a clear description of the administrative and authority structure of the program, teaching methods and strategies of clinical education, including the role of guest lecturers and other assistants, a brief history of pastoral care in the U.S., processes of assessment and evaluation, available resources for professional consultation and certification, and mechanisms for addressing any complaints or conflicts that may arise over the course of the training (Accreditation Commission 2005). Figure 1 summarizes the key components of training centers for clinical pastoral education.

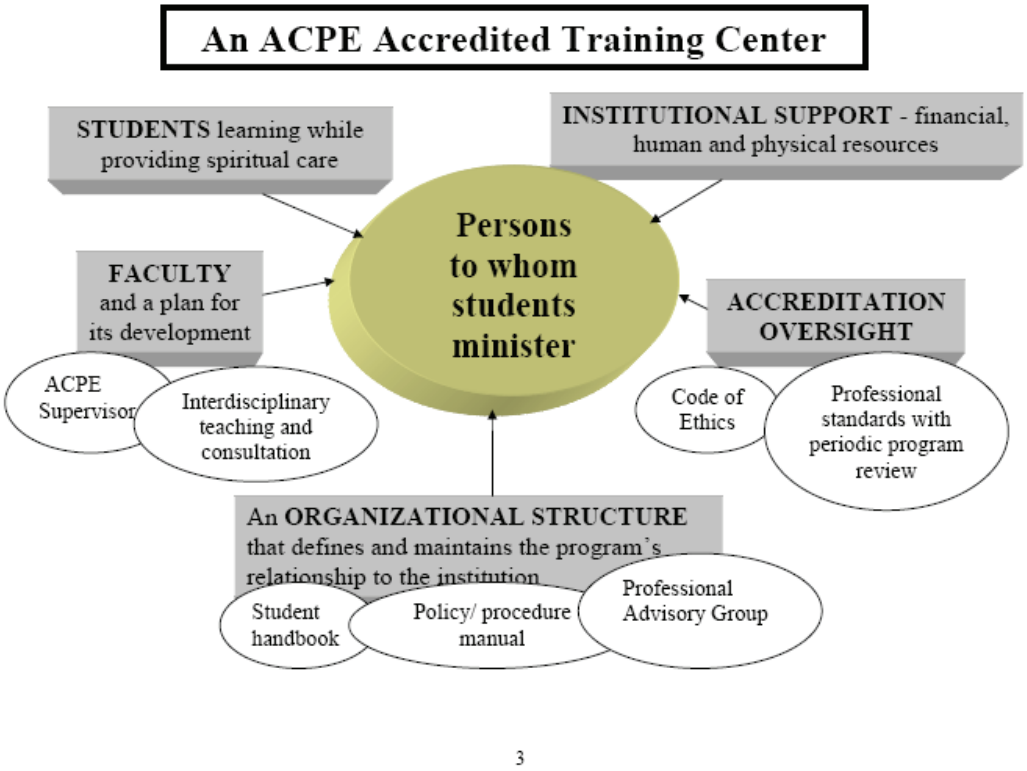

Figure 1. A schematic diagram of the interrelated components that comprise the training of hospital chaplains in accredited centers in the U.S. [Accreditation Commission 2005:3]

In consultation with the ACPE, the medical center provides a variety of resources to facilitate learning and reflection while students offer clinical services to its patients and others. These means typically include basic employee training, name badges and keys, charting privileges, the right to attend patient care meetings and center-wide educational workshops, consultation spaces to meet with family members and friends, a "professional advisory group" of selected hospital and local ACPE members to advise and support students and supervisors in the ongoing work of the program, and other instruments that grant the program and its trainees institutional legitimacy and the exclusive right to provide religious care to persons within its walls (including the right to determine if and when community clergy may have rights of visitation of their own members). Placement sites likewise agree to ensure "students' access to a population that offers significant opportunity for ministry, on-going support and consultation for the student(s), opportunities for interdisciplinary and professional interchange, and an environment that encourages human growth and dignity" (Accreditation Commission 2005:53). They also ensure that a training cohort will have at least three

and no more than thirteen students per supervisor at any one time. Finally, medical centers have specific, signed agreements that grant students access "to appropriate clinical records and informed consent with regard to use of student materials; and agreement by the student to abide by center policies protecting confidentiality and the rights of clients/patients/parishioners."

The CPE supervisor exercises considerable latitude in the construction and maintenance of the training program, within the structure established by the ACPE. Likewise, his or her own intellect, personality, leadership style, vision of ministry, spiritual journey, and life experiences have a significant impact on the esprit de corps of both the department and individual CPE groups.

Supervisors perform a number of duties in CPE programs. In addition to curriculum development, they meet with students individually each week for an hour, oversee group educational and pastoral formation sessions, organize unit assignments for residents, are responsible for various aspects of departmental scheduling (e.g., chapel leadership and on-call schedules), write student evaluations and certify levels of competence. The supervisor thus functions as teacher, interlocutor, mentor, administrator, counselor, strategist, and advocate.[5]

Indeed, one of the most important aspects of an effective program is the competence of the pastoral supervisor. This includes strong interpersonal skills; personal integrity; emotional and spiritual maturity and self-supervision; an ongoing refinement of professional identity as an educator; and a sophisticated appreciation of the ways in which social norms, values, and differences affect professional identity (Accreditation Commission 2005). Likewise, the supervisor should also have at least a modest amount of ongoing clinical work himself, in order to keep the demands and opportunities of pastoral care fresh in his mind and to assist students in the formation of their professional identity.

Given the range of personalities and traditions that students bring to training cohorts, the supervisor should master a wide range of modes and theories of instruction applicable to the clinical environment, including "educational theory, cultural sensitivity, knowledge of behavioral science, professional and organizational ethics, theology, and pastoral identity" (Accreditation Commission 2005:112). The supervising chaplain should also demonstrate a familiarity with new theories that exist in current literature, so as to assist individuals with their pastoral function, reflection, and identity formation in the application of these theories from unit to unit. This includes an ability to

[5] Most trainees also had outside spiritual and/or counseling support during the residency, in addition to the weekly individual sessions with the program supervisor, to decompress and receive ongoing support. Several had been diagnosed with depression in the past, and some were taking antidepressants while in the program, ostensibly for their own issues, but arguably also to help manage the emotional and psychological onslaught of the program.

assess "an individual student's learning patterns, personality and religious history as a basis for supervisory strategies," oversee both clinical and written work produced by residents, discern students' pastoral and personal resources—and the use of these strategies—for coping with the demands of the work, helping them to take responsibility for their own learning and actions, and shaping the ability of distinct individuals to work productively as members of teams (Accreditation Commission 2005:111).

APPLICATION AND SELECTION PROCESS

> The interview for admission to CPE provides an opportunity for a qualified interviewer to meet with the applicant to discuss the application, to provide information and answer questions, to dynamically engage the applicant as a person and learner, to assess the applicant's readiness for CPE, and to discuss the selection of particular centers suitable to the educational goals of the applicant. [Accreditation Commission 2005:76]

CPE attracts a wide range of individuals from both Western and Eastern world religions. Due in part to the history of pastoral care in the 20th century, patient demographics, and the exigencies of ministry in secular clinical settings, hospital chaplaincy programs in the U.S. are rigorously ecumenical. Likewise, national policy states that an accredited center must have an admissions policy "that does not discriminate against persons because of race, gender, age, faith group, national origin, sexual orientation, or disability" (Accreditation Commission 2005:97). CPE training is designed primarily with the needs of seminarians and clergy in mind, but it is also open to qualified laypersons—adults who in almost all cases have completed the bachelor's degree or its equivalent and who have undertaken graduate-level study in theology.

Applications for CPE are not simply or primarily a question of intellectual ability and good letters of reference. Nor is it simply a matter of making a good match between training site and the interviewee, though this is certainly important. It is, rather, a process, a journey in which potential students demonstrate their capacity for vulnerability and self-awareness through a lengthy, highly personal set of essays and intensive in-person interview that is part confessional, part psychoanalysis, and part adoption agency.

All candidates complete a 10-12 page application essay, which includes the individual's life history, family relationships, religious and spiritual development, description of illnesses that the

person has experienced or witnessed, examples of situations in which s/he was called to be a supportive presence to someone in distress or struggle, personality strengths and weaknesses, preferential learning methods, openness to self- and other-critique, and experience ministering in a non-judgmental fashion to individuals whose beliefs and values are at odds with one's own.

Interviewers look at a number of factors to determine suitability for training and work with afflicted individuals. Interpretative assessments of psychological issues—affect and demeanor, ability to relate to people with empathy and sensitivity, motivation, openness and capacity to share feelings candidly, and maturity. All of these elements are subjective yet are central to the final decision (Accreditation Commission 2005). Because CPE is a uniquely demanding mode of instruction, the supervisor must determine why the individual is seeking training in such an environment, if the candidate is suited for the clinical method of learning and reflection, and how such a pedagogy could fit into his or her broader educational goals and vocational journey. Similarly, she will discuss the candidate's family background, religious history, practical concerns apropos to participation in the program (financial resources, accommodation and transportation issues, any physical limitations, potential impact on the applicant's family and other relationships, and so forth). For older applicants who are contemplating a change of career, supervisors are keen to know why an individual desires such a move and seeks to determine if CPE is an appropriate arena in which to consider a new vocational path.

In addition, those who select a hospital like the one in which I did my research should know at some level that they are going to face dramatic, emotionally charged situations in extremis, far more so than at a local or community hospital that doesn't have a trauma bay, medical and nursing students, transplant programs, experimental procedures, and an abundance of huge egos on staff.

Clinical Duties and Skills Development

Residents are typically assigned two or three inpatient units for the duration of the program. At the beginning of the year, students tour the various units and, together with the supervisor, select one or more floors to cover; combinations are frequently thematic (for example, neurotrauma and general neurology or cardiac ICU and cardiothoracic surgery). Usually, this means that the student will be *the* chaplain for that unit during regular business hours (Monday – Friday 08:00 – 17:00). He or she will spend the majority of the time on the assigned floors visiting patients on the unit and talking with family members and friends of patients. Unless an individual specifically requests a chaplain from his/her own religious tradition (e.g., for the administration of sacraments or to discuss

specific doctrinal issues), the chaplain on that unit will work to address the needs of those present, regardless of religious affiliation. Residents also consult with nurses, social workers, physicians, and others regarding various aspects of a patient's status, review and document interactions in medical charts, attend discharge rounds and bioethics meetings, advocate for patients when needed, administer sacraments or other rituals of healing, and serve as a mediator in situations of disagreement or conflict between parties.

While ACPE guidelines stipulate that accredited centers must provide students access "to a population of sufficient size to provide opportunities for ministry and learning" (Accreditation Commission 2005:94), this is usually not a problem in most hospitals, because—especially as lengths of stays decrease and as hospitals increasingly operate near capacity—there are far more patients than chaplains to visit them.

In terms of the division of labor on the various floors, personalities and life experiences influence the choices that residents make for particular units. Such decisions are often a matter of proximity: the student may have had that particular class of illness or knew someone who did. Conversely, s/he may be afraid of a certain unit, such as inpatient psychiatry, or may feel that s/he is not ideally suited for the unit—such as male residents on OBGYN. That said, packages at large, multi-specialty hospitals almost always include an intensive care unit (ICU); choices more generally are structured so that a resident will encounter a range of degrees of illness severity, gender, age, patient load, and some sense of continuity of care across units (e.g., neurotrauma, neurosurgery, and general neurology).

In addition to work on their assigned units, chaplains also assume a number of additional tasks throughout the medical complex. Hospitals with trauma centers frequently have a chaplain respond to all trauma codes, primarily to address the needs of family members and friends, but also to comfort the trauma patient. Chaplains may also respond to code calls to provide similar assistance as part of the response team. Beyond their clinical duties, chaplains may also serve on bioethics review panels, conduct chapel services, serve on various hospital committees, offer workshops and support sessions for hospital staff members, give lectures for medical/nursing students and community clergy, coordinate morgue viewings and memorial services, and conduct scholarly research.

Centers that provide 24/7 pastoral coverage have a chaplain who covers the entire complex on an on-call basis after business hours. Regular staff chaplains and alumni/ae volunteers may contribute to overnight, weekend, and holiday coverage, but CPE students are typically assigned to cover most, if not all, of these slots. When it is a person's turn to assume this duty, she takes the on-

call chaplain pagers and remains in the hospital for the duration of the shift. Overnight work varies widely in terms of the number of calls: rarely does a chaplain get six or seven uninterrupted hours of sleep in the on-call room—three or four is typical—but instead may be awoken multiple times to attend to traumas or to other needs throughout the hospital. On a busy Friday or Saturday night, particularly when the weather is hot and townspeople are out and about, the chaplain can expect a sleepless shift.

There is a crucial difference in the training of chaplains versus those of other clinical trainees. From their first day as practitioners, residents work on their units without direct supervision. The CPE supervisor is not present with them when they are with patients, and he neither models nor critiques the trainee's work as he is doing it. Instead, the resident brings to the supervisor and to the cohort transcriptions *from memory* of encounters for analysis. Each week, a resident selects a clinical interaction that seemed particularly challenging or frustrating and, following that meeting, types the conversation as she remembers it, noting both verbal exchanges and non-verbal cues—facial expressions, moments of silence, and significant artifacts in the room. In addition, these so-called "verbatim" accounts also include general information about the patient's current medical status, significant relationships, vocation, education, socioeconomic status, religious affiliation, spiritual history, and any life experiences that may have impinged upon the conversation and the person's state of mind in the pastoral encounter. This information, and the experiences of the participants, are interpreted in a variety of ways but are ultimately considered religious encounters that must be seen through a theological perspective.

Particularly through discussion of these verbatims, residents develop an indirect sense of the supervisor's own clinical pedagogy; his questions, suggestions, and comments help residents to guide their attention and reflection in preparation for subsequent clinical work. The supervisor thus "provides guiding frameworks and tools to help the novice chaplains make sense of what they encounter in the hospital" by helping them to organize the immense amounts of information "that they must process when visiting a patient and also help them track their growth in the personal role" (Compton 2007:226). He must nonetheless seek a balance between allowing students enough space to struggle and grow without giving them complete freedom in such a way that a patient or family member would be harmed by incompetence or malice.

PHILOSOPHICAL DEVELOPMENT AND MATURATION

In terms of coordination between program requirements, clinical opportunities, and philosophies of intervention, ACPE requires that "each type of CPE program offered requires students' involvement in a ministry to persons appropriate to the type of program offered" (Accreditation Commission 2005:104). Specifically, the clinical limits and possibilities of various patient populations must be such that residents may "become familiar with and apply relevant theories and methodologies to one's ministry specialty," develop their own philosophy of care for particular units/patient populations, and demonstrate competence within that particular specialty (Accreditation Commission 2005:104).

The pedagogy that has emerged from the various schools of thought emphasizes a variety of relational, diagnostic, hermeneutic, and other skills for use in the range of encounters that chaplains face in hospitals and in other settings in which they are called to intervene. Some of these skills are mechanical in nature and can be learned through reading or observation. More commonly, however, they are epistemological and phenomenological abilities that can be honed through experience but which presuppose a certain affect, emotional intelligence, and intuition that are identified when individuals apply for the training.

The place of theology in pastoral ministry is a central consideration and provides a good starting point for understanding the development process. Ideologically, CPE views itself as an educational program designed for a wide range of religious beliefs and so, within certain parameters, it does not attempt to instill a particular doctrinal outlook within students, but rather to introduce opportunities for them to draw upon their beliefs in their interactions with a wide range of persons within the clinical setting. This process is designed to help students to utilize their convictions to guide and shape their exchanges with individuals, to analyze the exchange in subsequent reflection, and then to re-affirm or challenge the beliefs in preparation for the next clinical encounter. Tradition and experience are thus situated in a dialectical relationship; CPE does not demand that students change their beliefs, but it does require them to confront dramatic life situations in such a manner that residents are forced to confront problems of uncertainty, evil, and suffering—issues that have long been problematic for doctrines that attempt to be unified, consistent, and universal. In this sense, students are expected to develop their own theology in a manner that accounts for what natural scientists might call exceptions that prove the rule, destabilize it, or cause it to collapse altogether.

Such challenges also emerge as students meet, and attempt to support, individuals from religious traditions that are different from their own, without attempting to proselytize or condemn the afflicted person for choosing said theological framework (Accreditation Commission 2005).

Relativism is an issue that students in any large, diverse patient population will necessarily confront, as they discern how, and to what extent, to relate to the person in need. The program is structured in such a manner that students are taught to seek a holistic view of patients' lives—family history, socioeconomic status, vocation, significant relationships—and to consider these factors in light of a range of behavioral sciences theories to attempt to develop a sophisticated, empathetic understanding of the patient's lived situation, and particularly (if implicitly) to view the person's theological understandings as reasonable in light of these data. This often means learning the doctrines, history, ecclesiology, and mission of other traditions, not to convert students to a new belief system, but instead to increase their proficiency as caregivers and specifically their ability to respond accurately to questions of belief that patients may raise in the clinical setting. Thus residents are expected to note the idiosyncrasies of each person's life story while simultaneously seeking to discern what are considered to be universal human emotions such as suffering, fear, and hope.

Key factors in the development of the ability to relate to such a diverse population are basic psychological and interpersonal needs in moments of crisis, particularly when dying, death, and loss ensue (Accreditation Commission 2005). If there is a single, overarching ethic of CPE, it is the determination that chaplains will offer an unconditional, altruistic regard to all persons in the clinical setting, especially through the student's work to initiate and sustain therapeutic relationships with anyone, regardless of religious tradition, age, gender, ethnicity, sexual orientation, height, weight, language, medical condition, voting behavior, taste in furniture, or any other factor.

Because the vast majority of individuals who enroll in CPE never become hospital chaplains, but instead take a single unit in preparation for other forms of religious leadership, the pastoral skills developed and processes utilized are intended to be applicable not only within the clinical setting, but also in any context in which persons interact with other human beings in a healing capacity. Diagnostic skills, basic listening techniques, multi-specialty teamwork, periodic supervision by experienced practitioners, interaction with other professionals, management and public speaking skills, and the dialectic of theological beliefs with everyday life experiences (Accreditation Commission 2005) are examples of abilities that the program views as critical to successful ministry, and one might add, to successful functioning in society in general.

It is reasonable to consider a substantial amount of the training of CPE, the formation of "pastoral competence," little more than a savvy habitus, a particular way of being-in-the-world that is compassionate, patient, other-centered, and altruistic. But religious? This is a key question that I consider at various points throughout the thesis, for there is no clear, simple answer to this issue. Residents learn to see themselves as religious specialists and reflect upon the ways that they interact

with and affect other individuals, most notably persons experiencing great uncertainty and distress; specifically, they learn to identify and analyze how their "values, assumptions, strengths, and weaknesses affect their pastoral care," in order to be more effective healers (Accreditation Commission 2005:107). They develop an awareness of pastoral conversations as a unique and intensive (and often also extensive) form of narrative interaction, one that may or may not contain explicitly theological content but which is, for a variety of psychological and emotional reasons, necessarily a distinctively religious social phenomenon. Students vary widely in the extent to which they view the world in primarily religious or primarily secular terms, yet while they are enrolled in the program, they become aware of the ways in which various "persons, social conditions, systems, and structures affect their lives and the lives of others" and in which they must attempt to address these issues as religious figures (Accreditation Commission 2005:104).

For example, students increasingly aim to "initiate helping relationships within and across diverse populations" (Accreditation Commission 2005:108). This goal might at first glance seem both obvious and mundane: *all* clinical hospital workers, regardless of religious inclination, should be able to accomplish such a task. Anthropologically, however, this posture is interesting because of its scope. It is unusual, if not culturally unique, for a religious specialist (a) to initiate interaction with another person of his own volition (b) with the intent of offering healing through a relationship (however brief in nature) (c) to individuals whose cosmologies often differ from his own, (d) where he receives no compensation or reward from the person(s) involved, (e) does not proselytize or (except in exceedingly rare cases) attempt to convince, and (f) offers no solutions to his interlocutor.

Residency Peer Group Activities

While residents work almost exclusively solo in their direct patient care, teamwork with their chaplaincy peers is an absolutely crucial component of the training process. This is not to say that collaboration in the classroom will be instantaneous or facile, however; initially, it is often the opposite. Many supervisors intentionally select a diverse cohort in order to challenge students, to force them to confront, and work alongside, persons from different theological, socioeconomic, and other positions. Much of the rationale for such groupings recognizes that patient populations—to say nothing about potential sites of employment and service at the end of the student's period of theological study—tend to be quite heterogeneous.

Entropic tendencies notwithstanding, there exists a clear, firm boundary that demarcates each cohort as a unique, exclusive group. The confidential nature of this setting exists not only to

maintain the privacy of patient information discussed during the two weekly verbatim sessions, but also to protect the integrity of the members of the group, in order to give them a space where they can be candid about their fears, frustrations, hopes, and struggles without worry that such information will spread to other parties. It gives them wide berth to rethink many of their basic assumptions about human behavior, social interaction, and the supposedly universal content of belief systems.

Groups exist reflexively, to help participants learn about themselves in the process of doing ministry. This "relational learning environment" is designed to foster growth in pastoral formation, reflection and competence; such an environment involves "mutual trust, respect, openness, challenge, conflict, and confrontation" (Accreditation Commission 2005:105). The classroom component of the program is also structured "to develop students' ability to engage and apply the support, confrontation and clarification of the peer group for the integration of personal attributes and pastoral functioning" (Accreditation Commission 2005:107). The refinement of interpersonal awareness can occur through group leadership, conflict resolution, and the recognition "of relational dynamics within group contexts" through a range of communication skills (Accreditation Commission 2005:110). Cohorts meet daily with the supervisor for a variety of such training and reflection activities, including the verbatim presentations, documents that serve, in the words of Cole, as "mediating artifacts in the development of human thinking" (Compton 2007:13); guest speakers; didactic training sessions with experienced practitioners; and a monthly current literature review meeting. In these and other activities, there is a great deal of mutual training and development, particularly through reflection on mistakes and points of resistance and fear, and through mutual education on various religious traditions and life experiences represented in the group.

Another key element of the program is Interpersonal Relations (IPR), a 90-minute slot of unstructured time each week for residents to raise issues of personal concern regarding themselves, the emotional and spiritual demands of the program, and struggles in key relationships in their lives. There is a wide range of emotions and affect at these meetings, from crying and screaming to laughing and whispering. Sometimes little is said, sometimes more, but the time is meant to be cathartic as well as edifying. The meeting occasionally resembles group therapy but is just as often an existential round table. Depending on the cohort, camps or cliques may form, leading to sentiments of jealousy and mistrust. There may also be infighting due to personalities, senses of competence, and different work ethics. Residents can be sharply critical of each other during these sessions and quickly dispel the myth that chaplains are naturally winsome.

The residency thus presumes a fairly mature willingness to stand emotionally naked before others and to confront one's innermost fears, biases, and revulsions with the presumption that self-

knowledge will lead to greater empathy and compassion for the weaknesses, fears, biases, and revulsions of others. This process of learning to see the self as fragmented, broken, and flawed as the starting point for interacting productively with patients and others in vulnerable states may seem a strange way of nurturing authority, yet this prodding of a person's points of weakness can indeed make trainees stronger and more able to function productively when they confront similar issues back on the units. It utilizes recent experiences and past memories to generate near-instantaneous action on units in an ongoing dialectic with the slow, deliberative, and meditative nature of the classroom setting, a sort of bricolage-meets-habitus pedagogy. Likewise, it demands a consistently heightened awareness of the experiential elements of the program, a practice of heightened consciousness without the peyote.

Students also take an active approach to their learning through the development of quarterly goals for personal and professional development. Each term, in consultation with the supervisor, residents articulate 1-2 areas of focus for reflection and discussion with the peer group. These activities can range from increasing an awareness of how the student's identity as a minister affects other persons to developing a greater sense of personal authority to setting aside time each week to focus on the person's own spiritual journey, exercising, or simply getting enough sleep. Residents then report back to the peer group periodically on progress with these self-defined learning goals.

BETWEEN COMPETENCE AND EFFICACY: GAUGING PROGRESS IN CPE

National ACPE Standards

Three levels of CPE exist: Level I, Level II, and Supervisory.[6] Both Level I and Level II emphasize the development of pastoral formation, competence, and reflection:

- *Pastoral Formation* includes basic awareness of and facility with theories of pastoral care and counseling as applied to specialty interests, theories of human development (personal, moral, faith), theories of change (personal, organizational), applied theology (social justice, interfaith dialogue), and theories of spirituality and spiritual assessment.
- *Pastoral Competence* denotes pastoral care skills and includes short-term strategic counseling, crisis care, planning care based on

[6] Supervisory CPE was offered at my field site, but because it was for all intensive purposes distinct from my training and research interests, I do not elaborate on it in this thesis. Those who are interested may read more at www.acpe.edu.

spiritual assessment, goal setting and prioritizing regarding spiritual program development, ministry with diverse populations. It also covers a student's self-management of learning through professional certification organizations and requirements and the use of consultation for learning and professional growth.

- *Pastoral Reflection* highlights self-awareness through in-depth personal and theological reflection, use of self in the ministry encounter, and the formation of pastoral/professional identity. [Accreditation Commission 2005:110]

Level I "addresses the fundamentals of pastoral formation, pastoral competence and pastoral reflection through one or more program units." (Standards Committee 2005:11). Level II "addresses advanced competencies and issues of pastoral function, reflection and interaction in a program of at least four units of CPE, including Level I CPE units completed in one or more authorized ACPE Centers" (Standards Committee 2005:24). Likewise, Level II emphasizes proficiency such that students may attain professional certification and, if so desired, the ability to apply for admission to Supervisory CPE.

The ACPE Standards specify a variety of forms of assessment over the course of the residency, from informal feedback in lunchtime conversations to quarterly evaluations of the student's CPE experience by the supervisor and by the student. CPE supervisors use a range of devices to gauge the quality of a student's interactions with individuals and the thoughtfulness of their reflections on these conversations. Verbatim reports are a primary mechanism for determining the sophistication of a resident's work and his ability to grow as a result of previous clinical encounters. Active participation in other classroom activities and the thoroughness of a resident's weekly report to the supervisor are also significant gauges of a person's assimilation of materials. Such documents are important because they speak to residents' ability to recognize patient needs and respond to them effectively with approved pastoral techniques, but also because they help a supervisor to assess the resident's growth as an individual, a component of the overall assessment that is equally important.

Formally, the foci of the evaluation experience are "the student's individualized contract and learning goals, learning issues that have emerged in the CPE experience, [and] the objectives and/or outcomes of the CPE program" (Accreditation Commission 2005:78); each center develops a curriculum plan that "describes its procedure for developing individual learning contracts and

completing an evaluation of the student's progress" (Accreditation Commission 2005:108). The supervisor's assessment "reflects professional judgment about student's work, abilities, strengths, [and] weaknesses" and accompanies the student's own final evaluation in the candidate's dossier (Accreditation Commission 2005:106).

A complete list of CPE outcomes for Levels I and II can be found in Appendix D.

Discussion

One of the central tasks for chaplain residents in CPE is to cultivate a stable, compelling therapeutic authority through the mastery of specific clinical skills in the absence of formal, graduate-level biomedical training that aims to solve patient problems. This is no small demand, in large part because scientific knowledge is the main currency of the hospital cultures. Yes, attentive chaplaincy students often develop a fair amount of lay knowledge about certain medical specialties through informal conversations with staff colleagues and the observation of procedures—medications, common symptoms and side effects, intervention sequences for codes, and the like—and such information may prove helpful for understanding patients' broader situation. Importantly, however, while a chaplain can *learn* such facts, she cannot *claim* this knowledge as her own, nor can she attempt to utilize it as part of her interventions. She can attempt to claim authority via humanistic knowledge (e.g., religion, morality, narrative, social anthropology), and the right sort of affect can also bolster her status within the culture of a given unit, but this potential for influence will necessarily remain limited to certain elements of therapeutic endeavors.

Herein lies a central inequality in the cultures of this hospital: physicians and nurses can claim authority through their command of diagnostic and interventional scientific knowledge, and they have specific, quantitative tests to measure changes in health status in response to many of these tasks. Further, I argue that the nature of such knowledge in the clinical milieu gives them credibility that extends to the moral realm as well. Yes, patients and family members may challenge or resist normative prescriptions that accompany scientific pronouncements, yet I suggest that at this hospital, at least, such authority among the medical staff was something to be lost, rather than gained.

By contrast, the moral and theological knowledge of the chaplain carries with it essentially no scientific power or authority, despite numerous attempts in recent years to quantify the effects of various clinical religious practices (see Koenig, et al. 2002 for a synopsis of such studies). On the surface, at least, this situation from the perspective of the patient parallels that described of psychoanalysis as described by Luhrmann: "there is no public and clear-cut threshold of adequacy, no basic competence, as there are in diagnosis and psychopharmacology" (2001:72), despite the aforementioned Level I/II CPE goals. That is, meeting personal and curricular goals of CPE is not

the same thing as meeting therapeutic goals related to particular patient outcomes. Hence, a student may learn to be an extraordinarily good chaplain according to the standards set forth by CPE, but this does not automatically imply that the person will be an effective healer. Yet if there is no straightforward way of determining if interventions have any effect, we must then ask if there is anything substantial to be gained in trying to ascertain if an apprentice has mastered a particular set of skills.

Several responses are in order here. First, recall that chaplaincy and religion operate on temporal horizons not always aligned with those of biomedicine. A significant amount of clinical pastoral work attends to issues not specific to the illness event(s) for which the person was admitted but to larger life experiences and ways of being in the world. A chaplain may suggest a particular change or option for a patient—spending more time with one's children, for instance, or trying to be more compassionate toward one's co-workers—that will not commence until after discharge. Unlike medicine, which can schedule follow-up appointments to check the progress of interventions begun in the hospital, chaplains possess no such mechanism for tracking patients and hence never know the results of such intermediate- and long-term interventions. As clergy, residents should have been accustomed to work in which the impact of their words and interventions was not always or immediately obvious.

Second, I argue that, while biomedical knowledge carries with it the potential for repair and for causing patients to internalize its rules and suggestions about self-surveillance for preventative purposes, its tendency away from contextual, humanistic interpretation and symbolism, in favor of iconic and indexical relations between images and things, renders the concept of healing opaque for most biomedical clinicians and ultimately limits the moral resonance of their work. Such semiotic under-determination, particularly if we accept the notion of the body's insistence on meaning (Kirmayer 1992) gives the interpretive, dialogical work of chaplains significant healing authority over events in the present. True, chaplains at my field site would agree that it would have been exceedingly odd to expect the repair of physical bodies in the absence of biomedicine, but I argue that it is just as difficult to claim healing simply by satisfactorily controlling somatic damage, even if the patient agrees that the intervention was successful on a somatic level. Such reductionism manifests itself as de-contextualized repair without space for forgiveness and judgment without the possibility of reconciliation, both key elements in social considerations of causality and culpability. Or, perhaps more charitably, we could say that the biomedical work of the clinic can oversee the physical repair needed for reincorporation of the afflicted back into society, but it is still not as well positioned as religion to facilitate the reincorporation of individuals suffering from internalizing

misfortunes—afflictions that they have brought upon themselves—back into their social worlds through reconciliation with themselves and others, human or divine.

The point I am trying to make here is that healing for CPE students is more than simply a question of learning techniques to negate or minimize disease or injury, and it is here that it becomes possible to develop a sense of pastoral competence. Chaplains play an important role in the work of confronting misfortune through hermeneutics and mediation, both at the individual level and at the level of the corporate, communal body. Rather than appealing to scientific technologies to determine (or pronounce) a person's state following hospital admission, chaplains emphasize a person's self-assessment of her own condition to help her to articulate her own understanding of the situation and then, from there, to explore possibilities for the future. The facilitation, or perhaps co-construction, of this state is largely dependent upon the chaplain's prowess with words and his ability to grasp the patient's own voice, her thoughts, and her interpretations in light of his own growing self-awareness. Therefore, a key component of the therapeutic process is the ability of a resident to facilitate movement from disease (or injury) pronouncement to disease interpretation, then to illness interpretation, ever with an eye on spiritual, psychological, and social ramifications. This last step is perhaps most significant in terms of healing and most unique to the work of chaplains, for here the emphasis is not only the act of interpretation but also the contextualized rationales for various interpretative and conciliatory methods as related to a person's overall well-being.

It is here that a third component of proficiency comes into focus. Is a resident able to articulate a clear vision of the cultures of the hospital in light of his own theological beliefs and life experiences, and can he then identify, and realize, concrete goals related to perceived weaknesses and inequalities in the ways in which the clinic functions as a social and therapeutic entity? Inasmuch as CPE views disease and injury as inherently social events, a key goal for trainees is to understand the ways in which the cultures of the hospital frame and influence the (1) processes by which patients and family members relate to their own everyday social settings, (2) affliction event in these various cultures, and (3) ways in which these cultures relate to each other. In other words, chaplains are adjudicated in part on their ability to recognize what we could call a cross-cultural, or even cross-cosmological, aspect to the illness journey and assist participants in their ability to understand and relate to these various worlds throughout the therapeutic journey.

Very occasionally, chaplains receive verbal affirmations or other clues as to the effectiveness of their work with patients, but the very fact that residents are so frequently called in when death is immanent and/or has occurred means that many of the same standards of success that biomedicine applies cannot hold here. This does not mean, of course, that there aren't more and less appropriate

ways of handling such events, but rather that patient recovery simply cannot be the sine qua non of their work. This is true not only because the chaplain's therapeutic work often intensifies post-mortem—comforting distraught family members, arranging morgue viewings, or providing information about funeral procedures—but also, from a metaphysical standpoint, because death is not viewed in the same ontological light.

OUTLINE: A DAY (AND A HALF) IN THE LIFE OF A HOSPITAL CHAPLAIN RESIDENT

08:00 Morning report. Recap of the previous night (24/7/365 coverage of entire hospital), brief discussion of any new clinical issues that emerged, divvying up duties for the day (am/pm pager, chapel), meetings and seminars. Offer support to person going off duty. Chance to de-compress.

08:45 Resident verbatim presentation to peer group and supervisor.

10:15 Morning rounds on my units. Follow up on a patient referral from a charge nurse.

11:35 Spontaneous conversation with colleague about a patient.

12:00 Chapel. Monday to Friday. Residents take turns leading. Inter-faith. Fair bit of leeway in liturgical style but not in terms of doctrine. The chapel space is open to all, day and night. Ministry often occurs there with distraught family members.

12:30 Lunch. Usually taken in hospital cafeteria with peers.

13:30 Afternoon rounds. Prioritizing patients to visit, talk with unit secretaries, consult with nurses, chart, and meet with family members. Meanwhile, another resident has weekly individual meeting with the supervisor. Another is covering an additional floor for a staff chaplain, who is on vacation that week. Another spends part of the time working on the final evaluation for the quarter in the seminar room and then goes for patient visits.

16:30 Receive on-call pager. My turn—usually once a week. Get report on happenings from colleague. Tidy up these cases.

18:00 Pick up dinner from cafeteria.

18:10 Trauma #1. Motor vehicle collision. Patient taken to surgery and admitted. Meet with family and provide updates about patient's whereabouts. Escort trauma surgeon to meet family and answer questions.

19:00 Eat a bit; log two new phone messages that will require attention in the morning.

19:15 Trauma #2. Gunshot wound to arm. Consult with police and comfort family.

19:20 Trauma #3. Stab wound. Domestic violence. Contact family by phone. Long pastoral conversation with patient.

19:45 Death on medical ICU. Offer prayer and words of comfort to widower and kin.

21:00 Back in seminar room. Finish dinner. Return to trauma to check up on patients and escort family members of trauma #1 to inpatient floor.

22:00 Evening rounds on the other ICUs. Quiet for the moment.

23:00 Check phone messages. Nothing new.

23:05 Page from neonatal ICU for Sacrament of the Sick. Contact Catholic priest on call.

23:10 Documentation. E-mail. Work for a few minutes on Employee Diversity Committee project.

23:30 Page for prayer on cardiac unit. Surgery tomorrow.

00:10 Trauma #4. Fall at nursing home. Ham it up with a couple of nurses and ED night clerks. I end up being chaplain for them as well. Offer support to adult child of patient by phone living on the West Coast; her brother just took a job in Hong Kong—she will contact him. The trauma surgeon subsequently calls the daughter to give an update.

00:30 Trauma #2 discharged. Offer prayer for patient and family.

01:00 Sleep.

03:12 Trauma patient #3's family arrives at hospital. Return to the bay to comfort them.

03:30 Call for emergency fetal baptism on Labor & Delivery.

04:00 Documentation. Read *The Onion* online for a few minutes to clean out my head.

04:30 Sleep.

07:45 Get up. Print out on-call report.

08:00 Deliver morning report.

08:30 Breakfast from the cafeteria. Plenty of sugar and caffeine please.

09:00 Follow up on a couple of patients on psychiatry.

10:00 Monthly departmental research seminar. I sit near the back and try to stay awake.

12:00 Chapel.

12:30 Pack and go home to cats. Shower, cover the windows with thick curtains, and sleep for 17 hours straight.

4

NEW ENCOUNTERS AND DESTABILIZATIONS

THE COMMUNITY MINISTER BECOMES A HOSPITAL CHAPLAIN

Preparing for a New Role

Residency cohorts are designed to bring together a diversity of ages, denominations, personalities, and life experiences. Such was the case in this program: eight residents total (five women, three men), ranging in age from 29-55 and representing a wide diversity of theological (including Methodist, Episcopal, Northern Baptist, Pentecostal, Presbyterian, and Interfaith traditions), socioeconomic, and embodied perspectives. Some knew the hospital reasonably well, either through visits to loved ones there or through their first experience as a 10-week chaplaincy intern many years ago. Some had lived within a few miles of the hospital their entire lives, while others came from other parts of the country and had only been introduced to it during on-campus interviews.[7] Each had ideas about what the patients would be like, how the doctors would act, and what the medical center thought of chaplains and religion. Also, residents realized that they would need to have support structures and resources away from the hospital setting to find emotional and spiritual refreshment and to be diverted from the pain and suffering that they would see on a daily basis. One resident from another state explained that he "studied the city and explored as I worked passionately creating a somewhat splendid environment for myself. This was not particularly an indulgence; I knew I would really need this in the months to come." Indeed, most appeared to realize that their work could very easily become all-encompassing.

The concept of Western medicine was variously familiar to all of the residents through their own life experiences of health and illness and those of family and friends. All had been hospital patients at one point or another; they could identify basic devices and apparatuses in this cultural

[7] Due to confidentiality restrictions at the hospital regarding clinical information, I do not present more extensive specifics about the residents or their connections to the specific cases discussed in Chapter 6. While this level of anonymity may leave some social science readers longing for greater detail about the ways in which individual life histories are manifest in the classroom setting and on the inpatient units, I believe that the sensitivity of the issues presented warrants the highest level of concern for the protection of informants—be they patients, family and friends of patients, CPE co-workers, or other hospital staff—and as such justifies the lack of greater identifying characteristics in the pages that follow.

world—syringes, x-ray machines, blood pressure monitors, sacs of saline solution—and recognized these objects as normal and appropriate components of the healing enterprise. Cognitively, they didn't question the usefulness of stethoscopes any more than they wondered about the value of elaborate infection precautions. Such was the nature of science, as reasonable and familiar now as it was during routine check-ups during their youth. As one chaplain said at the beginning of her residency, "Because I have experienced several hospitalizations and surgeries for major and potentially life-threatening illness, I understand some of the patients' experience on a gut level. I know what it is like to receive bad news and to suffer through certain wretched medical procedures." We shall return to questions of memory and projection in due course, but for now, it is important to note this epistemological posture as indicative of a certain familiarity with the phenomenology of health and illness and a corresponding desire to pursue a therapeutic vocation in light of this chaplain's own recovery episodes.

At the same time, there was a great deal that chaplains neither knew nor understood—and that none would expect them to understand—about the practice of advanced medicine in the 21st century. Through repeated exposure and conversation with medical staff, a resident might develop an amateur sense of when intubation is appropriate for a trauma patient, which anti-psychotic drugs seem to work best with certain types of patients, and when it is appropriate to use stents for cardiac patients, for example, but they would not be the central workers in these procedures.

This division of labor reflected a pact, of sorts: medicine would not expect chaplains to know science in order to practice in this setting, but this meant that chaplains would forfeit the right to challenge biomedicine on the theories behind its procedures. For that matter, it would be difficult for these religious specialists not to be dazzled by the technology of the institution—by its complex diagnostic and interventional equipment and by the workers that operate such devices—and to question what they might do that these technologies could not. How could a chalice compare to a CT scanner? How would a prayer hold up against a pap smear? Could a chaplain really detect anything that a radiologist could not? While such questions would not arise frequently, there was nonetheless a vague anxiety about what sort of cultural or intellectual influence religious figures could wield when confronted with such a therapeutic armamentarium. Quite apart from the question of liturgical versus biomedical technologies, pastoral skills appeared to residents to pale in comparison to the training and prestige of biomedical staff.

Thus, when one resident said "I feared coming to this program. I asked myself, 'Can I really serve the sick, suffering, and terminally ill?'", she was expressing her anxiety not only about handling the psychological demands of working with the afflicted, but also, on a more basic level,

she was asking what she could contribute. She knew that biomedicine could not solve every problem of the human body or mind, and her faith in God was fervent. According to her worldview, God used biomedicine yet was not limited to it. By herself, she could be a kind listener and an icon for God. Whether or not her presence could stimulate any positive supernatural outcome—whether or not she might have privileged access to God and hence to negotiate a more favorable outcome when biomedicine could not—was a question that she would soon begin to confront.

Still, there was recognition among these new residents that, in taking on this role, their relationship with medicine would change. They would see medicine from the inside. As hospital employees and as care providers on clinical units, residents would be expected to notice how medical practice affected people—patients, staff, family and friends—on a phenomenological level. They would not learn how to perform a thoracotomy, for instance, but they would see enough of them to know that it is a dramatic, dangerous procedure that is exceedingly stressful for practitioners and rarely saves a patient's life. They would never be able to prescribe medications for a patient's pain, but they would encounter great suffering and would listen as individuals talked about the experience of it.

Entering the Hospital Space

Although residents are "in training," they are also acting—from the day they arrive—as religious specialists, practitioners with a willingness to step into intensely volatile situations for the benefit of others. As such, they must find a way to believe in themselves and in their ability to accomplish certain tasks, often through trial and error, in the first few weeks of the program.

Clinical pastoral legitimacy is ostensibly derived from the office more than from the individual in the first unit of the residency. The hospital as a social institution ascribes the role to individuals, and new residents are thereby activated, deemed valid, and justified. That may nonetheless be of little consolation to a student in her first week of training, who may feel quite fraudulent, and perhaps also visibly timid, interacting with patients and staff.

There were a number of aesthetic reasons for this lack of clear identity or role. Chaplains at this hospital do not wear distinctive clothing, such as a specially colored lab coat, to identify them as religious practitioners. True, a few elect to wear a small pectoral cross or yarmulke, and one donned the collar, but everyone else wore business/professional attire, which meant that it was not possible to identify these religious specialists visually, and this lack of unique identity further added to residents' initial senses of ambiguous function within the hospital. Similarly, the director encouraged them not to carry a Bible or notepad with them, further limiting the symbolic associations that individuals

might make. They looked like ordinary people in the outside world, and they would have to establish their identity in different ways.

Rather than familiar sacerdotal cues, chaplains were to be identified by their demeanor. They were just to be present—available—with nothing to hide. They learned to pay careful attention to the speed of body movements and to operate at a different tempo than many other practitioners, who often ran, yelled, and gyrated in the course of their interventions. Chaplains quickly recognized the value of a calm, stable affect in response to the often cacophonous nature of the clinical setting and sought to project reverential, engaged, and available persona.

A certain amount of this modesty reflected the change of venue for trainees. Most of the residents in my cohort had held positions of leadership in parishes or in other church-related organizations, in a couple of cases for nearly two decades. They were accustomed to certain checks and balances, to certain liberties as a person in command of an organization. They were skilled practitioners—trained and ordained. They had learned how to relate to people from the pulpit, at the potluck, and in the committee meeting. Pews, stained glass, and altars were familiar symbols of their workplace. They typically supervised multiple staff members and organized events for teams of volunteers or participants in church programs—boards of deacons, a youth group, or a soup kitchen. Some met individual parishioners to provide short-term counseling, say after the loss of a spouse or in preparation for a marriage, and they often found such encounters meaningful, but these meetings were usually a small part of their weekly duties. Likewise, most of them visited parishioners and others in hospitals, but always as outsiders, as visitors.

When they weren't in group meetings at their parish or in clergy meetings of the regional presbytery or diocese, they were usually in their office, working with words and texts, both ancient and modern. For most Protestant clergy, their public, official duties are three: preaching, teaching, and the administration of the sacraments. Depending on the denomination, the last occurred infrequently and, as forms of ritual, were in any case regulated by formulas and codes of conduct. The other two, by contrast, are highly idiosyncratic and demand originality. To prepare a weekly sermon, a minister will typically spend many hours consulting Biblical texts (in English, Hebrew, Greek, and occasionally Latin), commentaries on the Biblical texts written by eminent scholars, theological and perhaps philosophical writings, and other documents—anything from works of poetry to the morning paper—that help to make a sermon relevant and thought provoking to its audience.

All this is not to say, however, that residents were afraid of the hospital as a whole or viewed it as an undesirable place, one in which their previous skills and activities would be useless. Indeed,

no one in Christian ministry is required to complete a yearlong hospital residency program in order to practice his or her trade. They were there because they felt a special call to work in this environment, to interact with persons in this unique cultural setting and at very distinctive points in the lives of individuals and wanted to expand their professional skills in order to be able to meet this particular set of needs. As one resident remarked about his experience many years prior as a Eucharistic visitor[8] in a hospital, "I was led ceremoniously to a floor of the hospital caring for patients immediately before and after major surgery and left there. I felt instantly comfortable in that milieu, although to this day I cannot say why. Simply, I felt at home."

Even for those most enthusiastic about beginning the new role, residents felt the strain of assimilating a significant amount of information in a short period of time. In addition to the basic geography of the medical center, with its 21 floors on a dozen inconsistently interconnected buildings, chaplains must learn basic evacuation and building emergency procedures, get health clearance for patient contact, memorize protocols for trauma alerts and morgue viewings, and prepare daily chapel services. They obtain access codes to computerized patient charting systems and learn to document everything. Everything. Patient contacts per unit. Staff contacts. Family interactions. Types of services rendered (prayer, life history, grief counseling, guided meditation, sacrament, and more), length of interaction, initial or follow-up visit, perception of emotional state, and any referrals or plans for future visits. Gradually, they learn names of personnel throughout the hospital, develop a sense of the comparative medical and spiritual needs on various units, and start to get a sense for clinical temporality—lengths of patient stays and the implications of shifts from these norms, the nature of each half-minute of a code call, and the seemingly endless amount of waiting that patients experience for laboratory procedures, a new organ, or an infection to heal.

During the first few weeks, residents had yet to differentiate between the absolutely crucial, the important, and the optional, for everything seemed vital. They understood that they would participate in life-and-death situations on a daily basis, and as such, there was a significant anxiety about both making mistakes and being seen making mistakes. They who were once confident and poised as leaders were once again reduced to novices, middle-aged beginners, neophytes. "The unit began with the tour of the hospital," one resident explained, "and description of procedures (the trauma protocol was itself six pages long) and things looked unfathomable. They hovered above me like a massive and inviolable system I was continuously about to break with the most disastrous

[8] In the Roman Catholic tradition, laity may volunteer to deliver the Eucharist, previously blessed by the priest, to hospital and nursing home patients and others who are unable to attend Mass.

results … I felt I could not really relax into the people I was seeing until I got all these procedures down …. There was an embarrassing sense of, for lack of a better word, warriorship."

The hospital presented residents with additional complexities and apparent contradictions that made it unique as a site of religious intervention. For in fact there was not one hospital in which they worked, but two: the hospital of the daytime, when most of the clinical interventions and interactions occurred, and the hospital of the night, a very different social setting, with its own shifts of workers, routines, and senses of space. It is too easy to call the daytime hospital a high-pitched laboratory-classroom and the nighttime hospital a hotel, but the distance between the frenetic and the sepulchral could be quite jarring for residents, both emotionally and sensually. Entire floors, wings, and offices were abandoned, as though when the business day ended life drained out of the complex. Elevators that usually took forever and were perpetually crowded now came freely and afforded floor space for the cha cha. Waiting rooms themselves waited in the dark for footsteps, a cough, the rustle of file charts—signs of activity, signs of intentionality. Some (female) residents mentioned senses of fear, or at least discomfort, walking through empty corridors—the place was reasonably well patrolled by hospital security staff, but it was not Fort Knox, and they learned which hallways and corridors to bypass, if possible. Particularly at night, residents could look out certain windows across a grey brick walkway into the dorm rooms of university undergraduates, providing a stark contrast between bedrooms of brokenness, disruption, and isolation and community, effervescence, and playfulness. These were subtle yet important reminders that life was going on elsewhere.

Much of this new enculturation was common to every new hospital employee. Chaplains attended many of the same orientation sessions as nurses, food services workers, and patient records clerks. They heard the same corporate messages about institutional vision, learned the mission statement, and collected paraphernalia with the hospital's logos and slogans. They were encouraged—expected—to see themselves as part of a team, a service industry that prided itself on excellent rankings and customer satisfaction. The goal, it seemed, was to think in terms of client feedback and brand loyalty at least as much as salvation and Psalms.

Apart from the elements of the hospital that were unfamiliar yet need to be mastered, there were various processes of unlearning that would occur in the transition from parish to clinic. The documentation mentioned a moment ago reflects a degree of formal accounting and administrative duty that is frequently missing in most ministry settings. I sensed that few clergy enjoyed paperwork or quantitative satisfaction measures and could often avoid them in the parish. In the hospital, by contrast, personnel of all sorts faced formal performance standards and were expected to work at a

certain speed to earn their keep. Although chaplains were paid salaries,[9] they gradually learned to see their work in terms of contacts initiated and meetings attended—this many prayers offered, that many blessings given, so many fears about the future discussed. Conversations with the afflicted had the potential to become patient interactions. Reflections following meetings with the grieving were guided by software programs with specific fields and categories from which to choose. Residents struggled at the outset to balance such seemingly rigid, impersonal demands with a more flexible view of their work that acknowledged a variety of needs and responses. One resident, talking about the thick procedures manual for chaplains, nonetheless conceded that "We clearly need guidelines to keep this program running smoothly, and while I find such protocols about as pleasant as reading the tax code while constipated, I have been able to satisfy the letter of the law while recognizing the spirit that lies behind it."

Spontaneous encounters, "guided by the Holy Spirit," could still be powerful and meaningful, but they seemed to some chaplains to be routinized, categorized, and increasingly predictable. Residents acknowledged that they could never be prepared for every possible event or scenario that they would encounter at the hospital; there were always new techniques to learn, skills to refine, questions that they had never confronted. Still, the structure of the training program indicated a large degree of standardization in their work. In theory, family members might respond in an infinite number of ways to a drunken driving incident, but in practice, four or five prototypical reactions were likely to appear, and residents unconsciously or tacitly began to think in terms of these broad categories, even as they consciously attempted to leave space for idiosyncrasy.

These processes point to the broader several broader issues. As parish ministers, residents were accustomed to particular ways of relating to those in their charge. Depending on the size of the congregation, they knew many in their congregation on a relatively limited basis from the vista of the pulpit and the greeting line at the end of a service. Ministers knew better those who volunteered in the choir, for Sunday school, or on administrative committees, both as members of their flock and as collaborators (but not peers). They visited some in their homes, and a very few they visited in hospitals. Importantly, they knew many of these persons over a period of years, in a few cases baptizing them, confirming them, and later marrying them in the same sanctuary. They were present for many of the significant moments along the life journey, often in a ritual capacity, as persons moved from one religious stage to another.

[9] i.e., they were compensated not on a case-by-case or procedure-by-procedure basis.

Familiarity is not the same thing as intimacy in the clerical role, however. A pastor may see the same face in the same pew for years on end but never be invited into that person's innermost emotional and spiritual world. A congregant may never reveal his deepest fears, aspirations, frustrations, or longings, though he always has his envelope ready for the collection plate and his picture in the church directory. In many cases, this does not reveal a lack of trust or respect for the minister, but simply a lack of clear event or crisis that precipitates such a one-on-one meeting. It may also be the case that such a man is simply reserved with his feelings, has never reflected intentionally on his own life, or believes that he would just be wasting the minister's time with his feelings. Such persons may simply be unfamiliar with the pastoral counseling and support roles that clergy offer. They may know no one who has made an appointment to talk with a religious leader or may perceive it as something negative or inapplicable to them, such as Roman Catholics receiving the sacrament of Confession (or "Reconciliation"), a relationship that may strike them as vulnerable or prone to abuse. If a person does open up to his minister, it may a gradual process that occurs only after many years of relatively innocuous contacts at coffee hour or a weekend church retreat.

In the hospital, the nature of chaplains' interactions with persons is quite different. Although residents are encouraged by their supervisor to see each of their inpatient units as a parish, the parallels are in fact few. This metaphor may help new students to develop a sense of responsibility to their floors and to claim a certain sense of connection to the space. Over time, residents may develop relationships with medical staff members not entirely like those that she formed with secretaries, groundskeepers, and the music director at her former church. The patient-parishioner analogy is far less obvious, however, and residents learn quickly that they cannot approach these individuals in the same manner as they do the laity in their former work. "Unlike my previous work in a congregational setting, the time frame for interacting with my patients is limited to the duration of their hospitalization, which seldom lasts more than a week," one resident noted. For her, "this short span of interaction seldom provides the time required for developing a relationship of trust that is the optimal context for that partnership which is effective pastoral care. When my patients are in the hospital for more than a week, it is usually because the severity of their illness renders them incapable of receiving or responding to pastoral care," meaning that even if there is the possibility for multiple meetings, they are not necessarily productive conversations between two conscious and engaged persons.

Yet issues of temporality and degree of alertness are by no means the only factors that may differ in residents' work in the therapeutic role. In the hospital setting, biomedicine classifies patients using distinctive nosologies over which religion has no say. Individuals are grouped

according to disease and injury, not age, occupation, political outlook, or theological stance. My point here is not that diseases bear no relation to socio-economic factors—they often do—but that apart from gynecology and the neonatal ICU, the ways in which actors are bundled together at the hospital bears little resemblance to the ways in which groups emerge in the ecclesiastical realm. For example, it is common in a large city to find parishes organized primarily around class (e.g., old money vs. inner-city poor), ethnicity and/or language (e.g., Chinese-American, African-American, Polish), theology (e.g., fundamental, evangelical, liberation), and liturgical style (e.g., charismatic, traditional, New Age). Within a particular congregation, individuals are often identified according to a particular group or activity (the choir, board of elders, youth group, women's ministries, social outreach, etc.). Ministers may not consciously pigeonhole their flock according to such taxonomies, but the nature of their interactions one on one, and through group activities, emphasizes these distinctions within the larger parish community. For example, work with the youth group may invoke schemas of pizza parties, iPods, and discussions about dating, while work with the buildings and grounds committee may emphasize sanctuary roof repairs, painting Sunday school classrooms, and concerns about carbon footprints.

In the hospital, chaplains learn to re-conceptualize groups of people according to diseases imposed by science first and subsequently learn to get a sense for key topics that will organize their work as religious specialists. As one resident said of the psychiatry unit, "I am struggling to be an effective chaplain because the strengths I have come to rely on (intellect, education, life experience) are of limited use in the face of severe mental illness." The dynamics of the setting, from the physical space to the power relations between religious specialist and care recipient, are dramatically different from parish to hospital; even the same topics will have different trajectories because of these different contexts.

The end result of this migration to the cultures of the hospital is that residents learn through hands-on engagement. They can memorize certain protocols and observe various clinical phenomena, but such activities only become real through participation. Clinical pastoral care, in other words, emerges slowly, and imperfectly, through an intentional willingness to be present, to enter the fray, and to demonstrate relevance. Residents are expected, after the first week, to be able to handle a night on call solo—to be the only chaplain in the hospital and to meet all of its needs. Such opportunities shape the chaplain's senses of identity and purpose through a lack of direct supervision during clinical encounters as a means of fostering clinical perception, spontaneity, and creativity. It also helps them to recognize that their clinical work can be either crucially valuable or bypassed: a church service cannot realistically continue without the minister, yet a code call can.

Residents learn quickly that they are not the ritual or linguistic center of attention in the hospital as they are in the parish; their perspective and assistance may gradually be welcomed, even embraced, but it is never necessary from biomedicine's point of view. The chaplain must speak up if she is to be heard; few if any medical staff members routinely seek the religious specialist's input on patient care.

THE ANTHROPOLOGIST BECOMES A CHAPLAIN

The "action-reflection-action" model is the instructional method used today in Clinical Pastoral Education, and it is through this lens that I was taught to interpret the training that my residency peers and I received. This process reflects a number of parallels with other ethnographic accounts of initiation and enculturation: entering a more-or-less foreign culture, identifying and internalizing modes of governance and discourse, meeting key figures and discerning how to blend into their social environments, learning and applying particular healing skills alongside other trainees, reflecting upon one's emotions and sense of purpose, supporting and critiquing peers, and gradually developing a unique identity as a specialized practitioner. For this dissertation, action and reflection thus proceed on multiple levels: engaging in clinical activities with the mindset of a chaplain, analyzing these activities within the hospital from the perspective of chaplain resident, analyzing activities and reflections with the training cohort as a fellow religious trainee, and critiquing both of these endeavors as an anthropologist back in the academy, in the fullest reflexive sense of participant-observation. Discourse was not simply a therapeutic technique; it was, equally, a means of gathering data for reflection, both as a religious specialist and as an ethnographer. The persons I counseled and the meetings that I chose to document would require justification both in the didactics in the hospital and, subsequently, in this thesis. The nature of these questions would be different: the former focused heavily on self-actualization to uncover biases and weaknesses as a clinical care provider, while the latter would emphasize my methodological and analytical skills as a social science researcher.

It may not surprise the reader that this ethnographer experienced significant difficulties balancing these two roles, both during the program and in the subsequent redaction in Montreal. I was a student twice, training to be both an anthropologist and a hospital chaplain, moving from texts to conversations and theory to praxis. In both cases, I was learning by doing and learning by reflecting and analyzing encounters in a particular cultural setting. I struggled to be objective as a researcher while fulfilling the curriculum of the training program authentically and unreservedly. I

realized quickly that it would be difficult, if not impossible, to turn off my phenomenological self when writing up my field notes—I could not extract myself as researcher from the emotions and experiences that my work as a chaplaincy student generated while I was in the field. For a time, I felt that this reflected a shortcoming on my part, an inability to stay objective or to compartmentalize the clinical work from the rest of my time in the city. After a while, I simply accepted the fact that I would be unable completely to shut the hospital out of my consciousness while in the field and instead accepted this reality as part of my data. For better or worse, I did not intellectualize the experiences or reduce them to theoretical constructs; anthropological theories of religion, biomedicine, death, and narrative informed my gaze, but they seemed to have little impact on my visceral reactions to patients' emotions or their experiences of pain.

Likewise, I struggled with the anthropologist's role in what could arguably be considered a neo-colonial enterprise. I was wary about siding with power structures in the hospital, both religious and biomedical, in ways that might lead to exploitation or abuse. At the beginning of the research, I did not feel this particular tension. I was a Christian and believed in the work—the ministry—of chaplains as legitimate and appropriate. Through group discussions and the CPE curriculum in general, I became sensitive to the ways in which chaplains can abuse their roles and harm patients, but these insights provided data, rather than a response, to the question of the ethical nature of this work as an anthropologist. The fact that I believed in the work as a person of faith justified the work as research from the perspective of the social sciences, as did the enthusiastic support of the hospital's institutional review board and McGill's IRB clearance. Still, the tension between engaged researcher and ideologically conditioned practitioner remained a topic of concern for me throughout the training program.

REACTING: EMPATHY, PROXIMITY, AND SOLIDARITY

Difference and Otherness: Recalibrating the Normal (or, Habitus on its Head)

There is a range of categories and classifications that are challenged for residents in the first few weeks of the program, ways in which otherness is re-conceptualized and evaluated as both an epistemological tool and as a relational mode. Indeed, the hospital is a space that highlights otherness. Through a wide range of signs and practices, it demarcates in ways that are both familiar and foreign to the religious leader. Gender demarcates. Infections demarcate. Mental status demarcates. Ethnicity and socioeconomic status demarcate. Less obviously, guilt and agency demarcate. A significant portion of chaplains' training and enculturation reflects institutional

demands that they think in terms of these categories. General, or perhaps polysemic, divisions between purity and pollution/impurity/danger may seem reasonable to chaplains, even if the content of these categories is orthogonal to those of biomedical taxonomies. Others, such as compliant/non-compliant, may arouse suspicion and even resentment.

The residency also introduces new ways of experiencing, seeing, and conceptualizing people and the human body. The average human will look, smell, sound, and feel different from the average group of persons clergy see in congregations, in rush-hour traffic, and at the supermarket. Conditions that they have only read about, or seen on television, they will now experience immediately: the discourse of a patient diagnosed with paranoid schizophrenia, the smell of someone in acute renal failure, the glance of a middle-aged father waiting for a heart transplant. Death becomes routine and the grotesque mundane. Emotions that are uncommon are magnified and ubiquitous. Questions take on a new urgency. Everyone seems at least a bit desperate.

The world of the hospital is, in other words, strange. Chaplains see many people that they would not have seen, or necessarily have even noticed, before they entered the program, one in which the statistically improbable becomes quotidian. They may initially view such encounters in terms of evil, sin, and brokenness, but most commonly strangeness becomes a common catchword. "I was taken on a journey where to a greater and greater degree, I found the unique *strangeness* of each person or situation," one resident explained after a few weeks at the hospital. "This unique strangeness, or inimitable quality of each situation became a sort of amazement or awe with what actually is—truth *is* stranger than fiction, and it also holds much more wonderment and haunting beauty than fiction" (emphasis added).

In their roles as chaplains, residents are called to interact with persons at the extremes of what it means to be human in one of the most technologically sophisticated hospitals in the world. They often intercept the full, initial onslaught of emotions that accompany dramatic changes in life status. In part, this reflects a recognition that the chaplain is herself the other, the physically and psychologically intact, the exception among those she meets—friends and family may be composed on the surface, but they are typically disheveled on the inside.

Such a world of superlatives, a culture that is both magnified and exaggerated, a milieu routinely over-determined by minute shifts in somatic states, can appear both simpler and remarkably more complex than activities across the street from the front entrance. So many of the usual signposts of discourse, affect, and value are suspended—or at least modulated—by disease and treatment processes that it can be difficult for a chaplain resident to know how to interact with individuals. Particularly in the trauma bay, family and friends present themselves to the hospital

quite literally caught off guard, in sweats and T-shirts, hair uncombed, and a fresh coat of makeup nowhere to be seen. Patients, meanwhile, reveal lesions, scars, scabs, amputations, lacerations, outsize tumors, hairless heads, and artificial orifices.

A good deal of this variation in response to the other depends on the resident's own background. Those who have spent their entire lives in the area near the hospital will necessarily experience the hospital enculturation process differently from those who grew up in the West or abroad and for whom the main thoroughfares and public utilities of the city are still novelties. Likewise, those who worked in or attended inner-city churches will identify with some of the patients and their diseases/injuries, particularly physical violence and diseases related to stress, poor nutrition, and irregular access to health care, more than others. An important component of the training program is for residents to share these insights with their peers, to generate a collective cultural competence for interaction a wide range of patients—the idioms, the unspoken codes of behavior, the subtle cues—to overcome that which separates the insider from the outsider.

In this sense, a goal for chaplains is to make everything normal, by which I mean that a chaplain aims to be shocked by nothing. No situation, no visual stimulus, no dialogue, no reaction, no perspective should overwhelm or debilitate him. He should be calm, composed, and clear-headed no matter what the situation—or situations, as is often the case—may present. The hospital is a culture of inverted normality precisely because biomedicine has dictated that particular types of abnormality should be removed from everyday life and housed there for repair. Everyone is normal here because everyone is pathological, and residents must acclimate themselves to such a world. This is not an environment where people wear their Sunday best, or where crisis strikes only occasionally. There is no luxury of planning weekly schedules or developing familiar routines at the hospital, as there is in the parish; a chaplain must be prepared at any moment for everything and nothing.

Such an environment may at first seem carnivalesque, yet chaplains quickly discern some forms of logic and patterns beneath the apparently chaotic. Consider the following remark by a colleague: "Monday afternoon pagers, all is quiet until 2pm and then five traumas hit in just two hours. The tension in the trauma bay is crackling in the air. The waiting room is a heaving sea of malcontent humanity, the pager is bleating incessantly, adding demand onto unmeetable demand." Normal in such situations valorizes flexibility and ingenuity. Unmeetable demands must somehow be met. Chaplains often jump between radically different cultures and ideological outlooks within the hospital over the course of a single hour in a manner that may initially be foreign for them as religious specialists. They may circulate back and forth between death, waiting, fear, resignation,

psychosis, bawdy humor, and fury as a sort of psychosocial polyglot that somehow seeks to maintain a sense of cognitive integrity.

At the same time, residents are taught to see *nothing* as normal. Normal for the hospital is decidedly *not* normal for most patients and visitors, and chaplains must find a way to maintain this tension within them. Pain, suffering, fear, and yes, evil cannot become banal for them, lest they lose their ability to empathize or mirror. Phenomenologically, this is a difficult balancing act: chaplains must learn to distinguish the newness and uniqueness of each person authentically from their own reactions to the somatic. Such experience is a dialectical process that is by no means straightforward and which may become a life project, rather than a skill that is mastered over the course of the program. As one resident said during a quiet moment in the trauma bay, "I'm writing down events like stab wounds, MVCs [motor vehicle collisions], GSWs [gunshot wounds], etc. in a very matter-of-fact way. I'm trying not to reduce trauma patients to basic demographic statistics, but it happens sometimes."

Part of this trend reflects the biomedical gaze (see e.g., Ong 1995) and the tendency for chaplains to adopt the clinical mode of presentation. They learn to reduce encounters such as traumas to a few key items: name, presenting medical event (fall, stab wound, vehicle collision, and so forth), mode of arrival to the hospital (e.g., ambulance, helicopter, walk in), actions on patient's behalf (e.g., calling family members), religious interactions with patient and family/friends (e.g., pastoral conversation, prayer, grief support), and disposition of the patient (admitted, died, or discharged). Still, they are expected to demonstrate to their chaplaincy colleagues an emotional investment in each case, a sign that the interaction impacted them in some spiritual, interpersonal way.

On a deeper level, such interactions generate new perceptions of human relations and connectedness. Chaplains confront the questions of how and why disease leads to senses of otherness, both theologically and culturally. Some come to question the necessity of illness and injury as mechanisms of social division. In this sense, residents may be perceived as counter-cultural from biomedicine's point of view. To the extent that chaplaincy seeks to foster social and spiritual reconciliation, however, attempts to critique what they view as inappropriate forms of othering and exclusion and subsequently to mediate separated parties should not surprise us. The ways in which residents come to terms with this issue is absolutely crucial for their philosophy of pastoral care, their framework for intervention in the clinical space, and indeed the phenomenological nature of their interactions.

One of the more mystically oriented residents framed these issues this way:

> My philosophy of pastoral care is that the patient and the caregiver are not ultimately separate, and this may be experienced in any given moment, yet I most often fail to recognize it. It is there when we notice we are not separate from our experience …. Logically and experientially, non-duality is right in front of our nose—there is a space where our consciousnesses, our souls, our awareness, our true beings are not independently existing. We can touch into this and I believe this is what empowers our prayer and our ministering.

For him, otherness was something to be minimized, a surmountable barrier whose successful outcome represented an ethically and therapeutically successful *communitas* that might be fleeting but was nonetheless desirable for chaplains. Whether or not such an ontological state is the goal of patients is a question to which we shall return.

Fear, Rage, and the Fine Art of Self-Denial

An inner-city teaching hospital is rarely a dull environment. Even for those who have no direct patient contact—secretaries in the accounting department, laundry crews loading and unloading huge drums full of industrial linens in the sub-basement, carpenters building cabinets in the in-house woodshop—the realities of birth, disease, and death are never far away. A minivan pulls up to the front entrance with a woman in labor just as a group of transcriptionists heads out for lunch. In an elevator car, a patient on a gurney suddenly stops breathing next to the FedEx guy.

Chaplains, like other medical center staff, must learn to keep themselves calm at such moments, in order to be useful to others. Some of this emotional stability comes through repeated exposure to similar events—the fiftieth gunshot wound to a limb is not as shocking as the first—yet even here it is difficult to make gross generalizations. That fiftieth limb with a new piece of metal in it may not surprise a chaplain from a biomedical perspective, but it may arouse a fury at the city's systemic violence and availability of handguns that the 16th, 33rd, and 49th ones didn't, and those emotions must be subdued in the name of clinical care every bit as much as the ones in which the visual appearance of the injury seem overwhelming.

Early on, one of the residents wondered "How much suffering can I stand to experience? Will I cry less or more at the end of this year and which will be better? The deaths of the children leave an indelible impression, I feel as if each of their faces is etched upon me deep inside. How many dead children can I carry in my heart?" Such questions demanded not answers but space for

reflection on how she wanted the hospital to shape her as a person. They recognize the quandary of internalization and presuppose a certain, as-yet unspecified volume or capacity that residents possess for clinical encounters. These accumulation processes are onerous; there is weightiness to experiences, a load factor that must be respected. Being a chaplain seems to residents, at least at the outset, to imply less a healthy experiential metabolism than storage without processing and release.[10]

But if a chaplain cannot release such pent-up reactions at that moment, then what? Running away is not an option: when called, chaplains are expected to stay with individuals as long as needed (or at least logistically feasible) to process initial reactions. Other staff may come and go, but the chaplain remains. One chaplain framed her ability to cope in terms of supernatural aid: "During my first unit of CPE I was surprised [that] this historically easy-to-cry person … seemed strong and stable in large circles of grieving family members. I can recall one father of a patient in SICU [surgical intensive care unit] thank me for spending time with the family say, 'How do you do this? It has to be so difficult.' I can only respond [that] God's strength gives me this ability."

Another possibility, of course, is indifference: the chaplain simply stops caring and goes numb. Death loses its social and psychological significance as the cessation of life becomes a failure of protein production. Screams become sinusoidal sound waves. Unique persons become statistics. Intervention becomes a technical act, a mechanical duty, rather than a meaningful interpersonal exchange.

It is important to note that many cases are decidedly easier for some chaplains to approach than others in terms of their own strengths, biases, and priorities. These often reflect broader cultural ideologies and perceptions about the normal order of things: an octogenarian's death is easier to accept than a toddler's. Disability is easier to accept than death. Predictability is easier to confront and manage than uncertainty. A return to prior health is preferable to a permanent alteration. Mirroring broader trends in the specialty, the chaplain for obstetrics-gynecology and the neonatal ICU is almost always female, reflecting the belief that women are more suited than men to discussing and reflecting upon issues of the female body and reproduction.[11] Inpatient psychiatry likewise elicited strong reactions among chaplains: some were visibly frightened at the thought of being on a locked ward with patients diagnosed with mental illnesses, whereas others jumped at the opportunity, either because of experiences with depression in their own lives or prior scholarly work with such

[10] The image of the medieval collector of the dead as a sort of mobile repository seems an appropriate analogy here.
[11] For that matter, there was always at least one woman in my residency cohorts eager to accept this assignment, perhaps reflecting the belief that personal experience with these health issues is significant for good spiritual care with these patients and families. Male chaplains, by contrast, seemed relieved not to be assigned these units.

issues, often reflecting a desire to give something back to those who were experiencing some of the same struggles that they once had.

Still, even in cases of familiarity, cases can shock. One chaplain on obstetrics learned to navigate almost daily requests for baptisms for stillborn infants. She knew that there would be more of them, and she did not grow indifferent to the uniqueness of each patient or family. Likewise, some injuries or diagnoses never ceased to arouse strong reactions, no matter their frequency. Another resident, a self-confessed "trauma junkie" who never missed an opportunity to do additional shifts in the trauma bay, took teenage suicides very personally. He comforted with skill and precision and absorbed the wails of mothers, yet he could never entirely release these individuals from his memory or his persona. Their deaths, and his encounter with the immediate aftermaths of their self-executions, changed his outlook as a practitioner and as a person. Over the course of the residency, several of his peers noted a shift in his emotional availability, his religious outlook, and his increasing reluctance to contribute during case studies involving the death of young patients.

For chaplains, by contrast, the nature of emotional management is rather different from that of other clinicians. Like her medical colleagues, the chaplain should perform without bias or prejudice. Whatever she may think of the appearance or demeanor of a family member or patient must be acknowledged—and promptly set aside—in the name of what could be described as spiritually objective care. The emotions expressed by the actors, however, are by no means irrelevant or to be blocked off in order to do some other task at hand: they *are* the task at hand. There is no de-contextualization, no depersonalization process that occurs. When the body screams, medical staff listen and intervene. When the eyes scream, when the voice screams, when the face screams, the chaplains become the specialists.

Both the hospital and CPE recognize that strong emotions are usually present during such events; the goal here is the creation of a safe place to release and explore these emotions in the presence of a clinical professional who can facilitate such manifestations. Residents learn to anticipate, confront, and interact with these emotions through a unique form of reciprocity: they restrain their own emotions and reactions in order to engage with patients and family according to the latter's needs and coordinates. If a father wants space for silence, then the chaplain is expected to locate and offer a quiet room or hall and then may sit with him in silence or allow him to be alone, according to his preferences. If siblings want to scream in reaction to a mother's overdose, the chaplain is expected to be present to give the siblings an audience, an interlocutor, a target for their lamentation. Chaplains must learn how to cultivate the trust necessary for individuals to be able to formulate and release these emotions—they must, in other words, learn techniques to encourage the

direction of emotions at them—and receive them in a manner that allows the sender to feel acknowledged without allowing unbridled sentiments to spread to the rest of the hospital.

At the beginning of the program, several residents had the impression that revealing their own emotions in the clinical setting, beyond a vaguely empathetic smile, was so unprofessional as to be contraindicated. They questioned whether expressing themselves necessarily signaled a lack of control over the self and the situation, an inability to manage the moment and thus to be emotionally, spiritually, and intellectually available for others. As one chaplain remarked, "Sometimes I wonder if it would be as helpful to go ahead and share that tear. I remember how moved I was by the nurse practitioner who wept openly during a family meeting. I have not cried with patients and families. My tears come in the drive home or in the quiet of the seminar room in the middle of the night." Here, the chaplain does experience catharsis, away from the gaze of others in the hospital. Such a demeanor reflects a rather traditional, conservative liturgical posture for chaplains and generated a fair degree of ambivalence for residents who came from more visually and orally expressive churches. For these persons, such calls for affective restraint challenged their understandings of the minister as a conduit for the supernatural and their ability to represent God in the clinical space. Hollering, weeping, glossolalia—such articulations of religion and the self were deemed strictly unprofessional forms of behavior for hospital employees and were not tolerated.

This returns us to the issue of proximity and distance, this time via culture. Can the perpetually dry-eyed chaplain be empathic, or is he destined to remain slightly aloof? More broadly, what physical gestures are legitimate for these religious specialists? More than once I heard colleagues expressing mild envy at the medical staff for their ability to have tactile therapeutic contact with patients. Changing a dressing, inserting a stent, flushing a line—such interactions give medical staff a palpable closeness to patients. They also give patient and practitioner alike a sense that something concrete, something real, is being done. True, the Roman Catholic priest and his lay assistants can administer the Eucharist to less critical patients, and occasionally other chaplains will anoint patients with oil, but these sacramental acts are the exception for residents, rather than the rule.

Some chaplains nevertheless find ways to provide creative responses that meet both others' needs and their own. Hear these words:

> I am wondering when in pastoral care might it be helpful to share a common experience so that a patient (or family member) knows that your empathy is not without some understanding. Toward late spring there were the sheer numbers off gunshot deaths: mothers I held, or

> consoled after they learned their sons had died from gunshots. Holding their shaking, rocking back and forth, bending over, straightening up, they say, 'What am I going to do, what am I going to do?' Wet jacket lapel through to my shirt, their tears mixed with my sweat. Bad, but not as bad as not being able to hold them, or worse, having them resent you—that's the worst …. It was immensely cathartic to do this *physical* thing to help.

This is not to say that chaplains only experience their work as sacrifice or a form of self-denial. Far from it. All of the residents saw their work in terms of a calling and a fulfillment of divine purpose. Their work reflected their loyalty to God and their dedication to religious exhortations to the service of others. It is important to recognize that the demands of the program are counterbalanced by feelings of satisfaction in serving others, propagating a certain religious model for society, the sense of encountering God closely and regularly, the accumulation of valuable skills, and enhanced senses of self as mechanisms for nurturing and maintaining feelings of empathy.

The Non-Judgmental Presence: Fostering Hospitality and Altruism

Consider the following Level II goal of CPE: "Provide pastoral ministry to a variety of people, taking into consideration multiple elements of cultural and ethnic diversity, social conditions, systems, and justice issues without imposing one's own social perspectives" (cf. Appendix D). This objective can be seen as a corollary of the previous section. There, the focus was reactions to bodies and diseases. Here, it is reactions to persons and behaviors.

The U.S. hospital presents unique opportunities to explore hospitality in light of its potent methods of determining selfhood and the growing place of biomedical thought in social consciousness. Indeed, the hospital is a space that highlights—if not actively promotes—otherness. Through a wide range of signs and practices, it demarcates in ways that are both familiar and foreign to its inhabitants. Infections demarcate. Gender demarcates. Mental status demarcates. Ethnicity and socioeconomic status demarcate. Less obviously, guilt and agency demarcate. Strict rules determine the circulation of bodies and ideas and have important implications for the reproduction of power relations across multiple cultural domains.

Or so it seems.

Such depictions of hospitality in the therapeutic setting generate a host of questions. What are the experiential consequences of such taxonomies for "guests"—compromised bodies and persons—who appear on the hospital's doorstep? In a space where social roles appear fixed yet none is omnipotent, how do increasingly flexible relationships and chains of command challenge

anthropological schemas of guest and host? Given the fact that such key life transitions as birth and death typically occur there, what implications does the hospital as a distinct social space have for broader societal understandings of hospitality over the life course?

Historically, the concept of hospitality has been central to Christianity, from the Biblical parable of the Good Samaritan to Kant's ethic of universal hospitality. Monastic hospitality centers for pilgrims and the ill gave way to dedicated buildings for the sick persons, yet distinctions were few: the morally worthy received admission, whereas sick prostitutes, drunkards, and the lazy did not. Men were separated from women, but there was little or no division according to physical condition; a single room might house 20 patients with 30 different ailments, yet they were kept under strict supervision and were expected to be grateful, passive recipients of care, despite lengthy stays that often seemed more like incarceration than hospitable recuperation.

Gradually, the work of such scientist-reformers as Nightingale and Semmelweis introduced the pavilion architectural plan (Marland 2004) and antiseptic procedures to the clinic to minimize infections (Schlich 2004) and to categorize patients according to disease, as the pathological status of the body increasingly determined the conditions under which clinical hospitality would proceed. More recently in the U.S., insurance plans and new technologies have led to shorter stays and the replacement of large halls to single-occupancy rooms as individualism and privacy have become valorized. At my field site, practical issues related to scale and traffic flows in an 800-bed hospital, along with its location in a rough inner-city neighborhood, aroused significant fears of chaos, violence, and contagion among staff workers and led to new forms of restriction and exclusion.

It seems that, while important, images of the unconditional nature of hospitality appear rather conflated in the clinical space. The hospital is, on one hand, hospitable—open—to the undesirable, the poisonous, and the condemned. If hospitality here simply means a willingness to offer high-tech medical care to all in need, then yes, my field site qualifies as hospitable. If we gauge hospitality via material considerations—that is, in terms of an atomistic, rationally objective, utilitarian perspective that views individuals as malfunctioning bodies in need of amendment—then yes, the hospital strives toward pure hospitality.

Here, we must pause to consider a wrinkle, namely the distinction between the means and ends of hospitality. If the chief scientific end of the hospital is bodily recovery, then those who consent to be admitted to the hospital must be prepared to sacrifice a certain measure of privacy, a certain degree of freedom, and a certain sense of time in order to achieve the sought-after goal. Many forms of chemotherapy have significant side effects, for example, yet the desperate cancer patient may be prepared to experience such somatic intrusions, such submission to strangers and their

chemicals, in order to prolong life. Similarly, the neurosurgery patient may face significant risks on the operating table yet may decide that he has no choice but to accept his doctor's plan. Yet can we really call such activities hospitality if there is no viable alternative, if a person must submit in order to live?

Non-judgmental hospitality for chaplains serves several functions. In addition to the theological-ethical imperative to welcome the stranger as fellow human being, there are social implications of offering emotional and religious hospitality to the diseased and injured. From a diagnostic perspective, one chaplain noted that "radical hospitality … engag[es] others in such a way that they will not feel ashamed to be vulnerable in front of them." Hospitality can breed trust and openness, a more relaxed and comfortable sense of relation to a foreign space where dialogue may be less guarded and reflections more open to speculation and imagination. It can likewise be empowering and can challenge the image of the hospital as either a panopticon or a total institution. To the extent that chaplains and others can encourage patients to "make themselves at home"—to customize rooms with cards and balloons, to encourage visitors, to verbalize their questions and concerns—they can help the latter to conceptualize therapeutic exchanges as more relaxed and potentially as less performative or scripted.

Nonetheless, hospitality is indeed something that can be withdrawn, and in the eyes of some chaplains, it is not offered at all by biomedicine to some patients: "If you are a clean and sober and preferably silent individual your care will be fair," as one of my colleagues argued. However, she continued, "if you are inebriated or under the influence of drugs, or confused or psychologically sick you can expect a markedly different level of treatment: your cries for assistance and pain will often go ignored or you will be told in no uncertain terms that you need to calm down or be quiet that there are other 'sick' people who need assistance." From this perspective, hospitality implies gratitude. It is a gift, a bonus, a social add-on that is entirely contingent upon the behavior of the guest. Part of what makes clinical hospitality unique among various forms of cultural hospitality is that, rather than evicting guests who overstay their welcome, biomedicine can indeed become a source of bodily and social constraint.

This brings us to a second wrinkle, namely the social and cultural aspects of clinical hospitality. Derrida asked what human beings become when dispossessed, not of their possessions, but of what links them to interiority (2000). Consider his question in light of the link between bodily repair and the interpersonal attributes of hospitality. Just as hospitals in previous centuries offered social hospitality but little scientific hospitality, it is possible today to offer the latter without the former. Such uneven forms of hospitality—such circumscriptions, such forms of reductionism,

where bodies but not mindsets are given wide berth—can easily lead to fragmented senses of self for both guest and host.

If clinical hospitality presupposes both gratitude and passivity on the part of guests, yet the increasingly capitalist nature of the provider-consumer relationship dictates that the customer can never be wrong, then what are the consequences for social interaction and for religion in the hospital? A good portion of the work of hospital chaplains is to make science hospitable. Alongside objectivity, it offers subjectivity. Instead of sterility, it offers warmth and even messiness. In place of passivity, it offers a modicum of agency. Hospitality for chaplains implies service, but it does not view guests as helpless or as Pygmalion. It anticipates that many guests will be fearful, confused, exhausted, and sometimes impatient. For one resident, this aspect of hospitality implied "learning to embrace and console the humiliated; challenging the implicit moral judgments that society, medicine, and occasionally practitioners place upon people and their conditions; and generally functioning as anti-stigma machines" where hospitality "is a component of solidarity."

At the same time, chaplains must learn not to play the concierge or be co-opted by beguiling patients or visitors. A lack of condemnation for them does not equate with moral or social indifference. It does not condone violence toward the self or others. Residents gradually learned that permission as a component of hospitality was a form of art: too little, and a guest may remain unable to process thoughts or consolation. Too much, and the social structure of the hospital may unravel. Because they serve in a variety of ways as gatekeepers, chaplains are expected to learn when to say "No" and to discern the difference between positive and negative forms of freedom as indicative of true hospitality. Reflecting on a particularly difficult trauma case, one resident spoke of the relationship between cognition and judgment. While holding the hand of the man whose very same hand previously held a gun that killed his wife and nearly also killed him, she found herself wondering, "Is my kindness to this (violent) person idiot compassion? Compassion that is fostering their aggression? But if the compassion is based on some genuine feeling, touching their anger, aggression, and hate, then I seem to have no question anymore, and I intuit what to reflect." She explained later that "it was almost a natural reflex, if you will, to simply see him as an individual in pain, both emotional and physical, and to attend to his human needs in spite of what he had done."

A corollary to such a duty to be able to say "No" in hospitality is openness to rejection from guests. Chaplains are instructed never to force themselves—through conversation, presence, or theology—upon others, and while this too requires a level of discernment that may only be imperfectly mastered, it reserves the right for guests both to offer and decline invitations to serve as hosts themselves. Medical staff needed no permission to enter patients' rooms. While many

physicians, nurses, and others were indeed sensitive and thoughtful to their patients and tried to accommodate their needs, there was little space for reciprocity. Perhaps this is a strange notion, the idea of a guest offering a host hospitality within the latter's own dwelling. Yet this is precisely the affect that chaplains are taught to proffer. "When I meet angry people," remarked one resident, "I find that I become fearful and my instinct is to close down and to withdraw. The continuing challenge remains to neither retaliate nor retreat but to express myself in integrity and to attempt to resolve conflicting situations." Such a mentality seeks to foster, or perhaps restore, a sense of agency for guests without sacrificing their own ability to maintain a measure of professional identity. Here again we see a spectrum: chaplains who may initially be timid or eager to please empower neither themselves nor others; entering a room full of emotionally fraught strangers is often demanding for new chaplains, yet to the extent that hospitality also requires measures of courage and self-confidence, hospitality cannot come to pass until one person invites another to interact.

Permit me to introduce one more type of hospitality—phenomenological hospitality, an endeavor that affords space to experience disease and injury freely, on one's own terms. Consider: the anxiety of an unknown space like a hospital leaves many unsure how to respond when faced with dramatic changes in health status. Such affective ambiguity may be particularly pronounced for individuals who feel an inner urge to react palpably to, say, unfavorable diagnoses or new proximity to death. Some may fear appearances of weakness or vulnerability under the eyes of strangers. Others, lacking familiar symbols and resources, may decide that they will burden staff or other patients with an outburst of emotion and so remain mute under the guise of propriety.

A chaplain's duty to provide hospitality to toxic emotions can seem frightening, dirty, intimidating, or even humiliating. We could debate whether receptivity to persons in such states comes naturally to chaplains or is something that is constructed through experience, but the goal is the same: to configure the immediate physical setting as a unique cultural zone that valorizes spontaneity and ensures confidentiality. Such hospitality is an ethic, as well as an action, as the following vignette from one of my colleagues demonstrates:

> When I entered a dying patient's room a few weeks ago, I took his hand and he pulled me right down to his face, eyeball to eyeball. His eyes were encrusted and his breath was beyond foul with neck and throat cancer. In the suddenness of the situation fear and repulsion caught in my throat. Then, the vividness of my fear was what reminded me: I remembered I knew in the core of my being to open to everything. I let go of holding on—I relaxed and let everything in:

> fear, repulsion … death. Then the patient's eyes relaxed, they mirrored mine I suppose. I relaxed further, by letting repulsion, fear … "in," there was suddenly no problem. Oddly, my allowing death in seemed to let the patient to allow death in, and *vice versa*. After this, the patient locked on my eyes for quite some time. I noticed his sister was cowering in the corner, and I realized these few minutes had probably been quite intense to anyone standing in the room.

Here, the "ministry of presence," as chaplains call such interactions, reveals a profound, even stark, dialectic. Openness becomes contagious. Death, the quintessential other, sheds a bit of its foreignness. Hospitality in this moment invokes mutual recognition and, consequently, recognition of the inevitability of the future. Such hospitality is not an act of denial but, rather, an acknowledgment of finitude and a willingness to share it with others.

One of the great challenges for chaplains is to infer guests' openness to their presence during such experientially charged moments. Chaplains are trained to grieve *with*, celebrate *with*, and reminisce *with*, convinced that life need not be lived in isolation and that—particularly in points of despair and loneliness—no one need be alone. Yet such an outlook can easily lead to trespassing through an overbearing presence. Particularly when the chaplain's visit is unannounced or comes through referral from another staff member, there can be profound problems of inaugurating a dialogue where nothing was planned, and guests may feel extremely uneasy about suddenly being asked to host a religious figure when they would rather sleep or watch TV.

Language, both spoken and unspoken, thus becomes a crucial point of analysis for our understanding of religious hospitality in the clinical space. Even if a chaplain can foster an environment of trust and openness for a guest, both parties must contend with the fact that the hospital's lingua franca is dictated by biomedicine, not religion or the guest's home culture. At best, conversations may resemble pidgins as parties try to align their modes of speech. At worst, interactions abandon the search for middle ground, especially if a novice chaplain expects his guests to speak in a manner foreign to them, in a move that adds additional burdens to the guest's experience of hospitalization and can lead to increased anxiety and feelings of foreignness. Questions become interrogations, extractions of information that align the chaplain with the biomedical and leave the patient feeling both manipulated and wary. As I learned, the challenge for chaplains was, and remains, how to practice these distinctive forms of hospitality without becoming a handmaiden of larger institutional forms of control and oversight.

Patient Selection (or, Looking for Trouble)

How to know which patient to see? That one or that one? The one who has been on the unit the longest, or the new arrival? The one making the most noise or the one making none? In a small unit such as an ICU, a chaplain can realistically stop by each room on a given day, but on a floor with 40 beds, it is not feasible to have that many conversations of any substance. Apart from trauma responses and referrals, to which they always respond, residents utilize a range of different methods for selecting patients to visit.

Before I discuss specific techniques, it is important to recall an important aspect of patient populations. Chaplains have no influence over who should go to the hospital or when an individual should be admitted. Their "congregation" is determined by others; they work with those present and make assessments accordingly. There are those who, from a pastoral standpoint, have no need for a chaplain, whatever their medical diagnosis may be. Likewise, individuals such as patients' friends and relatives are not part of the inpatient census but may ultimately prove the ones most interested in pastoral support.

Residents have types of patients that they like. They like to feel needed, and they like to see tangible results. Moreover, because they cannot realistically see every patient, chaplains have both the burden and luxury of choosing whom to contact, and while each developed his or her own methodology for seeing patients, selection bias was present. Most residents found that there were certain types of patients that they liked to visit on their units—those who would be grateful for the attention, those likely to manifest some emotions and not others, and generally those in a certain sort of psychological and spiritual frame of mind. Few had patience for idle chatter yet could be said to be addicted to authenticity and unvarnished expressions of selfhood. As one student noted, "when I meet people of the Christian tradition, no matter their particular denomination, I feel very much at ease to use religious resources. I must admit, that a Protestant wanting communion was a real blessing to me this unit."

Other challenges exist. Several residents admitted that resistance toward certain types of patients—due, say, to age, denomination, ethnicity, or diagnosis—could also present opportunities for growth. This same chaplain confessed that "As I repeatedly choose to enter rooms that I initially would not have, I am on the road of self-discovery and hope to be able to interpret what I learn from doing so." Consulting unit staff can be useful in terms of learning about a patient's status but can also suggest weakness and dependence. Visiting intubated or otherwise non-communicative patients and offering a prayer or words of comfort can give a chaplain a sense of personal satisfaction and an aura of productivity but may in fact be a tactic to avoid conversation with strangers. Similarly,

avoiding a room because many are present can be an acknowledgment that pastoral conversation is generally most effective one-on-one, but it can also reflect shyness and an inability to manage a dense social space for therapeutic ends.

Boundary Issues

As we have seen, chaplains must adopt a basic availability to the stranger if their work is to be in any way productive. There can be a tendency to romanticize the work of the chaplain, to believe that residents can handle every demand and every encounter with sublime compassion. One chaplain commented that "I think I've unconsciously come to view these persons as fellow human beings with whom nothing can be truly foreign. A sense of spiritual, charitable, perhaps even metaphysical, connectedness is helping me to have an unconditional regard for the lives I encounter—however full or fragile they may be." Such a tendency, however noble, can lead to false assumptions and a willingness to experience someone else's predicament to a greater degree than he or she does. Chaplains are increasingly accustomed to experiencing intense emotions frequently and may easily forget their own initial encounters with the shocking, instead coming to view every tear, every diagnosis, and every gaze as amenable to analysis when the patient may instead see certain topics as strictly off limits.

Similarly, a key element of clinical development is the establishment of appropriate professional boundaries. Residents struggle to learn how to manage emotions and emotional expressions not as an amateur, but as someone skilled in anticipating and choreographing feelings. To the extent that they mirror and absorb emotional outbursts from others, they must learn to distinguish untargeted versus targeted attacks and understand when not to take comments personally.

Due to the brief nature of most encounters, there isn't the problem of worrying about whether a patient will become a close friend. It nonetheless remains difficult for most chaplains not to be affected by the lives/situations they encounter, not to take stuff home, not to be shaped by people's reactions to the chaplain's interventions. Some patients and family members are utterly charming and cause chaplains to want to be with them. They know how to weave spellbinding stories that will keep an audience attentive, and it can be easy for new residents to lose objectivity with such individuals and to succumb to passive therapeutic stances that perpetuate unproductive outlooks. Such dangers are particularly acute on the psychiatry unit, where many patients diagnosed with schizophrenia demonstrate unusual needs and manners of relating to staff members. They may be consciously or unconsciously manipulative and are far more skilled than novice chaplains in understanding how to configure patient-provider relationships to attempt to achieve particular ends, such as courtyard smoking privileges or an early discharge.

There are additional implications of proper proximity. As one chaplain noted, "I am learning clear boundaries are very connected with an appropriate use of power. When various patients request my phone number, either for further meditation support, further grief support, or further contact, I find I need to in that moment let go of the excited feeling of … accomplishment, or acquisition, or personal opportunity, or asserting my power." Because chaplains do not maintain contact with patients or others outside the hospital, this boundary can seem artificial, even bizarre for residents, who must learn to shift their mentality from the parish setting and accept the fact that the scope of their work will necessarily be circumscribed by physicians and admission/discharge clerks. They must recognize that their ability to help the afflicted navigate through intense emotional situations can lead to strong senses of gratitude but also dependency. Residents' work is designed to foster psychological and spiritual independence, not to generate novel senses of helplessness, either toward chaplains or toward clergy outside the hospital, and so they must discern the appropriate type and degree of attention to give persons longing for acknowledgment.

Such neat, tidy closures are not easy to perfect. One resident remarked that "sometimes I feel cheated by the experience of encountering these people on such awesome, intimate terms, and then having the relationship end abruptly with death or discharge." Chaplains soon recognize that intense proximity with strangers often comes at a price: interactions may end as hastily as they began, leaving them with regular senses of discontinuity and loss, like being handed an exquisite novel and being told to begin reading in the middle of chapter five, only to have the book snatched away a paragraph into chapter seven.

What are residents to do with such seemingly arbitrary temporal boundaries? How do they process such encounters, such incomplete data, in a meaningful way? Consider the following account: "Earlier in the year a young man died in the trauma bay after being involved in a freak motorcycle accident, and I ended up spending hours with his family, his parents, his brother and girlfriend. Hardly a day passes that I do not think about [the patient] and his family. Perhaps this has something to do with experiences of loss and grief in my own life, and I need to take care that empathy does not overwhelm. But I don't want to change the richness of those emotions." There is a sifting process that must occur in order for chaplains to maintain some sense of personal control over passing events. They try to demonstrate gratitude, even reverence, for each encounter, without letting the past hold the present hostage.

Similarly, the chaplain must resist the urge to describe his previous encounters in successive cases, lest the meeting focus artificially on the resident and not on the primary actors. One student described his progress with this goal in this way: "The more sensitive I become with

listening/attending and empathic reflection, the more I find that there is really very little opportunity to disclose myself. I suppose it is somewhat surprising to learn how close, intimate communication is possible without talking *about* yourself." By bracketing certain discourses, images, and sensations, and by positioning himself as someone who may learn parts of a drama without needing to know final outcomes, the chaplain strives to be a unique resource, a modified catalyst that is minimally changed by individual encounters yet interacts intimately with various persons to facilitate often dramatic transformations in their basic nature.

Staff Interactions

Among the most ideologically and logistically challenging aspects of CPE for residents is the move from solo practitioner (in most parishes in the U.S.) to member of a multidisciplinary team of clinical practitioners. Where they once practiced in an environment conditioned by religion, in which auxiliary staff members such as choir directors and secretaries were their underlings, now these religious specialists work alongside social workers, admissions clerks, lab techs, health sciences students, physical and occupational therapists, nursing assistants, janitors, cafeteria and laundry staff, management personnel, clinical psychologists, security guards, and of course doctors and nurses, yet they exercise control over none of them. Residents have both the luxury and the burden of an essentially blank job description; in few instances does anyone have a clear expectation of what a chaplain absolutely should do in a particular unit or setting, and as a result, there is usually a high initial degree of ambivalence among these other staff members about how to relate to a new cohort of chaplain residents.

Despite this wide range of potential interactions with fellow staff members, chaplains have a broad degree of latitude in the extent to which they wish to integrate themselves into a particular unit. One staff chaplain explained that it is theoretically possible, though inadvisable, for chaplains to function essentially as outside consultants, near-foreigners who parachute into units to meet with patients and their families and friends with little or no contact with the medical staff. Possible, that is, because patients and their kin are the main priorities for chaplains, just as parishioners are considered the main priorities of church ministers. Inadvisable, because chaplains do not practice in a therapeutic vacuum and lean heavily on the knowledge and insights of other staff members to understand patients and others.

Given the programmatic expectation that chaplains will learn to interact productively and routinely with other staff members, the questions are not if or why, but when and how. All of the residents at my field site were aware that they were on new ideological terrain and soon recognized that their assimilation into the social landscape would not be stress-free. On one level, this should

not be surprising: religion aroused an extraordinarily wide range of reactions at the hospital, and chaplains were forced to learn quickly how to gauge staff members' openness to issues of faith and spirituality. This distinction between the chaplain as a person and the chaplain as a position assumed several forms: some actively supported religion, some largely ignored it, a few were passively hostile, while most took a wait-and-see approach, acknowledging that religion mattered to many of their patients but reserving judgment on the new guy on the unit.

On another level, clinical staff were no less demanding of chaplains than any other new practitioners on their units and engaged in a variety of forms of hazing to test the mettle of the wide-eyed novices. Nurses and unit secretaries—those who were routinely on the floor and could be extremely protective of their patients/families—in particular utilize subtle forms of surveillance to figure out who the new person is, what she believes, and how she interacts with people before *allowing* her access to their patients. Here, the ancient dictum "Do no harm" became a biomedical criterion for religious interventions as well; scientifically-trained professionals played a significant role in assessing whether or not religious specialists would be able to practice competently in such a setting. Staff might quiz chaplains about a range of topics to gauge their general intelligence and ability to think on the spot, parse their body language when accosted, or be curt to get a sense of a chaplain's capacity to be persistent when faced with a difficult issue. Code calls, deaths, and traumas are particularly good methods for testing chaplains. Can he handle stress and chaos? Will he get in the way? Is he a hindrance, or does he help medical colleagues to manage the situation, particularly when distraught family members are present? Can he be left alone to manage a room full of electric emotions, or will he run? Chaplains were forced to learn to recognize these informal tests quickly and figure out what the unit as a culture expected from its workers.

Because staff colleagues can be crucial sources of information regarding patients and others, chaplains must learn to speak various languages and dialects utilized by the practitioners. By this I do not mean that they must memorize Latin anatomical terms or scores of drug names—though a certain amount of this would occur over the course of a year—but rather that residents must appreciate the ways in which narratives are produced, packaged, and regulated by biomedical practitioners. Medical staff neither expect nor want chaplains to master scientific discourse, in part because it is their unique domain of expertise and control, but there is nonetheless an expectation that those who want their attention will be able to understand the length, cadence, formality, volume, and function of professional exchanges on hospital units. Patient-centered discourses are largely focused on accomplishing clearly defined goals and leave little room for pondering. Chaplains must discover how to configure both the nature and content of their dialogue with others according to specific

topics and specific actors, recognizing that usefulness breeds relevance and hence credibility. Residents know not to play scientific diagnostician or to suggest biomedical interventions, but they can articulate important issues not addressed by others, including religious matters, but also socioeconomic factors, family dynamics, feelings and emotions, aspects of belief systems, and logistical concerns not noticed by others. They study how to provide crisp, focused answers during rounds, when and whom to ask questions, and how much of themselves to reveal to clinical colleagues as they gain familiarity with these varying linguistic norms.

Such processes of accommodation may nonetheless lead to unrealistic expectations and skewed images of colleagues in the opening weeks of the program. "One of my learning goals for this term was to develop a more effective, professional, and compassionate relationship with physicians, not only as colleagues in the patient care enterprise, but also in terms of my ability to see them as fellow human beings and not as some authoritarian and soulless Other," one resident noted after the initial unit. He explained that he began the term "with the impression of physicians as uniformly brilliant, omnipotent, self-assured, often arrogant, and disdainful of the rest of the hospital staff." For him, the tendency to be deferential to medical doctors was deeply ingrained in his cultural outlook and made the concept of physician as peer all but impossible. Not only did he give them more power than was warranted by the unit culture, but he also implicitly saw them as enemies, or at least as competition—mean-spirited barriers to what he viewed as compassionate, sensitive healing. These images additionally caused him moral anxiety to the extent that he was judging his fellow workers and was thus being a poor Christian and hence hypocritical religious emissary.

Lest I seem too critical of new residents, it is important to recall the many demands on their attention at the beginning of the program. No beginner is able to process as much information as possible or take advantage of every conceivable opportunity to interact with new co-workers. As one resident remarked, "When I began CPE I did not seek to intentionally know or understand staff. All I could seem to do was focus on getting a grasp on my patient/family care, verbatims, reflections, and statistics … I could not seem to remember staff names or how their roles worked together for the good of the team. I was preoccupied with family pressures and divided in my emotions … I almost wish I could start over again."

Likewise, the desire to be liked and wanted also influenced the ways in which residents interacted with various colleagues. For some, this led to various forms of projection, self-doubt, and reluctance to engage the other. As one peer noted, making the initial move "is very uncomfortable for me. It feels like I'm on foreign soil, potentially an unwelcome intruder. Although the majority of my experiences tell me otherwise, I sometimes wonder if the staff values what I do as a chaplain as

much as I value what they do in their particular areas of expertise, and sometimes I fear they do not." This general uncertainty manifested itself both in terms of residents' personas and in terms of their self-assessment about the value of their expertise. In an environment that valorizes hard forms of power and bold, decisive interventions, the tendency for these naturally shy chaplains to vacillate and avoid confrontation could lead to substantial self-doubt and compromised patient care. One chaplain initially found himself so doubtful about his value to the healing enterprise that he was practically apologetic about introducing the topic of religion in conversation, despite the fact that he was the chaplain, the religious specialist, on the unit. Another "deemed the staff to simply be too busy" to talk to her and was so focused on developing her identity as a care provider for patients that she "simply did not want to do the work to build relationships with staff." In these first few weeks, there was neither the time for new forms of relationship building nor the energy to deal with yet more layers of uncertainty amidst the other demands of the program.

Gradually, however, most residents began to risk vulnerability and rejection in order to foster greater openness and familiarity with staff members. One, for instance, recounted that he "had developed a good working relationship with the unit secretaries and consulted occasionally with the nursing supervisors" but wrestled with how to "confer with my colleagues and share meaningful information without pestering them with vague questions about the status of a given patient." In his mind, "such comments were often misunderstood as, for example, requests for permission to visit the afflicted individual that often left the nurses confused and me looking timid and unprofessional." This resident slowly gained enough confidence in his own presence as a staff member and as a diagnostician that he did not feel the need to consult with staff members each time he visited the unit in order to determine which patients to visit. When there were questions, he asked, but he eventually shed the implicit need to ask permission to talk with persons in distress. He developed a sense of purpose and hence a set of tasks to occupy his time in the presence of his colleagues.

Over the course of the year, relationships often deepened and moved beyond the strictly clinical to include a broader range of topics. One resident, for example, identified quiet moments in the life of units to talk with staff members one on one about everyday matters that had nothing to do with medicine or religion. She found that it was "in creating that friendship apart from the normal call of duty that enables me to have the relationship that I developed with most of the staff I worked with." The recognition that care teams work together on very demanding cases can provide chaplains the opportunity to be a resource to their colleagues—to invite them to share their reflections about common experiences and to unload a bit of their stress on someone who will not view their comments as bizarre. By offering compassion to colleagues, they can fulfill another goal

of CPE, namely to be a resource for all persons in the hospital—to see all persons as potential *patients* who might benefit from their attention.

Finally, it is important to recognize that even the most charitable, experienced staff members may have very particular ideas about how to relate to religious leaders and may interact with them in manners that to them are sensible and even respectful but to the chaplains may seem distant, formal, or even deferential. Several residents recognized such limits to proximity and, while occasionally frustrated, appeared to acknowledge it as part of the makeup of the hospital. "I still have questions about boundaries in relationships with non-pastoral colleagues. Certainly, I do not joke around with medical staff in the same way that I do with my peer group," one resident explained toward the end of the second unit. He continued: "my genuine affection for some of my medical staff colleagues would ordinarily lead me to pursue friendships with them outside the workplace—if I were not a chaplain. There seems to be a culture at [this hospital] which says that job categories do not cross-pollinate socially …. This is disappointing for me." This remark caused another resident, who had attempted unsuccessfully to shoot the breeze about dating with close colleagues in the emergency department, to wonder aloud if chaplains were in fact seen as eunuchs, pious celibates who only thought about God and never swore, drank, or kissed.[12]

The Chaplain-Deity Relationship

The residency is not a secular apprenticeship, detached from larger cosmic forces. It is, in the view of these students, a collaboration between deity and human, a process in which chaplains are not left to their own devices to confront their tasks but are accompanied, supported, and guided by God. It is for them this divine assistance, this unmerited grace, which gives them the stamina to accomplish their work and to cope with the stresses of the workplace. It is this uniquely configured relationship that most self-consciously distinguishes them from other practitioners in the hospital: though other staff members hold religious beliefs and take their faith seriously in their work, chaplains are exceptional in that their social identity and therapeutic prowess are framed in terms of a relationship to a distinctive being. Their strength and skill lie in mastering particular texts or techniques combined with a metaphysical bond that motivates and energizes their interactions.

In this model, this relationship between chaplain and deity is threefold: residents (1) represent God to the hospital community, (2) alert patients and others to divine availability as a resource, and (3) are as believer-practitioners nourished and guided by God's availability. Each of

[12] In fact, a chaplain resident at this hospital did date a trauma surgery fellow many years ago, and the two eventually wed. The story delighted successive waves of new residents in both programs and helped to promote a particularly close bond between the two departments.

these three points is significant in terms of anthropological analyses of supernatural-human relationships, both in the clinical space and in general. Indeed, chaplains are highly symbolically charged specialists. Whether or not they wear a cross or collar, their very presence embodies a huge range of concepts and images for those they meet, and chaplains recognize quickly that they often have limited control over such imputations, regardless of their own personality or narratives. By far the most common initial association made by patients and family members links chaplaincy and hopelessness: the chaplain, many initially assumed, came to herald the Angel of Death and the failure of biomedicine, an interpretation that residents sought to anticipate and quell. Others, basing their initial impressions on media portrayals or events from their own lives, viewed chaplains as kind servants, pompous blowhards, greedy charlatans, sexual predators, pop psychologists, or dime store diplomats.

Beyond these initial glances and symbolic associations with the past, chaplains appealed to narrative to introduce particular divine attributes to others as therapeutic offerings and to position themselves within the therapeutic space. God, they explained, is love, compassion, mercy, trust, steadfastness, and truth. These virtues were options that patients could choose to experience firsthand, attributes that were continuously and freely available commodities that required neither prescription nor religious intercessor. This thinly veiled Reformed theology implied immediacy in divine-human interactions uncharacteristic of many strands of Roman Catholic and Orthodox thought or, for that matter, many forms of shamanism, where the religious leader is a necessary and sufficient conduit with the supernatural. These chaplains saw their work not as gatekeepers to therapeutic resources or as salespeople for a newly patented substance but as reminders of the positive aspects of the familiar. True, residents were taught not to gloss over theological struggles that patients and others faced or to hock panglossian images of a too-sweet Jesus—though this was a frequent problem for novice chaplains unaccustomed to confronting the grief and rage of the clinical setting—but rather to present a particular hermeneutic on a supernatural being that could bolster the afflicted person's sense of agency and ability to connect with therapeutic goods. Chaplains promoted in their interlocutors a sense of empowerment and self-sufficiency in drawing upon metaphysical resources, rather than making them perpetually reliant upon the mediation of the chaplains.

I used the term "unmerited grace" a moment ago because the residents believed that this divine availability was not automatic, nor could it be earned. While chosen for this task, chaplains needed to perform appropriately. They were not to abuse this special relationship with God or neglect to acknowledge the contingent nature of this support, lest it be withdrawn due to a lack of gratitude and adoration toward God. For example, one chaplain commented on his first day of

hospital orientation, during which residents met nurses in charge of various units: "As she took us around to the Trauma Bay and the Intensive Care Units, she kept checking in with us. 'Are you OK?' she asked. 'This can be overwhelming for someone who isn't accustomed to the environment.' I was decidedly not overwhelmed, not then and not now, by the grace of God." This resident acknowledged the demanding sensory nature of the hospital environment but assessed his own reaction as stable. For him, this stance should have been surprising; he agreed that it was *unnatural* to feel calm, and even motivated, to engage the overwhelmingness of the situation. His written reaction to this experience, which he shared with his peers, served at least three functions. First, it was a testimony: God is present and at work in the hospital. Second, it was a prayer of thanksgiving: God has been gracious to him, and he wants to acknowledge this kindness publicly, to demonstrate his gratitude before others—to be seen and heard as an appreciative believer. Third, it is a source of validation: if God did not want him to do this work, to be a chaplain, then he would have felt queasy. This was his way of saying that he belonged in the program because God wanted him there, and therefore his peers should as well.

Recognition of this assistance as a gift can likewise lead to a strong sense of reciprocity. "I believe that I am accountable to God because of God's faithfulness and loving kindness toward me," a colleague explained. "In this regard my sense of moral obligation is born out of a sense of love and gratitude. I believe that I am accountable to the patients and the families whom God entrusts to my care." God has been generous to her in the past; this generates for her a sense of willing obligation to reciprocate. However, rather than offering sacrifices at a shrine, for example, or going on a pilgrimage, mimesis is her reply. The deity has assisted her in the past and continues to be present; this led to a particular moral outlook, a distinctive way of relating to other human beings based on her relationship with the divine. She honored her spiritual master by caring for the afflicted with which she came into contact.

More generally, the perception of the supernatural in the biomedical space could serve as sources of legitimacy and humility beyond the CPE group. One resident noted after a couple of months on the job that "I am more cognizant of the presence and providence of God in some circumstances that I encounter here at [this hospital]. I believe I see Him at work in the lives of all people, regardless of ethnicity, religion, or any other characteristic that we use to measure." Several points deserve mention here. First, the perception of divine presence and activity serves as an enormous source of strength and credibility for residents in the self-assessment of their work. Such sensations and interpretations validate their work as substantial and substantive—they serve as demonstrable proofs of a particular ontological reality with which they are associated professionally.

Chaplains were not insensitive to the demands of the scientific method in clinical assessment; in their own way, they too looked for evidence that would confirm their beliefs and desires. We shall return to the question of the reliability of these analytical techniques later, but for now, it is important to acknowledge in the statement above the sense that such clinical spiritual perception develops over time, with practice; it is a skill to be honed.

Second, the statement posits the ubiquity of the divine throughout the hospital complex. This too is distinctive, both in terms of clinical therapeutics and various cultural forms of religious intervention. The supernatural, in this resident's view, is not limited to the work of the chaplains as religious specialists. It has an agency independent of particular human assistants, and the fact that spiritual interactions occur in instances apart from the direct activity of chaplains is not interpreted as a shortcoming on their part or a lack of an ability to control/channel the supernatural. Rather, it points to the fluidity of the resource as a therapeutic mechanism. This is a source of both relief and potential ambiguity for chaplains. Relief, in the sense that they are not responsible for ensuring that everyone who desires a religious or spiritual element in the hospital experience will get it, and ambiguity, in that it can be difficult to know how they as practitioners fit into a therapeutic modality over which they lack firm control. It is one thing to acknowledge that some individuals will want to receive assistance from an embodied religious specialist even in light of divine omnipresence and omniscience. In fact, it is logical for residents to see such requests as supernaturally endowed or affiliated; for these cases, it could be reasoned that God has decided to utilize chaplains as the delivery mechanism for divine aid, whereas in other cases, the mechanism might be the Bible, a dream, or a religious get well card.

So far, so good. But as we have seen, chaplains do not *only* interact on the basis of referrals; they also make rounds and approach random strangers in hallways, waiting rooms, and elsewhere to offer assistance. Given the reality that there are far more patients and family members than they can possibly see, how do they choose? As we saw a moment ago, there appeared to be no single, uniform answer to these questions. The development of a religious therapeutic intuition is idiosyncratic and incorporates a variety of experiences, reflections, and suggestions that can influence the when and why of clinical pastoral interactions. We shall investigate this topic in greater depth in the next chapter, but for the moment, the following vignette from a first-year resident introduces some key considerations:

> As a Christian it is imperative for me to draw spiritual strength [in order to] be fed and led by God as my source of direction …. I began to understand this transforming power of love that consumed

> my fear. I feared not saying or responding appropriately with patients. I began to understand periodically how God anointed me to be receptive and more sensitive to a patient's strengths when visiting. This occurred as I yielded more to God. As a result, I gained the ability to discern more intentionally the emotions expressed by patients. I do this with hope of somehow verbally or nonverbally communicating that God's presence prevails and is always available.

For this chaplain, faithfulness to God in the hospital was itself a learned process. Her desire to respect and honor God through clinical ministry was initially complicated by her senses of self-doubt and anxiety about the work that she felt called to do. Fidelity for her implied an openness to love, both given and received, as a way of overcoming the stress of potential error. Through this love, she found that she had become a more skilled apprentice of the supernatural and hence a more effective therapist. She was able to receive and broadcast benevolent attributes more fluidly, a result of which was for her a more robust amplification of God's being as an instructional and recompensive device.

Such lofty imagery does not, however, always bear close relation to the messy reality of clinical encounters. Residents had their own personalities, life experiences, and unique relationships with the supernatural, and they were encouraged by the supervisor to develop a solid connection to the divine in a manner that was productive for them, recognizing that others might nonetheless not find such a relational style natural or productive. One resident stressed the shepherd model to inform her understanding of how to relate to patients: just as Jesus was for her the divine shepherd, she saw herself as the shepherd of her flock of patients on her various units. Another viewed his ministry as a form of teamwork with the divine, a partnership not of equals, but of close companions on a common assignment. Such images served the chaplains well in their own sense of purpose and ability to serve, but there was no guarantee whatsoever that they would resonate with patients. The resident who applies the shepherd model may encounter confusion and even resentment from a patient inclined to a womanist/liberation theology perspective who sees in the shepherd arrogant male domination and gross paternalism. The chaplain who favors the partnership model may talk past a family accustomed to a transcendent, royal God who wears not jeans but gold brocade and whose earthly representatives should at least attempt to convey an air of such noble solemnity.

5

REFLEXIVITY IN (AND BEYOND) THE CLINIC

CLINICAL REFLEXIVITY

When Doctrine Meets Experience I: Inter-Religious and Inter-Cultural Ministry

Each resident enters the program with particular notions about divine sovereignty, omnipotence, omniscience, and other attributes, and these beliefs will have an enormous impact on the ways in which they see the role of the supernatural in the clinical space. Someone who is absolutely convinced that God is the prime mover can be expected to offer prayers and counsel differently from someone who takes a "watchmaker" view of his deity. These doctrinal positions may, of course, shift over the course of the training and may cause the residents to see themselves and the divine-human relationship differently. Still, these initial impressions impact the nature and degree of therapeutic optimism that they hold.

Each trainee likewise brings to the residency beliefs about the nature of evil and causes of suffering—specific doctrinal positions about what generates particular outcomes. Some of these notions may be extremely rigid, while others are fluid or hazy in light of understandings about science and medicine. For example, some of my colleagues believed that only baptized Christians would go to heaven upon death, and that every human being possessed unlimited free will, and it was visibly difficult for them to accept the departmental policy not to proselytize as part of their work as chaplains or to believe that actions considered negative could be something other than the result of conscious, deliberate sin. It is hard to overstate this sense of limitation on what for many is *the* central component of their sense of call to ministry, their outlook on the world, and their commitment to God.

Further, residents' understandings about the role of human beings in the particular cosmology they hold—Reformed visions of humanity as depraved and utterly reliant on divine grace, Roman Catholic notions of the co-creation of the natural world, syncretic mixes of Eastern and Western traditions—have important implications for the ways in which they conceptualize the work of

chaplains and religious leaders in general, in relation to whatever thoughts they may have about the healing work of the transcendent in relation to their own interactions with patients and others.

These struggles lead us to the broader issue of religious diversity in the clinical setting. So far, our discussion has centered primarily on Christianity and has bracketed other religious traditions. This was intentional for two reasons: first, it allowed us to discuss a number of issues without the need to pause for each one and consider the implications for other systems of belief. Second, this is the implicit theological starting point for CPE. As we recall from chapters two and three, clinical pastoral education was founded on liberal Christian principles and is still influenced by theologies of liberation and social justice from the 1960s and 1970s. Even for many Protestants sympathetic to these views, there will be periods of adjustment, as they seek to understand the local theological parameters within which they will be expected to operate.

This process of spiritual enculturation can be quite jarring for residents, particularly those who have had exposure to other religious traditions and whose own lives reflect syncretic understandings of the supernatural. As one resident commented, "When I first went to chapel [at the hospital], the hymnals were frightening. One point, early on, I dreamt that [the CPE supervisor] was asking me if I would like to put an angel on the wall. He went into the closet and came out with a winged elephant—shades of Dumbo meets Ganesh—I was awestruck and when he asked me if it would do I said 'Yes, Yes!' in absolute surprise and delight." Another chaplain said simply that "Leading chapel was like trying to learn some foreign, ritualistic dance, and then having to perform it in front of people."

In my residency program, there was a tension between what some residents considered outdated, even archaic, modes of religious expression and more modern, flexible manifestations of belief. Whether through dreams or conversations at lunch in the cafeteria, residents struggled with how to fulfill the demands of the program faithfully, in order to (1) assist persons from a variety of religious traditions and none, and (2) maintain a stable sense of self-identity. There was also a struggle between a search for universals common to a wide range of belief systems and a relativism that rejected the possibility of truth altogether. Each chaplain brought an awareness of cultural and ethnic diversity to the program and was expected to be able to listen sincerely to others, even when the beliefs were very different from their own.

That said, I suggest that the phenomenological process of encountering dramatic pain and suffering had an important theological leveling effect for chaplains. The notion of "unconditional positive regard" in an interfaith setting, as one colleague described work with persons of different religious traditions or none, reflected both a particular ethic of Christianity and the secular

biomedical norm of providing care to all who enter the hospital, regardless of whatever life experiences or convictions they may hold.

Yet this posture posed a difficult therapeutic dilemma for chaplains. It is one thing to be hospitable to the stranger and to be compassionate to those who are different; such are the moral mandates of many religious traditions, and in this sense residents could justify their interventions simply as demonstrations of faithfulness to their god, however conceived. Active participation in religious rituals of other traditions, or the willing suspension of one's own cosmology in order to enter another's for therapeutic purposes, is quite another matter, and this expectation of openness to other religious traditions proved to be a significant distillation device for trainees. For example, universalists held fewer reservations about praying with Jews, Muslims, and others than exclusivists. For the former, the question of whether the deity they knew would care for—or about—patients of other religious traditions was implicit. Residents inclined to see persons of other religious traditions as inherently sinful or as radically other struggled with the expectation that they would minister to such individuals, operating under the assumption that real therapy could only begin with the work of conversion and, at the extreme, convinced that disease and injury reflected divine judgment consonant with false belief. To be sure, some patients and family members did want to be served by someone from their own tradition; such cases made the chaplain's task much easier, for she could simply make a referral and move on to the next room. When this was not the case, the resident was left in a difficult position: what, if anything, could she offer to someone whose understanding of the metaphysical universe in no way aligned with her own?

The fact that such radical forms of exclusion and othering gained little traction reflects in part residents' intentional search for so-called human universals, common conundrums faced by a wide range of persons. As one resident explained, "I began my CPE experience … based on my previous working experiences of multiple elements of cultural and ethnic diversity, and social conditions. I have been richly challenged in exploring new ways of understanding how these concepts connect or disconnect me with patient care. I see people one by one and enter their worldview, envisioning needs common to humanity. Every human being shares an element of desire to live, love and be loved in meaningful ways." For this chaplain, the desire to assist the afflicted stemmed from repeated exposure to diversity, the development of clinical hermeneutical charity, and a few basic assumptions about human needs and longings. The starting point was the human condition, not religious doctrine; the latter was interpreted—distilled—in terms of the former. The question for him became less how to configure the suffering patient to a particular set of religious beliefs, on the assumption that the individual could only gain the benefits of a single, true religion by conforming to

its dogmas, but rather how the religious belief system could provide something beneficial to the person in pain. The issue of conformity thus became essentially moot for this chaplain; he did not believe that his patients needed to conform to a particular religion, yet it was also the case that the religion did not need to conform to the person.

In essence, what we see in the program is a growing separation of the ethical from the metaphysical. All of the residents agreed that it was possible to extend to everyone in the hospital sentiments of genuine concern, patience, and compassion. Such philosophical virtues were consistent with their own religious traditions and did not compromise their own belief systems; they served as genuine sources of therapy without demand or threat of exclusion. One resident described this process of accommodation in the following way: "I recognize each individual as a human being created by God and of worth to Him. As such, we humans share a universal need to be comforted and encouraged when in distress, whether physical, mental, psychological or spiritual." He continued, "If the person does not believe in God, then I am to bring my human empathy and compassion alongside her/him and use the ministry of presence to calm and ease the person's suffering. I am careful not to impose my beliefs and experiences upon the patient, family, or staff member."

Even when chaplain and patient come from the same general religious tradition, such as Protestantism, there could be significant cultural and liturgical differences that residents learned to consider in clinical interactions, and these divisions could be even more painful and more pronounced than between two religions that have nothing in common. Two months into the program, one chaplain described her experience of

> coming out of the comfort and fire of Pentecostalism, into the adventure of frozenness in the Episcopal environment. Both worlds though very different [are] full of the Agape love yet [are] culturally and denominationally diverse. I learned quickly with this new beginning and exposure [that] God was still very present [in both], though the volume of His voice [emerged] at various levels …. My philosophy of pastoral care began with many assumptions. My approach was fixed, narrow, and limited. I assumed that everyone wanted prayer, scripture reading, and a hymn sung.

For this resident, the key issue here was not whether God would be present or even applicable, but how. CPE broadened her exposure to a wide range of ritual and narrative expressions and forced her to rethink the normative nature of her own tradition's response to human suffering.

Other residents discovered creative, and perhaps even subversive, responses to denominational differences in the hospital. A seasoned and highly pragmatic resident recounted the following story:

> I remember the elderly Anglican woman who wanted to receive the Eucharist in Holy Week. "I have two patients who want to receive Communion," the nurse said. "But one of them is not Catholic." "What I heard you say was that you have two patients who want to receive Holy Communion," I responded … "Do you need to tell me anything else?" "No," she said, "that's all. Two patients who want to receive Communion." With these and others I was blessed to partake of the grace of mutual hospitality and to experience the Real Presence in a profound way.

This chaplain had a highly inclusive vision of Christianity and, in part stemming from his own experience as a former Roman Catholic, had little patience for the theology of the closed table that is the official policy of the Vatican toward other Christians. With the assistance of a sympathetic nurse, he interpreted ecclesiastical rules according to his own hermeneutical priorities. It was precisely this ability to bring people of different traditions together, as well as regular opportunities to resist (or undermine) what he considered unjust religious practices, that made hospital ministry so attractive to him. Though he was still technically responsible to the leaders of the denomination that ordained him, they exercised little day-to-day oversight over his work, thus giving him significant leeway to demonstrate what he considered a purer, more just form of his faith than was possible in a parish setting.

Another approach that some chaplains take is to offer pastoral care according to the tradition of the patient and family:

> In September I went into a room on [neurology] for a random initial visit with a patient and his wife. After a short visit, I asked whether I could pray with them. The wife suddenly had a look of discomfort and hesitated but then said, "Yes that would be OK. All prayers are good. I will be praying for my husband today and tomorrow." It was the Jewish New Year. "Ah," I said. "Then please permit me to say in my pathetic Hebrew pronunciation, *L'shana Tova.*" Now the wife had a look of relief on her face. I began to pray, "God of our

> ancestors, God of Abraham and Sarah, of Isaac and Rebekah, of Jacob and Leah and Rachel …"

In providing pastoral care to non-Christian persons, this resident believed that one of his strengths was a genuine respect for different religious traditions and a desire to make that respect known to others. He saw wisdom and value in many religious traditions and felt comfortable partaking of them with others for mutual benefit. Such work was also, as he explained to me, "an energetic repudiation of Christian imperialism," a recognition of the historical injustices of Christianity toward persons of other religions, notably Jews, in American hospitals. Such an encounter was an act of social justice for him, a public form of contrition on behalf of his fellow believers, and an attempt to provide a bit of structural reconciliation. In this particular case, the gesture was received gratefully and was not perceived as phony or political, though as we shall see in the following chapter, such attempts to bridge differences are not always taken kindly by patients or others.

When Doctrine Meets Experience II: Epistemology and Suffering

The question of inter-religious pastoral care points to a broader and more central issue for chaplains: epistemology. Individuals enter the residency program precisely because they hold religious beliefs. They are familiar with basic tenets and understandings of the world as explained through their tradition and see human events in particular through the lens of these teachings. Especially for the Christian residents, sacred texts and life experiences have provided unique ways of interpreting bodily phenomena such as sickness and death in light of broader teleological conceptions. Most of them had reflected on a range of longstanding doctrinal quandaries and seeming inconsistencies in the religious tradition prior to CPE, through seminary papers, sermons, and conversations with colleagues yet had managed to keep their faith intact.

Chaplaincy represented a potentially dangerous intellectual undertaking for several of these religious specialists. While all of them had encountered disease and injury in the past, none had worked exclusively with sick persons full time for a year or more. None had subjected his or her beliefs non-stop to pain and suffering that held the potential to undermine their outlook so radically. Whether or not they realized it at the beginning of the program, clinical ministry would force upon residents key questions about the rationality and consistency of their religious ideologies and would force them to take stands about how thoroughly they would allow their interactions with the sick and dying to challenge the intellectual coherence of their enterprise. This is because CPE encourages reflection on the ways in which the phenomenological experience of chaplaincy impacts theological beliefs, but it does not specify the extent to which subjects must question their most deeply held tenets.

That decision is essentially left to the individual. A resident can, if she chooses, interpret every cognitive disjuncture between cosmology and reality as reflecting a lack of human understanding, in order to maintain *in toto* her belief in an all-powerful deity that will make all things known someday. At the other extreme, she can utilize the analytical tools of her biomedical colleagues and critique, if not dismiss, many of her religious beliefs as inconsistent with scientific evidence. She can also take a number of intermediate positions regarding the limits of human knowledge and the functions of religion, for example casting religion for the living primarily in terms of ethical social interactions while retaining particular beliefs about existence beyond death for patients that die.

The point that I wish to make here is that there is nothing *a priori* in the philosophy of the training that stipulates that practitioners must always and everywhere find a way to reconcile their clinical experiences with a philosophical system of belief. CPE leaves room for hermeneutic flexibility, and it is in large part this methodology that makes it both attractive and challenging to residents. From a clinical interventionist point of view, it can be viewed much like the ancient Elizabethan approach to Anglicanism: so long as practitioners used the *Book of Common Prayer* in communal activities, they were largely free to believe whatever they wanted. So long as hospital chaplains utilize certain methods of interaction with patients and others, they may enjoy broad freedom to conceptualize the supernatural as they wish.

Such an intellectual outlook might seem highly suspect, even shoddy or dangerous, in light of biomedical knowledge in the hospital setting. Shouldn't chaplains have basic agreements about causality and mechanism? Isn't there some sort of basic set of confessions to which they must agree in order to practice? If there is little or no consistency in belief between practitioners, how can anyone possibly know what works and what doesn't? Who can distinguish the true, legitimate practitioner from the quack?

There are several answers to these questions. The first is essentially demand-driven pragmatism. Once again, chaplains do not proselytize or attempt to change the beliefs of patients, but instead work within the causal and soteriological frameworks that individuals bring with them to the hospital. If a resident can help a patient to find meaningful peace and hope within the latter's system of beliefs, then that, from the chaplain's perspective, is sufficient; there is neither time nor need to engage in apologetics. In terms of the psychological experience of biomedical treatment, residents stress emotional techniques and symbolic imagery from the patient's own worldview that will help them *cope* with the physical and spiritual demands of the inpatient stay.

A second and more difficult issue relates to questions of causality and purpose. Many, though certainly not all, patients, family members, and friends sought meaning in the midst of disease and injury. Those with religious beliefs at my field site frequently viewed medical maladies as semiotically rich—divinely sent messages—and searched for insights contained in these messages. In this aspect of their work, several chaplains found themselves offering different answers to such requests, depending on the setting. On the units, residents had the hermeneutic and pedagogical luxury of ignorance. Chaplains listened and explored without pronouncing airtight solutions when faced with weighty existential questions. This is significant, particularly in terms of conceptions of explanatory models, because residents were trained to exercise enormous restraint in pastoral conversations. Their main function was not to provide panaceas but space for uncertainty in such a way that the unknown did not overwhelm the afflicted. They listened to the "Why me?"[13] questions and helped them to articulate their tacit and unconscious assumptions and emotions, but they did not adjudicate the models or their contents.

This tactic was strategic in several ways. Residents noted that many who ask such questions have grown weary of well-meaning but facile answers from others and reject such simplistic forms of reasoning, preferring instead someone who will acknowledge the gravity of the question itself. Likewise, chaplains who can offer insights but do not proclaim confident answers shield themselves from falsification. They provide assistance—possibilities—but essentially tell patients that they must come to their own conclusions regarding their own beliefs; this is not something that others can do for them.

Back in the CPE seminar room, however, chaplains may assume a very different stance. Why *did* that kid die of leukemia? What *was* God saying to that woman who was shot? As believers, many residents longed for answers to such questions as fervently as did their patients. They struggled to accommodate unfavorable outcomes into their cognitive religious framework, often with great difficulty. Consider the following mid-year statement from one of the students:

> [God] is in charge of the world. He does not make us sick or suffer but because we live in a fallen world, sin and disease will be a part of it. Suffering will be a part of it. I do not think God is a helpless onlooker; rather, I believe he grieves with us. He cries with us …. But practically, it is hard for me to bring that head knowledge to match my heart knowledge especially when I see children die even

[13] One colleague suggested, only half jokingly, that the next time someone asked "Why me?" he would respond "Why *not* you?" To my knowledge, he never did, but his riposte was nonetheless evocative.

> before they are born. When I see young people given the "death sentence" because of cancer, my heart bleeds. This is where I am today; struggling with my head and heart hoping some day they will merge. And I sincerely hope they do merge. Till then, I will just continue to live with this tension.

This reflection captures a number of sentiments held at various points throughout the year by several chaplains. There is a supernatural being; this being exercises some form of control over the human world; events at the beginning of time brought about various forms of human affliction that continue to the present day. This being espouses the highest ethical principles and takes an active interest in the status of individual persons. Cognitively, this schema rationalizes a great deal of what residents encounter, yet the experiential nature of their interactions does not always fit neatly within this theoretical paradigm. Something is amiss: either the deity is not all-powerful, is not entirely compassionate, or is not engaged with the world to the extent that they have been taught. This particular resident acknowledges the paradox and yet continues to engage others in the midst of this uncertainty. Her faith seeks understanding here not through theory but through ongoing clinical engagement. It is unclear from this statement how doubt informs the nature and content of her interactions with patients and others, but it seems likely that there is a certain hesitation present in her work, a certain ambivalence that one does not see in practitioners who believe wholeheartedly in their therapeutic system.

Others, meanwhile, acknowledge such difficulties but do not wrestle with them. One decided that "the mystery of God's will for human suffering remains just that, a mystery" and "is something that I have learned to accept rather than attempt to understand," even though she remained convinced that "in some way God will be glorified through all human suffering." This position led to a group discussion on the necessity of suffering and its value as a social phenomenon. All agreed that suffering would persist, that they as practitioners needed to accept it as a component of human life, and that the world as they knew it was unlikely to become the sort of utopia described in apocalyptic literature and cargo cults any time in the near future.

They were, in other words, resigned to the fact that suffering would happen, though they also continued to believe that they had a role to play regarding its incidence and prevalence.[14] Some

[14] It is important to distinguish here between disease, injury, pain, and suffering. Chaplains rarely spoke of the former, not because they were unaware of it, but because they were unequipped to respond to disease as a somatic phenomenon. Disease, in effect, was morally neutral; it was often associated with pain and suffering, but it was not the target of their interventions. Likewise, pain was something that was undesirable but was largely the domain of biomedicine; it could usually be managed through appropriate chemical/neurological interventions. Injury and

agreed that good could come as a consequence of suffering, through new insights or through gratitude for good health that was often taken for granted. Similarly, one chaplain noted in a rather counter-cultural vein that "suffering is just as much a part of life as joyous memories" and was critical of those who would wish the complete disappearance of suffering, viewing it as a unique mode for understanding and relating to the supernatural. A colleague was sympathetic to this position yet wondered about the distribution of misfortune throughout the local culture, noting that some individuals were statistically far more likely than others to experience certain forms of pain, disease, and injury. He seemed particularly unsettled by the relatively good health that he had enjoyed in his own life in comparison to the suffering that he encountered as a resident. He was convinced that "there are those who have far more suffering in their lives than anyone should have to bear," and that while suffering "can be the catalyst for growth, change and redemption … this is not always the case. There are many whose suffering does not lead to a positive outcome and challenges them to the very core … there are occasions of suffering where it is hard to find any redemption."

This brings us to a third and final level of interaction between chaplain and supernatural being in response to our earlier questions about efficacy and verification. Beyond the level of emotional support, beyond the level of interpretation, lies the level of divine intervention. Chaplains pray with the afflicted, and they often pray for specific outcomes. They appeal to the transcendent for assistance that biomedicine has not been able to provide. In moments of crisis, residents often beseech the divine for mercy, for this life to be spared, for that biomedical intervention to succeed. Particularly when sudden calamity strikes an otherwise healthy individual, residents may find themselves nearly as emotionally invested as a patient's loved ones and may pray for divine aid as much out of desperation as anything else. The possibility of a sudden death was as psychologically jarring to residents as it was to biomedical staff who understood many of the underlying scientific mechanisms in such patients yet who also tended toward anxiety during code calls and trauma alerts. Culturally, the concepts of good and bad deaths held enormous resonance in this space, and bad deaths still carried metaphysical overtones for those forced to stand and watch these events unfold. Chaplains knew as well as any that death is ubiquitous, yet certain deaths, and apparently unanswered prayers, challenged their beliefs and the validity of their interventions in ways that most other clinical duties did not. One resident expressed his struggle this way:

> I still find myself praying for physical healing, for the miracle, for positive and concrete intervention, according to my own sense of

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suffering, however, were different. Both of these activities involved elements of human agency and intentionality and were, to varying degrees, amenable to religious oversight.

> what is best in a given situation, and I expect that God will respond accordingly. Is it wrong to pray for God to spare the life of a teenager who has just been shot? No. Can I expect that my prayer alone will rouse God into action, to do my will? Alas, no, however pure my intention might be. This situation is entirely frustrating for me.

The presence of uncertainty did not curtail this chaplain's desire to intervene, to do whatever he could to promote a good outcome. He realized, however, the old anthropological distinction between religion and magic: he was no conjurer, and his deity was under no compulsion to behave in this way or that. He gradually concluded that the moral posture of the chaplain and the content and sequence of the words uttered guaranteed nothing. He wanted to believe that such actions could make a difference but frequently saw no evidence that they did. It led him to predictable responses, such as questioning his own goodness as a supplicant and the strength of his faith, yet clear answers did not come forth. His compassion did not wane, but at times he began to feel somewhat fraudulent and hence became more guarded in the content of his prayers, which often focused on peace and compassion but which expected less in terms of specific outcomes. Prayers that once expressed confidence seemed more modest, more skeptical.

Toward the end of the program, his outlook had changed quite dramatically. He saw the world more darkly, the result of continual exposure to seemingly senseless acts of violence, whose recipients found no recovery in the hospital. He did not abandon religion altogether, but the theologies that once informed his outlook no longer worked for him. Perhaps influenced by the positivism that seemed to him to pervade biomedical practice, he became frustrated by the lack of clear connections between religious intervention and somatic outcome. Perhaps he had fallen prey to the culture of immediacy that so informed the world outside the hospital and had become impatient with arguments about the lack of synronicity between human plans and supernatural ones, preferring instead to focus on results that he could gauge himself as indicative of progress, much in the same way that a nurse could follow a change in body temperature as the result of a particular drug regimen. He explained that the more he read and reflected on the concept of suffering, the less convinced he was of the notion of undiluted benevolence toward creation. He acknowledged that "we humans bring an enormous amount of suffering on ourselves" and that he had not yet decided what he thought about the concept of random misfortune,

> though out of necessity I am more amenable to the idea. In my mind, it is entirely possible that God simply chooses not to become

> involved in this accident or that illness, even when individuals pray for assistance, and perhaps it is wrong of us mortals to desire divine intervention when we call upon God's name with a sincere heart. This is not to say that God doesn't care or is indifferent to the suffering of our patients and their friends and families, but rather that we may be forced to walk away from a given encounter disappointed.

Learning to Appreciate Biomedicine's Strengths and Weaknesses

As a source of therapy, clinical biomedicine was not foreign to these residents. It was not a rival power today in the way that it has been for religious specialists in many other cultural settings but is a system that students in my program had utilized since birth. Their work at my field site did not reflect a form of warfare between religion and science; chaplains accepted the ability of biomedicine to offer significant therapeutic resources to the diseased and injured.

These students did not elect to work in a hospital to attempt to sabotage or subvert this system, but neither did they agree with all of its ideologies or practices. The residency program encouraged them to conceptualize affliction and healing in the broadest possible way and expected them to pay particular attention to the clinical institution itself as a unique social milieu whose values might or might not be consistent with those of residents' religious traditions. Their training was decidedly *not* atomistic; they did not think in terms of repairing the body in the bed, wheelchair, or CT scanner. Individuals were unique persons, both socially and spiritually, and were always contextualized, both within the hospital itself and within the broader network of social relations in which they were connected. Any therapeutic regimen that neglected these factors was therefore suspect.

One of the more interesting ways in which this particular hospital distinguishes itself from an ethnographic point of view is in terms of its emphasis on scientific research and in various rankings and league tables. Due in part to the unique system of health insurance and reimbursement in the U.S., hospitals compete with each other for patients and advertise in magazines, freeway billboards, and elsewhere to attempt to lure customers with the newest high-tech equipment, most decorated physicians, and industry awards. This market-based approach to scientific research and intervention adds an additional layer of ambiguity for chaplains in terms of the implicit and explicit goals of their work vis-à-vis the broader corporation. As one resident reflect, "There is little question that the place continues to pride itself foremost on its technological prowess and only secondarily on its patient care." While she admitted that there were "many, many practitioners who provide outstanding and

inspiring treatment, who are sincerely concerned with the welfare of those who pass through our halls," she was convinced that theirs was "a place of muscular, athletic medicine, a place in which Type A personalities dominate and have little time for the softer, less quantitative aspects of medicine. Even those in positions of influence seem frustrated by the high-tech inertia of the institution."

This extract raises several important issues. Several of the residents acknowledged that the institution as a whole embodied pride.[15] It was intensely concerned about how others viewed it as an enterprise and seemed to enjoy looking down upon "lesser" hospitals in the region. Self-congratulation was frequent in various internal newsletters and communiqués, though being the best was typically gauged in terms of research funding and guest amenities like single rooms, internet access for patients, and increasingly gourmet foods like sushi and cappuccino at the cafeteria. The clinical experience seemed to some of the chaplains like a domestic form of medical tourism, where somatic repair teamed with entertainment and diversion to create an anesthetized holiday, replete with optional valet parking and tastefully appointed common areas designed to distract and mollify. This combination of marble halls and MRIs made biomedicine appear august, exclusive, and desirable. Perhaps unsurprisingly, chaplains felt ambivalent about their place in the midst of such strategic esteem. These were not aspiring bishops who regaled in sunlight-drenched cathedrals or mega-church pastors who controlled small media empires and advised presidents, but did they struggle not to become enveloped in this mindset of greatness?

Yes. They wrestled with how to be prophetic in a culture that enjoyed being the object of envy. They entered the program primarily to learn how to work with afflicted individuals yet found themselves struggling to address a system that employed and in many ways controlled them but whose motives often seemed suspect. These residents wrestled with a sense of urgency to be voices of conscience to a therapeutic culture whose main goals seemed to be self-perpetuation and the extraction of profit.

These images above suggest a dichotomy in which biomedicine is equated with traditional concepts of masculinity—aggressiveness, numerical assessments, machines, solution-based outlooks, bold decisiveness, a lack of concern about consensus, and a military/warfare mentality—while chaplaincy evokes softer, more stereotypically feminine notions of listening, reflection, patience, nuance, diplomacy, and polysemy. In part because it lacks so-called objective measures for efficacy, clinical religion tends toward diagnostic and analytical modesty. This led some residents to faith in

[15] i.e., one of the seven deadly sins

the unknown in a double sense: they drew upon their faith in the supernatural for guidance in the encounter with the unknown (i.e., faith amidst the unknown), and their epistemological outlook also placed a certain faith in the unknown itself as an ontological state in which their work gained significance and distinguished itself from biomedicine's model of engagement (i.e., faith in the social usefulness of the unknown). The following reflection captures some of this sentiment:

> Confronted with the mysterious and often unpredictable outcomes of many of our patients, words about the ways of the Lord being strange, inscrutable, not human ways, etc., I have been forced into a position of far greater humility, and occasional frustration, than I had anticipated. Why does this one die while that one recovers? Why did that [gunshot wound] to the head expire, whereas the one next to him go home later that evening? Such encounters have helped me to realize that ministry to others often occurs within the context of such uncertainty.

Residents intervene alongside biomedical practitioners yet without foreknowledge of the latter's interventions; as a result, chaplains react along with patients to the therapies administered by other clinical practitioners. This division of labor tends toward hermeneutic duplication through epistemic fragmentation: the same somatic event can lead multiple actors to potentially incommensurate interpretations and either parallel or, more frequently, sequential analyses and responses that entangle cause and effect. Such admixtures of the material and noumenal can, depending on an individual's belief system, make it exceedingly difficult to separate religion's function as a framework for responding to biomedically generated change from its function as a therapeutic system that includes its own interventions and means for thinking through the effects of these activities.

Assessing the Self in Front of Each Other

Let us turn our attention now from the health system at large to classroom sessions with the peer cohort and the supervisor. These didactics are a key component of training that runs alongside clinical work and place a heavy emphasis on developing residents' abilities to reflect on their own duties as practitioners, here under the gaze of their CPE peers—to defend their actions, to explore their thoughts and assumptions, and to process the emotions that spring from clinical encounters. Chaplains are expected to reveal all in this room, including their relationships with their own families and details about their lives away from the hospital, precisely because such interactions bear upon their roles as practitioners. As one resident remarked, the program has provided her with "the context and impetus for the most intensive soul-searching (more accurately perhaps, 'searching for

my soul') that I have ever experienced, as I explore my unconscious with a heretofore unknown depth and breadth."

Another trainee, however, struggled early on with how to make this process of radical openness to the other useful. In her words, "I sense a need to focus on the outcomes rather than the process of pain I have often endured." She had a rough sense of what the program expected of her and wanted to be open to these processes of contemplation and critique but struggled with how to articulate what were to her vague yet powerful sensations in an analytical vein. Pain was something that she was feeling as a consequence of her early interactions with patients. Her religious beliefs convinced her that such pain was not an end in itself but was suggestive of something for the patient as well as for her. How was she to move forward in a meaningful, productive manner? If this pain contained some sort of divine message, what was it? How could she access it?

A key goal of CPE is to give residents the experience of receiving the same interventions that they offer to patients—to help them understand what it feels like to confront and attempt to articulate uncomfortable thoughts in a biomedical setting. This component of the training proceeds on several levels: residents critique themselves and in turn receive assessments about these critiques; they critique peers and get feedback from both these persons and onlookers about their work in the provider role; they provide feedback to peers who critique each other and in turn receive responses to their insights as onlookers; and they receive critiques and then provide responses, subsequently receiving feedback about their responses from others.

Thus every word, every glance, every dialectic is open to analysis in work that aims to heighten consciousness and elicit justifications for convictions. This development of diagnostic and analytic skills forces residents to confront their own health and illness histories in order to develop a religious-biomedical empathy that provides a unique perspective and proximity to the afflicted other. In these classroom settings, interactions can be petty at times, but they are usually demanding and constructive. Residents learn how to identify spiritual and social vulnerable spots and struggle to approach these topics with confidence and frankness, rather than with anxiety that stems from political correctness or a fear of being perceived as nosy. They learn to notice when a colleague is avoiding a topic, person, or clinical unit. Hiding is pointless, and attempting to defend mistakes gives colleagues occasion to be relentless, even ruthless, in their feedback. Mistakes admitted are quickly and sincerely forgiven; defensiveness is the psychological equivalent of giving the supervisor and peer group legal permission to perform surgery without anesthetics.

Such invasive modes of relating to the other can seem threatening, even violent, to new residents, who are just beginning to get a sense of appropriate levels of disclosure and inquisition.

One resident, for example, found herself reluctant to talk about her strengths yet "too open with my insecurities." Though she was not herself entirely aware of her strengths, she struggled to articulate her inner fortitude in public and recognized the need to speak up more regularly during classroom sessions. In particular, she confessed that she didn't contribute "when I feel I might risk offending someone and so hesitate to offer critiques which might be constructive." She nonetheless believed that there was a very good level of trust and mutual regard in the cohort and saw in this forum important opportunities to help train others, even as she underwent her own education. "I believe that in this peer group all the members are sincerely seeking to be genuine with one another and sincere, competent pastoral care givers," she explained, "so I don't want to give the impression that I think otherwise." She was becoming more comfortable participating in this unique clinical training process, but she was still concerned how her words and actions would be interpreted by others and was careful not to offend or cause harm, a sentiment that others found understandable but nonetheless challenged her to separate into more and less useful components as they bore upon therapeutic processes. In particular, some of the residents helped her to consider her use of narrative to frame topics in a way that would encourage reflection and growth without belittling or appearing to attack the other.

Now consider the following statement from a resident at the end of her beginning unit of the program: "[At the start of CPE] I came to visit patients just as I was. I did not assess their strengths; at least intentionally I did not. I was blinded by what I believed their need was. I thought surely prayer would encourage and comfort them. What I needed to ask myself was whose desire this was. I am more sensitive to assessing the needs of those I serve now." This is fairly typical of an early self-assessment in the program. The chaplain identifies her initial method of relating to patients, essentially using techniques from her previous work as a parish minister. She came "just as I was," meaning that while she sought to be authentic and did not come with an agenda of her own, neither did she have a particular analytical or relational frame of mind for interacting with an individual in a hospital bed. She had no tools for assessing the patient's emotional, spiritual, or relational strengths or weaknesses and so was in a weak position to contextualize the comments that arose in the conversation. Words were simply words; they did not index larger issues or struggles. As a result, this resident made assumptions about what an average, rational person of faith might find helpful in such a predicament and did that. She soon recognized the limitations of such an approach and utilized the classroom setting to demonstrate her new insights.

A third resident touched on a number of similar themes and emphasized a growing ability to supervise himself, a shift that he attributed both to a clear understanding of his role as a chaplain (as

opposed to a more generic type of religious specialist) and to his "perfectionist background." This struggle stemmed in part from his passion for philosophy and theology, a focus that provided him excellent exegetical skills for preaching and teaching but difficulties relating to others at an experiential level. He confessed that his learning goals were "too intellectual" and that he should have given more attention to "greater self-awareness and increasing my understanding of how my sense of self shapes and informs my interactions with patients, families, colleagues, and peers." His desire to perform his job well was both a strength and a challenge, however. His acknowledgment that he had become "able to recognize that my initial judgment of a situation was not at all what was happening in reality and was able to quickly recover and immediately began to reassess the situation" was met with preliminary approval, yet his remark that "I was and am constantly trying to 'get it right' or improve on the method I use to assess a patient" generated less enthusiasm and led to a prolonged debate about motivations and ambitions for being a chaplain.

It is one thing to internalize the values and norms of the program and to work to refine techniques; it is quite another for a resident to want to be perfect or to appear ambitious for his own sake. Residents in this program were smart and genuinely wanted to be the best practitioners that they could be for the benefit of their patients, but they occasionally struggled to steer clear of the cockiness of the institution as well as any sense of self-sufficiency that failed to acknowledge divine assistance. This last point reflects an expectation that residents would be frank about their own finitude and the limits of their ability to perform at some ideal level. It was simply impossible to take detailed notes on every patient visit or to pause to analyze every hidden existential issue in a given encounter; demands from other patients or for self-care placed limits on growth, even as they themselves provided occasions for useful insights for self-management. As one resident noted, "[The CPE experience] is more self-reflection crammed into a short space than many people do in years … sometimes I find myself thinking, I am just too tired to reflect on a thing or remember well enough to write down the words of a patient encounter, much less use those experiences for real growth." The fact that these residents were not vying for subsequent fellowships or prestigious research posts helped to mitigate tendencies toward one-upmanship or to believe that every encounter, however mundane, demanded thick description.

This is by no means to suggest that such reflections were always or even often strategic forms of posturing, yet some residents unconsciously found themselves torn in terms of the materials that they presented to the group. If they appeared too competent, they ran the risk of being labeled fraudulent or lazy, unwilling to confront difficult cases or to admit weakness. However, if they appeared too overwhelmed, peers might question their suitability for the program. It was crucial, for

example, to be able to acknowledge analytical tasks that do not come easily or naturally, but it was equally important to demonstrate to the group how residents would confront these issues. The following reflection strives for such an honest yet perceptive middle ground: "I am constantly aware of how much I have to learn. To this end, I am constantly evaluating. When visits remain superficial I constantly ask myself if I missed clues. On days when I feel distracted and less engaged with patients, I am generally aware that this is so and recognize that I have less fulfilling patient encounters." This resident acknowledged that she had been encountered enough situations and techniques to realize how much she did not know. She concluded that significant matters could emerge in pastoral visits and implied that a successful visit was one in which she was attuned to subtle cues that patients provided regarding their unconscious feelings—cues that she as a budding clinician would need to recognize to be a competent practitioner.

Occasionally, these programmatic expectations of openness took a toll on residents, some of whom felt like they had forfeited any residual sense of privacy in the names of transparency and insight. For example, the "perfectionist" resident that I described a moment ago said the following as he neared the end of the program: "It feels like my depression is driving me to build a wall between my peers and myself to protect myself against feeling too vulnerable. This is particularly true of my relationships with my second-year peers. On some level I worry that they see too much, know me too well, see more than I want them to see, know more than I want them to know. For lack of a better word, this frightens me." Working so closely with others in such an emotionally charged setting could easily become overwhelming. Particularly in the second year, some residents simply struggled to get through another day with their personality intact. Constant visibility, constant vulnerability could give them extraordinary insights into the plight of patients, but it could nonetheless be exhausting and humiliating. Even when surrounded by supportive colleagues, they were all the same still surrounded, and such constant surveillance caused residents intentionally to try to restrict access to their inner world, even if this meant deliberately halting participation in one of the key elements of the training program.

Such decisions were not uncommon and occurred several times over the course of the residency, as individuals oscillated between openness and guardedness on a variety of spiritual, psychological, and existential issues. A few, however, steadfastly refused to open certain aspects of their belief or personality to inspection at any point during the program. Those who are determined to keep their theology intact can usually find ways to do so, though given the ubiquity of suffering that is confronted, most find it impossible to emerge without at least questioning previous beliefs, understandings about the divine, and the place of religion in this cathedral of science. It can take a

sort of willful ignorance to continue to believe the same things after a residency program as before it, a determination not to reflect critically upon the lives that a chaplain encounters but rather to jam their unique circumstances, needs, and personalities into set dogmas and theodicies.

Assessing Each Other in Front of Each Other

Critiquing one's peers publicly is not something that came easily for residents. Even when comments were positive, there was a certain social awkwardness to the activity, in part because such tasks could lead to the formation of alliances and camps within the training cohort. The formal questions and assigned topics built into the program structure helped to focus feedback, and residents knew before they began CPE that they would regularly provide and receive critiques for each peer, but this did not entirely mitigate the anxiety about how others might respond. Initially, at least, this could lead to forms of self-censorship in the name of civility. This was true when offering feedback both about verbatim and other formal presentations and about interpersonal attributes and activities observed during their time together at the hospital.

Some chaplains saw these assessments as a generally positive activity. "I think these end-of-unit evaluations are a real concrete source of self-evaluation. After we residents have spent several days reading these I feel as if we have all passed through a trial of fire or *rite of passage*," one colleague noted. "To *see*, to recognize my strengths and weaknesses—that for me is the real work of developing self-supervision" (original emphasis).

Others, meanwhile, were more reluctant to critique either peers' personalities or their clinical work. As one resident explained, it was hard for her to assess her colleagues because she did not observe their clinical work directly. This was a common refrain; chaplains read verbatims pre-selected for them by their peers and observed each other around the office, but they almost never saw each other in action on units and so made inferences about skills and affect. Methodologically, this structure of limited and indirect vision serves a clinical purpose, because this task is similar to other interpretative activities for chaplains: based on extremely limited data, they had to draw conclusions about a person's character and mindset and proceed accordingly.

There are a variety of topics that residents are asked to address regarding the performance of their colleagues. Consider the following assessment:

> Tanya has an enormous heart and offers generous love to all persons … [but] I am not sure what to make of her rather panglossian view of the world and human motivations. Given her rather strict views on judgment, sin, and personal accountability, she often seems torn between a theology of condemnation and a psychology of chipper

> optimism, between a world in which everyone deserves damnation and one in which no one can possibly have bad thoughts or intentions.

This critique offers a glimpse into Tanya, into the author's perspectives and priorities (in this case, my own), and into the author's relationship with her. As the commentator, I held Tanya in very high regard as a person and as a colleague but perceived a tension between what I saw as competing demands on her pastoral outlook. I wanted to acknowledge this struggle, as I interpreted it, and to elicit her response, both to see if she agreed with my impression, and also to see how she responded to someone else's assessment of her in general. Yet how did our colleagues see this interlocution? One felt that I had caricatured Tanya's hermeneutical stance and failed to see the broader religious context in which issues about sin and guilt are situated. Another, however, also noted certain paradoxes in her Calvinist background, sensing that she was reluctant to enforce the doctrinal rules that she believed operate in the world.

Now, compare my assessment with this next one:

> Tanya's pastoral work is characterized by her good nature and optimism. I am not sure if this is a product of or exists independently from her cultural background but on occasion she seems to be either naïve or in denial regarding certain grittier aspects of this American life and work. In her clinical presentations I have noticed that her desire to give comfort occasionally overtakes her intention to listen and to follow the agenda of the patient.

Once again, there is no question of this resident's intellectual capacity—she was completing her doctorate in theology alongside the clinical program—but rather there was a concern about her ability to integrate the analytical and phenomenological elements of her encounters in a productive manner. This colleague was concerned about Tanya's capacity accurately to understand a patient's emotional and spiritual status and to provide appropriate pastoral resources, rather than to interact on the basis of the resident's own needs and interpretations.

Yet another resident voiced similar concerns about the ways in which Tanya introduced religious topics in her clinical interactions. This resident noted that Tanya "has an unwavering trust in God" yet sensed that "she feels hamstrung by what may seem the rather secular methodologies of hospital chaplaincy, for I think that she would gladly turn up the evangelical tone of her outreach if she could. This is not to say that she is indifferent to other manifestations or experiences of God … but my sense is that she often finds herself retreating to familiar verses and images rather than struggling to stay with individuals in their unique moments of need." This colleague recognized how

the theological expectations of the program could prove frustrating for someone accustomed to discussing religious issues in particular linguistic and hermeneutic ways. Such feedback is not normative—he does not tell her how she should discuss God with her patients—but it does indicate a conviction that residents should be attentive to the diversity of spiritual needs in the hospital and should respond in kind, tailoring the mechanism (if not the content) of the pastoral message accordingly.[16]

One of the most frequently discussed sets of topics in the classroom is authority and the development of self-confidence in the role of chaplain. At the end of the first quarter, one chaplain said of a colleague, "It has been exciting to watch Martha grow over the course of this unit. I wonder if she remembers her beginnings as a timid, uncertain proto-chaplain, asking for directions at every turn. There are still times when it seems that she is more comfortable letting others make decisions for her than standing on her own feet, but these occasions happen less and less as the year progresses." This resident sensed that there was still a fair part of Martha that felt a need to be liked by others, particularly on her units, and he lacked a good sense of whether or not she had overcome her early feelings that she as chaplain was somehow marginal to the work of the hospital. Martha's compatriot sensed that it was still difficult for her to claim authority and even wondered if she unconsciously liked "the role of subservient wife and mother more than that of decision-maker and leader." For him, chaplaincy in this hospital demanded a certain bravado, a sentiment that was echoed by several of the other residents and which Martha seemed to acknowledge.

Feedback on a given person varies from peer to peer, with colleagues typically emphasizing different aspects of a resident's character at any given point in time. One chaplain noted of her co-worker that "Sarah's dedication to her patients is quite simply stunning, and I believe that she is most at home in her role as advocate. Justice is not an abstraction for her, but a concrete set of realities that impinge upon every contact she makes at the medical center. I believe that she enjoys empowering people and is quick to align herself with the frail, weak, and marginalized." Ministry for Sarah was, in this resident's eyes, intimately connected to questions of social inequities. Outreach in the clinical setting was no different in this sense from her previous religious roles; power and its abuses were every bit at the front of her consciousness in the hospital and were

[16] Very occasionally, a resident will get the chance to observe a colleague in action. These opportunities can prove quite illuminating and can highlight sides of a resident's work that do not emerge along other routes, as the following anecdote demonstrates: "I once was walking by a room and as I glanced inside there he was, listening to someone. He was not at all obsequious, he was standing up quite straight with good head and shoulders, and his feet were solidly planted. He laughed at something that was said, but he laughed on his own terms. In fact, he was quite magnetizing in that he manifested a certain power I had never seen before. He did something with patients he does not do with us. He was quite a powerful presence. I saw it; I am not making this up."

unambiguously linked with issues of health and well-being. While her peer applauded this ability to contextualize healing processes in general, he worried about its effects on her willingness to collaborate with biomedical staff members and to foster a sense of teamwork. He felt that Sarah was wary of authority figures at times and seemed to view other hospital employees as enemies, or at least as potential barriers, to compassionate medicine. This comment elicited initial resentment but subsequently became an important topic of discussion for the entire group and led Sarah to rethink her understanding of the collaborative nature of the therapeutic enterprise.

Closely related to these issues of authority and self-confidence is pastoral leadership, the ways in which a chaplain learns to relate to others through oversight, suggestion, and exhortations. Several chaplains noted that Joyce is a take charge, buoyantly outgoing person, whose extroversion is an asset with most staff members and in many patient encounters. They told her that they could easily envision her advocating for patients and taking the lead in getting conversations going when they might stall with another pastoral care giver. Likewise, another person said that "I am getting a feel that her ministry is fearless. It is competent. She is a rock that laughs. I rely on her … yet sometimes I hope for her sake that she is not too competent." This resident saw her as a natural leader and found himself modeling his own care in part on hers, though he was concerned that her strength did not become a liability for her. Similarly, it seemed to a couple of her peers that her directing of others sometimes led to "parent-child" encounters rather than "adult-adult" relationships and that her desire to resolve conflicts did not allow her to be sufficiently vulnerable as a religious specialist or to allow her to recognize that the weight of the entire hospital was not on her own shoulders. At the end of a subsequent unit, though, this same person remarked that "Joyce has clearly made progress in her goal of being less directive. She has managed to do this without a loss of the sense of care she demonstrates."

This issue of openness to the emotional demands of the work was perhaps the most difficult issue for residents to address to each other, yet it was also among the most important, for the ways in which chaplains confronted and processed their own emotions spoke volumes about their ability to connect with others in distress. Residents worked to develop a sense of an appropriate or healthy emotional range within which they could operate to be effective practitioners and kept an eye on each other to ensure that they stay within this spectrum. Too close, and the chaplain was likely to become psychologically exhausted and unable to maintain a healthy inner sense of self. Too far, and they might lose their capacity for empathy. For example, one resident noted in an evaluation that Sarah had clearly been impacted by the pain of her patients and families. He commended her willingness to share her pain openly with the peer group, both to promote her own sense of closure for various

cases and to help her peers to learn from her experiences. Still, he suggested that her processes of grieving would be eased if she could learn to "differentiate a bit more" and "not take in so much of the pain that surrounds her."

This need to filter the cries and gazes of others was something that was difficult for Sarah but was nonetheless something that she acknowledged as one of her struggles in light of her finite emotional reserves. Similarly, one of my colleagues noted at the beginning of the second year that I continued "to be deeply impacted by deaths in the trauma bay, particularly young victims of violence." She took a broad view of individual encounters of brokenness that we as practitioners saw and suggested that "while such instances ought to and inevitably do grieve us, I hope that he has enough outside support to both process these events and to engage in the hopeful and happy arenas of life in a way that makes sharing such deep pain manageable." She was aware that I was still a relative newcomer to the city and lacked some of the social support mechanisms that she and other locals had accumulated over the years and could draw upon to process her clinical encounters.

Not all peer-to-peer comments are constructively positive, however. Occasionally, residents may determine that one of their colleagues is simply not well suited to this type of ministry. Such was the case of Gail. At the end of the second unit, and following a series of fiery arguments involving the entire cohort, one of the residents wondered aloud whether or not she had grown at all over the year. If she had, he concluded, it was entirely within the confines of a pre-existing theology and concept of self. He conceded that she might have acquired some practical/technical skills as a hospital employee but remained wholly unconvinced that she had challenged any of her core assumptions. Others agreed and felt that she was only comfortable interacting with patients and others who believed exactly what she did and who experienced the supernatural accordingly. One charged that her theological position was so closed-minded that any deviations from her favored doctrines represented error, sin, naïveté, or some combination thereof:

> Rather than effecting a dialogue between the Bible and human experience, she seems to adopt a trans-temporal, trans-cultural view of the accuracy and authority of the text. Just once I would like to get some sense that she has wrestled with her faith and hasn't just blindly accepted the mixture of ungrounded pious clichés and cheap sentiment and shallow emotionalism that gets passed off as authentic Christian doctrine.

This resident felt that Gail had made no attempt whatsoever to consider other points of view, theoretical or experiential, and only visited patients who would make her feel comfortable as a

practitioner. The tone of a third resident's comment captures well the largely toxic nature of her relationship with the rest of the cohort:

> I am not certain whether or not Gail realizes that she presents herself as one playing a role, similar to those we played as children. In essence, she appears to be playing the role of a chaplain/teacher and seemingly lacks the depth of understanding to take her from role-playing into reality. I was surprised to learn that she interpreted feedback concerning her pastoral work as her being "picked on." It seems as though she is interested in self-preservation at any cost.

Her interpretation of such comments as petty attacks that demonstrated the wickedness of her peers led one colleague to suspect that Gail viewed CPE as a test from the devil, in which she needed to hold onto her beliefs all the more firmly if she were to emerge victorious at the end of the year. That interpretation seemed reasonable to a number of others in the group, given Gail's religious background and demeanor. It also highlighted residents' awareness that CPE held the potential radically to transform their very being and to generate growth that could not come from other means. Their openness to such enormous self-refashioning led them to sharp criticism of anyone who entered the program but was unwilling to countenance such paradigmatic shifts.

This category of comments provides a bridge between reflections on residents' clinical work and their status within the peer group. Those who completed their share of the work, were flexible with on-call duties, were not seen as arrogant or ambitious, and were considered genuinely open to feedback from others could expect favorable assessments from their co-workers. In some cases, interactions quickly revealed common sentiments and shared outlooks and could lead to fast friendships, as one resident/wife/mother said to a fellow resident/wife/mother: "With you, I feel very much at home in our shared values, experiences, and in the little things of life that bring us joy. In that sense, I don't feel alone. Thank you for that."

Acknowledgment of the value of these relationships reflected the importance of feeling a sense of kinship to overcome sentiments of loneliness and otherness that permeated other aspects of the training experience. For example, one resident and middle-aged man said to his fellow middle-aged male colleague, "[He] is genuinely human and available so people also like to talk to him about this and that, things that bug them or things that amuse them. My relationship with him is pretty necessary for me; I need comrades." In other peer relationships, there was recognition of philosophical and theological differences yet an appreciation of a common core of values that led to openness and respect. The comments made by the first resident/wife/mother to one of the middle-

aged men acknowledged their ability to work harmoniously and to find points of convergence, despite multiple socioeconomic differences that would seem to segregate them: "Though you would term yourself a liberal and perhaps I will term myself a conservative, I find we share a lot of the things that matter most; a love for God, for his church and the traditions of the church. I experience you as a very spiritual person."

These commentaries can also be used as an indirect form of communication, a structured way of conveying concerns, frustrations, and critiques between co-workers under the guise of therapeutic intervention. When multiple residents independently express the same or similar sentiments in their written evaluations, this can add legitimacy to their claims and can also be taken as evidence of their acumen as diagnosticians. Consider the following statements about a peer made by three different colleagues:

- "I just hate to see people sad … I must say though that God must have placed you in my life to help me be at peace even when someone is sad and wants to be left alone. That is very hard for me."
- "[He] is often the urbane sophisticate, yet he has a world-weariness that reminds me of the narrator in *The Great Gatsby*. As a peer, I found him at first to be somewhat elusive, perhaps more shy than withdrawn. I felt a little wary of approaching him especially when he seemed to be unhappy."
- "[He] seems open to feedback and willing, perhaps even eager, to understand what one is saying to him. I am impressed with his willingness to bring forth his struggles in his search for spiritual truth and identity. He does this again and again, and it always brings a sudden riveting silence to the room."

Such assertions frequently change over time, as residents both reveal more sides of themselves and are shaped by the program. Nonetheless, all three chaplains here struggled with how to react to their peer's affect in group sessions. They identified a number of key emotions that they saw him demonstrate—sadness, elusiveness, candidness—and all struggled with how to respond in a caring manner. They were concerned about him, and the first two in particular wanted to reach out to him, to use their chaplaincy skills to try to make him feel better, yet both sensed that at times he wished to be alone and were able to distinguish when he wanted to interact and when he didn't. They wanted to respect his right to privacy yet also recognized that there was a great deal that they could learn from him, and they saw in him an openness, at times, to hear what his peers thought of him. The fact that he could be so brutally honest about his uncertainties and struggles was both captivating and

perplexing and helped them to realize through their colleague some of the unpredictability that they could expect to encounter on their clinical units, particularly among those they visited multiple times and for whom openness to conversation could not be taken for granted, even when trust was present.

The Supervisory Relationship

The relationship between residents and the CPE supervisor is a complex one that defies neat master-apprentice classifications. At this hospital, the supervising chaplain oversaw all classroom activities with the training cohort and was responsible for the general implementation of the curriculum. Once again, residents were alone when they enter patient rooms and interact with family and friends, but the supervisor was always available—even at home, by phone—for consultation on how to handle unusual questions or dilemma. He held an enormous wealth of knowledge, both in terms of pastoral counseling and institutional protocol, and he was always willing to help when a patient situation demanded it. There was nonetheless an unspoken expectation that residents would not take advantage of this availability and would attempt to manage situations themselves before asking him for help.

Given these structural aspects of the training program, there were significant interpersonal factors that contributed to the ways in which the supervisor shaped residents. For example, one gay resident commented early in the program that "feeling safe and comfortable relating to authority figures—in particular, straight white male ecclesiastical authority figures—is not easy for me." He had undergone a number of painful and demeaning experiences in the church and was leery of history repeating itself. Those past encounters were traumatic enough for him but could have been far worse in the hospital setting, where he would be expected to be significantly more emotionally and spiritually visible than he was in his parish role. This resident knew that the supervisor was not homophobic but was nonetheless wary of trusting him for much of the first year.

Another resident commented on what he perceived as a disjuncture between the messiness and unpredictability of work on the wards and the seemingly cold, rule-laden structure of the department of pastoral care. This chaplain explained that he spent half of the fall quarter highly ambivalent about the supervisor, coming only toward the end of the term to develop a deep respect for him. Initially, the resident mused, "he seemed sterile, bureaucratic, and authoritarian, with little time for sentiment or grace, someone who was more concerned about the status of the duty pagers than about his underlings." It was only with time that this resident came to recognize him as a deeply spiritual individual, someone who cared immensely about the welfare of others and about their development as human beings. One of this resident's colleagues shared some of these impressions early in the year but also learned to relate to the director in productive ways. "I feel that I've

developed a sense of when and how I can challenge him versus when to keep quiet," he commented in one of his evaluations and noted the supervisor's "curious, endearing sense of humor."

As this particular resident grew more familiar with the supervisor, he felt more comfortable raising concerns about the program and what he considered possibilities for improvement. In his words, "I appreciate his openness to change and new ideas at the departmental level, though I'll admit that I am less convinced that he sees a need to update the CPE program; I sometimes wonder if [the supervisor] stopped reading new texts and theories of pastoral care and theology sometime in the early 1980s." This student, along with a couple of his peers in the second-year class, began to feel that they had mastered several elements of the curriculum and longed for new opportunities for advancement.

This attitude is significant for a number of reasons. First, it suggests that while clinical learning and growth would be a lifetime project—there would always be new scenarios to encounter and new techniques to master—the classroom tools designed to process such work had their limits. Second, the various analytical tools that this supervisor introduced were useful, in the eyes of these residents, yet they longed for additional perspectives that incorporated more recent ideas about organizational behavior, developments in psychologies of grief and uncertainty, recent theological treatises about the body and bioethics, and so forth. Third, the program included monthly research seminars, where students and other hospital staff heard about new findings in the field of religion and health, but there appeared to be a need in chaplaincy for what we could call *translational religion* in a manner similar to the need for translational medicine, to bring new ideas from the research arena to the bedside.

The biggest criticisms of the program and the supervisor—for the two were indeed nearly synonymous—were at the level of social justice. Most of the residents in the cohort were interested in the hospital as a social institution as well as a place where individuals received treatment, and they were committed to speaking to these structural needs and weaknesses in addition to those of individual patients and family members. For these chaplains, healing was an interpersonal concern as well as a macroscopic issue, and they as religious specialists felt a strong sense of responsibility to address these multiple therapeutic levels on behalf of the afflicted. This sometimes put them at odds with the supervisor, who at times seemed to them sympathetic to their concerns yet was cognizant of the perpetually tenuous place of pastoral care within the larger institutional framework and was hesitant to raise a prophetic voice to challenge the power brokers of the clinical culture, be they attending physicians or the management team. This posture seemed curious at best to several of the residents; they understood the idiosyncratic place of religion in the hospital yet recognized that the

director had cultivated a number of close relationships there with persons of influence and felt that he had accumulated significant social capital with which to confront issues of racism, classism, and other forms of marginalization.

One resident, for example, found the director extremely committed to the welfare of the CPE program and a model listener, yet he sensed that the supervisor was averse to confrontation and prophetic ministry: "We as a department do an enormous amount of good work here at the hospital, but it seems at times as though [the director's] theology with regard to the institutional bureaucracy is one of accommodation, rather than liberation." This resident acknowledged that he expected a great deal of his supervisors and wanted them to be strong on behalf of his underlings, yet at the same time he was increasingly frustrated with what he perceived as the supervisor's stock methodological response to criticism, which the resident saw as the director's trying to spin criticisms of him as psychological maladies or shortcomings of the person raising the complaint. In the resident's words, "*Psychoanalysis is no substitute for concrete action.* Holes in levees are not fixed by suggesting that the dam be more introspective. The waters are not held at bay by sitting atop a hill and suggesting that people in low-lying areas are showing real insight by noticing that their homes are being flooded" (original emphasis).

This criticism of the program, and indeed of pastoral care in general, points to several key methodological struggles that residents faced. How useful is insight? Is clairvoyance therapy? Is heightened consciousness an adequate religious response to the existential issues that actors bring to the clinical space? In reality, most of the residents recognized that their work with the grieving was extremely significant, just as their ability to raise questions about socioeconomic and cultural issues in discharge rounds, at nurses' stations, and in elevators gave them opportunities to address issues that linked consciousness with the potential for cultural progress. They recognized that the facilitation of meaning could be a worthy end in its own right, yet some of them occasionally longed for quick, potent interventions—akin to those wielded by biomedicine—to fix institutional inequities and were skeptical of the idea that heightened consciousness necessarily resulted in senses of empowerment or the will to act. On several of these issues, the residents and the director remained at odds.

THE WORLD OUTSIDE THE HOSPITAL

Always on Duty?

CPE involves more than acquiring a particular set of skills. It is ultimately an epistemological and phenomenological system of social engagement. Hospital chaplaincy is not simply something that one does; it is something that one is. It provides a particular mode for understanding and reacting to causality, uncertainty, and social customs. One resident described this shift almost in terms of a conversion, of "learning to see people in a new light" and "noticing things about people that weren't particularly obvious before." Residents became attuned to a great many aspects of individuals and groups that they had previously taken for granted or simply not realized. Data become both more substantial and more contingent. One more experienced resident explained that she was coming to prefer this "open, non-judgmental, non-habitual, actually hearing, precise, and generous way of encountering beings as opposed to my more habitual method." Significantly, she saw this interactional mode as much a suitable religious posture as a diagnostic and therapeutic one that "gradually expand[ed] to all those I contact," both in and beyond the hospital.

Such a physiologically demanding mode of engagement can prove almost addictive for chaplains, yet as several residents noted, it can be difficult to switch off this analytical approach, even in relaxed social settings. "It's as though data throw themselves in our faces," one said. "We can't simply ignore behaviors or idiosyncrasies, even if we wanted to do so." Such finely attuned perception could be exhausting for these religious specialists and perplexing for those they met in daily life, for the latter might resist residents' urges to see all interactions in the therapeutic mode and could even feel intimidated by deep gazes in response to casual comments.

Most residents recognized the need to erect various sorts of barriers between their hospital duties and the rest of their lives, to try to prevent the methods and experiences of the clinical space from overwhelming their entire selves. For example, one resident explained that he rarely listened to or read the news during the program because he found daily headlines about the war in Iraq and local violence too close to the suffering he was encountering firsthand. This kept him from developing as thorough a sense of the region as he would have liked, but he recognized an increasing need to run—physically or at least mentally—from a setting that exposed him to quotidian sorrow. He found a partial outlet in the foreign films that he checked out from the independent video store on his way home from work. Another, meanwhile, noticed through this clinical training an overlap between her tendency to "over-mother" her offspring and friends and increasingly let go of her need to try to solve (or at least oversee) their problems. She listened more intensely than ever to loved ones outside the hospital, but she was able to restrain her desire always to intervene when she detected a

conflict. As a result, she "found them quite capable of handling the difficulties they would normally bring to me" and gradually accepted the newfound "independence" that they were coming to acquire as a consequence of her new outlook.

Strangers and Familiars outside the Hospital

Residents demonstrated a range of ways of relating to society beyond the hospital. Although it was never articulated openly, there was a tight bond that developed among chaplains, a spiritual and emotional athleticism that stemmed from their realization that they were surviving the experience of CPE. They increasingly realized that they could handle grief and agony that many—including other clinical practitioners—could not. These religious specialists saw that most individuals, both inside and outside the hospital, had no idea what they experienced on a daily basis and shrank back when they attempted to share clinical anecdotes and stories, thus seeming to confirm a newfound social and experiential gap between them and other people. Among some of the chaplains, this sense of otherness contributed to an increasing sense of loneliness, even as they embraced the fact that they saw more clearly, and interacted more profoundly, with other human beings than they ever had. This paradox of positionality remained unsettling for several of the residents, even after the completion of the program.

One of the ways in which this sense of otherness emerges is through the internalization of emotional experiences and the subsequent shift to alternate worldviews from constant exposure to, as one chaplain noted, "death, gore, white-hot rage, and the fact that the grieving family members we're consoling may also be packing heat." There was at times a sense of almost magical contagion at work for residents, who occasionally wondered if they would start to resemble some of the patients they served. A second-year chaplain, for example, was present when a family member punched a hole in the wall of the consultation room upon receiving bad news from the trauma surgeon; this resident noted rather ruefully that the walls in that room had been patched so many times that they were more spackling than sheetrock. Yet would he become so accustomed to physical violence through such encounters that he would begin throwing fists himself when confronted with unfavorable information? Might I, the psychiatry chaplain, begin hearing strange voices or develop an urge to change my bed linens over 40 times a day?

Such specific concerns were not particularly acute among the residents, but there was substantial worry that they would identify with their patients in terms of gloominess of outlook or through repeated exposure to hopelessness. Several residents confessed that it was extremely draining for them to attempt to convey hope to the hopeless, love to the unloved, and compassion to the hardened. Even non-life-threatening interactions could become challenging in terms of the

robustness of their religious convictions and emotional frame of mind, to the point that a couple of residents occasionally confessed to viewing even the healthy outside the hospital as future patients or as pre-cadavers.

This sense of distance flows in both directions. Hospital chaplains lack significant social capital outside the hospital; financially and politically, it is difficult for them to claim high cultural status, despite their advanced degrees and professional training. More to the point, several residents experienced rather undesirable associations when talking with people on the outside of the hospital, despite their best efforts to avoid being labeled Angels of Death within the clinical space. Chaplains were the sorts of people that passers by both admired and tried to avoid, largely due to residents' symbolic association with suffering, uncertainty, and finitude.

It may well be that a hospital chaplain is seen as dirty, polluting, or dangerous when out of place, i.e. outside the medical center. To the extent that the hospital is liminal real estate, it may be that residents become accustomed to thinking and experiencing life and its contents as transient and come to view any apparent lack of turbulence or change outside the clinical setting as misleading and those who view themselves as clean merely fatuous. As one resident confessed midway through the program, "When I walk back in the house I am amazed that in the incongruous sunlight everything still looks exactly like it did before. There are no signs of the tragedy and the suffering; the hurricane that I have been in has left my house unscathed." The world of the hospital had become a total institution for this practitioner as well; the fact that the environment outside this self-contained "war zone" appeared visibly unaffected by the violent deaths that she had encountered seemed like affronts to her moral and experiential sensibilities. This daily oscillation between the sacred and the profane (Which setting was sacred? Which was profane?) seemed impossible to reconcile into a single, coherent life world, even though she supposedly inhabited both equally.

Another resident reflected on how CPE had in fact heightened her sense of the contingency of her environment. For her, life had taken on a constant air of fragility. Her clinical experiences etched within her a perpetual realization that "my life could be changed in a twinkling of an eye." Her work in the trauma bay in particular brought new meaning to previous religious beliefs that seemed at times merely philosophical. "I can no longer live without the real life experience of the meaning of the depravity of man," she explained, "as I see people shoot not only their enemies but people they claim to love or people who love him." Life was no longer as "simple" as she had taken it to be. It had become semiotically over-determined: "I have seen enough tragedy in these nine months that I might have seen in ten lifetimes had I not done this residency. Now when I hear the

siren of an ambulance, I do not just hear a siren. I see and hear the anguish of the people whose lives are being changed by that incident. It is not abstract thinking."

While such interpretations no doubt involved the occasional act of projection, they nonetheless helped to open residents to interaction with the stranger that they had heretofore not known. At the end of first year, one resident found that he had actually come to see less of a distinction between the people he met in the hospital and those he encountered on an everyday basis. He wrestled with his ability to remove the mantle of chaplain entirely when off duty, but he explained that it had become easier for him to approach strangers and talk with them without feeling either fraudulent or intimidated, due to the social and interpersonal requirements of the program. Later, he experienced less of a need or desire to see strangers as wholly other, as people to be avoided or dismissed as unworthy of his attention, if they were not riddled with bullets or in need of a heart transplant. The events inside the hospital still retained an edginess that he saw only occasionally outside the clinic, but there was less of an ontological gap in his mind between citizen and patient than there was early in the program.

For other chaplains more familiar with the history and culture of the area, the realities of inner-city life provided a far clearer sense of continuity between hospital and street corner. This is another example of how residents were able to teach each other about various aspects of culture and diversity in order to serve patients more insightfully. One student, for example, found himself asking colleagues question after question about local politics and the social roots of misfortune, inequality, and injustice in the region, and they were able to provide him with a much greater awareness of the complex circumstances that brought various individuals to the hospital. Drives through impoverished sections of town, an overnight police ride-along, talks with hospital security guards, and reflections with patients and family members also helped him to understand better the meanings that various subjects ascribed to precipitating clinical events and to ways in which religion could be used as a resource for coping with such encounters. Another confessed along similar lines that he was still working through a number of stereotypes that he held and was trying in particular to develop "proactive approaches to young African-American male family members of trauma patients," in order to understand better their values, presuppositions, and needs, particularly in a largely white medical center that typically viewed black men with suspicion.

Coping Strategies and Emotional Outlets

Chaplains are most definitely *not* the center of attention in the hospital. In most cases, no one is remotely concerned about how they feel, despite the fact that the religious specialists are among

the first ones called when there is a crisis. Yet how do chaplains contend with the surfeit of emotions that they encounter through these interactions?

Consider the following meditation by one of the residents:

> My philosophy of pastoral care is that ultimately the patient and the caregiver are not two …. By not two, I mean there is a space where our consciousnesses, our souls, our awareness, our true beings are not independently existing …. Speaking more relatively, when I enter a dying patient's room, even if I have never met them, often we come together completely in the moment we join hands and look in each other's eyes. What is this? It is startling. I have begun to let go into it, and relax in the question. Nothing has to be said; on the other hand talking is fine, especially in the awareness of the ultimate connection.

There is much that we could analyze in this passage, but I want to focus here on the phenomenology of grief. Several chaplains were deeply moved when they initially heard this reflection and came to embrace it as a model for good pastoral care. Yet such a tight, almost Hegelian, sense of proximity begs the question: how do chaplains process the grief and the agony that comes with such unity between afflicted patient and religious practitioner? The chaplain is in a strange emotional and ontological space here, for he both identifies deeply with the other in their oneness and yet must separate himself enough so that he can counsel the other as an *other*. He must simultaneously experience and respond. Occasionally, this dual activity of identifying and giving can be mutual—the patient can also give amidst this process of tight co-identification—but more often than not, the patient's gift is gratitude, not catharsis, from the perspective of the chaplain as recipient.

This is not to say that the chaplain *removes* affliction from the patient through this temporary unity (or perhaps communitas) and takes it upon himself—though such an act is conceivable—but rather that he *shares*, *co-inhabits*, or *co-experiences* it with the patient. This in itself could be a form of therapy or gift, to the extent that the chaplain lessens the patient's sense of experiential isolation. More to the point, however, the chaplain seeks to provide the patient with options—visions of possible futures, methods for connecting with others, concrete assistance navigating the hospital experience, whatever—that will make the encounter with the disease and injury more manageable. That is, he attempts to empower the patient through religious and other resources to cope with clinical phenomena more productively.

Well and good. But our question remains unanswered. How, we must ask, does the chaplain manage the aftermath of the affliction that he has just encountered, that he has just come to embody? If he has been spiritually or emotionally *infected* or *compromised* by exposure to the suffering other, what resources are there for him, beyond the aforementioned gratitude, to metabolize such phenomena? Continuing with the epidemiological metaphor, does such a chaplain himself become a carrier of suffering, a bearer of calamity who must himself undergo some sort of therapy or purification in order to be healed?

Such questions lack easy answers. Yes, residents lean upon each other for support and become particularly close with each other, but this in turn suggests an infinite regress. Reflection and articulation through imperfect identification is one possible pathway; weary chaplains can unload some of their grief onto their peers, who assume some of the burden but not all of it, such that residents perpetually carry some sorrow with them as embodied memories but keep these levels low enough within their consciousness to be able to function adequately. Other endeavors, including food, exercise, meditation, art museums, arboretums, scripture study, humor, and even sleep were utilized by various residents to attempt to release some of the tension associated with these encounters, or at least to counterbalance some of the necrotic sounds and images with healthy ones.

Sometimes, however, residents found it impossible to identify a stressor in order to try to manage the sensations that they had accumulated. One chaplain explained rather sardonically that "In the final weeks of the unit I felt that I was increasingly functioning in survival mode. In particular this manifested in an almost permanent state of high anxiety, which did not even have the decency to attach itself to a particular problem or issue so that I had no option to work on a solution to relieve it." Was this some sort of divine communication? A question for neuroscience? An unconscious statement of resistance? Though no clear solution emerged for this resident, this lack of conclusion itself functioned as an important reminder to the peer group of the fact that the very sentiments they often shared with patients, and subsequent searches for meaning, could—like struggles to find biological cures—prove frustratingly elusive.

6

PASTORAL CARE IN FOUR HOSPITAL CULTURES

GENERAL INTRODUCTION

What does it mean to talk about the culture**s** of the hospital? Significantly for the purposes of this thesis, how do chaplain residents and religion operate within these cultures, and to what ends?

While there may be an overarching sense of mission or identity to the large U.S. teaching hospital, it is far more helpful to speak in terms of particular wards, units, labs, and so forth when trying to understand cultural norms and practices of the hospital as a particular social environment. These differences may take very tangible, observable forms, such as the physical layout of a particular floor, leadership hierarchy, and rules for visitors, but variables such as personality, current patient population, and the staff composition of a given shift (i.e., morning, night, weekend, or holiday) can effect dramatic differences in the social and cultural processes of a particular group of hallways.

This chapter builds upon residents' narrative reflections and insights presented in the previous two chapters and introduces here case studies of interactions between chaplain residents and patients and family members on four types of hospital units: the trauma bay, intensive care units (ICUs), inpatient psychiatry, and other general/intermediate care wards. Following a brief introduction on the concept of the chaplain's patient, I introduce three cases for each unit. These cases represent a range of students and issues that emerged over the course of my fieldwork that address key questions of rationality, reflexivity, hope and uncertainty, and mediation raised in chapter 1. Each case presents narrative interactions and residents' own reflections from verbatim transcripts and subsequently includes analysis on multiple levels: the clinical interaction itself; the resident's reflection of the interaction; and, in selected cases, the CPE cohort's discussion of the verbatim. These twelve cases are by no means exhaustive in their scope but highlight a range of some of the more significant challenges, opportunities, and dilemmas that residents faced in the clinical component of their training and some of the ways in which the residency group struggled with particular issues in ways that shaped their own senses of self, use of narrative in pastoral

interactions, understandings of the supernatural in the clinical setting, and perceptions of the mediating role of chaplains between particular actors in healing. In a few cases, group discussions were either brief or lacked significant anthropological import, and so I elected not to include them in the dissertation. All of the cases in this chapter were introduced to the CPE cohort for analysis, and I was present during each of these sessions, either as the presenter (Cases 5 and 11) or as a peer offering comments on the case (the others).

The reader may wish to pay particular attention to the extent to which cases reproduce or challenge the ideologies and protocols of CPE outlined in chapter 3.

LEARNING TO BE A CHAPLAIN'S PATIENT: AN ODD ONTOLOGICAL CATEGORY

> "There is a complex dance between what a clinician learns to treat
> and how a patient learns to be treated."
> — T.M. Luhrmann, *Of Two Minds*

For many patients and their families, the hospital is already a very foreign culture, with strange signs, terminology, orders of command, and secular rituals. It may bear some resemblance to the world outside, but it is often a decidedly liminal domain, one in which everyday ways of viewing and interacting with the environment simply do not apply.

Where, then, do religion and religious specialists fit into the inpatient experience? Most individuals had at least a vague idea of the presence and activities of doctors and nurses, and some also knew of the work of various therapists, technicians, social workers, financial counselors, and secretarial staff. But religious workers—at a secular hospital? What do they do? One resident explained that he received a number of questions from patients about his job at the hospital. "Who pays your salary? Is it hard to do your job? What qualifications do you need? What do you do all day?" He gradually concluded that "so long as these sorts of questions do not persist too long, I am happy to answer them, in part because I believe that it helps patients and family members (and, not infrequently, staff members) to understand what I do and how I can be of service to them."

Some of this visibility was intended to be strategic. During evening shifts, chaplains were directed to visit each ICU to check for any needs, a move that sometimes led to visits but more often seemed to the residents to reflect a desire on the part of the department director for chaplains to be seen, remembered, and justified members of the care team. While residents often wondered if the

nurses and unit secretaries had a good sense of patient needs for the chaplains, they generally accepted these rounds without complaint.

At the same time, residents sometimes grew weary of the gaze of others. "Are we always under the microscope as chaplains?" one senior resident wondered aloud one afternoon, particularly with reference to their words, carriage, and affect. A colleague agreed: "Can we escape the roles/IDs that people ascribe to us at the hospital?" Even as residents developed a clearer sense of self and role, they continued to struggle with the fact that patients and family members in particular seemed to have curious beliefs about what chaplains were capable of doing. Several of them also struggled with how to see themselves in light of these beliefs, requests, and glances. These thoughts parallel in several respects the conclusions that Von Furer-Haimendorf reached about religious specialists. On a personal level, he explains that some groups place relatively little emphasis on celibacy or chastity as prerequisites of the priesthood, while others may observe certain ritual prohibitions but are otherwise expected to structure daily life in a manner similar to that of the laity (1970). One resident's comment, "Does anyone here see us as sexual beings, as people with desires and longings like everyone else?" resonated with the group and pointed to senses that chaplains felt that they were supposed to be model members of the hospital community—morally flawless, charitably selfless, kind and unbiased saints—rather than flawed fellow humans who ate junk food, ran the occasional red light, and *gasp!* sometimes uttered profanities when frustrated.

Whom do they serve? To whom are they accountable? If one stops by, what will he want? Will it mean that death is near? Will she try to convert me? Others will be intensely interested in incorporating a religious component into their treatment and may even see the hospital stay as a religious event in its own right but may be unclear how to do so. That is, they want to experience the divine but are unsure how to coordinate the problem of presence in a biomedical setting.

Whatever the case, a meeting with a hospital chaplain may well be a once-in-a-lifetime encounter. Many of the patients and others that chaplains meet have never had a deep, one-on-one conversation with a religious leader of any sort, much less one in a clinical setting, and so many have no mental map or schema of how such an interaction should proceed. Because chaplains wear hospital ID badges like other staff members, will patients and family initially treat them as clinicians and frame their responses in terms of biomedical topics? If the resident wears the collar, will that elicit memories from church school and perhaps images of discipline and punishment? If the resident is soft spoken, yet their Sunday morning pastor is forcefully demonstrative, will the chaplain seem fraudulent or somehow deficient? We must wait and see if such cognitive processes do in fact emerge in conversations with chaplains and hence if they parallel Dilthey's concept of scanning the

past until a person identifies a perceived similarity with the present, an enterprise that rejects the notions of "raw encounters or naïve experiences since persons, including ethnographers, always enter society in the middle" (Bruner 1986:12).

Questions such as these run in both directions for new residents. They are often just as concerned about being—or at least seeming—competent, compassionate, and relevant. One chaplain explained that when he began CPE, "it was somewhat difficult to assess if there was a need for me to be in the room. Now that difficulty has developed three distinct branches. 1) Does the patient want me in the room? 2) Does the patient *need* me in the room, even if he doesn't really want me? and 3) Do *I* need to be in the room?" Gradually, these three questions became intuitive, and he was able to assess more efficiently if the answers were *yes*. If so, he stated that he then began to "sense further into the strengths and needs of those served" in light of his sense of emerging theological principles that participants brought to the conversation. He developed a sense of purpose that recognized, perhaps paternalistically, that some patients will be leery of pastoral contact but that, from a therapeutic perspective, they would benefit from conversation that might help them to articulate points of tension and thereby find a greater sense of calm amidst the biomedical interventions.

Chaplains, at least, knew that most of their work would focus on conversations. To varying degrees, they understood that this itself could generate tension between the very clearly material nature of biomedical interventions and cultural conceptualizations of illness, the body, life worlds, particularly in light of the ostensibly noumenal, immaterial nature of religious beliefs and experiences. They were, in other words, positioning themselves as counter-cultural figures, curious beings who would often find themselves attempting to straddle the worlds of empiricism and faith (or foundationalism), holism and atomism, and representationalism and expressivism (cf. Murphy 1997:40). They could not assume that conversation would take a standardized route, with diagnosis as the destination, but would instead be forced to become a particular type of chaplain for each type of patient, on the basis of narrative exchanges and often subtle, unspoken cues.

Such a position parallels Crapanzano's impression of many, if not most dialogic exchanges, which he sees not in terms of a single genre, in which the possibility of attraction can be presumed, but rather as a broad range of strategies and types that frequently fail to align. He contends that "there are many genres of spoken as well as written communications with different implications, even within a single culture … and these genres can be distinguished not only through linguistic and stylistic analysis but more immediately, though not necessarily explicitly, by the culture themselves" (1992:198). Further, "the failure to master the genres of social conversation is the outsider's weak point" (1992:199), something that chaplains recognized they would have to overcome if they were to

be effective practitioners. Whether or not discourses epistemologically or linguistically would resemble hybrids of familiar modes of speech, or in fact completely new categories of knowledge exchange and phenomenal experience incommensurate with previous webs of conceptualization—or, for that matter, other modes of discourse simultaneously occurring throughout the hospital space—is another question that chaplains confronted, implicitly, in the cases that follow.

I. THE TRAUMA BAY

INTRODUCTORY REMARKS

Trauma, both as a concept and as a cultural phenomenon, has received increasing attention in recent years by social anthropologists. A flurry of articles, monographs, and collections has investigated various aspects of events that shock and undermine the very foundations of individual and collective lives. Specific topics have included, for example, war, violence, and the body as cultural trauma events (Henry 2006); the globalization of local large-scale traumas, such as earthquakes (Breslau 2000); violence in periods of war and peace (Scheper-Hughes and Bourgois 2004); and cultural and psychiatric perspectives on trauma (Kirmayer, Lemelson, and Barad 2007).

Less common are ethnographies of the experience of trauma treatment within the hospital space. The field of traumatology itself has produced an enormous literature on scientific aspects of traumatic events, and some articles have attempted to address cultural and social components of these interventions. These include responses to pediatric trauma (Arlidge *et al.* 2009); traumatic brain injuries (Kendall and Terry 2008); Myopericarditis and sudden death in student athletes (Durakovic *et al.* 2008); rape, sexual violence, and trauma (Campbell 1998; Longombe, Claude, and Ruminjo 2008); demographic, injury, and crash characteristics of MVC victims admitted to a regional trauma bay (Stoduto *et al.* 1993); anxiety and emergency surgery following traumatic events (Herrera-Espiñeira *et al.* 2009); mass casualty traumas and hospital responses (Karp *et al.* 2007); posttraumatic concerns and the hospital (Zatzick *et al.* 2001); and the development of the Aberdeen trauma screening index and post-accident psychopathology (Klein *et al.* 2002). Others have investigated social elements of the trauma unit from the provider perspective. These include social and psychological consequences of exposure to trauma patients (Badger, Royse, and Craig 2008); professional nursing culture on a trauma unit (Tutton, Seers, and Langstaff 2008); stress reactions treating war-related injuries in a hospital under missile attacks (Koren *et al.* 2009); moral

interventions following alcohol-related traumas (Monti *et al.* 2007); and pastoral care in a trauma center (Landry 1996).

Apart from the last entry, however, religion has been little investigated in this setting, and issues of narrative and belief have likewise received little attention in trauma units. These are a few of the topics that I shall highlight in the following case studies.

Overview of the Unit

The trauma bay is physically attached to, but administratively separate from, the Emergency Department (ED). Patients coming to the hospital for urgent care are directed to one space or the other, depending on the presenting malady. The trauma bay receives patients with piercing or crushing injuries to the head, neck, torso, and proximal limbs; all other conditions are handled by the ED.[17] Trauma bay patients arrive via ambulance, helicopter, police, or private transportation (i.e., family or friends).

The bay itself has three main stations: three gurneys, each with its own diagnostic and interventional equipment, allowing the trauma team to handle three active traumas simultaneously. It also includes space for two additional gurneys for patients who have been stabilized and who are awaiting either admission to an inpatient unit, further diagnostic tests such as a CT scan or MRI, or discharge.

The cast of characters for each trauma patient includes the attending trauma surgeon, trauma surgical resident, ED physician (to manage the patient's airway and respiration), a minimum of two nurses, at least one nursing assistant, a radiology technician for x-rays in the bay, ventilation specialist, admission secretary (from the ED, who also tends to the patient's personal effects), intra-hospital blood bank transporter, security (as needed), and the chaplain.[18] Additional medical specialists (e.g., orthopedics, neurology, maxillofacial surgery) are paged as necessary. Exception: usually no social worker—chaplains perform most of these functions.

There is a strict standard protocol for each patient at both the symbolic level and the physical/literal. Patients are transferred from the transport gurney (including a hard board to which they are tethered) onto the trauma gurney. Within seconds, their identity is stripped to the solely biological: all clothes are cut off, jewelry is removed, and purses and wallets are stored with security. They lie naked, on a table illuminated by an intensely bright spotlight, surrounded by seven

[17] Patients with severe burn injuries are stabilized in the trauma bay and then transferred to a nearby hospital with a fully equipped burn unit.

[18] The attentive reader will notice that this list does not include a social worker. Although there is a social worker attached to the department of traumatology, her duties are restricted to discharge planning.

or more strangers. Blood samples are taken and the airway is scanned for obstructions. The pulse is taken and a quick assessment of cognitive status (awake, alert, and oriented to place, time, and name) is made. An ultrasound scan of the abdomen is made to see if the gastrointestinal tract has waste in it. A rectal exam (the finger probe) checks for internal bleeding. X-rays are taken. Depending on the case, a patient may be intubated, undergo CPR, receive one or more injections of medications (including a tetanus shot), and receive blood transfusions. In very rare cases, the team may crack open the rib cage in an attempt to resuscitate the heart muscle directly.

Such activities demand order and a clear delineation of duties. There are sharp, yet ever-shifting, demarcations of space—sterile vs. non-sterile, irradiated vs. clear, patient vs. worker, biomedical vs. other staff, dead vs. living, and criminal vs. victim. Team members learn not get in each others' way. In the best-case scenario, colleagues work together organically and the protocol flows smoothly. As a busy teaching hospital, however, this is rarely the case, given the ubiquitous presence of various types of students, other patients and their visitors, visiting scholars, security, police, and others. It is a loudly masculine, visceral environment, one in which hazing may in fact be necessary. It is decidedly not for the faint of heart, indecisive, timid, or jittery. The staff frequently juggles multiple cases at once, and thirty or more people may weave between and around each other on a busy Friday or Saturday night in the summertime.

That said, the amount of time that a patient spends in the trauma bay varies widely. Some are in the room but a few minutes before being whisked to an operating theater. Others may spend hours there as other patients come and go, depending on their condition and particularly the availability of beds for patients being admitted. Yet not all are admitted: some are discharged home directly from the trauma bay, while still others are pronounced dead shortly after arrival.

Dynamics of Chaplaincy on This Unit

Pastoral care manages many of the emotional and logistical functions of family care for trauma cases. Chaplains respond to every trauma at this hospital (approximately 5,000 per year, on average). Due in part to this regularity of contact, they enjoy an unusually warm, trusting relationship with trauma surgeons and other team members.

In the trauma bay, pastoral duties are most predictably formulaic and relate most closely to the interventions of the biomedical staff. Because social work does not respond to trauma calls, chaplains are responsible for coordinating a good deal of data collection and information processing

during the opening minutes of a trauma, while clinical colleagues on the other side of the green line[19] work to stabilize the patient. Chaplains obtain contact and other non-medical information about the patient (date of birth, pickup location, mechanism of injury, availability of photo ID and/or Social Security number to verify the person's identity) from transport personnel, compiling it for both medical and admissions staff. When the patient is an adult and is able to speak, residents offer to phone family and friends to alert them to the situation as the initial and primary points of contact between families and the hospital.[20] If and when family members arrive, the chaplain greets them and documents any relevant scientific data (e.g., list of medications, allergies, significant previous medical history, and contact information for the patient's other doctor(s)) to forward to the recording nurse.

This, of course, is the ideal scenario. More often than not, crucial bits of information are missing. Like the person's name. Or address (presuming s/he has one). Or information on what caused the injury. Or if the person in the waiting area claiming to be the brother really is the brother. In these and other situations, the chaplain must play the role of detective, questioning various sources for any clues that might provide answers to these and other mysteries.

Chaplains also offer a range of informative functions when family and friends arrive at the hospital. The trauma surgeon speaks with the family when she is free, but in the interim, she may have the chaplain convey non-technical updates to loved ones. Residents play an important mediating role to attempt to keep family and friends pacified in terms of waiting times and explaining that treatment is actively occurring. As soon as feasible, chaplains bring family and friends to visit the patient in the bay and may subsequently escort them to one of the floors following the injured person's admission.

Perhaps most significantly, chaplains listen. They listen to questions, shrieks, tears, memories, admissions, lapses, threats, prayers, pleas, and fulminations.[21] They sit in silence as families digest the information that they have received and ponder the future. They offer tissues and cups of cold water. They help family members make phone calls and sit supportively through police questionings. When necessary, they arrange for linguistic translators.

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[19] A line of green tiles against a white background on the trauma bay floor, demarcating sterile and non-sterile sections of the room.

[20] If the patient is a minor and/or is unable to speak, protocol dictates that the hospital attempt to contact the next of kin on the bioethical presumption that this is what the patient would want. Police, however, may override this rule for security or legal reasons.

[21] A more senior resident once confessed that he thought that he'd seen it all in the bay until he heard the sound a mother makes when her only son has just committed suicide. It is a haunting, jarring wail that has never left him.

CASE 1: LOVE, LOSS, AND SUICIDE

Background

Mike's life presents a complex, frustrating, and occasionally toxic mix of life circumstances and yearnings that stand at cross-angles with broader societal norms, and his health reflects this dissonance. Robust and personable, with a "self-effacing … childlike innocence," he seems equally at ease with his working-class upbringing and sophisticated friends from his university days. He currently lives with two male roommates and works as a bartender. Though he attends Mass rarely, his years in Roman Catholic grade and high schools and college, imbued him with strong moral sensibilities.

The patient has been a heavy drinker for some time and "self-medicates to deal with his depression." Further, he explained that the patient identifies himself as a person who suffers from "severe situational depression." The chaplain's intuition was that Mike was at times highly introspective and reflective in matters of faith but only rarely shared this intimate part of his life with others.

Mike arrived in the trauma bay after attempting suicide by shooting himself in the chest. This is the second suicide attempt in as many years; the previous one was an overdose of tranquilizers that was thwarted when one of his roommates found him. On this occasion, he was taken to surgery shortly after arrival to repair damage to several internal organs pierced by the bullet. The chaplain spent several hours with his mother and family members upon Mike's arrival at the hospital and subsequently visited the patient multiple times following the surgery, where doctors predicted a lengthy but complete recovery.

The conversation that follows is the chaplain's fourth interaction with the patient and takes place on the trauma recovery unit six days after the suicide attempt. Their dialogue occurs in the absence of other visitors, per the patient's request.

The Encounter

Chaplain: (pulling up a chair to the side of the bed and settling in) Hey there! Sorry I kept you waiting. I got tied up in a meeting that lasted longer than I thought it would.

Patient: No problem. (brief silence) When my mom heard that you were coming by, she pushed me to really talk to you and not just bullshit. That seemed like a good idea to me, too. I feel like I'm at a crossroads of some kind in my life. I think it would be good to get your take on things. As long as I'm here, I want to take advantage of your wisdom.

C: Wow, you really know how to put pressure on a person … Seriously, I'm very happy to talk to you. (short pause) Let me start off our conversation this way. (looking directly into his eyes) Mike, I am so very glad that you're alive. I think that it would have been a real tragedy if you had succeeded in ending your life. I'm glad that you're alive and that you're recovering.

P: I'm glad I'm alive, too. I'm actually feeling really good right now. Except for these chest tubes. You know, I think what happened was really an accident. The truth is that my life has been out of control for a couple of years now. I wanted to die. But I never could do it. I was there with the gun, holding it, seeing how much pressure I could put on the trigger. I wanted to die but I didn't want to do it myself. I used to have this fantasy about going into a convenience store just as it was being robbed and throwing myself in front of the robber and getting shot to death. That way I could die and go out as a hero. But that night I was just putting pressure on the trigger and seeing how far I could go and then the gun fired. But no one believes it was an accident.

C: I believe you when you say that it was an accident. I think there is such a thing as an accidental suicide. I think there are lots of them every year. But you still wanted to die. And yet you called 911 after you shot yourself. I think it's interesting that you shot yourself in the chest and not in the head. It seems like most folks who use a gun to commit suicide shoot themselves in the head. Maybe the fact that you shot yourself in the lower chest says something about your wanting to live.

When patients are able to talk, and particularly when they were involved in an act of violence, it is common to recount with the chaplain the moments immediately prior to the attack. This patient is struggling with a variety of conflicting desires and stressors and is starting to articulate and acknowledge them in the presence of this religious specialist. Here, the chaplain offers a preliminary interpretation for the shooting location with the conditional *maybe*—he affirms his concern for the intrinsic well-being of the patient as a person but tries not to impose his view of the events on the patient. This narrative activity seeks to promote further exploration of key issues in a unique form of mirroring that interprets even as it returns the conversation to the patient for his reaction. Such an interactional process suggests a personal investment of the chaplain in the well-being of the patient and is not simply a clinical meeting regarding somatic outcomes devoid of social or existential investment.

Before returning to the conversation, let us consider one more element of the conversation thus far: the confession. As an educated Roman Catholic man, Mike is well aware of the church's teachings on the sanctity of life and on suicide. He knows that his act is being treated by the medical staff as a suicide attempt, an interpretation that renders his deed a grievous sin. The patient is caught between two institutions in a unique juridical sense: biomedicine, effectively acting as a prosecuting attorney, argues that the gunshot was an intentional act, a pronouncement consistent with his prior behavior and one that carries both spiritual and pecuniary implications: spiritual, because suicide is a gross violation of doctrine that requires sacramental intervention to correct; pecuniary, in the sense that many insurance companies in the U.S. do not cover medical expenses related to suicide attempts. In his plea to the chaplain, the patient argues his case: it was an accident. He didn't really want to die; he was conflicted, yes, but he ultimately wanted to live. In effect, he is asking the chaplain to be his defense attorney: he wants someone to believe him for psychological and pragmatic reasons. The Church is likely to accept biomedicine's clinical diagnosis as a spiritual one as well and to pronounce second layer of judgment on the patient. This chaplain is quite possibly the patient's only advocate; he has the power to mediate with both institutional powers. The chaplain's response? He believes the patient, but they both know that the social and spiritual stakes are too high for a simple up or down vote from a chaplain resident. This isn't a case of a curious toddler and an unlocked gun cabinet. He does not allow the patient an easy escape from the precipitating issues—he stays with them and encourages Mike to confront them.

> P: Oh, that's not it. I would never shoot myself in the head. (he smiles) I know my mom would want an open-casket funeral.
>
> C: (smiling back) So, even in the casket it's important for you to look good? (the patient is athletic and strikingly handsome)
>
> P: Sort of. Besides, what if you shoot yourself in the head and you don't die? Then you have to go through life looking ugly and having trouble functioning. (pause) It's just that my life has been so out of control the past couple of years. And it seems like I can't get things together.
>
> C: Can you tell me what "out of control" looks like for you?
>
> P: Well, I can say that most of my problems have to do with women.
>
> C: (smiling) Do you have lousy taste in women?
>
> P: No, I have pretty good taste in women. The problem is with me. Well, there was Nanette. She and I were together for seven years and I really loved her. But I was notoriously unfaithful. Finally she got tired of it and dumped me.

C: So you're a dog?

P: Sort of. For the last two to three years Nanette and I were together, I was also dating Tanya. And Tanya knew about Nanette but not the other way around. Tanya was OK with me having a girlfriend. But I wasn't just being a dog. I really did care about Tanya, too. I can be attracted to more than one woman at a time and feel genuine affection for them.

C: I believe a person can feel that kind of attraction and affection for two people at the same time. I don't believe you're a dog. But it sounds like your behavior had some pretty painful consequences for you.

P: It sure did. After Nanette dumped me, I decided that I was going to start over. I wasn't going to be a dog. I was going to be faithful. So I had been seeing Tanya and really liked her but when I was available, she wasn't interested anymore. Then I started seeing Brenda and I was really committed to her. But all my unfaithfulness earned me a reputation and she started hearing rumors. I swear I wasn't doing anything. But she got angry and dumped me anyway.

C: That must have been a real kick in the gut. You decide to turn over a new leaf and relate to women in an honest and faithful way and you get blamed for something you didn't do. I imagine that was painful.

Despite the severity of issues at stake, the conversation is quite fluid. Mike corrects the chaplain about the interpretation of the gunshot location, but the mistake doesn't appear to lower the trust or bring the conversation to a standstill.[22] Rather, it leads to a new aspect of his social world and his struggles, specifically the motif of lack of control. The chaplain identifies this theme and asks for clarification, which opens up a crucial underlying set of issues on gender, relationships, and fidelity. The chaplain's gender contributes to their frankness and allows them to oscillate between formal, intimate theological language and informal slang ("dog") that the patient recognizes and incorporates into his own narrative. Such a term is significant also because it implies on the part of the chaplain a subtle moral judgment but without the sharp edge of psychological or theological

[22] The patient also demonstrates a certain awareness or rationality behind his decisions and the consequences that alternate targets might elicit: shooting in the head would be ugly; that in itself would disturb his mother (apart from the fact that he would be dead). Scientifically, he believes that a GSW to head would most likely be fatal or would lead to a pathetic pseudo-life afterwards, whereas a GSW to the abdomen would somehow either be less fatal or would lead to less dramatic consequences if he lived. Both outlooks reflect some truth about human anatomy but are significantly incomplete. Lateral bullet trajectories can be absolutely lethal in the abdominal region, whereas frontal shots are less likely to be fatal and would not lead to a loss of cognitive capacity, though the right trajectory could lead to partial paralysis and/or one or more dysfunctional organs.

labels. Also, by phrasing it as a question, the chaplain allows the patient to make his own assessment of his behavior, rather than imposing one directly, thus emphasizing the role of the chaplain in leading the patient to assess his own behavior utilizing his own terminology.

P: It hurt like hell. It seemed like life was kind of pointless. Then I tried to reconnect with Tanya but she still didn't want any kind of relationship. We would see each other and go out now and then but nothing else.

C: I think it's interesting that you went after Tanya and Brenda with such persistence. I'm not sure what that means. I'm not a psychologist and I don't want to guess. But I think it's something worth thinking about.

P: Oh yeah. I really went after them. Now, I should back up and tell you that I was raised by four women—my grandmother, my mother, and my two aunts—so maybe it's not surprising that I have issues with women.

C: So "out of control" looks like unhappy relationships with the women you're romantically involved with? Is there anything else?

P: Well, yeah. First, my uncle—he was like a father figure to me—he died last year. Then my grandmother was diagnosed with breast cancer. That threw me for a loop. It just seems like everything is out of control. Everything just kept adding up and adding up until it was too much. I tried to kill myself about a year ago by taking an overdose of Xanax but my roommate found me and made me throw up.

C: Well, Mike, it seems to me that in what you have described things have been out of control. At least, they were out of your control. Your uncle's death was very painful for you. But it was not something you could control. You could not keep him alive or bring him back to life. And with your grandmother's breast cancer, there's nothing that you can do to control its trajectory. So that's something else that's out of your control. And you can't control the choices that Nanette, Tanya, and Brenda made about having a relationship with you. So, I think it's accurate to say that things have been out of control for you.

P: You're right.

C: What I also hear is that you have had a lot of pain in the last couple of years, perhaps more than you have acknowledged. I know it hurt you a lot to lose your uncle. I know it's scary to think that you might lose your grandmother. And these women whom you loved not to continue a relationship with you. They chose not to accept the total gift of yourself. That had to hurt a lot. (pausing and looking directly

into Mike's eyes) Mike, I'm very sorry for all the pain you have experienced in the past couple of years. You did not deserve that pain.

P: (There is silence, and tears begin to well up in Mike's eyes) Thank you. It helps a lot to hear you say that you're sorry even though it's not your fault.

Part of what makes this segment unusual in terms of confessional technologies, in which a patient is expected to internalize a fixed set of moral norms, is the chaplain's recognition of Mike's life history, particularly the formative influence of the four strong women from his childhood. He is wrestling with conflicting social norms and a sense of cultural dissonance. He is aware that faithfulness on the romantic plane is equated with monogamous relationships, yet nowhere does he suggest that he was spending time with multiple women for nefarious reasons (e.g., to punish or manipulate, out of a sense of conquering or amassing victories, or the thrill of secrecy). Here, the chaplain provides his own opinion on these relationships, yet he keeps the focus on the patient and also points to the potential problems of Mike's choices: the patient may have certain feelings and relational outlooks that lead him to view social networks in a particular way, but in the culture of this part of the U.S., most of the people in his social networks view relationships differently. The chaplain points not to specific religious or biomedical norms within the clinic but to broader social expectations with an emphasis on gaining cultural insight into social functioning.

This plug for a more robust theory of mind for the patient is both a form of therapy and an interpretative exhortation. It acknowledges that the patient's inability to form satisfying, meaningful, and deep relationships can lead to a sense of life as pointless and as lacking direction and purpose. It highlights for the patient the value of imagining multiple points of view to minimize future disappointment and senses of hopelessness, with the hope that this will give him a greater sense of control over his daily life, his health, and his body. It is, in effect, a hermeneutic disguised as preventative medicine *and* preventative religion, a form of self-control designed to assist the patient on his ongoing search for the profound, rather than the superficial, even as it encourages him to modulate his behavior in light of cultural norms. It recognizes the patient's tendency to allow others' reactions to him to dictate his reaction to himself and proposes a mechanism to buffer such influences.

Consider the affective content of this module. Both the chaplain and Mike name specific feelings and emotional elements related to these encounters with a particular phenomenological emphasis. Yet the chaplain is careful to appeal to imagination in framing his coordinates: he is not suggesting that he understands Mike's journey firsthand—he keeps himself at an outsider's distance in order to affirm the uniqueness of the patient's experience and to suggest that others can never

know exactly what he felt, even as he invites him to utilize narrative to crystallize the sensations in words. The patient is a keen analyst of his own emotions and is able to utilize this narrative-emotional framework to identify lack of recognition as one of the most difficult elements of his saga. This allows the chaplain to express his own regret that the patient has gone through so much and—crucially—to proclaim that such pain was undeserved, words that Mike finds cathartic.

This reaction is significant for a number of reasons. It points to a unique form of solidarity with the stranger: the chaplain cares, even though he is under no obligation to do so. These words reflect a theological and interpersonal expression of concern; they are, in the eyes of the chaplain and his peer cohort, a gift freely given. Yet why should the chaplain be interested in the question of whether a patient does or does not deserve the existential pain that he is feeling? He is not paid extra to do so—he does not bill it on an insurance reimbursement form. This is not a question that we can answer here, but we shall return to it in the discussion of subsequent cases.

However, we can appeal to the apophatic to gain a few insights from what did not happen in this interaction. The chaplain could very easily have said that these events were all punishment for infidelity. He could have blamed Mike for his suicidal thoughts. He could have pronounced judgment on him in front of his mother and hence could have chosen to make him feel worse by isolating him further—socially, spiritually, and bodily. The chaplain could have appealed to the image of a punishing, judgmental God and chastised Mike for a lack of faith in God's providence, for not trusting God's wisdom in the affairs of his family members.

Such a response would seem to be more in line with Foucault's vision of the hospital as a confessional space, at least in terms of linking confession with judgment in the actions of hospital staffers. Here, however, there is confession without condemnation. Mike may expect spiritual judgment, yet it does not happen. Biomedicine judges his actions and, at a minimum, pronounces his hopelessness as pathological; it decrees his hermeneutic abnormal and in need of clinical intervention via a future stay on inpatient psychiatry. Is this for his own protection? It could be—there are no guns on the psych unit—yet with the increasing pharmacologization of mental disorders, it is unclear what clinical inpatient biomedicine can offer Mike, beyond the repair of his physical organs.

Chaplain's Reflections

Let us consider now this chaplain's own reflections on the interaction as a second layer of analysis that will help us to understand better how residents perceive their own interactions in terms of strengths and weaknesses. Following this section, we shall turn to the residency cohort's discussion of both this case and their colleague's analysis for additional insights.

A key goal for this chaplain was to attempt "to provide hope for someone whose life is so painful that he wants to end it" and who "doesn't want to struggle through the pain." This is not simply an aperspectival or naïve intervention, however: the chaplain explains that he feels "a deep sense of connection" with the patient because of his own "struggles with depression over the years." His "sadness at the depth of the patient's pain" reflects his own familiarity with suicidal ideation and suggests an insider's understanding of the patient's plight. The resident admits feeling conflicted regarding professional boundaries but also fears that the patient will successfully complete a future attempt. This fear of loss generates for him an enormous and personal sense of responsibility for the patient that reflects a desire to play a preventative role in his life in some manner.

Indeed, his recourse to the images of the Pieta in the Vatican and the statue of the winged angel in the Philadelphia (U.S.) train station both evoke notions of rescue and protection of the vulnerable, but also a certain sense of powerlessness in light of what he considers a broken and hostile world. He draws upon other images of innocent loss from his own life history to attempt to make sense of this clinical case and, it appears, to try to draw generalizations regarding the premature death of good people. He confessed that he felt a special kinship, or at least sense of shared plight, with patients with broken souls yet was frustrated that he still lacked the skills to mend such outlooks. He saw Mike's illness primarily as a form of communication, an indirect and poisonous attempt effectively to express his pain; "rather than being conscious attempts at self-annihilation, [they] are loud screams of pain and loud cries for help."

Here, the chaplain is attempting to form some sort of interpretation of the patient's underlying motives. Through his narrative interaction with Mike, the chaplain makes inferences about the patient's presenting illness—his motives, his interpersonal skills, and indeed his cognition—in an attempt to configure his own intervention as a religious specialist. He makes no mention of biomedical classifications and pays little attention to the surgical interventions provided by his medical colleagues and instead focuses on social and communicative aspects of the illness experience. He acknowledges his own life experiences and outlook as significant to the way in which he as a practitioner interprets the patient encounter and relates to the man, the familiar other, in the bed. Such a stance initially, at least, presents a view of clinical pastoral intervention that is largely disconnected from the rest of the inpatient experience, one that may be extremely significant for the patient but which is not readily connected to biomedical processes. This division of labor without a clearly articulated, joint final product in mind is not uncommon in the beginning of CPE programs, when students focus on identifying key points for their intervention and refining their

skills before contextualizing their interventions within the broader framework of intervention of the hospital encounter.

This apparent lack of a common goal or target is highlighted by at least two other considerations. First, proximity: the resident was well aware of the differential nearness that he had with the patient vis-à-vis biomedicine. The latter wielded the power (and the duty) to strip the patient physically naked, strap him to a table, cut his skin, and insert their hands into his body cavity. We could debate the extent to which the patient effectively gave the medical team permission to intervene in this way based on his choice of bullet target, but it appears that his decision to allow the chaplain to enter into such close *emotional* and *psychological* proximity was more of a conscious, deliberate decision. Granted his mother's prodding, the patient did *not* have to meet with the chaplain multiple times and, presuming his narrative to be more or less candid, did not have to make himself vulnerable to the chaplain through such intensely private revelations about his personal life. This is not in any way to suggest that biomedicine is always coercive in its reach and chaplaincy always voluntary—such absolutes have little place in such nuanced encounters—but rather to highlight the fact that the ability to wade into a patient's world seems to involve a complex mixture of conscious and unconscious desire from the perspectives of both provider and recipient.

The second consideration is religion itself. What is the relationship between the patient's religious leanings and his health? The chaplain sees "no evidence that his religion has made him more vulnerable to depression and suicidality. But likewise I see no evidence that his religion has been a bulwark against his psychic pain. To the extent that his religion puts him in touch with his pain he is likely to avoid it. To the extent that his religion affirms his innate goodness when he cannot see that goodness himself he is likely not to hear it." This is a standard reflection question for verbatim presentations. It does not presume that religion is necessarily helpful or even relevant to a particular illness experience, but it is significant in that it conditions the chaplaincy student to pay attention to an element of the person's being that is routinely overlooked by other clinical practitioners. In this case study, the chaplain draws upon his conversations with the patient as the main form of evidence by which to come to his conclusion about religion's role in Mike's depression and suicide attempts. He believes firmly that religion can be a source of hope and feelings of self-worth for the patient, "a greater awareness of himself as God's beloved and a greater sense of his own innate goodness." Likewise, he is convinced that engagement "in spiritual disciplines" would give him a greater sense of "strength, wholeness, healing and joy" and could lead to "a greater depth and integrity in his relationships with his family and close friends, so that his depression would not be "so isolating and alienating." From this verbatim presentation, however, we lack a sense of how

the patient might come to such a place or what role the chaplain might have in bringing about such a change. We also lack a clear sense of whether the patient agrees with the chaplain's view of the positive potential of religion or in fact sees it in wholly juridical, condemnatory terms.

Group Discussion

How should this chaplain's peers respond to this presentation? What should they say, and why? Most of the comments at the beginning of the didactic session focused on particular phrases and word choices—Why did you pick that metaphor? Are your responses too long? What sort of tone does that remark set for the discussion that follows?—and thus seek an elaboration of the chaplain's thinking at particular points in the conversation. There was a general sense in the group that such questions were appropriate, though this emphasis on technique stayed largely on the level of mechanics and did not delve into the larger spiritual, emotional, or philosophical issues that underlay particular sentences or turns of phrase. The supervisor wanted the group to think about both of these levels of analysis and gradually sought to steer the discussion in this second direction.

One colleague suggested that "sometimes all we can do is lift up the brokenness"—sometimes there is no cure, no direct therapeutic intervention for existential angst, and that they may be present with a patient only long enough to testify to the patient's sorrow. That is, they may serve as witnesses to it, both to validate its presence for the patient and also, in a broader cultural sense, to herald it for other practitioners and trainees as a key affective component of the sickness process that deserves recognition, if not also interpersonal reflection, in its own right, prior to any move to contain or reverse it. When bodies become broken due to violence directed toward the self, this colleague suggested, the chaplain's reflexive move toward seeing the potential for self-violence can indeed promote a phenomenological proximity useful for attempts at healing as "wounded peacemakers," so long as this role imagination does not stifle the patient's own experience or reduce it to a caricature of the practitioner's own musings.

On a different but related topic, several colleagues expressed concern about their colleague's tight investment in this patient's case. The supervisor honed in on the resident's statement regarding his sense of responsibility about the patient's outcome and explained that as practitioners, they typically should not do this, because it comes too close to boundary crossing for the emotional good of the chaplain. In cases of suicide, however, he suggested that this objective distance is mediated by a pastoral sentiment of solidarity, of wanting the other person to hear that his life matters, that others are glad that he is still present, alive, and intact. Affirmation of the other's being can be one form of therapy; it is a technique that was to be used intelligently but also generously, especially when the possibility of death is or has been close. The supervisor articulated what several of the residents

were trying to say about one of the key roles of chaplains in such situations: there is great social and psychological value in having someone who will demonstrate a universal regard toward a patient's own life and a certain stubbornness in helping the patient to realize that he is not alone, spiritually or culturally. Such insights proved helpful, both for the presenting chaplain in terms of his own work, and in terms of the sorts of questions that his peers posed to him in the group discussion and would formulate in future didactics.

CASE 2: CULTURE, TRAUMA, AND MOTHERHOOD

Background

Ranu is a college student from Nigeria studying at a university in the region. He was playing tennis one afternoon in the spring and collapsed on the court. A coach defibrillated him four times while awaiting the ambulance, using emergency equipment at the sports complex. He was given additional electrical cardiac stimulation by the ambulance team en route to the hospital. The patient arrived while in full cardiac arrest; a monitor showed ventricular fibrillation that was unresponsive to shocks. The trauma team noted soft wheezes on ventilation, suggesting weak lung function, yet bedside ultrasound revealed no cardiac motion. The patient was pronounced dead a short time thereafter.

The conversation begins in the trauma bay's family consultation room just off the main emergency department waiting area, when the chaplain and the attending trauma surgeon meet with Ranu's family to notify them of his death. In the room are his mother, standing and quite agitated; his two sisters; his uncle; and a young Indian man, who was later determined to be one of Ranu's friends. Ranu's father is currently in Nigeria; the hospital has been attempting to reach him but without success, most likely due to the late hour in Lagos.

The chaplain notes in her report that this interaction takes place in the midst of her care for several other trauma patients and their families.

The Encounter

C-Chaplain, TS-Trauma Surgeon, M-Mother, S-Sister 1, SS-Sister 2, YL-Young Lady, P-Pastor, DS-Dean of Students, F-friend of mother

Trauma Surgeon: Hi, I'm Dr. Flanagan and this is the chaplain. Could we all have a seat?

Mother: (emphatically) Tell me! Tell me! Where is Ranu?

TS: What do you know about what happened?

M: Tell me! Where is Ranu? (even louder) Where is Ranu?

TS: If you could…possibly sit down…

At this point the mother sits down but is quite agitated. She is rocking back and forth and pulling on the young Indian man's shirt collar, yanking him back and forth. I am not certain as to whether or not she is aware that she is doing this. The tension in the room is comparable to a lit stick of dynamite whose explosion was being fearfully anticipated.

M: Tell me! Tell me! Where is Ranu?

TS: (looking completely helpless) Ranu has died.

Simultaneously each family member releases shrieks and hysteria begins to resound. The mother pulls harder on the young man's collar now and has grabbed his tie and is pushing him toward the floor as well, giving the appearance that she is going to harm the young man, albeit unconsciously.

M: What are you telling me? What are you telling me? Ranu is dead? My son is dead? What are you telling me?

TS: Call security!

I do not feel as though I should leave the room because some type of intervention on the young man's behalf is becoming apparent and Ranu's two sisters are screaming to the top of their lungs as well. I decide to push the panic button. Almost instantaneously the mother flings the door open and runs screaming into the main emergency department (ED) waiting area. Ranu's uncle appears bewildered and bedlam ensues as unbridled grief consumes the family.

This opening sequence reflects a standard, formulaic script from the trauma surgeon: she introduces herself, tries to take command of the situation (here, by have folks sit down), and asks what people know about the situation. If the patient is still alive, that's the first thing that the physician says, even if the condition is very critical. In fact, if the patient is still alive, the chaplain is free to say so to the family, in order to calm them and to allay immediate fears of death. In such situations, the physician's narrative interlaces activities in the present tense ("He's at CT scan," "She's been intubated," and so forth) with a synopsis of the injury mechanism and the concerns that it raises (e.g., "The bullet pierced the abdomen, so we had to rush her to surgery," "He fractured his femur when he was flung from the motorcycle, so we've taken x-rays and are going to apply a cast"). When the patient has died, the narrative takes a different structure: the physician moves directly to the beginning of the traumatic event, explaining what happened at the scene, what ambulance

personnel and/or police did for the person en route to the hospital, and what the trauma team did when the person arrived in the bay to attempt to save the person's life. This quasi-ritualistic process situates the physician as the person in charge and the one who will answer any scientific questions that may arise, leaving the chaplain to tend to emotional and logistical issues afterward.

While this formula is reasonable according to biomedicine's logic, inasmuch as it attempts to convey crucial information, the delayed punch line is rarely lost on family members. This narrative attempt to cushion bad news is often perceived by family members and friends as a paternalistic withholding of information, despite the reality that anything said by the physician following the news of a death is rarely met with comprehension due to the shock of the proclamation.

In this particular case, the formula breaks down almost from the beginning. The trauma surgeon, currently working at the hospital on a fellowship, has had limited experience delivering bad news in emotionally tense settings and is unable to convey sufficient authority to assume credible command of the moment. She demonstrates a mix of emotions herself—frustration and disappointment at the loss of a young patient, the stress of other critical patients in the bay, the prospect of a long night ahead—yet her inability to take narrative and emotional control of the moment results in an enfeebled volley of world-rupturing information. The physical and verbal consequences lead the physician to two actions: the call for security and her subsequent flight from the room. While perhaps understandable as reactions to a chaotic situation, these decisions cede the credibility and influence of biomedicine, as embodied in her role, to the brute force of security officers …

… and to the chaplain. Significantly, it is the chaplain who presses the emergency button to summon security; the physician's statement "Call security!" is actually rather ambiguous. Is it an imperative, an order directed at the chaplain—for there are no other staff members in the room to execute the order, as there would be in the bay—or is it instead a generalized call for help, a reflexive reaction when a situation becomes too much to control? The mother's roughhousing of the young male student required intervention, but why didn't the physician simply press the emergency button herself, rather than escalating the tension with a call for security intervention and then retreating to the safety of the bay?

Such decisions present a significant challenge to the notion of biomedical practitioners as the premier power brokers of the hospital. Here, family members receive the message that physicians oversee crises embodied on gurneys but leave somatic and emotional crises elsewhere in the medical complex to other practitioners, suggesting a more nuanced, circumscribed role for scientific authority in the clinic than the family was led to expect through the physician's introduction. The security

guards' role, meanwhile, is relatively straightforward in such a crisis: they have the physical means to prevent—or at least minimize—bodily violence in the hospital space. But the chaplain? Why does the chaplain remain? What is her armamentarium? What could make an African-American grandmother more suitable to choreograph a room full of hysterical foreigners than a white surgeon?

Quite a bit, in fact. As a chaplain resident, Margaret has embraced the position that chaplains run from nothing. She stays focused, assesses the situation, and seeks appropriate assistance while remaining present as a source of continuity for the family, an increasingly familiar face in a spasmodic montage of sounds and images. Second, she acknowledges her active role in clinical violence and illness prevention, in addition to her duties at the forefront of spiritual consolation. Such occasions force her to hone her crowd control skills and to read body language quickly and effectively. Third, grief and paroxysms are for her elements of the sickness process that are to be facilitated, not managed or repressed, a view that sees emotions and the manifestation of cultural beliefs as intricately intertwined with bodies and their movements, rather than moieties that must be kept separate.

Finally, the chaplain's actions point to an important dichotomy in the culture of the emergency department/trauma bay section of the hospital, arguably akin to the village/wilderness distinctions seen in many early British ethnographies. The area is divided physically into two main sections: the waiting areas, which are open to the street and hence to the external world, and the clinical space, a restricted zone protected by card access. In the former space, visitors and patients come into contact with non-medical personnel such as registration clerks and insurance specialists, who sit behind inch-thick Plexiglas barriers and determine who will be granted access to the clinical space either for medical treatment or as visitors of those who receive it. As such physicians, nurses, and other biomedical technicians essentially never enter this general space. There are three types of workers who move back and forth across this divide: ambulance personnel, who come from the outside to deliver patients into the clinical space; city police and hospital security, who guard against physical violence and process certain bureaucratic information; and chaplains.[23] Of these three workers, ambulance personnel only cross the boundary in one direction—from outside in—and do so only once for a given patient. Police and security may move back and forth, but only on an ad hoc basis. This leaves the chaplains, who routinely bridge this physical and cultural divide in both directions, communicating with parties on both sides and are thus attuned to the cultures, mentalities,

[23] Clerical personnel also enter the clinical space to collect information but provide no patient interventions; their work, while absolutely crucial to the smooth functioning of the hospital, thus lacks significant import for the question of clinical boundaries.

and discourses on each side. Chaplains learn to work within the ostensibly rational, scientific, physician-directed culture of the clinical space as well as the unpredictable, emotional, potentially dangerous culture of the waiting area. Let us return for a moment to the latter zone:

> Sister #1: Nooooo! Nooooo! Not my brother! How can this be?
>
> Sister #2: (pacing) No! No! No!
>
> S: He's only nineteen years old! He's only nineteen years old!
>
> The sisters cling to each other intermittently as the one sister paces back and forth. After a few minutes, it appears that they are stable enough that I can check on the mother. I choose to leave them in the family room. As I open the door to the waiting area I see the mother screaming in her native tongue, rolling on the floor. As the sisters get a glimpse of this, it seems to ignite them afresh.
>
> S: (at the top of her lungs) My brother! My brother! He's only nineteen years old! He's only nineteen years old! Nooooo! Nooooo! Nooooo! I want my brother! I want my brother! This is not possible! He is only nineteen years old! He's nineteen years old!
>
> SS: This cannot be true! This cannot be true! Where is my brother? Where is he?

In such chaotic moments, the chaplain must decide where to focus her attention. It is not uncommon for some family members or friends to rush out of the family consultation room back into the main ED waiting area, to retreat from the small and symbolically charged space to the company of others, to go outside to catch a breath of fresh air, place phone calls, or light a cigarette. In this situation, because the mother has friends in the main waiting area, and out of concern for the two sisters and classmate in the consult room, the chaplain decides to remain with the latter, trusting that the friends—and, if necessary, security—can tend to the mother. With the mother out of the room, the chaplain determines that the threat of imminent physical danger has subsided; rather than issuing instructions to the three young adults, she sits with them and gives them space to recover from the shock of the moment. She may also have provided some practical information about Ranu's location not included in the verbatim account.

> In the meantime, there arises from the ED waiting area the sound of mass wailing. Students from the university are sobbing almost uncontrollably as the mother's behavior has undoubtedly informed them of Ranu's death. There is very loud praying coming from somewhere in the room, but I focus on the mother. She has been helped up from the floor by her friend and Ranu's uncle; I think he was the mother's brother. (I am told by one of the registration clerks that she had broken

into laughter at one point while she was on the floor.) I am able to make eye contact with her and maintain it somewhat as she runs through the waiting area. I try to grab her and so do her friend and brother, but we are unsuccessful because she is very tall and appears to weigh over 200 pounds.

She stops almost in the middle of the floor and continues to scream in her native tongue. She then throws up her shirt, still screaming. Suddenly she grabs at her breasts and shakes them, yelling at the same time. Then she grabs her stomach, shaking it, and continues to scream in her own language, all the while looking at me.

I am suddenly distracted by someone grabbing my arm.

Dean of Students: Are you in charge? Someone said you're in charge! Is there somewhere I can take these students? They're becoming hysterical.

Chaplain: (regrouping) Just a minute.

DS: I'm the Dean of Students. Is there somewhere we can go?

This segment illustrates further the chaplain's difficult balancing act between connecting emotionally and spiritually with each individual and trying to keep the larger situation from spiraling completely out of control. This is a particularly acute concern given the reality of the hour in the ED; its 40+ seats were most likely occupied by other individuals awaiting treatment, in addition to the students from the university. The mother's actions thus do not occur in a social vacuum—there is the very real potential for the entire room to explode in violence and chaos, for many of these other participants and their loved ones have been waiting several hours for treatment and are sufficiently on edge without this woman's histrionics.

On another cognitive level, the chaplain finds herself trying to interpret the mother's behavior in terms of what appeared to be coded messages and linguistically unintelligible monologue. This situation results in a bizarre, almost hypnotic connection between the mother and the chaplain: once again, the chaplain listens and becomes the target of the mother's radical communication. For a brief moment, they are linked, mother to mother, Christian to Christian, strong woman to strong woman. This is a hyper-conscious exchange, one in which an accusation and confession and plea and lament are all discharged at the lightning rods that are the chaplain's eyes. The chaplain attempts to wield this provocative phenomenology usefully: she attempts to focus the mother's attention away from others in the room. This is a very real, though unspoken, type of power, one that she utilizes with some success.

Success, that is, until she is faced with yet another distraction in the form of the Dean of Students. Who exactly said that the chaplain was in charge? In charge of *what*? Here, the chaplain

confronts a common scenario in the extra-clinical space of ad hoc oversight of a social situation. The chaplain looks responsible—or at least is wearing a hospital badge and isn't running—and so gets called upon for additional assistance managing the flow of turbulent bodies.

> I turn and realize that the mother has gotten away from everyone who had been attempting to bring her under control and she has run outside the hospital, still screaming. The voice that has been in the background gets louder. I cannot tell whether or not the gentleman on the other side of the room is praying with someone on the telephone or just praying out loud in the waiting area. I learn later that this man, who also spoke with an African accent, is either a pastor, or their pastor. I am not certain which.
>
> Pastor: God, you said, (unintelligible) in the name of Jesus, breathe! Breathe! You shall live and not die! Get up Ranu! Breathe! In the name of Jesus!

In addition to the sisters and Indian classmate, the mother and her kin, and the Dean of Students and her flock vying for the chaplain's attention, now there is a charismatic preacher in the waiting area, praying at the top of his lungs for the resurrection of the dead. This particular outburst, though brief, highlights another tacit function of the chaplain: keep unsanctioned, rival would-be healers under control. Due to the ambiguity of this man's relationship to the family, the chaplain does not have the man ejected from the hospital property—the family might in fact want him there—but instead works with security to ensure that the emotional and psychological consequences of his attempts at religious intervention are kept under control. This is one place where the chaplain's power is quite explicit: local clergy may be present with family members in the waiting area, so long as they do not intensify the grief, chaos, or uncertainty of the moment. Here, the man's prayer is less a direct threat to the chaplain's own religious authority as a practitioner than to the overall work of the hospital, and as such, he is to remain firmly at the periphery of this case.

> The pager goes off just as I am on my way outside. I see the mother in the middle of the street, appearing to beckon cars toward her. Hospital security guards and city police officers (who happen to be at the hospital for another patient) are attempting to get her out of the street. I come back into the waiting area and the pastor is still praying. It is at this point that I call Chaplain Will, who is still in the CPE office. I ask him if he will respond to the page to the MICU and he agrees to do so. Next, I escort the Dean and the students to the waiting area outside of occupational health and return to the family room because it is clear that the mother has been taken into the ED to be treated.

SS: (loudly) I want to talk with my father! I need to speak with him!

C: That's not a problem, I can call him for you.

SS: He's in Africa!

C: (trying to calm things down) That's okay. That's not a problem. I can call him for you.

Young Lady: (looking at the sister who wants to make the call) No! You can't do that! It's 01:00 a.m. there!

SS: But I need to speak with him!

S: (looking at her sister) She's right! We can't call there now! We can't tell him this in the middle of the night!

Although still quite upset, the sisters are a little calmer now; the presence of the other young lady seems to help them.

C: I am going to go check on your mother.

SS: Can I go with you?

C: No, I have to find out where she is first. As soon as I find out how she is I will come back and let you all know.

SS: Okay … okay.

The work of the rest of the hospital does not cease in moments of chaos in the trauma bay, and chaplains are often paged at particularly inconvenient instants. Often, the request is such that the chaplain on duty can stabilize a situation in the trauma bay before leaving to go elsewhere, but occasionally, another chaplain resident will be around after hours and can assist in extraordinary moments of need. I happen to be in the office working on a report and so am able to relieve Margaret of the MICU call. This allows her to reconnect with others in the waiting area who have sought her assistance and to bring the situation under greater logistical and emotional control. Here, we see that the initial emotional shock has subsided a bit, and attention has turned to practical concerns about contacting family. Chaplains routinely place calls on behalf of family members; in this case, she defers to the sisters and their friend in terms of cultural norms about calling their father. She continues in her supportive/informative role by keeping various parties abreast of unfolding events regarding the mother and attempting to connect and re-connect individuals in consultation with medical colleagues in the clinical space.

This segment also points crucially to another element of the extra-clinical space and processes of grief. Emotions of family members are largely the therapeutic dominion of the chaplain, so long as they stay within certain bounds. Screaming in the waiting area is both familiar

and acceptable, so long as the aggrieved do not harm themselves or others. But when emotions and so-called cultural behaviors lead to certain manifestations, such as the mother's running out into traffic in an attempt to end her life, she crosses a boundary and becomes amenable to medical management in response to the events within the clinical space of the hospital—the behavior is now pathological and is medicalized. For these actions, she gains admission into the clinical space.[24]

> The mother has been taken to a room in the ED and her friend is there with her.
>
> M: My son is dead. My son is dead.
>
> Family Friend: And it is well. It is well.
>
> M: (emphatically) How can you tell me "It is well" and my son is dead?
>
> F: (more sternly) Yes, he is dead, and it is well … it is well![25]
>
> M: I have no reason to live now. My son is dead!
>
> C: (softly) I am so sorry. Is there anything I can do for you?
>
> M: Yes! You can get me my son!
>
> F: This is the chaplain. Maybe you would like her to pray?
>
> M: No! I just want my son! I have no reason to live without my son!
>
> I stay with them for a few minutes and then I go to check on the mother's medical status to inform her daughters. I learn that she has been treated and the psychiatrist consulted. As I return to the family consultation room the psychiatrist is speaking with the family (which has grown by three or four), and she has told them that a decision has been made to keep the mother overnight as a precaution because of her actions and words. The daughters ask to stay with the mother, but the doctor replies that this is not standard hospital practice. I subsequently escort the daughters back to the ED to be with their mother, which appears to quiet her down considerably. However, she states repeatedly that she has no reason to live, now that her son is dead.
>
> I believe that the mother spent the night in the ED and that her daughters were allowed to stay in the room with her.

[24] Trauma bay phone calls to next of kin by chaplains further highlight this inside/outside demarcation of the clinical space and present religion as part of the public face of the hospital in such circumstances.

[25] The phrase "It is well" is part of a longer refrain found in the Christian hymn "It Is Well with My Soul," sung in many Protestant churches in North America and abroad. It is sometimes uttered by believers encountering great despair or loss, with the effect of curtailing cognitive reflection and related overwhelming emotions by convincing oneself that God is in charge, that everything is part of a divine plan, and that because these plans are necessarily and unambiguously good, the current events must somehow be good—or at least meaningful—as well. The hymn was penned by Horatio Spafford, a 19th century Chicago lawyer who experienced the death of his own son, the loss of his fortunes in the great Chicago Fire and, subsequently, the drowning at sea of his four daughters.

Chaplain's Reflections

Due to the prominence of this teaching hospital and the ethnic diversity in the surrounding region, individuals from an incredibly wide variety of cultures go there in search of treatment. The medical center has developed a number of programs and protocols that attempt to respond to this range of beliefs and practices, particularly at the level of language, where a telephone medical translation service allows staff to communicate with patients and others in their own language; the hospital also runs a monthly continuing medical education (CME) series on the basics of various cultural groups and traditions. Because cultural elements are seen by many biomedical practitioners here as extraneous to their own work, however, culturally competent care for patients and particularly their friends and family can by no means be assumed. Nurses on inpatient units may attempt at least to ask some questions about beliefs and practices in order to minimize conflict in clinical decision making, but more often than not, if a cultural factor (I use this term here in the broadest, vaguest possible sense) arises in a case, and a chaplain is present, she or he will likely be the one to spearhead the effort to understand and incorporate such components into the broader treatment plan.

Such was indeed the case with Ranu. The chaplain here knew nothing in particular about the family's cultural background but soon recognized that it was a crucial component of their dynamics and sought to pick up as many cues as possible in order to keep the situation in the waiting room from spiraling completely out of control. She recognized that the mother and her family had just suffered a traumatic loss in the midst of a culture that was not their own. In her write-up of this case, she commented that "although loss and grief are universal, the majority of people (including this chaplain) witnessing their grief had no idea of the depth of their actual suffering from a cultural standpoint." Hers was "primarily a ministry of presence with the family" that included sentiments of protectiveness and sorrow for the mother, rather than fear, as she sensed that most in the setting had related to her. In that moment, she had neither the time nor the energy to process the multifarious expressions of grief in the ED waiting area but was struck in particular by the emptiness on the daughters' faces and later interpreted the mother's grabbing her breasts and shaking her abdomen as maternal signs that said, in effect, *This abdomen once held that child! These breasts once nursed that boy! And now he's dead?!*

Unfortunately, the chaplain resident from Africa was unavailable during this event and so could not assist in providing insights into the family's possible beliefs and priorities, but the presenting chaplain did consult with her as she prepared her presentation of this case, a process which helped both her and the cohort to understand the situation more clearly. Chaplain Giles

explained that Ranu's full name is *x* which means "God loves me." His ethnic group in western Africa has traditionally held a strong embrace of the West but still demonstrates "significant cultural roots, especially in death." Beyond the emotional weight of Ranu's death, his passing was significant because it robbed the family of a male heir and a protector for his sisters. While the family had developed a partial social network in the U.S., it was unclear whether the sense of community that the mother and his sisters were used to in Africa were at all similar to those in this city and whether they would be helpful in the days and weeks to come. The CPE cohort learned that "the whole clan gathers around you in Africa and helps you to mourn your loss" in such circumstances and that, according to their colleague, "the number of people doing that here could possibly be much different from the number that would be involved in Africa."

Beyond these emotional and ritual issues, there remained a number of practical considerations to be resolved. The chaplain learned from her colleague that most Africans in Ranu's lineage have family burial plots or cemeteries, but it was unclear if they would be able to afford to ship the body back to Africa for a proper internment. Meanwhile, the hospital was intensely interested in his several perfectly healthy organs and was determined to obtain approval to remove these rare jewels for the benefit of other patients. The chaplain learned of some of the complexities of this process according to Ranu's African culture, some of which she was able to utilize in an attempt to broker discussion about the decision to donate.

CASE 3: A FAMILY UNRAVELS

Background

Todd Benford is an African-American male who appears to be in his late teens. Todd was admitted to the trauma bay following gunshot wounds to his abdomen and ankle. He was conscious and communicative when he arrived. He had been shot outside his home in front of his mother and siblings. Initially, the trauma team was told that he was 13; later, this was changed to 16. He appears healthy, of slim to average build with very short hair. According to the chaplain, he seemed quite composed and even stoic under the circumstances.

The patient lives with his mother and two younger brothers, one of whom appears to be around 12 years old. He also has an older brother who is 26 years old. Todd is in the 10th grade of high school. The economic status of his family is low income. He is single, although he has a girlfriend, with whom he has a 4-month-old baby. Todd's father was stabbed to death a few years ago. According to the chaplain, his mother appears to have some special needs.

Todd had no past medical history prior to this shooting. His mother described him as a healthy young man. The gunshot wound to his leg broke his ankle but this injury is considered minor by comparison to the wound to his abdomen. Initial surgery revealed what one doctor privately described as "terrible" injuries. The bullet had perforated the walls of the stomach twice, damaged two regions of the small intestine, and torn a pelvic blood vessel. The trauma attending explained to the family that due to the severity of the injuries and their location, more than one surgery would be required and that the healing would need to occur in stages.

Neither Todd nor his family makes any mention of religious affiliation. The neighbor who accompanied his mother to the hospital describes the family as very isolated and without support.

In addition to the gunshot wounds he sustained that night, just 36 hours later, Todd's younger brother came to the hospital as a trauma patient. He received a fatal gunshot wound to the head. According to the social worker there is concern for the safety of the family—there is a privacy/security restriction in the chart and yet when the chaplain visited again the police were no longer present. She was told that the detectives had taken the patient's mother back to the family's home.

Encounter #1

C = Chaplain, P = Patient, UP = Unknown Person on Phone, BM = Baby's Mother, M = Patient's Mother, N = Neighbor, F = Friend of the Family, B = Brother

Chaplain: (at the patient's bedside in the bay) Hello Todd, my name is Siobhan, I'm a chaplain. Is there anyone I can call for you to let them know you're here?

Patient: Yes, please call my baby's mother.

C: Your baby's mother?

P: Yes.

C: What's the number?

P: It's xxx-xxxx.

C: xxx-xxxx. And what is her name?

P: Lacy.

C: That's L-a-c-y? Is that correct?

P: Yes, thank you very much.

C: You're welcome. Is there anyone else you would like me to call?

P: No, just Lacy.

C: I'll go and call her right now.

Shortly thereafter Todd's blood pressure suddenly fell and his visit to the OR become urgent; he was sedated and intubated emergently. As the attending was preparing to leave and hurrying the team he asked about family, and I said I would try and find parents and pass the information on as I got it.

C: Hello can I speak to Lacy please?

Unknown Person on Phone: She's not here right now.

C: This is the [hospital name] calling and it is very important that I speak to her.

UP: Hold on, I can give you a cell-phone number xxx-xxxx.

C: OK, that's xxx-xxxx.

UP: Yes.

C: Thank you.

I dial the cell number—it is picked up by a voice mail which I presume to be some celebrity with a message which ironically is saying "Don't be getting all uptight now about having to wait." This goes on and on, but eventually it is interrupted by a real person's voice.

Baby's Mother: Hello?

C: Lacy?

BM: Yes?

C: Hello, Todd Benford asked me to call you. My name is Siobhan Powell and I'm calling from the [hospital name].

BM: I know.

C: Lacy, can you tell me how to reach Todd's parents?

BM: His mom should be there already.

C: She's on her way?

BM: Yes.

C: And will you be coming down?

BM: Yes, as soon as I can get a ride.

C: Well, I will be looking out for you then, just ask them to page the chaplain on duty when you get here and I will come and meet you.

It is not much later that I am paged by a registration clerk to let me know that Todd's family has arrived.

C: Family for Mr. Benford?

Some voices call me over—there is a group of three adults and one child.

C: Hello, I'm Siobhan Powell, I'm the chaplain and you are…

They introduce themselves as Todd's mother, younger brother, a neighbor, and a friend. I show them into the family waiting room and explain that I will return shortly hopefully with a doctor who can give them some medical information.

This segment is significant for the chaplain in a number of respects. Asking about contacts is usually a good indication of who is significant to the patient, both socially and in terms of a designated medical decision maker. In this case, the chaplain appears surprised by the patient's response: she learns that this teenager is himself a parent and gets clues about the nature of the relationship between him and this woman. Siobhan seems particularly concerned to get in touch with Todd's mother; this reflects not only state regulations regarding the treatment of minors, but it also speaks to her view of the patient as an adolescent, rather than as an adult capable of making independent decisions. This may reflect her own maternal instinct or her extensive clinical work with neonates and their parents, but as the situation unfolds and she places the phone calls, she appears surprised by, if not unaccustomed to, the patient's social network—the baby's mother and the patient's are already aware of the incident and are planning to come to the hospital. The chaplain's call is valuable in that it establishes her identity to the family, but unlike many trauma phone calls, the content of her message is old by the time it reaches its audience. With time, the chaplain becomes increasingly accustomed to the reality of the tight and intricate social/kin networks that operate among many of the African-American families that come to the hospital, networks that seemed to her indecipherable and yet usually resulted in large, supportive cohorts that arrive in the ED to sustain the patient and immediate family members.

Returning to the conversation in the consultation room:

Mother: You know, I had just given him his dinner, I had just given him his dinner and this must be some case of what do you call it mistaken identity or something because these kids, they just came from behind a car, and we was outside the house and I see them and I called out "What you doing? You must be looking for someone else, my kids are good, it's this neighborhood, my kids are all good," and this one he has a hoodie and I know him, from around, I know his face, and then they start shooting. It's awful, it's awful, I just gave him his dinner and he falls down and says he's shot and holds his stomach and I think he's kidding around at first, about the stomach, this must be a case of what do you call it mistaken identity or something, yes, and I said "What are you doing?" and they didn't answer me, but I know one of them, yes he had a hoodie and I know his face …

At first, I think it could be shock and then I realize that there is something not quite right about her reaction. There is something in her repetition and insistence on telling me exactly what happened as though I am a police officer and will be able to make use of the information that does not seem right. I excuse myself and return to the bay, and when it becomes apparent that I cannot get a doctor to come speak with them right away I return to them. Detectives are now in the room. She is on the phone; it sounds as if she is talking to more children. She tells them to be good and that she will be home in about twenty minutes. This doesn't seem right to me either. Someone new has joined the room; I guess rightly that it is Lacy.

C: Hello, I'm Siobhan, we spoke on the phone.

BM: Yes.

C: I just wanted to come out and let you know that I should be able to get the doctor out to speak with you in a few minutes, I wanted you to know that I'm aware that you're waiting and anxious to hear what is going on.

M: (Vehemently) Oh No! I can't be waiting for some doctor to decide how my son is—you need to tell me right now he's ok, you tell me right now he's ok, my son's ok, I can't be waiting for some doctor to decide how he is. I can't take this, I need to know he's ok, you hear me.

I am totally startled by her reaction. Initially, I am scared as she turns towards me but she quickly averts her eyes and starts pacing in little circles. The woman who had earlier introduced herself as a neighbor catches my eye and draws me aside.

Neighbor: (Speaking quietly) She's very fragile, mentally, you need to be careful.

C: And you're a neighbor, right?

N: Yes.

C: And that's … (I'm looking toward the man who is standing close to Todd's mother, trying to calm her)

N: A friend. (The friend comes over to me, he has had his hand on the younger sibling's shoulder.)

Family Friend: I'll stay and look after the kid. Maybe you better give news to us first and we'll tell her.

C: Is there any other family?

N: No, they're quite isolated really.

C: Thank you for being here with them. I will be back as soon as I can with the doctor.

(end of transcript for Encounter #1)

This segment presents the chaplain with a number of dilemmas. She must attempt to balance giving information about the patient with listening and supporting the family, particularly the mother, who presents challenges of her own that are not immediately obvious, either in terms of the coherence of her thoughts or her apparent comprehension of the unfolding events. The family friends provide crucial information and appear ready to help, yet they present a difficult issue in terms of patient confidentiality and the release of information in a sensitive yet practical manner.

Such a patchwork of characters, emotions, and practical insights is idiosyncratic but not at all unusual in trauma cases. Particularly when the presenting mechanism is a violent assault, information often comes in dribs from an eclectic range of sources, and the chaplain must make continuous inferences and reassessments about the broader social framework in which the injury is situated as the therapeutic process unfolds. This detective work is not an obvious part of the chaplain's official duties but is crucial both to effective pastoral care and to collaboration with other members of the trauma team, who often come to rely on the chaplains to give quick contextual snapshots of a patient's social world beyond mechanistic data provided by ambulance personnel. Likewise, the chaplain's role as the *de facto* go-to person is something that is not explicitly stated in training but becomes a clear and accepted part of the protocol for residents, as family and friends come to rely on them as a point of continuity, particularly when patients are moved from the trauma bay to other parts of the hospital.

Encounter #2 (two days later)

As I listen to morning report I learn of a trauma victim who perished from a single gunshot wound to the head and soon realize that it was Todd's brother. Chaplain Derby had been on duty, and as neither he nor the trauma staff chaplain was currently available, I volunteered to follow up with Todd and see how he was coping with this tragic news on top of his own serious injuries.

Initially, Todd did not appear in the patient database, and I feared that he too had died; I soon determined that his records had been changed to an opt-out privacy status.[26] When I found his record I read a report completed by the social worker. I

[26] Patients may voluntarily choose to be "unlisted" in the hospital's computer system for privacy purposes. Certain individuals may also be categorized this way at the discretion of the medical staff, often in consultation with police or with other officials when there is a concern for a person's personal safety. Police sometimes keep watch over

was relieved to have done so, for when I read it, I learned that Todd had still to be informed of his brother's death; the announcement was to be made that afternoon.

According to the report, the mother believes that the shootings were not related. Further, it explained that Todd's father had been killed in a shooting a few years prior and that the family had received counseling for that tragedy. In spite of the mother's thoughts, the social worker expressed concern for the family's safety. It also mentioned that Todd had not yet spoken to detectives in relation to his own shooting incident.

Several traumas intervened in my plan and when I re-checked the patient database prior to finally going to visit Todd, I discovered that according to social work he had now been informed of his brother's death and that police were present conducting further interviews; relocation of the family was being considered.

Here, the chaplain is able to provide multiple visits over the course of a patient's stay. She is able to obtain crucial information regarding both the patient's own physical status and a startling update on his family circumstances. Such news is extraordinarily helpful for planning subsequent visits in terms of what topics can and cannot be discussed and the proper affect to assume. Inevitably, data such as these impact the nature of the relationship between chaplain and care recipient, and in situations where the chaplain learns something that the care recipient does not yet know, it can be extremely difficult to maintain an air of ignorance when interacting with the person.[27]

I arrive outside Todd's room and was surprised when I peep through the glass to see neither police nor his mother present. Lacy, however, is with him; she is sitting in the chair next to him with her head resting on his chest. I am also surprised to see that Todd's other younger brother is there sitting on the bed, watching TV. Todd has been extubated[28], and aside from the oxygen line he looks surprisingly well. In his hand, resting on the coverlet, is a paper towel, which looks as though it has been used for tears. I knock on the door; Todd looks up and beckons me into the room:

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patients—criminals as well as victims—at the hospital to prevent further attacks. Hospital employees relevant to the care of such patients, including chaplains, may access and add notes/orders to such records, but access to these files is closely monitored by management officials to prevent the unauthorized release of such highly sensitive information.

[27] To say nothing, of course, about the ethical quandaries in such a decision or the culture of collusion between family, hospital employees, and police in which actions are taken.

[28] i.e., the plastic tube for artificial respiration placed in his mouth and down his trachea has been removed. It is common for patients in such situations to remain on a supply of oxygen, either through a facemask or nasal cannula, as an intermediate step toward normal, unaided respiration.

C: Hello, I don't know if you remember me …

P: Yeah, I do.

BM: Yes, you were there …

Brother: I remember you.

C: I wanted to come and see you—how are you doing? (he half nods, half shrugs) I'm so sorry … (turning to Lacy) How is the baby?

BM: She's fine.

B: Are you a social worker or something?

C: No, I'm the chaplain, I'm here to support people, to look after their spiritual needs, which is sometimes the same as religious and sometimes not … I thought your mom might be here.

B: She's gone with the detectives back to the house. There's questions and there's a lot of people there, and at school too … (he is looking at the TV and subconsciously playing with the lid of the water pitcher as he talks to me)

P: (to brother) Stop that.

B: Sorry.

C: (to the brother) And how are you doing?

B: I'm ok, I'm being strong for my mom.

C: That's a lot to carry on such young shoulders. (He turns away from the TV and looks at me momentarily but doesn't answer. A heavy silence falls in the room. I wait.)

P: Here. (He hands me a paper towel. I take it from him and I guess I look at him waiting to hear what he wants me to do with it.) You have a tear.

C: Oh, thank you (I dab my eye). Well, I wanted to let you know that I am thinking of you … and your mom …

P: Thanks.

C: Take care.

Once again, the chaplain expresses surprise at the cast of characters. This situation is characteristic of many where, in bricolage fashion, the chaplain learns to deal with what is present. She is not indifferent to the others, but she must focus her attention on those in the room, however unexpected the situation may seem in terms of emotions or voices.

The chaplain similarly has a difficult time finding herself talking with the three. Are they adults? Children? Both? Neither? One of the difficulties of pastoral conversations in hospitals in

general, and particularly in trauma cases, is that biological age can mean relatively little in terms of affect and outlook, and it is often exceedingly difficult for residents to know how best to relate to such persons. The patient and his brother have witnessed street violence firsthand, the death of their father, an apparent lack of stability and guardianship from their mother, and now the death of a sibling. Despite his own life-threatening injuries, Todd—the high school sophomore—is calm, authoritative, and even generous in this encounter. He provides stability for Lacy, their baby, and his younger brother, who in turn is being "strong" for his own mother. They have each other, yet according to the neighbor, that is all. They are isolated in their home community and now sit in an antiseptic, technologically sophisticated room in a culture that is not their own, even though they are only a few blocks away from their house.

At first glance, it is entirely understandable why such an exchange would be awkward. Todd and his kin have absolutely no reason to trust anyone. Nearly every face that has entered their world over the past 36 hours has been owned by a stranger, biological adults in positions of power—police, surgeons, nurses, chaplains—who cared about their welfare and yet who remained emotional outsiders. The fact that the three of them even remember Siobhan is remarkable in its own right. They sense at some level that she is committed to their welfare and that she wants to help. But who is she, exactly? Or, more to the point, what is a *chaplain*? The younger brother has at least a vague idea of what a social worker is, and all three seem familiar with the concept of kindly women coming to offer practical help, but given the family's lack of religious involvement, a chaplain must have seemed an odd duck indeed. She explains her role, awkwardly, and tries to engage them in a bit of conversation yet is unable to elicit clear, committed responses. She is there, she cares, yet in her mind she has nothing concrete to offer, no obvious point of connection or task to accomplish that will ameliorate any of their problems. Her tear marks her pain for the family and perhaps also her frustration at her inability to provide more for them; perhaps ironically, it reinforces Todd's role as a care provider, yet it also highlights different emotional possibilities for responding to such events. The three may have secretly longed to be able to cry along with the chaplain but either could or would not, due to the shock of the events and the need to maintain a certain demeanor for others. The encounter ends with much of the same ambiguity with which it began.

Encounter #3 (later that day)

Telephone call to the social worker:

> I am very disturbed after this visit, particularly because when I read in the social worker's chart notes that there is no mention of the special needs of the mother. There is also nothing about the young brother and I am concerned that he is

having to witness more than is appropriate for a child and also who seems to be feeling a burden of care for his parent.

I page the social worker. She calls me back and I explain who I am and that I had just come from a follow up visit with Todd having spent a lot of time with his family when he was admitted.

She tells me that she is actually on her way home and has spent a lot of time on this case today. I explain that I wanted to touch base with regard for particular concerns I had for the family, especially in view of my impression that the mother may have some special needs and the welfare of the young sibling.

The social worker explains that in view of the circumstances it has not been easy to assess what behavior might be a normal reaction to the shock and grief. She asks me to describe my impressions, and I explain what I had found to be bizarre in my dealings with the mother on Wednesday. I also relay what the neighbor had told me about the mother's being fragile and that the family had a lack of support in the community. The social worker told me that one cause for concern was that the mother wanted the staff to tell Todd that his brother had died of a heart attack rather than being shot.

The social worker's primary concern today was the safety of the family, for despite the mother's assertion that she thought the shootings were unrelated, the police reported that the brother had been shot execution style, and this gave cause for concern. I reported that the police were no longer in the room. The social worker was not aware of the younger sibling or that he was still at the hospital. She mentioned that the nearby children's hospital has some services available for adolescents who are witnesses to traumatic events and said that she would speak to the person who would be responsible in her absence.

The social worker expressed that this was indeed a very vulnerable family and was appreciative that I had taken the time to call with my observations and hoped that we could all continue to work as a team to support them.

Here we get an important glimpse of behind-the-scenes work at the hospital that patients and families rarely see. Despite the social worker's efforts, she lacked significant pieces of information relevant to the family's emotional status and well-being. Siobhan's determination to consult with other colleagues reflected a growing awareness of the diverse types of work that occur within the clinical space and ways in which chaplains can contribute meaningfully to improved outcomes, even

if the intervention does not involve direct patient contact. No one required her—or taught her—to contact the social worker assigned to this case; her ability to make inferences based on chart notes and then to act upon gaps in the official narrative demonstrate the sort of logistical ingenuity and mediation that can ingratiate chaplains with other professional care givers in the hospital. It also provides a distinctive and broader image of the role of religion in the hospital space, one that is not limited to prayers, dialogue, and grief support but one that can also include advocacy and negotiation.

Chaplain's Reflections

For this case presentation, the chaplain answered a specific set of reflection questions that all residents utilize for one of their verbatims in the winter unit of the CPE program. I present here these questions and her reflections and then end with a brief analysis of this pedagogical method for the training of chaplains:

Can this illness and/or the patient's way of dealing with it be seen as characteristic of their approach to life in general?

It seems obscene to conceive of the suffering of this family—I am at a loss to know how they can approach life "in general" in the wake of a father already killed and now a serious injury and another death, all in the space of a few days.

Can this illness be seen to serve any purpose in the patient's relationships, current or past?

It feels so inappropriate to pose this question in the case of violent injury and death. If there is a purpose, it is a question that can only be answered by God.

Can the illness be seen as a communication by the patient?

In the sense that this occurrence should communicate something to our society in order for action to be taken to alleviate this misery.

Can this illness be seen as the result of life stress?

Yes, in the sense that statistically, Todd's race, age, social status and location all increase his chances of being a victim of violent crime.

Has the person's religion served to make them more or less vulnerable to this illness?

I don't know.

What is the person seeking or deriving from their religion in this illness?

This is not clear yet.

What spiritual outcome would you like to see for this patient's illness?

My prayer is that somehow Todd will survive this without becoming poisoned by bitterness and hatred.

How might such spiritual change be reflected in his relationships, life course, and course of illness?
My hope is that Todd will be inspired to seek a better life and world for his child, that his every day will be suffused with the grace that comes from knowing that life is fragile and precious, and that this will make him more loving, patient, and compassionate.
What pastoral influences in the person's life are contributing to or inhibiting such development?
From all reports there is an absence of pastoral influence in Todd's life. Robbed of his father, there did not appear to be any other mentors or protectors around him.
What interventions by the chaplain did or could contribute to such development?
I don't know; I am overwhelmed by this case and feel helpless.
What is the nature of the pastoral relationship with the patient?
This relationship is characterized by the intensity of the suffering as I meet with Todd on two of what I imagine have been the three worst days in this young boy's life. (The third I surmise is when his father died). My initial contact with the patient is very pragmatic—time is of the essence and there is no time for any elaborate pastoral intervention … I seek to communicate without words of compassion and comfort. The second contact with the patient, I feel utterly useless. I want to think that coming back means something, that my presence offers a sense of community in continuity of the nightmare that this family is living. I feel protective of this patient, I feel afraid for him and his family, and I feel that I want to do my part to ensure that what little help can be offered is given.
How were you drawn to the patient?
His youth and his seeming vulnerability drew me to him; he looked at me when I spoke to him. He seemed grateful for our brief interaction.
How were you resistant to this patient?
I felt that we had so little in common, due to the fact that he was a father whilst still in high school, as well as our gender, race, and socio-economic background. These seemed to be barriers in my mind that he would not want to receive much from me.
What factors did you quickly recognize in this situation?
I quickly recognized that the family had complex needs, in particular that the mother had some cognitive deficit, that there was at least one young sibling directly involved as a witness in the shooting and potentially being traumatized by being present through the night at the hospital, that the patient was managing dual responsibilities of education and fatherhood at a very young age, and that socio-economic factors were also very much at play.

What factors were you slow to recognize?

That it would not be obvious to everyone that this family had special needs and that I should be proactive in alerting social work. That this family did not have strong community religious and social networks.

What new insights into your pastoral functioning did you gain?

That my fear of not being able to mitigate great suffering perhaps inhibits me.

How well did you serve this patient in the broad context of their life?

I am not sure that this is a case in which I can feel I have impacted the broad context of this patient's life. I feel tortured by the grim reality of the broad context of this patient's life.

Group Discussion

These reflection questions give us important insights into Siobhan's understanding of her work, of the situation, what she could have done differently, and the effects that this case had on her as a person and as a care provider. Theologically, this set of encounters is opaque for her; she can find no doctrine or religious explanation that provides satisfactory closure or meaning for her or, for that matter, the patient and his family. The events are too overwhelming to fit into her existing framework of beliefs and challenge her deeply on a personal, spiritual level. She does not go so far as to suggest that such horrors thereby prove that notions of God and religion are shams; she instead resorts to the familiar demarcation between what humans can and cannot know vis-à-vis supernatural knowledge in response to larger questions of meaning and purpose. She also does not assume that the apparent lack of religion in the patient's life should be seen as a sort of punishment or attempt by a supernatural being to get Todd's attention. Likewise, she acknowledges that some patient events are so overwhelming that formulaic questions cannot begin to do justice to them and that the range of afflictions seen by chaplains resists straightforward categorization or responses.

The chaplain struggles with the appropriate roles of chaplaincy and religion in such a case and has longings for his future welfare that may or may not bear little resemblance to reality. Her doubts about the usefulness of the actions that she did take in the family's presence point to a lack of clear sense of accomplishment or impact, a common sentiment among residents that often jeopardizes their sense of proficiency and ability to offer assistance to others. Such a view may reflect an unconscious interpretation of her work through the lens of quantitative biomedicine, with its charts, scales, and formulae. Whatever the case, her comments about her own feelings of helplessness suggest an ambiguous relationship to the patient and others she meets; her reactions suggest both counter-transference and infantilization (*They're just young kids…*).

II. INTENSIVE CARE UNITS (ICUS)

INTRODUCTORY REMARKS

Like the trauma bay, ICUs have received some attention as ethnographic spaces of inquiry. Researchers have been drawn in particular to experiences of parents and other family members on neonatal units (Brown and Middleton 2005, Landzelius 2003, Wind 1986, Gotlind 2002, Schlomann 1994, Briggs 1985, Frader and Bosk 1981, Mesman 2005) and also to cases of pediatric (Miller 1996) and adolescent complex traumas (Jonsson 2009). Not surprisingly, the question of death has received significant attention; issues here have concentrated on topics from death among the elderly in the U.S. (Kaufman 1998) and cultural practices surrounding death (Hadders 2007) to the process of dying (Pascalev 1996), organ donation (Salloway and Volek 1987), and teleo-affective limits near life's end (Iedema *et al.* 2005).

Interpretative issues, meanwhile, have investigated the contingency of health and treatment outcomes on ICUs through such topics as meaning making (Cadge and Catlin 2006) and narratives (Layne 1996) in the neonatal ICU. Other inquiries into discourse include the connection between narrative and dying (Johnson *et al.* 2000), first person narrative accounts of the ICU experience (Rier 2000), post-discharge memories of the ICU experience (Ringdal *et al.* 2006), and communication problems on units (Robillard 1994). Interpersonal topics include staff-patient interactions (Schneider 1985), the cultural question of compassion in the ICU (Wax 2003), family coping practices (Coombs and Goldman 1973), professional ideologies in surgical ICU nursing (Merkel 2003), epistemological crises and "reflexive scientification" (Wagner 1995), cultural and epistemological mechanics of daily rounds in ICUs (Carroll, Iedema, and Kerridge 2008), emotional and psychological burnout among ICU staff (Ĉubrilo-Turek, Urek, and Turek 2006), and debates about medical heroics and therapeutic restraint (Guillemin 1982), reactions to indeterminacy (Harvey 1996). First person accounts from religious specialists has received little attention, however, and the phenomenology of the ICU space as a religious domain is likewise under-conceptualized. I address these two topics and several others in the verbatims that follow.

Overview of the Units

ICUs offer the most technologically intensive treatment to the sickest patients at the hospital, and many of the patients on these units are transferred there from other hospitals unequipped to deal with such complex cases. They cover a broad range of medical specialties: intermediate and advanced cardiology, neurology-neurosurgery, intermediate and advanced internal medicine (severe

pulmonary complications, sepsis, and multi-system organ failure), surgery (following certain complex operations like organ transplants), and neonatal medicine, though most patients on a given unit face multiple medical issues that physicians are attempting to manage simultaneously. All of the rooms on these units are single occupancy, shaped in panopticon-style arcs around a nursing station, so that every patient's room is visible from a central location. All patients are also attached to cardiac monitors, and frequently additional monitoring devices, visible on screens in both the room itself and at the adjacent station. Most of the units have a dozen or fewer rooms; the two intermediate-level units can hold around 30 each.

Much like the trauma bay, there are very strict rules and procedures that operate on these units. There are frequently infection warnings outside rooms with large bins of clean gowns and boxes of gloves and facemasks for anyone who passes through the patio-style sliding glass doors to interact with a patient. There is usually a 1:1 or 1:2 nurse:patient ratio on these wards, and medical staff of all types are among the most skilled, senior, and highly paid in the hospital; students and junior medical residents are not allowed to work with these patients. Each unit is equipped to handle its own code calls (when a heart stops beating) and do not need to wait for the hospital's general code team to respond. All of the units lie in close proximity to surgical floor for rapid transport to an operating theater, just in case. Patients often experience significant periods of waiting, uncertainty, and setbacks and may be intubated or otherwise unconscious for portions of their stays on these units. Staff and family members often get to know each other closely as a result.

Socially, these units oscillate between periods of relatively quiet stability and loud, hectic intervention and foreboding; there are usually far fewer people meandering through these halls than on general inpatient units. Biomedical staff members are caring but tough and exude a no-nonsense attitude similar to the trauma bay, though for all of the deaths that they have seen, they too can have sense of humor.[29] It is probably just as well: statistically speaking, one out of every three patients on several of these units will die there and will never make it back home.

Dynamics of Chaplaincy on These Units

Each chaplaincy resident is assigned an ICU. They often spend a considerable amount of time working with families because the patient is unable to communicate. Here, it is possible to have multiple visits over several weeks, both to follow a patient's (and family's) progress and to get a sense of a disease trajectory. ICUs are particularly valuable places for, as one resident quipped,

[29] "Here comes my next paycheck!" one nurse often said with a cheeky grin upon the arrival of a new patient to his unit.

learning "the fine art of being a wall fly"—when to talk and when to sit silently and be present, available but unobtrusive, especially when clouds of mortality gather.

These units can also provide particularly rich, if destabilizing, moments for significant self-reflection and semiotic analysis, as the following jotting from one of the residents attests: "Midnight. IMCU. Sitting outside the room of a patient with end-stage liver failure due to years of heavy alcohol consumption. The fluorescent lights and monitors betray the hour. A very pregnant nurse is consoling a spouse who can't stand the sight of blood." Such observations help to generate what are often intensely personal existential meditations on the limits, promises, and charades of human existence.

CASE 4: TWO COPING METHODS

Background

Carla is a single woman in her mid-30s who has been admitted to the medical ICU for complications related to her lupus. The goal of treatment is to relieve symptoms and protect organs by decreasing inflammation and the level of autoimmune activity in the body.

The patient is a mother of three children and is currently unemployed. This visit lasted over 30 minutes.

The Encounter

Chaplain: (walking into the room) Hi.

Patient: Hi.

C: (observing the telephone on her lap and the receiver in her hand) It looks like you're just about to use the phone. I'm the chaplain and I'll come back when you're done.

P: The chaplain? Yeah, I'm getting ready to make a call.

C: Yes, I'm just coming by to see how you're doing. But you go ahead and make your phone call.

P: Okay.

C: (approximately 15 minutes later, the patient is climbing back into the bed) Hi. Carla, right?

P: Right.

C: I'm Margaret Sear and I'm the chaplain for this floor. How are you doing today? (I suddenly became aware of the reason she was climbing back into bed. She had just used the commode. This is going to be a short visit!)

There are several subtle but significant points at the outset of this visit, one of this resident's earliest in the program. First, the opening introduction seems vague. Who is this woman walking into the patient's room? What does she want? The fact that Margaret enters the room, makes a quick survey of physical artifacts, and then makes a verbal observation before identifying her role and intention—and without using her own name *or* greeting the patient by hers—gets the conversation off to a rough start. The chaplain notices the phone cue and offers to come back, but the tone set by this initial ambiguity and awkwardness, as well as the ostensible maternalism / directiveness ("you go ahead and make your call") makes it more difficult for the chaplain to establish her credibility. The second introduction goes more smoothly. She addresses the patient by name and uses her own, elements which show a sign of interest.[30]

Second, Margaret's thought to herself about the commode adds a potent reminder about a common element of pastoral care, one that contributes to the initial awkwardness of the encounter: hospitals are a dubious cornucopia for the senses. CPE students spend a great deal of time refining their listening skills, emphasizing the need to recognize and filter noise while developing a radically heightened consciousness when talking with individuals one on one. Likewise, the training emphasizes the use of the eyes to collect information and to convey sentiments, yet it also cautions against the fatigue and shock that can come from the observation of visceral images and attempts to give students techniques for managing the content of such gazes. Touch is also in terms of proper uses of one's own body to support others—handshakes, hugs, tears, and the like.

Scents are perhaps the most troublesome of the five senses for residents.[31] Chaplains learn quickly that their olfactory sensations at the hospital will include everything from industrial-strength cleaners to excrement to sepsis. Even in hospitals with high-tech ventilation systems, certain rooms, and certain bodies, will emit decidedly unpleasant odors. Sometimes patients will be unconscious or will otherwise be unable to detect such scents, but more often than not they can, and for most it is a source of unspoken shame. Such smells index contamination, disease, feebleness, and undesirability. The fact that the chaplain in fact stays for more than "a short visit," that she is willing to be present in spite of the odor, is likely not lost on the patient.

P: I don't know how I'm doing.

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[30] It also reflects sound clinical practice. Indeed, correct patient identity for prescriptions, consultations, surgical procedures, *et al.* is an enormous medical concern in hospitals of this size and complexity, quite apart from social and interpersonal matters.

[31] Apart from some rather dodgy entrees at the cafeteria, taste is not much of a consideration for chaplains during CPE, though they may find themselves empathizing with patients who have lost a sense of taste due to medical interventions such as chemotherapy or who endure the decidedly less palatable patient food.

C: (Realizing now that this patient might need some kind of interaction with me, reluctantly I pull up a chair). So, you don't know how you're doing. What's that all about?

P: (patient turns toward me and curls up in the bed) I don't know.

C: Well, what was going on that you had to come to the hospital?

P: I was throwing up pink stuff.

C: Pink stuff? Did they find out what caused that?

P: Yeah. They said I was bleeding.

C: Internally?

P: Yeah.

C: Do they know what caused that?

P: I don't know.

C: You didn't ask them?

P: No. And they didn't tell me nothing. Maybe it's the disorder.

C: (she seems so young) Oh, you have a chronic disease. How long ago were you diagnosed with it?

P: Seven years ago.

This segment of the conversation highlights a number of challenges common to new residents. Having decided to talk a bit with the chaplain, the patient responds frankly to a vague question: she doesn't know how she is doing. Or, rather, she doesn't know much about her current medical state. Her speech is curt, her words minimal. This discursive mode could reflect stonewalling or an attempt to get rid of the chaplain, but I wish to suggest another possibility: because the chaplain asked how she was *doing* rather than how she was *feeling as an individual*, the patient gave a rational, typical response. She is in the hospital because something physical is wrong with her body, and most hospital employees who talk to her engage her at that level. *Are you in pain? Are you nauseous? Can you sleep?* Such algorithmic questions are designed to arrive at a diagnosis and an intervention. Because she has a chronic disorder, Carla has undoubtedly learned how to be a medical patient—she is familiar with the routine of talking to physicians, nurses, phlebotomists, and so forth. But a chaplain? What exactly is a patient with a chronic disorder supposed to say to a chaplain, and what are the implications of doing so?

This ambiguity runs in both directions. What exactly is a chaplain supposed to say to a patient with a chronic disorder? Here, Margaret takes an approach commonly seen in early pastoral interactions: she asks questions. Medical-related questions. She does not move directly into

questions about religion or spirituality, or even about the phenomenology of the illness. Rather, she takes what is ostensibly the default cultural approach to someone who is not feeling well: she plays doctor. She asks factual questions that call for no introspection or contextualization. Much as a mother queries a sick child, the chaplain senses a need and longs to help but quickly reaches the edge of her scientific expertise.

Equally revealing is what the chaplain does not immediately address. She observes the patient's posture in bed but does not suggest that such a position might signify something. Likewise, she notes that Carla has not been receiving clear information from the medical staff but does not offer to help or advocate on her behalf. Instead, she returns to questions. This inquisitorial posture keeps Margaret at a safe emotional distance from the patient and also keeps her in a position of power—she asks the questions and thus determines the trajectory of the conversation. The patient is communicating important information about her emotional state, obliquely, yet the chaplain does not meet her on this level.

C: How have you been dealing with that?

P: Not so good.

C: (not sure just where to go with this) No? Carla, what religion are you?

P: Baptist.

C: Okay. Does that help … your faith?

P: Not really.

C: So, what do you do? How do you process all of this?

P: By getting high.

C: (well!) Aren't you afraid you might get addicted to whatever you're getting high with?

P: I'm already addicted.

C: You are? What is it that you're getting high with?

P: Crack.

C: Okay. They say that's instantly addictive.

P: Yeah it is.

C: Are you getting any help with that?

P: Yeah, well I was clean up until Saturday.

C: What happened Saturday?

P: I just got to thinking about the MS and how tired I was of all of it, so I just got high.

Here the conversation slowly moves to a more personal, affective level. The chaplain asks about coping methods; those involving chemical substances can be seen as medical issues, yet CPE training encourages residents to get a sense of how patients relate to their medical conditions and what resources they sense that they can draw upon in the midst of illness. In her write-up, Margaret admits frankly that the conversation seems adrift and steers the dialogue toward religion, the topic that one would expect a chaplain to address. Yet this overture too proves unsuccessful: Carla states her religious affiliation but then says that it isn't a significant aid in her illness.

This response leaves the chaplain in a strange position. She could interpret the response as suggesting that the patient is not particularly interested in religion and hence has no need for a chaplain, in which case there might be nothing more to say. Alternatively, she could read these words as a plea for help: Carla knows that crack is not an optimal coping method but has been unable thus far to find the assistance she wants in religion—or, it seems, anywhere else. Margaret isn't ready to give up on the visit yet is taken aback by this shocking revelation and retreats into the intellectual and emotional safety of factual questions. She does not criticize the patient directly, even though there is an obvious note of disapproval in her parenthetical remark; whether or not this inner sentiment was manifest in her body language we cannot tell. She seems torn between genuine concern for the patient's well being and the desire to give a lecture, an admonition—something from a standardized (or generic) Protestant clergy toolkit that will cause a change in thinking, a change in lifestyle, and ultimately a transformation of outlook and behavior.

C: I can understand how you got overwhelmed because that's a lot to deal with. You know Carla, in Psalm 42 the writer asked himself a question. He asked himself why he was so cast down, so distressed. Then he talked about how he used to go to church and how he had been so glad to be there. But he realized that he was so far down that he needed help.

Supplies Clerk: (enters the room with something in her hand) Excuse me.

P: (turning) Oh, I used the commode. Could you empty it?

SC: No, that's not what I do. I just restock the medical supplies. I'll get the nurse for you (she leaves and no one ever comes).

C: (As I pick back up where we left off, Carla turns back towards me and gives me her full attention) Okay Carla, the psalm writer realized he was down and needed help. When the scripture talks about being "cast down," it's talking about how a sheep falls over for one reason or another and then it isn't able to get itself up. It needs someone to help it get up. If not, it will die because it just can't get up.

Sometimes we're like that sheep and that psalm writer. We get so far down that we need someone to help us get up. The psalm writer said he was going to hope in God because he knew the day would come when he would praise Him again. Maybe it wasn't that day, but the day would come. Have you ever felt down like that?

P: (appearing to be deep in thought) Yes.

C: Well maybe you could do like the psalm writer and choose to hope in God even though things have got you down.

P: (face lighting a little) Yeah, I could.

C: Would you like me to pray with you Carla?

P: Um-hum, I would.

C: (holding Carla's hands) Precious Father we come before you in the mighty name of Jesus and we bring your daughter Carla before you. She needs you to help her Lord because she's so overwhelmed by MS. Please help her to stop using the crack and to trust You to be with her through all of this because You promised You would never leave her and never forsake her. Please let Carla know how much You love her and how much You love her just the way she is. Thank You Lord, amen.

P: Thanks for praying.

C: (getting up from chair) You're welcome.

P: I'm supposed to go home today, but I still don't feel right. I still feel sick.

C: Well make sure you tell your doctor because he won't know if you don't tell him. I'm sure they want to make sure everything is right with you before they send you home.

P: Okay. Thanks for coming back.

C: Oh, you're welcome. Take care.

Here, the chaplain appeals to sacred texts in order to attempt a therapeutic intervention. The message seems clear: many have been in difficult situations throughout history, and there are other options. Religion can be a substantial coping aid. Trusting and hoping in God has worked for people in the past, and it could work here as well. The patient acknowledges the parallels and, according to the chaplain, now pays full attention. Margaret offers a prayer, which appears to be well received. It is a concrete action, an appeal to the divine for assistance. It introduces important qualifications to her earlier exhortations about trust and hopefulness: those who trust in God need not fear isolation or abandonment. Hoping, the resident implies, is not a passive process or, worse, wishful thinking: it is therapeutic in the psychological sense that gives a person a sense of

connection. For Margaret, it is meliorative in the metaphysical sense of connecting to a supernatural source of power in terms of love and, potentially, a cure.

The chaplain thus offers the key resource at her disposal—religion—in a rather top-down manner in the presumption that, because it has helped her in her own life, it should be able to help her patients. She does not ask the patient about her relationship with God or why religion has not been helpful in the past, and we consequently are left to guess what this relationship may be. Perhaps the patient was baptized but has not attended church in years and hence knows little about organized religion. Perhaps she was abused by a pastor. Perhaps a church member abandoned her family at a point of particular need, in which case talk about divine loyalty might seem rather shallow. Without such information, we have no way of knowing whether the chaplain's words are for the patient a source of genuine hope, a trivial diversion, or an act of violence. The appeal to the divine through prayer might have opened a potentially therapeutic horizon by offering the patient a semantic framework within which to frame her clinical experience, but the prayer might just as easily have been an anodyne for the patient whose main function was to help the chaplain to clarify her authority in her own mind. It might also have been an act of desperation, an attempt to offer something under the presumption that, like biomedicine, she should offer the patient something if an encounter is to be clinically efficacious.

Such ambiguities are compounded by additional factors. First, as the chaplain would admit in subsequent reflections, she had a tendency toward mothering. Her pastoral persona, especially toward younger adults, was intertwined with her identity as a parent and led her more toward talking and advice giving (e.g., "Talk to the doctor," "Be hopeful") than collaborative exploration of issues or an offer to intervene with the medical team, aspects of pastoral care for which she was excoriated by her peers. Second, it is possible that her shared African-American identity may have caused her to assume a level of familiarity with this patient that she would not have with others in a way that undermined her objectivity and critical interpretative gaze as a care provider.

Chaplain's Reflections

Margaret spends a significant amount of space reflecting on socioeconomic issues and judgment in her analysis of this case. She argues that Carla "represents so many [patients] who are overlooked and/or disregarded because they have a nonchalant attitude." Based on the cues from her own interaction and from the patient's narrative about her care thus far, she concludes that "people tend to prejudge them and come to conclusions about them because they do not fit in with the norm, as defined by those who judge them." In this early encounter, the chaplain sees this hospital as a particularly derogatory and demeaning place, one where a great many "people" routinely apply a

paternalistic, even arrogant hermeneutic to uneducated black women. The chaplain seems already to have decided that the medical center has very narrow senses of what constitutes proper patient behavior and recognizes that Carla's affect, and quite possibly her own as a member of an ethnic minority, do not fit into this model.

At the same time, she admits that it would have been easy for her to reach the same conclusion about this patient and feel justified because of her initial attitude and behavior. It is by no means irrational, she implies, that many would conclude that poor, drug-using single parents should be expected to be bodily and narratively passive recipients of expensive, high-tech medical care, amassing bills that she will likely never pay. Similarly, she seems to reflect this judgmental mentality through the implication that someone whose body generates strong, unpleasant odors *should* be thankful for anyone willing to visit them. There were so many other patients to visit; it would have been easy for her to embrace the initial lack of interest in conversation pragmatically and move on to the next room, rather than humbling herself and offering her time, gratuitously, to such a marginal figure.

What we have here is in fact a confession: the patient is not as different, as strange, as she initially seemed. Margaret tells her colleagues that she doesn't approve of the patient's coping mechanism but appears to try at least to understand why the patient has returned to crack as a form of self-care, thus portraying the patient's actions as ignorant or desperate rather than consciously and freely taken. She concluded that "she is just like the rest of us, human," despite the fact that the chaplain herself would never utilize a chemical substance in a time of need.

This is not to say that the chaplain did not care about the patient or was willingly hypocritical. She did care, and she was determined not to surrender on her at the first sign of indifference to her presence. Explaining that "Carla relaxed considerably with me as the visit went on," she "would have liked to have had another visit with her, but it was not to be." Margaret interpreted her success in bringing a religious option, a spiritual alternative to crack, to the patient as "God at work," because "He helped me to get past the wall that the patient had obviously erected to keep others out for whatever reason. The amazing thing is that she actually wanted me to get past it, or over it if you will, but she had to see that I was genuinely interested in her first." The resident interpreted her ability to engage the patient in meaningful conversation as divinely mediated, as an encounter that would have been less effective, and perhaps impossible, if left solely to human devices. She suggested to her peers that some patients may actually want to talk but have developed defenses to keep out the curious and the uncommitted. The fact that she framed such behaviors in terms of supernatural factors suggests that at this stage of the training program, she viewed her work

at least in part in terms of cosmic battles between good and evil, in which chaplains would have to persist if they were to deliver "Good News" to those in need.

Group Discussion

Residents offered a number of critiques of this interaction. Several commented on her series of medical questions and wondered why she seemed to stay at the level of facts so long before introducing religion to the conversation, suggesting that while it was appropriate for her to show active concern about poor medical care, her exhortations about treatment toward the end of the conversation sounded maternalistic and seemed to validate the very system that she criticized. They were also interested in hearing more about her own emotional reaction to the patient, in order to understand the sort of mindset that she as the religious specialist brought to the encounter. She responded that she felt sadness at the patient's loneliness, lack of support system, and isolation. Margaret also compared the patient to a baby in a basket in the woods, someone secluded and defenseless but also on display for potential predators. Interestingly, she rejected comments about her own overtures as potentially abusive or high-handed. For that matter, while critical of some of her choices of words, her peers also saw only religion's possibilities for good for the patient, rather than as a potential source of judgment and disempowerment. They agreed that chaplains had an obligation to be attentive to the busyness of the hospital and to those most likely to be overlooked interpersonally, logistically, and therapeutically. This therapeutic optimism and willingness to intervene reflected what one resident called the "passive sin" of social neglect that seemed to them to characterize the hospital experience in their first weeks of the program. For them, grace and the promise of salvation were both appropriate and necessary offerings the chaplains could provide to such patients.

CASE 5: WHY ME?

Background

Todd is a 15-year-old single teenager of mixed ethnic descent from a suburban community approximately one hour from the hospital. He is currently on leave from school to receive medical treatment while he awaits a heart transplant. He is large (5'8", approximately 290 pounds) with medium-dark complexion and dark, curly hair. Medical staff colleagues have noted that he is frequently shy and withdrawn, though when he is in a good mood, he has a warm and inviting smile and can be quite talkative. According to the social worker, the patient was an athlete at his school before the current episode forced him to reduce his level of physical activity. Due to behavioral

problems, the patient was moved to a special services school three years ago, where smaller classes and greater attention brought marked improvements in his grades; the social worker has arranged hospital-based tutoring in the interim. On the unit, I observed Todd walking throughout the hall on a regular basis, though often with difficulty, but most often I saw him reclining in bed playing video games.

The patient lives with his mother in an apartment above a "smoky bar" with approximately 20 steps to enter. He has little contact with his biological father, but his stepfather has been an active part of Todd's life for the past ten years. His mother and stepfather are recently separated but have been present at the same time during visits to the hospital. In addition, the patient has a stepbrother in the area and a biological brother who is currently in college in Alabama on a basketball scholarship. His mother is the primary medical decision maker for his treatment and has been an active participant throughout his stay.

Economically, the family has limited resources and is currently receiving government assistance. His mother is a nursing assistant, but she reports that since her son's hospitalization, she has been unable to work and is worried about being able to pay bills. Social work is providing meal and parking passes for the mother during the patient's stay and is working to coordinate fundraising efforts on the family's behalf. A charitable foundation recently brought Todd a PlayStation and is making plans to take him shopping post-transplant, per his wishes.

The patient has no history of substance use or psychiatric illnesses, though he has shown mood swings during his hospitalization and has asked "Why me?" on a number of occasions. Earlier in the year, the transplant team expressed concern about the feasibility of transplantation due to the patient's high body mass index (BMI) and favored a left ventricular assist device (LVAD) as an intermediate-range solution to his cardiac illness, with the hope that nutritional counseling would improve his dietary regime enough for him to be able to lose enough weight again to become a viable transplant candidate. Todd's BMI has improved, and he has been seen by nutritionists nearly thirty times since admission to the hospital. P.T./O.T. has also given him a robust workout routine (3-5 times per week) to improve his mobility and to increase his ability to engage in basic maintenance tasks, such as bed and tub transfers, bathing, and dressing. A few weeks back, he was taken down to an operating room for the transplant, only to have the surgery canceled at the last minute.

The patient and his mother attend a local Methodist parish on a regular basis. She reports that the church family is incredibly supportive and is an important resource for the family. His pastor visits him on a regular basis, and the patient has expressed a strong belief in the efficacy of prayer.

Encounter #1

This encounter takes place mid-afternoon. The patient is in his room with the curtains drawn, as usual. We had met briefly a couple of times before this exchange. I had spoken with my supervisor in the interim about how to interact pastorally with teenagers and wanted to see if I could make any more headway than I had in the past:

Chaplain: (standing at door) Hey Todd, how are you doin' today?

Patient: (sitting upright on bed, busy playing a game on his Play Station) Aw right.

C: (looking up at screen) Watcha playin'?

P: (Still watching the screen, manipulating joystick, he says name of game, a boxing match where one person plays against the computer.)

C: Cool! (keeps playing game for a while) So … have you heard anything from your doctor?

P: (pauses game; looks up, annoyed) What?

C: (Oops! Not a good topic?) I was just wondering if your doctor had given you any updates.

P: (resumes game) Nah. (seems to tune me out a bit)

C: (looking back up at game, observing his boxer winning) Oh yeah, you got 'em … (his face is intense and focused; takes a blow) Oooh … 'ts all right, come on, you can get him … (round ends) So is this your favorite game?

P: (more relaxed/cheerful demeanor) Nah, I don't have a favorite. I'm just playin' this one for now.

C: You're really good! (smiles; next round begins)

C: (still watching screen) Whoa! Look at that hook … you got 'em … (opponent goes down for a TKO) Aw right! Do we get a dance? Do we get a dance? (his character does a victory dance on screen) Oh yeah! (Todd grins from ear to ear)

C: All right, man, I need to get goin', but I'll see you again in a couple of days?

P: (smiles) Yeah, ok.

C: Take care, Todd.

I was encouraged by this encounter. It had a certain momentum to it. Todd seemed more comfortable with me, and I with him. We did not have a profound discussion about theodicy or the future, but we did spend a good ten minutes together. So what if our exchange was mediated by a video game? It gave us a topic of conversation. It helped me to demonstrate my interest in him and his life and (hopefully) painted a more relaxed, informal picture of the hospital chaplain.

Encounter #2

This exchange occurs later that same afternoon. I had noticed my janitorial colleague speak with Todd on a couple of occasions, and they seemed to get on well. Somehow, she was able to connect with him. What was her secret? Was it because the two of them were closer in age? Both African-American? Was it because she also had a full figure (though, unlike the patient, was by no means obese)? What effect, if any, did her Muslim beliefs have on her ability to reach him?

Chaplain: (approaching environmental staff person) Hi, how are you doing today?

Environmental Services Worker: (busy with work) Not bad.

C: Looks like you get along with Todd really well …

E: (stops her work; face lights up) Yeah, he's a good kid. He's been through so much ….

C: I know! I was on the night that they wheeled him back from surgery after the false call [the new heart wasn't a match].

E: Yeah, sometimes it can be hard to get through to him. It just depends on his mood. He's usually better in the afternoons, when he's been awake for a while and has played his video games for a while.

C: He really seems to like those … he seems to open up more when I talk about them.

E: Uh-huh. They're a distraction. He usually doesn't like to talk about his health. But one time, I was in there with him, and he was watching Oprah, and she had on some woman who was really overweight, and she was talking about all of her health problems and was getting all sorts of attention throughout her struggle to recover, and he was saying that she didn't deserve any special treatment, because she didn't need a heart. She wasn't special.

C: Wow ….

E: Yeah, but his family comes to visit him, so he has ways of taking his mind off the stuff. He gets out and walks up and down the halls, but if he isn't in a good mood, he doesn't want to listen and just kinda retreats inside.

C: Yeah, I've noticed.

E: We've all got to keep at it.

C: Definitely. Thanks a lot for your help! I really appreciate it.

E: Sure, no problem. You take care.

C: OK, thanks. You too.

I was humbled by this encounter. *She* has been a more effective chaplain than I to this patient. He clearly trusts and likes her. The fact that she doesn't wear a white lab coat or a suit and tie seems to make little difference to Todd; he relates to her, and that is what is most important.

Their interaction made me realize that he is thinking very deeply about the issues facing him but spends a lot of time hiding and/or denying them. I tried to be less cerebral, less rigid, in my last encounter, and that seemed to help somewhat. Is it possible to raise the deeper, painful issues with him in such a manner that he wants to talk about them? He knows that I am the chaplain and realizes that he can talk with me about religious and health issues, if he wants. With teenagers even more than adults, it may be the case that I as chaplain must allow the patient to determine the topics of our conversations.

Encounter #3

This interaction takes place around 19:25 on a subsequent day, in two stages. The first occurs in the patient's room, with the mother and stepfather; the second, in the hallway with the patient. During this visit, I notice a micro-fridge in the patient's room. The mother is seated and is decorating a white T-shirt as I enter.

Chaplain: (at doorway into patient's room) Hi, are you Todd's mother?

Mother: (looking up) Yes...

C: I'm Will, one of the chaplains. (she smiles) I've been in to see Todd a few times, and I just stopped by to check up on him.

M: Oh, ok, that's nice.

C: How's he doing today?

M: All right. It's just one day at a time.

C: I've seen him playing video games (smiles and nods) in the afternoons. Unfortunately, this (motioning hands to indicate unit) isn't the most kid-friendly place in the world ….

M: Oh yeah, the games keep him busy.

C: (looking over at console) What is it, PlayStation?

M: (laughing a bit) Yeah. His cousin also comes to keep him company. He's about the same age; he's been coming the last couple of weeks. Yesterday was a busy day for him. Folks from Make-A-Wish were here, and lots of family members came to visit. (I nod) His tutors are coming three times a week now, but it's been a long road. He's doing better, though; he gets up and is able to walk on his own. (motioning to hallway) He's out there right now.

C: Yeah, I've seen him in the halls recently; was this a problem for him earlier?

M: Oh yes, he wasn't able to move a lot on his own. It's been about four months since this last started, and three surgeries.

C: (pieces are starting to come together) OK, because he was at Children's earlier, wasn't he?

M: Yes, one month at Children's and now here. He had surgery last summer. I don't know how he does it—I'm sure I couldn't! (slight pause) But you can see (motioning toward windowsill), they've brought him an alarm clock, to try to keep him on schedule. He likes to stay up at night ….

C: (smiling/sarcastically) Oh, that must go over well! (slight pause) How are things for him spiritually? I've wanted to ask, but sometimes he is kind of reserved (nods understandingly), and I don't want to press him, but how is this part coming for him?

M: Pretty well. His pastor comes in every week to see him. He says he knows that prayer works—he's had a lot of people praying for him … (looks up) Oh, here's …

C: (turning around) Oh, hi, I'm Will, one of the chaplains here.

Stepfather: (extending hand) I'm Cal. Nice to meet you.

C: I've met Todd several times-this is one of my floors—and just stopped by to see how he's doing today.

Stepfather: (nods) Oh, OK. (mother stands up)

C: Well, I'll leave you for now, but it was a pleasure to meet you …

M: What was your name again? (looks at my name badge)

C: I'm Will. I'll stop by to see you again.

M: OK, thanks for visiting. Bye.

SF: Bye.

As I leave the room, I notice Todd down the hallway, working at one of the staff computers. I approach to say hi:

Chaplain: Hey! How ya doin'?

Patient: (focused on computer) OK.

C: Checkin' your e-mail?

C: (more gently) How are you feeling today?

P: (still looking at screen) All right.

C: (pause) I just met your mom. She seems nice. Does she come here a lot?

P: Yeah.

C: (hmmm … going to be one of those interactions, is it?) Are ya still playin' the boxing game?

P: (still not looking up) Nah.

C: (Nope, not now. Maybe later.) OK, I'll check in with you later. (nods head) See ya—

Hmmm. Win some, lose some. Maybe it was a bad time. But is there such a thing as a good time to discuss religion—or death—with a teenager? I know that I'm not hip and am out of touch with the lives of teenagers in this part of the country (or any other part, for that matter). I don't understand their world, their priorities, or their values. I'm trying, but with this kid, it could be months before I have a real conversation with him.

Chaplain's Reflections

Here I present my reflections as chaplain resident in response to the questions utilized in the spring quarter of the program:

Patient's illness and coping mechanisms:

I attempted to draw inferences about the patient's physical status based on the insights that I had learned about his home life, dietary and exercise habits, and cultural world. I suggested to my colleagues that there appeared to be a tight causal web at work: the family had limited resources and could not afford a good quality diet. The patient enjoys foods high in salt/fat/sugar, which I was told contributed to his obesity, but which, I believed, likely led to social stigma and possibly ridicule, both of which conceivably placed additional strain on his heart. I also learned that the excess weight ultimately kept him away from football and from his team, leaving him with a more sedentary lifestyle and, quite possibly, lower self-esteem. I speculated that this pattern might also have been due to the complicated family situation and possibly to the absence of male role models in his home life, but it could just as easily have been due to genetic factors—I didn't know. His situation seemed to be out of his own control and, from my very unscientific perspective, thought that it made sense that he could benefit from the intervention of PT/OT, nutrition specialists, and others here in the hospital to introduce him to a new lifestyle and to promote recovery while he awaited a heart transplant.

Broader purpose of illness with reference to the patient's relationships:

I hoped, in rather general terms, that it would lead to stronger and healthier bonds. I recognized that it was having very practical effects on his relationship with his mother in terms of her work, finances, and travel to/from hospital, and it likely had psychological effects as well (e.g., fear of losing a son, possible blame issues, anger, and frustration). No one mentioned anything about a romantic partner,

but his current state and treatment plan could well have effects on his ability to develop such a relationship. It is clearly having an effect on his football coach and on his teammates, who are doing fundraising drives for his medical expenses. In terms of his biological (older) brother, I speculated that Todd might feel jealous toward him, because he was able to play sports, attend school, and engage in social activities. It was difficult for me to know what effect, if any, the illness was having on his biological and stepfathers. I had thought that being an overweight male would likely lead to social stigma, but one of my colleagues suggested that, in fact, social acceptance in the local African-American community depended more on the person's personality and that some physically large men were often "the life of the party."

Illness and life stresses:

The Marxist in me suspected that many of these factors were beyond the range of the patient's consciousness, that he is simply fulfilling a role consistent with the socio-economic world in which he finds himself. Then again, his home/neighborhood environment sounds anything but tranquil and—despite the ongoing support of his maternal family and church—may likewise have placed additional stress on his body.

Religion and illness:

I had a difficult time assessing the religious component of Todd's situation. He did not mention God or the church in our conversations, but I knew from others that it was a factor in his life and convinced myself that religion and mortality were not topics that most teenagers discussed spontaneously. I didn't have a good sense of how religion had helped to prevent the onset of his current condition, but it did seem that his religious connections outside the hospital were providing emotional support and a sense of continuity with his home community in the midst of his treatment.

Other comments:

It was equally difficult to know his reaction to me as a religious specialist. Was he happy when I visited? Indifferent? Annoyed? I had never been a big fan of sports, MTV, or video games and that, as a result, it had been hard to me to slip effortlessly into the patient's world. Moreover, I didn't particularly like teenagers in general, and I'm sure that this was evident to the patient. I lacked a clear sense of whether or not my presence was making a difference to him and was frustrated at the lack of a way to gauge efficacy. I reported that I was willing to continue seeing the patient but acknowledged that I felt that there would never be a good bond between us and concluded that this was an aspect of clinical work that I would have to accept.

Group Discussion

Several residents focused on the patient's emotional status and tried to read my description of his mood in the hospital in terms of broader life stressors. Three asked specifically about the special school that he had been attending in relation to behavioral problems and wondered if the system was working well for him. Another asked about his mood swings and wondered what sort of attention, if any, that they had received in the hospital in general. One speculated a connection between these issues and Todd's family dynamics and thought that he, as the child, might be reacting to some of his parents' problems.

Returning to the content of the conversations themselves, the supervisor spoke with approval of my attempt to reach out to a staff member like a janitor in order to attempt to improve my patient care and suggested that showing respect for her by treating her as a clinical equal was probably not lost on her. Elsewhere, he steered the analysis toward what he perceived as a tension between my tendency to see metaphor where it did not exist and cautioned against a hermeneutic that took every datum as indicative of some larger life struggle.

Finally, the group used this didactic to wrestle with how best to provide pastoral care to teenagers, thus responding to one of my key concerns as the presenter. One colleague argued that it was entirely unproductive to "try to be like them to get near them," lest the chaplain "come across as phony." Another, however, believed that there was a certain merit in "trying to speak Italian when in Italy." A third took a different perspective and suggested that I had been interpreting the encounters purely in a negative light, focusing solely on perceived shortcomings. She found that it was difficult in general, and particularly as strangers, to know when teenagers want to talk and felt that attempts to look for dramatic encounters or huge shifts in outlook would almost certainly lead to frustration. Her colleague agreed and suggested that I think back to my own teenage years to attempt to get a sense of how to enter into his world productively without overpowering such life experiences with the intellect.

CASE 6: GOD ON TRIAL

Background

The patient is a four-month-old infant in the ICU, where she has remained since her birth. She has a range of life-threatening defects and has undergone multiple thoracic surgeries, but to no avail. Over the course of treatment, the infant's mother in particular had become "quite hostile" toward the lead physician, and

> it appeared that there was an increasing breakdown in communication and shared goals between the family and the medical and nursing teams … the parents had declared a profound belief that their prayers for a miraculous recovery would be answered and were unwilling to accept any reduction in life-prolonging measures …. During the two weeks prior to this visit, [the patient's] condition had deteriorated on a daily basis …. She developed sores that would not heal and her skin began to break down. Her tears had become replaced by pus and a yellow discharge streamed fairly continuously from her nose around the ventilator and feeding tubes. Despite the placement of a central line, it was only possible to draw blood by turning her on one side, a procedure that required two nurses and caused her obvious distress.

Through daily visits, the family had come to know and trust the chaplain, confiding to her their concerns and beliefs regarding the infant's treatment.

The Encounter

The chaplain is on the phone with the mother; she has a day off but decides to check up on the family. She tells the mother that she had a dream about the infant the previous night, in which "she was healthy and happy and smiling down at me."

Right from the outset, we see that there is a range of conscious and unconscious issues at work here, including wish fulfillment for the chaplain and, arguably, magical thinking in response to repeated exposure to the family's cosmology. This resident is highly invested in this family and in the patient's welfare and longs for the infant's survival. She is an interfaith minister, so it is difficult to determine unequivocally here what her doctrinal beliefs are regarding death and an afterlife, but there is a clear hope for peace here, whether in the form of physical recovery in this world or, as the dream would suggest, in some future world in which the infant is freed from the constraints of her deteriorating body and is in heaven above, where she is in bliss and can look down with a smile upon earthly persons.

At first glance, this certainly seems a reasonable enough goal—who wouldn't want to see a favorable end to suffering and disease—a successful cure—particularly on the neonatal unit? Yet the family's goal of complete physical recovery in this situation presents many challenges, at least from a Christian theological standpoint. This sort of reasoning rejects the passive, trusting faith of "Thy will be done" in favor of a religious hermeneutic that privileges desired human outcomes. In terms of human expectations for control over life, individual initiative and responsibility, and

biomedicine's research-intensive culture that seems always to have another intervention at hand, there seems to be an unspoken wish on the part of the immediate family to hem divine agency in the view the perpetuation of human life must be the *sine qua non* of both scientific and religious intervention.

In this case, the desire for the infant's survival increasingly manifests itself in magical thinking and implies a deity that serves humans, rather than vice-versa. They are determined to achieve a certain outcome and are convinced that their faith will vindicate the infant's suffering. Does the family have faith in order that they may hope? Does the family believe only so long as it is efficacious to do so? To the extent that hospitals highlight the desiring/receiving aspect of human-supernatural relationships more than many other settings do, where does this leave both biomedicine and pastoral care, when the patient's status becomes a litmus test for the validity of others' religious convictions?

On the phone, the mother explains to the chaplain that "We're praying for her resurrection, we still have our faith and we are waiting for her to rise up." This statement significantly complicates the religious landscape of this case. Technically speaking, the living cannot be resurrected; they cannot be brought back to life, precisely because they are alive. Prayers for resurrection are only offered for the dead. But is this what the mother really means to say? Does she believe that her daughter is already dead, or is *as good as dead*? The latter would suggest that the mother tacitly agrees with biomedicine: science can do nothing more for this infant. In the mother's mind, God may raise her daughter's spirit from the dead, just as Jesus did with Lazarus, but death must come first.

It is difficult to know why the mother holds this view, if indeed her words reflect her beliefs under such emotionally and socially charged conditions. Yet if it is, then why persist with the biomedical interventions? Why try to keep the body alive at all costs? Why not let the infant die peacefully and then pray for the resurrection?

On another level, this statement to the chaplain reflects a sense of duty to pray, to do everything that they can on behalf of their daughter. The mother's actions are informed by Christian sacred texts that claim to attest to historical events. She is interpreting these texts in a particular (i.e., selective and literal) way and using them to guide their behavior in the present. This analogical reasoning nonetheless reflects a tension between (1) the need for the parents to demonstrate their faith publicly, to themselves and to others; to convince themselves that they have been faithful to God and have done nothing wrong; and (2) an unwillingness to give up on science, a modality that may at one point have been associated in the parents' minds with the supernatural but which appears

to them increasingly secular and hence worldly, human, and finite. They are caught between multiple systems of intervention and are hedging their bets: there is still a faint chance that biomedicine might yet work, yet if it does not, then they want to be ready when death comes with another system of intervention.

The chaplain senses urgency in the mother's voice and decides to stop by the hospital. She explains that "When I entered the room, I was struck by the empty crib around which we had spent so much time standing. [The mother] was sitting in a rocking chair holding [the infant]. I realized that this was the first time she had held her since her birth. There were a number of people in the room. I was introduced to them as friends from their church and also [the mother's] brother and mother were there; the father's family came later." The scene is different from what it had been in the past. There is a new physical relationship between the mother and the infant: it is no longer one of medicalized distance via the incubator, but instead a much more visceral, even natural, connection. "It's so good to see her in your arms," the chaplain says. "She's been holding her for hours," a relative notes.

It is here that we, like the chaplain, find some answers. The mother explains the day's events: "This afternoon, she coded … they resuscitated her … and then she coded again … they did the chest compressions, everything, after the second time I wanted to stop … I said to [the father] … but he said 'No, it must be on God's time' and I prayed to God, 'You do it, you take her or you bring her back' and we said 'The seventh time will be for God to decide,' but the sixth time … her heart would not come back … this is why she's so purple, from the compressions and she's yellow too."

Note the theological and practical disagreements between father and mother: for her, there was a significant religious element to the intervention, but she also saw the codes in terms of the damage being done to her daughter's body; the trauma and medical futility of those particular acts overrode other considerations in terms of continued *biomedical* manipulation. Still, she deferred to the husband's hermeneutic—it must be on God's time—and agreed to allow the compressions to continue another four times.

Here we note an enormous tension here between hope, faith, and desire. On one hand, the husband's faith in particular is unwavering, yet on closer inspection, the situation is a bit more complicated. The miraculous outcome is supposed to be on God's time, yet when resuscitation doesn't stick, they determine that it wasn't God's time and thus demand that the medical team continue its intervention. When the mother says "we said the seventh time will be for God to decide," we see the tension between their own desire for control over the situation and their determination to allow the transcendent to make a decision for them. A religious critic could well

argue that the parents are in fact testing God, as well as engaging in a sort of idolatry: they want to trust a deity that agrees with what they want, that does their bidding, and that sees the situation as they see it. They want their daughter alive and healthy and expect their God to come through for them.

Yet why seven times? Seven is a sacred, symbolic number in Christianity, and so it is understandable that they might pick this as the number of times to attempt physical (i.e., mortal) intervention. But why not 3, 12, or 40? These are also numbers of religious significance. I suspect that seven represented an unconscious mix of the religious and the biological. Religiously, seven iterations gave the parents enough opportunities to demonstrate their trust in the divine—who could realistically accuse them of a lack of faith after so many attempts?—and also acknowledged the historical nature of many significant biblical events of divine intervention and physical victory/healing, perfection, or completeness, particularly after humans repeat a certain act seven times.[32] Biologically, the parents realized that neonatal interventions are complicated scientific phenomena that often require successive interventions/modulations to find success, and so in a biomedical culture that prides itself in always having one more test, one more experimental drug or procedure, the parents may well have been encouraged—if not led—to believe that the final attempt was always further from the present than closer to it. Such optimism, however, can come back to haunt both the medical staff and the family in cases such as these. I shall not attempt to answer the pressing bioethical appropriateness of such an intervention but simply note the potential difficulties that arise when scientific and religious zeal—or is it desperation?—collude in moments of crisis.

There is another significant matter here: the chaplain has said almost nothing to this point. Particularly in light of the fact that she arrives after the multiple codes, she does not criticize the parents for their beliefs, nor does she attempt to convince them to alter their theology or their actions. She sits and offers words of support, as well as the occasional practical clarification regarding hospital protocol. For her, the primary tasks of the hospital religious figure in this drama are not to direct or demand but to console and facilitate. The chaplain offers a familiar, trusted, and stabilizing presence that embodies the pastoral, nurturing, and even grieving sides of the divine. By contrast, the parents' own pastor takes the lead in prayers for resurrection and embodies dramatic interventions, the spiritual equivalent to a medical code team. When the mother says, "Those doctors are going to be so scared … when she rises. I never lost faith you know … even now," the chaplain responds softly, "I know, I know."

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[32] Examples include Genesis 1, Genesis 7:2, Genesis 41, Leviticus 23:15-16, Joshua 6:1-16, Daniel 9:24-27, Matthew 15:32-39, Acts 6:1-7, Revelation 10:7.

Once again we see a distinction between talking and listening. The chaplain validates and bears witness to the mother's beliefs and her confession that her faith is still strong. She agrees that the faith is still there yet declines to make a comment regarding a resurrection, suggesting a neutral stance to the question of revitalization or the possibility of post-mortem supernatural intervention. The chaplain is in a unique—though in terms of the hospital culture, entirely familiar—position: the family believes one thing about metaphysics; she is not theologically in agreement with them but supports them nonetheless and does not want in any way to be a hindrance to their beliefs. She embraces the persons while remaining outwardly noncommittal regarding preternatural phenomena.

This is *not* to say that the chaplain is playing the charlatan. She does not reject the possibility of such a divine act but rather does not expect it (and certainly makes no claim to such power in her own right), and she does not want to encourage the family to expect it, lest she be accused of stoking false hope. One could argue that the chaplain is situating herself shrewdly: if a dramatic reversal happens, then she can rightfully celebrate with the family, but if not, then she has shielded herself, and ostensibly also the divine, from accusations of chicanery and impotence.

That said, it's difficult to know what the family thinks about the chaplain's ambiguity regarding the resurrection beliefs. They clearly respond well to her on a pastoral level, and they welcome her as a sincere, caring figure. There is no indication that they think less of her because she does not join them in their prayers for resurrection, nor do they ask her to do so. They know that she is an interfaith minister, someone from a different religious tradition, yet they are comfortable working with her and do not see doctrinal differences as a hindrance to the enactment of their own religious practices or the illocutionary force of their prayers. She is, most likely, a sort of hybrid in their eyes: a genuinely compassionate person for whom religion is a central component of her own life, as well as someone on the hospital staff with whom they can talk openly about their religious concerns without fear of dismissal, condemnation, or pathologization. However fervent the family may be about the correctness or fullness of truth of their own religion, there is something about this chaplain and this setting that allows them to make space for her. I see no compelling justification for the claim that they are simply humoring her or feigning civility, only to deride her behind her back: they have requested her ongoing support, going so far as to ask her to drive to the hospital on a Saturday in the middle of winter to be with them during the most turbulent moment of their daughter's life.

The mother continues: "I really believed that she was going to be ok, no matter what they said to me, I knew I was going to take her home. God has a purpose for her life … one of my friends

from the Church, they had a dream that she was a teenager and she was singing in the choir. Come on baby, come on …"

One could easily argue that such a statement reflects a combination of denial and wishful thinking. Given enough human faith, it seems, supernatural power may reverse the infant's terminal bodily malfunctions and will restore her to health. Not only will she live but, more dramatically, she will survive infancy into childhood and adolescence, singing her praises to God as a testament to divine intervention.

This statement adds a number of additional insights into the nature of the transcendent in the hospital setting. Perhaps the most significant of these is teleology: the mother believed that the infant's life had a divinely ordained purpose. We can infer that her desire for her daughter's resurrection meant that that purpose had not yet been fulfilled in her eyes—there was more that the daughter, as a living, embodied person, was to accomplish on earth, rather than as a memorial device, say, or a gift that had already fulfilled its purpose, despite the brevity of the lifespan. The dissonance between the mother's sense of purpose for the infant's life and the failed resuscitations magnified the role of the divine in this moment: this can't be all that there is—there must be more.

The chaplain paraphrases the mother's next comments: See that book over there? It was written by a woman who nearly died as an infant. She shouldn't have survived, and yet here she is, living as a vibrant, healthy adult doing great things for the Lord. And my parishioner's dream—this too is a sign from above that today is no day for a funeral. There is to be no mourning today: today shall be a miracle, an awesome display of God's power and majesty.

Is it irrational for the mother to interpret the book and the prayer as prophetic utterances? According to her belief system, the answer must be *No*. True, the book could be dismissed as fallacious induction: the daughter is sick; the mother reads a book about a person in a similar situation recovering and then extends the outcome of that tale to the present situation, believing that it is a sign of divine presence and divine intent. Yet why did this book appear in the first place? Was it truly wishful thinking on the part of the mother, a sign of desperation and the need for hope, or did she indeed come into contact with the book through some sort of supernatural agency, in which case its words could be logically viewed as divine speech? Unfortunately, we are not told more about the way in which the book made its way to the hospital room and so cannot draw firmer conclusions about the presence or absence of some divine message here.

The friend's dream is more difficult to dismiss, however. Dreams have long been seen as communications from beyond, as portals onto other worlds and as mediums for supernatural communication, in Christianity and a great many other religious traditions. For the chaplain, the task

here is not to attempt to validate or invalidate the etiology of the parishioner's dream, but rather to note that the mother interprets it in a way that favors her cause and that provides additional, ostensibly independent, evidence that God is at work. For the mother, such a dream in the mind of someone from her church family could be viewed as spontaneous, unrequested information from the divine, a communication that both prognosticates and instructs.

Similarly, one could say that the presence of the chaplain, the parish minister, and the other church members in the hospital room also embody the transcendent. The issue for the mother is thus not whether or not God is present; God is indeed present for her in a variety of objects and persons, conveying messages of hope and communion and animating the space with a palpable sense of the supernatural.

Crucially, however, there is one place where the divine does not seem to be embodied: the infant. This is the one space that appears to be void of a transcendent spirit; it is a site of negation. Because the daughter's spirit appears to the family to have departed, the body represents death. Its purple and jaundiced hues and putrid discharge symbolize the antithesis of all that is holy, and the dialectic that it generates with the rest of the room makes the gap between sacred and profane that much more pronounced.

Indeed, it is the mother that raises the therapeutic bar in this space: it was she who lay down the challenge: biomedicine cannot save this child, but she believes that her faith and her God can such that all who doubt will be humbled and afraid. This situation thus becomes not only a question of an infant's recovery, but more importantly, a competition between two seemingly opposed therapeutic paradigms, Christianity and biomedicine. I say seemingly because the division has never been neat or total in this case: the parents sought out biomedicine—these were no Christian Scientists—to aide their daughter in her distress, and so long as the daughter was alive, it could be ontologically and therapeutically consistent with their religion and could even be a tool of divine intervention.

When it could not resuscitate the infant, however, it became an enemy, a false religion separate from the true faith of Christ. Biomedicine was thus semiotically and phenomenologically contingent upon its ability to generate a specific desired outcome, and so long as it could achieve these ends, it embodied sacred healing. As soon as it could not, however, it was exposed and judged as fraudulent; it was not a divine instrument but a human one (or worse). The parents were no longer bound by its edicts, no longer caught under the biomedical gaze.

Indeed, what we see in this situation is a sort of reverse gaze, as biomedicine is placed under the watchful eye of an alternative system of authority and cosmology. This religious gaze[33] judges the validity of the biomedical system on its outcomes and can be seen both as a cultural critique of clinical medicine and as a gauge of divine presence or favor: if it works, then it embodies the spirit of the divine and should be honored as such, but if not, then it is a false prophet, a profane paradigm, and should be ridiculed accordingly. Such a paradigm creates a rupture in the culture of biomedicine, a discontinuity between thought and action, by raising a dilemma that the system seems at first pass unable to accommodate within its explanatory framework.

Or does it?

Once again, a consideration of the role of the chaplain may provide us with some clues to resolve this tension. Such demands from the parents, from the culture of Christian religion and the broader lived culture in which the hospital operates place the chaplain in a curious position: she is *in* the biomedical system, but is she *of* it? Is this religious leader part of the problem or part of the solution? Here too we see the ambiguous, intermediate nature of chaplaincy: she is present in the room, an important part of the therapeutic drama, a person familiar and respected, yet someone on the fringe. She is not asked to demonstrate her allegiance to one system or the other; the family does not quiz her on her views of the doctrine of resurrection.

The problem of metaphysics, however, remains unresolved. Does the chaplain represent a valid form of the divine, or has she been co-opted by science, a false practitioner posing as the real thing? Or is she something else, a mediator in a new sense of the term? I argue that this intermediate position represents a third pathway, an alternative to the all-or-nothing concept of embodiment suggested by the mother's stance. The chaplain's words, affect, and presence suggest the possibility of a different sort of divine activity, a different phenomenology altogether. Her role rebuffs the question of the religious validity of biomedicine as a therapeutic modality, just as it challenges the notion of divine absence in the body of the dead infant. Because the chaplain is present in the worlds of both the hospital and religion as an embodying figure, her continual presence presents the possibility that the divine too has been present in the infant's therapy and continues to be so now, in death as in life. I do not mean to suggest that the chaplain provides a shift from a literal to a metaphorical rendering of either transcendence or therapy, but rather that it opens up additional hermeneutical options. Just as divine presence can take on new possibilities through the role of the chaplain, so too can notions of therapy and healing.

[33] Not to be confused with the transcendental eye.

Shifting back to the hospital scene, the mood shifts as another friend enters the room. The mother introduces the chaplain to the friend, who is clearly glad to meet the woman about whom she has heard so much. Her response is fascinating: "God placed a burden in your heart for [the child]. God bless you." Initially, the chaplain rejects the notion of her work as a burden and describes it instead as "an honor" and "a blessing," yet the mother corrects her and explains it as a positive expression used in their religious culture outside the hospital to describe a situation in which an individual, through an openness to the work of the divine, receives an inner sense of compassion, of concern—commitment—for another human being in distress.

This trust and sense of the chaplain as a divine emissary can also be seen in the mother's act of allowing the chaplain to hold the infant, bequeathing the baby to her for a time after cradling her for hours on end. Such a move can also be read as a symbolic act of delivering the infant to God, of letting go. By giving the baby into the chaplain's arms, the mother is physically able to regain movement: "it's been hours she's just been sitting there holding her," a friend noted with a sense of relief. It also represents a psychological and spiritual reconsideration of the situation: the mother is not abandoning the baby; she is not being a negligent parent; she has not been an irresponsible Christian. The chaplain's bodily acceptance of the infant is an act of mutual recognition by a fellow mother and, I daresay, an act of absolution. Likewise, as a religious figure, the chaplain's act of receiving the mother's great burden holds therapeutic potential. It suggests that the child will not be abandoned, discarded like a sack of biological waste. No, this child belongs to God, and God, the paradigmatic parent, has received her. She is loved—cradled—by the divine on multiple levels: just as the chaplain holds the baby's body in her bosom in the hospital room, the divine spirit simultaneously, and literally, holds the baby's spirit in heaven.

But we get ahead of ourselves. The drama continues for several more hours, as additional family and friends arrive to support the parents. While the human dialogue continues in the room, the chaplain tells us that "I just keep praying and somehow the transformation is happening—there is beginning to be a silent change in the room—acceptance is beginning to dawn. The miracle is being redefined" as she sings along with the family to the "music of praise, faith, and devotion" CD that the mother has played throughout the treatment process.

There are several key points here. First, we see that the chaplain relates to the transcendent vis-à-vis the patient's family on a number of levels: as representative, instrument, intercessor, interpreter, fellow human being and object of the divine, but also as an independent person with agency, her own set of emotions, and her own desires and longings. The chaplain indeed longs for good to happen, yet because she works in the hospital culture, she is also keenly attuned to issues of

time, progress, and closure. As part of the pediatric palliative care team, her continual exposure to the death of children of families with strong religious convictions has inculcated within her a certain outlook about the religious acceptance of death. If there is to be no physical miracle, she is nonetheless adamant in her desire for a sense of spiritual calm and emotional acceptance for the parents. The effect is subtle but extremely important: the issue here is not one of rejecting superstition for rationality but of seeking a way to allow both realities to coexist in a meaningful way within the clinical culture, in light of the death event.

Second, and equally significant, is the cognitive and spiritual process of working through the unsuccessful resuscitations for the family. At some point in the singing and praying process, an uncle asks the chaplain to step out of the room with him. He wants to know "what has to happen," and the chaplain gives him practical information regarding funeral homes and the transfer of the baby's body from the hospital in preparation for burial or cremation. She states in her notes that the uncle "is sure that they don't have a funeral home" because the parents "have been planning for a resurrection." He is aware that the family will have to leave the hospital at some point but isn't sure how to persuade the mother to leave. He consults with the father and then returns to the chaplain, saying that the parents want to spend a bit of time alone with their daughter in prayer before inviting the rest of the group to rejoin them for a final reflection.

After everyone reconvenes in the room a final time, the mother places the baby in the arms of the chaplain sitting in a rocking chair. Slowly, the family files out of the room and the hospital, having decided upon funeral arrangements. The chaplain explains that she expects the nurses to enter any moment to tend to the body and the room, but no one comes for some time, and so she continues to sit in the chair, gently rocking the baby back and forth.

Discussion

Consider what it means culturally for the chaplain and hospital to receive the baby a final time. It is highly significant that an extremely busy hospital would allow a family to spend nearly twelve hours in an inpatient room processing their thoughts and emotions regarding the infant. Second, it suggests that biomedicine as an epistemological system is not threatened by such activities. Religious, spiritual, psychological drain on the chaplain? How does it feel for her to be put in this position, to be left holding a necrotic infant when everyone else has left?[34]

[34] Editorial note: While revising this chapter for thesis submission, I came across the following note that I had scribbled to myself and decided to include it for reasons not entirely clear to me:
"I must say that I find the process of writing up this case extremely draining, both mentally and psychologically. I know that there's more to say but honestly, I want it to go away. I want these people to go away and leave me alone. I want them all to go back to the U.S. and stop making emotional demands on me, the anthropologist. I

Can we speak productively of a function of religion, and particularly a function of the chaplain, in such an event? Yes, the chaplain assisted in the grieving process and in the ability of the family to achieve some measure of closure in the hospital space. Because the mother in particular entered the daughter's treatment process with a particular belief system, the chaplain ostensibly acted in a sort of preventative role, helping to provide some sense of psychological, religious, and emotional continuity in the face of rupture of both a social role (i.e., motherhood) and the apparent failure of both biomedicine and religion in a time of great need. The chaplain likewise provided witness as the living encountered death firsthand. At the hermeneutic level, the chaplain (and religion more broadly) helped the family to render a sense of gratitude for the life of the baby girl, brief though it was. The utilization of religion here made the life meaningful, as opposed to pointless or absurd. It made it something other than a random biological malfunction, a datum to blacken some statistical tail.

III. STEP-DOWN UNITS

INTRODUCTORY REMARKS

Introduction

In contrast to the other three types of units, this collection of hospital wards resists a straightforward connection with the social scientific literature on the clinical space, due to the wide variety of diseases present and the corresponding issues addressed. This sheer range of settings also corresponds to a much larger body of literature, thus making it practically impossible to summarize in a few sentences. Nonetheless, a few examples may help to orient the reader to some of the issues at hand. Hunt, for example, has studied issues of moral reasoning on oncology units (1998), while Mattingly has provided detailed analyses of narrative and other aspects of physical and occupational rehabilitation floors (1998b). A number of researchers have studied obstetrics and gynecology units in the U.S. and elsewhere (e.g., Sesia 1996, Davis-Floyd 1987). Less ethnographically inclined scholars have tended to analyze social issues on these units with reference to mental health topics such as fear, depression, and uncertainty. Examples of studies that parallel hospital unit divisions at my field site include pulmonology (de Voogd *et al.* 2009), geriatric neurology (Tsai *et al.* 2007), obesity (Jeffrey and Kitto 2006), immunology (Brown and Crawford 2009), cardiology (Somerville

remember the way we residents were all traumatized the first time around, and all of those memories are flooding back in the present, in my living room in Montréal. I don't need this."

et al. 2008), endocrinology (Rueda-Lara *et al.* 2003), rheumatology (Poiraudeau *et al.* 2006), and urology (McDade 1996).

Overview of the Units

This module includes a heterogeneous mix of inpatient units and is strictly my own classification system for purposes of this thesis. It serves as a catchall category for units that do not fall readily into other segments and reflects a wide range of conditions and treatments: general neurology, gynecology, inpatient physical rehabilitation, oncology, general surgery, obstetrics, bariatric surgery, infectious disease, and the epilepsy monitoring unit. Some are step-down units for ICUs and swap patients back and forth with these units as the condition improves or deteriorates. Other patients on these units are never moved to another unit. From a biomedical standpoint, it is a hodge-podge of conditions, but from the chaplain's perspective, it is a useful category in that it groups together dilemmas where the immediate threat of death is largely absent, where verbal communication is unimpeded by medical devices or pharmaceuticals, and where the length of stay is usually shorter than on ICUs, trauma, or psychiatry.

Physically, these are large units with 30-40 or more patients, multiple nurses' stations, and a mix of single and double occupancy rooms. They are not equipped to house ventilators, dialysis, or other advanced technological interventions. Most patients are mobile, and few have dietary restrictions. As a result, the long, straight halls are typically busy, noisy thoroughfares. Medical residents, nurses and nursing assistants, janitors, food services, personnel, lab techs and phlebotomists, visitors, social workers, and others crowd the hallways, navigating between spare gurneys, dirty laundry bins, medication trolleys, portable x-ray machines, patient trays, crash carts, and other paraphernalia.

Dynamics of Chaplaincy on These Units

Every resident is assigned at least one of these units. Pastoral needs and requests reflect this diversity, though apart from oncology and obstetrics, death is rarely an imminent threat, and so senses of existential angst are typically not as acute. Visits tend to be shorter than those on the three other types of units and generally focus on the patient, though there will sometimes be conversations with family and friends as well.

CASE 7: THE ATHEIST AND THE INTERFAITH CHAPLAIN

Background

Charles Harrison is a 47-year-old male with a diagnosis of stomach cancer with bone metastasis. His religious affiliation was listed as unknown. When the chaplain reported to the floor,

she inquired of one of the nurses whether she might visit Mr. Harrison. As she approached the patient's private room, she noticed that the doorway was blocked by a sophisticated electric wheelchair. Looking through the open door, she noted that the room was markedly devoid of personal possessions; she saw an attractive young woman operating a mechanism to lower a hoist towards the bed. The hoist supported a sling in which the patient was suspended. The woman seemed to be in her mid to late twenties; she had long straight brown hair pulled back in a careless ponytail and a pierced nose, her clothes were casual and slightly shabby. She had the air of a student and the chaplain's first thought was that perhaps she was the patient's daughter.

Fortunately, the resident knew not to verbalize such assumptions and learned that she was in fact his wife. She hardly spoke during the chaplain's visit, aside from a few words describing the dampness of another sling that had been used perhaps to shower the patient. In this brief exchange, which was uttered sotto voce to her husband, she detected an Eastern European accent, perhaps German, but more likely Russian.

The wife noticed the chaplain's arrival at the doorway but did not acknowledge her presence, merely continuing her work with the hoist. Standing outside was an IV pole with a large piece of white paper taped to it and handwritten block letters with the patient's name and "EPIDURAL" written on it. The chaplain knew that this meant that the patient was in significant pain.

Once the wife finished her arrangements, she beckoned the chaplain in but turned away as soon as she started to speak and began to adjust another sling.

The Encounter

Chaplain: Hello, Mr. Harrison? My name is Siobhan Powell, I am one of the chaplains here, and I received a note that you might like a visit?

Patient: Come in, so someone thinks I need a chaplain? Melinda—someone thinks I need a chaplain. (The patient was very well spoken and seemed intelligent.)

C: Oh, well I am not sure that it is a case of needing, perhaps they thought you might like a visit. Certainly chaplain visits are not mandatory, (smiling) and you are not under any obligation to see me!

P: It's ok.

C: Perhaps this isn't a convenient time for you to have a visitor …

P: No, stay.

C: How are you doing?

P: I'm fine, my mind is fine.

C: Well, Mr. Harrison, I don't know exactly what has been going on with you, is there anything you would like to share?

P: I have bone and prostate cancer, I am dying, and it is taking too damn long. (I nod in acknowledgment but allow silence to respond to this remark.)

C: How long is that?

P: Three years. (He has freckles and a tan, his cheeks are full, his eyes bright. I am really struck by the fact that he does not look like a man who is dying.)

C: You look well …

P: Do you hear that, Melinda? Someone thinks I look well. (He laughs bitterly. It feels increasingly odd that Melinda and I have not been introduced; I think of a way to find out who she is.)

C: It looks like you have some wonderful support here.

P: That's Melinda, my wife. She's a saint. I think she maybe needs a chaplain … (Melinda turns abruptly to look at him). Maybe not. (silence)

P: (to wife) Is it dry?

Wife: (speaking very quietly) There's a couple of places, here and here.

(silence)

C: Do you have a faith tradition that you belong to?

P: I'm an agnostic.

C: I'm an interfaith chaplain.

(silence)

P: I have had a couple of seizures and that was terrible. But, but I'm still here …(he trails off and plucks at the sheet distractedly)

C: And you are ready for this to be over? (He looks at me. For a moment, his expression is unfathomable, and then his face crumples.)

P: (a strangled cry escapes his lips) Melinda … Melinda … (Suddenly she is at his bedside. He buries his face in her chest; she wraps her arms around him, gently kissing his neck as he cries. Then she looks up at me and silently waves me away. I retreat from the room.)

Chaplain's Reflections

This chaplain was particularly frank about her choice of this case for presentation. She explained that her first instinct upon encountering a patient with a visitor was not to attempt to call at that time, because she believed that "the most fruitful pastoral interactions require privacy."

Nonetheless, the first two patient visits on her list of three had not gone well in her view, and the fact that she needed to present something to the group the next day made her determined to extract a conversation from the visit. The result, in her eyes?

> I left that room absolutely mortified by what I feared was a catastrophic pastoral encounter. I pride myself on being tremendously sensitive and yet it appeared … that I had reduced my patient to tears and then been told to leave … it was destined to be ignominiously immortalized for posterity as a verbatim, to be presented to my new supervisor and new peers. This was not the glowing first impression of competency I had intended to make.

Despite this lengthy confession, she was able to provide some analysis into the inter-action. She explained that she was unnerved by the wife's affect of disapproval and initially felt significant guilt for what she perceived as a therapeutic error on her part. Back at the computer, however, she revised her initial interpretation and realized that the patient's tears were not necessarily a bad thing and that they "smacked of denial and suppressed anger rather than a true admission of readiness or impatience for death." She acknowledged the ambiguity of entering a patient's room as a religious specialist without an invitation and suggested that, in the future, she would not proceed "without more information in this respect."

Religiously, she explained that she thought that her identity as an interfaith chaplain might have been helpful in offering pastoral care to an agnostic patient facing death, "as it perhaps implied an open mindedness," but it was unclear to her whether or not this was the case. From her own perspective, she said that she "would like to have more faith that even when an encounter does not [go] according to my agenda, or feels unfinished to me, that perhaps it is still in accordance with [a] divine plan." Such a comment marked both a desire for humility and a tentative recognition that as a hospital chaplain, she might not herself be able to see the effects of her interventions and would have to choose whether or not to believe that such work as hers fit into some larger cosmological plan.

Group Discussion

The group appreciated their colleague's honesty regarding her struggles with this case and agreed that it was a challenging encounter, particularly for a new resident. They applauded her ability to discuss the emotions present in the case, and several confessed that they too saw the place of religion in this case as problematic, in effect admitting that while religious principles such as hospitality and patience could be useful in providing her with a useful ethic for interaction, discourse about religion itself, at least in the early stages of such an encounter, could easily be unproductive.

One of the more experienced residents suggested that recourse to theological jargon with anyone contemplating death could be inappropriate or threatening and could easily exacerbate underlying fears of nihilism associated with an unknown future. Instead, he suggested a number of strategies for trying to keep the conversation open. Another seasoned chaplain agreed and also cautioned against the urge to be liked by family members, to try to feel relevant, or to attempt to minimize the distance between the patient and herself, thus suggesting that the work of chaplains may at times appear unrewarding or unpleasant for the resident yet may nonetheless prove useful in some fashion for the recipients of care.

CASE 8: TAKING SIDES

Background

Just after morning report, one of the residents received a referral for a patient on one of her floors by the patient's nurse. She consulted with the nurse and learned that Sandra Williams had been very fearful. She would not take her medication or follow any other instructions she was given. The nurse, it turns out, thought that the patient had post-operation depression. The resident soon realized that she had been called essentially to convince the patient to comply with the prescribed regimen.

The resident entered the patient's room not knowing what to expect. She was lying on her bed when the chaplain entered. A smallish woman, she looked quite feeble and wore anguish on her face. She had gorgeous red and white roses by her window and two get well cards on her table. According to the resident's notes, it was unclear whether the patient was unemployed or was a housewife. The patient has three children.

The Encounter

Chaplain: Hello, Sandra (I draw the chair close to her and sit down. I place my hand on hers), I'm back. Sorry it took me so long to come back for our visit. But I'm all yours now.

Patient: Thanks for coming back.

C: So how are you doing today?

P: I just want to go home.

C: Can you tell me why? (I knew that she just had her surgery the day before.)

P: I am so scared of this place.

C: What makes you scared about this place?

P: I am scared of hospitals. I want to go home.

C: What about hospitals make you scared?

P: The whole place. It just makes me sick. The smell and everything.

C: What kind of smell?

P: The smell of death.

C: What is it like to smell death?

P: Horrible. It is such a horrible feeling. The last time I was in a hospital, I almost died.

C: Hmm. So you are frightened you might die every time you come to the hospital. That must be hard for you.

P: It is hard, and then the nurses would get angry and shout at me because I did not want to do what they told me to do. See, the medicines only made me get sicker. So I refused to take them.

C: Makes you feel helpless and not understood, eh?

P: (she nods) I feel very lonely too. There are these people around me but they are different.

C: I can understand a little bit of that myself. Sandra, I am not too fond of medicines and hospitals either. It is good to know, though, that as Christians, God promises to be with us all the time. He holds us and puts his arms around us (pause, I can see change on her face). Do you know Psalm 23?

P: Yes, do you want to say it with me? I like that psalm.

C: Sure, we can say it together.

P and C: The Lord is my shepherd, I shall not want,
He maketh me to lie down in green pastures;
He leadeth me beside the still waters.
He restoreth my soul;
He leadeth me in the paths of righteousness
For his name's sake.
Yea, though I walk through the
Valley of the shadow of death,
I will fear no evil, for thou art with me;
Thy rod and thy staff, they comfort me.
Thou preparest a table before me

In the presence of mine enemies.
Thou anointest my head with oil;
My cup runneth over.
Surely goodness and mercy shall follow me
All the days of my life
And I shall dwell in the house
Of the Lord forever.

P: (pause, sigh) That feels good. (pause)

C: What feels good?

P: God is with me.

C: Feels good, eh? I know it feels good to know he is with us all the time. Both in good times and even at times when we feel horrible.

P: Thank you chaplain. (In walks her nurse to give her her medication. She is in pain and it is a Tylenol, but she refuses. There is an exchange for a time that goes nowhere, and the nurse is about to leave in frustration. Though I had kept quiet all the while I knew I had to intervene.)

C: Mrs. Williams, would you promise me that when the pain gets bad you will call the nurse?

P: Yes, I will.

C: (to the nurse) Thank you very much Jane. (she leaves)

P: See, I told you. They don't believe me when I tell them the medicines make me sicker.

C: Sandra, they just don't want to see you in so much pain. (At this point I can see the expression of pain on her face.)

P: I know, they even want me to go walking already. I told them I can't. But thank you for your concern.

C: You're welcome, and if there is any other way I can help, don't hesitate to ask for me. And don't forget my promise to call the nurse. (Smiling and standing up)

P: I won't forget.

C: Have a good day, and may you continue to feel God's presence with you.

P: Have a good day too.

C: Thanks.

Chaplain's Reflections

In response to the discussion question about how this interaction illustrates themes from her own religious heritage, the chaplain paraphrased a passage from the Christian Bible. For her, "the God of all comfort who enables us in our times of distress helps us who have gone through it to help others who are going through the same things."[35] This answer is extremely significant, both for its form and its content. It interprets a sacred text as literally and completely true for all persons and times and attempts to fit the clinical encounter into it based on her own life experiences. For her as chaplain, the interaction with the patient was metaphysically empowering; God had helped her in the past and was now utilizing her to bring strength and comfort to another.

The chaplain also elaborated in her notes on her interaction with the patient's nurse. The nurse had told her, "I can't get this woman to do anything; could you go in there and get her to take orders?", yet the resident said that she felt uncomfortable in that role because she did not want the patient to see her as "one of people who came to her room just to force her into doing what she did want to do," though the nurse was glad for the chaplain's intervention. This nurse subsequently spoke with the chaplain and explained that the patient "called for her as soon as I left; she took her medication and even went for her walk" and was discharged the next day.

Group Discussion

Several of her colleagues voiced skepticism to her interpretation of the events. Even at the level of literal interpretation, this position raised questions for them.[36] Why, they wondered, did the chaplain seem to assume that this patient's experience was the "same thing" as her own? It seemed to one that either the chaplain was not interpreting this part of the text literally or viewed affliction in such a broad, generic way as to undercut completely the nuances of this patient's situation. Second, they were unclear what exactly it meant for her to claim that God was helping her, for this seemed to be a problematic view of theological anthropology.[37] Third, from a therapeutic standpoint, they were

[35] II Corinthians 1:3-6

[36] Though not discussed explicitly during the discussion period, the resident's widespread appeal to sacred texts raises the enormous issue of competing exegetical methods in clinical affairs. The chaplain was highly intelligent and was no doubt aware of the range of interpretative tools, from form criticism to canonical criticism to translation issues in the original Greek text, which she could have applied to this passage even if she wanted to retain the Bible as the primary reference point for the encounter. Likewise, she surely knew something about the cultural dynamics of the fledgling church community in Corinth in the context of the ancient Roman world. In effect, she is aligning herself here with the author, Paul, who has been critiqued in recent years by feminist theologians and others for decidedly paternalistic sayings about women and their place in society (see e.g., Schüssler-Fiorenza 1994). Some will not doubt see this decision as ironic, in no small part because Paul himself would not likely have thought much of an ordained black woman or her paraphrasing of utterances ascribed to him.

[37] Theological anthropology is a branch of Christian theology that deals with questions about human beings in relation to the Trinity. It should not be confused with the anthropology of religion.

confused by her notion of a supernaturally enabled patient in distress and what such a person might look like or do. A final question from the resident's reflection concerned her understanding of the concept of "empowerment." Was this simply a synonym for endurance or perseverance, at the level of the physical body and/or in terms of spiritual or psychological strength?[38]

The broader concern here was the resident's appeal to the Bible as the sole reference point for her interpretation of the clinical encounter. This chaplain grew up in an evangelical household and attended a conservative Reformed seminary that stressed the absolute centrality of scripture in human affairs. Rather than looking to theological texts, church teachings, or her own personal life experiences—let alone the role of culture—the Bible was for her the chief interpretative tool in her work as a religious specialist. She believed that it contained everything necessary to guide the human soul in life and in preparation for salvation after death. For her, the Bible was never coercive but was "God's gift," an instruction manual and enchanted object that manifested the transcendent through human utterances. Neither she nor the Bible would, in her view, force the patient to do what she did not want to do, despite her exhortation for the patient to call the nurse when in pain and her subsequent discussion with the nurse about compliance. In her words, "I think the reciting of scripture together was appropriate in this encounter. Just because though I had mentioned it, I was only going to talk about it but she actually wanted to recite it. Since that was her agenda, I think it was appropriate." The chaplain appeared to realize that she might be questioned by her peers about her use of the Bible as a clinical methodology and so sought to pre-empt such a response in her write-up by explaining that she was simply fulfilling the patient's wishes, despite her own very deep love of the text and desire to incorporate it into her work whenever possible.

This clinical approach was problematic for them for other reasons. The words were familiar, and it was clear to them that their colleague was sincere in her use of them, yet they seemed somehow awkward, or perhaps facile. One noted that the patient appreciated the psalm recitation and agreed that in some cases, the act of verbalizing a familiar, comforting passage of scripture in a frightening place can indeed be reassuring to the sick and may relieve some stress.

At this level of religious discourse, however, there were a number of concerns about what was said. One colleague criticized her for the extensive use of declaratives rather than interrogatives;

[38] Several biblical scholars translate the word ὑπομονή in verse 6 as cheerful/hopeful endurance or patient waiting amidst various forms of bodily and social hardship, a reading that would throw the entire clinical conversation into question. Is the patient supposed to endure pain cheerfully and reject biomedical interventions? Her rationale for not taking the medications is that they make her "sicker," a term which may well mean that she saw them as contraindicated but which could reflect a belief on her part that it is God's desire that she experience at least some of this suffering. By following the suggestion of the chaplain and accepting the pills, she could ostensibly be rejecting a divine plan for her or overriding a supernatural exhortation.

this approach reflected assumptions about what the patient was experiencing and assumed a rather dogmatic theological stance—of course God is here—rather than asking the patient to describe her sense of divine presence and to discuss its implications for her current predicament. That is, it presumed that the mere verbal acknowledgment of supernatural proximity would be adequate therapy in its own right. Another resident suggested that such topics should only enter an interaction once a relationship of trust and credibility has been established with the patient, yet a colleague countered that the "relationship first, testimony second" strategy doesn't always work; for some patients, he suggested, credibility could only come as a result of such ritual or formulaic devices.

Still, the group found the clinical interaction notable for what it did not address, namely the patient's concrete problem of bodily pain within the context of biomedical staff relationships. The presenting chaplain explained that she interpreted the main issue for the patient as fear and acknowledged that she was in too much of a hurry to move on to other patients. Her peers agreed that this was an important insight into her own frame of being but wanted to push her further to understand why she seemed to avoid the specifics of this central issue. One gave concrete advice and suggested that she should focus on her own presence rather than statements of faith, thus implying that sacred words were only useful insofar as they were connected clearly to the lived realities that she was facing, rather than simply using them to gloss over the patient's interpersonal and physical challenges or to circumvent the possibility of her processing her concerns about mortality with the chaplain. Another resident challenged her to think about how, in future cases, she could help patients to explore the phenomenological dialectic between the experience of God and the experiences of pain and clinical intervention, particularly in relation to her own body, for it seemed to him that these two very powerful sets of sensations reflected common issues that were not discussed. In other words, he thought that there should have been an attempt to address the connection between biomedical and religious forms of pain management and to try to understand why the patient seemed to place them at such sharp odds.

In addition to the chaplain's own reflections, the group discussion left the impression that she was acting more on the basis of what she would have wanted from a chaplain in such a situation, rather than what the patient felt or needed. One peer suggested that while the presenter's desire not to make ethnic difference an issue in her interactions and to treat everyone equally was commendable, it was potentially naïve and neglected the question of what the patient thought about talking with an African female minister, thus reflecting a growing sense of importance for residents of cultural dynamics in pastoral contacts.

CASE 9: THE RIGHT TO WANT TO LIVE

Background

Jeanne Richter waves at the chaplain energetically through her open doorway on the intermediate medical intensive care unit (IMCU) and is smiling broadly following a double lung transplant. The chaplain has visited the patient three or four times before. During the previous visits, the patient was still in the early stages of recovery: disoriented at first, clearly weak, and very tired. The chaplain saw the patient briefly on another floor just after she had been admitted with breathing difficulties and requested a Bible from the chaplain. During the initial visit in the ICU post-transplantation the patient recognized her as the one who brought her a Bible. She has been extremely grateful for that small act.

During morning rounds, the staff talked about Jeanne's weakness/paralysis in her legs as being somewhat of a puzzle. Though she has been doing well, she has not had the strength in her legs to walk yet. It is two weeks since her transplant, and they plan to start physical therapy with her.

The patient spoke briefly of a husband and son during a prior visit. The chaplain has not had the opportunity to meet her family but finds herself wanting to know more about her support network. There are no personal effects in the room.

The Encounter

C: (walking in) Hi, Ms. Richter.

P: Hi Emily. How are you today?

C: I'm just fine, thank you. How are you?

P: I'm getting better, much better.

C: It is good to see out of the ICU. How is it going?

P: Yes, I am making progress. (pause) Do you remember I told you I want to donate some Bibles?

C: Yes, I recall.

P: I want to give back tenfold the gift you gave to me.[39] How should I do that?

[39] The patient may have been alluding here to Zaccheus' remarks to Jesus, "Look, half of my possessions, Lord, I will give to the poor; and if I have defrauded anyone of anything, I will pay back four times as much." (Luke 19:8) This meeting between a rich, unscrupulous "chief tax collector" (v. 2) and Jesus is usually interpreted as a confession, a form of repentance in which the sinner admits to his wrongdoing publicly and fulfills the laws of restitution prescribed in the Torah (see e.g., Exodus 22:1). It is unclear whether the patient's remarks are intended to be read simply as a thanksgiving offering or a confession of guilt (specifically, theft or unlawful accumulation) as well.

C: The Bibles came from the Gideons. They may be donated from the Gideons. You could either give a gift to the Gideons or to the Pastoral Care department of this hospital.

P: I would like to give them to this hospital if there is a way.

C: I am sure that can be arranged. I will find out how and get back to you.

P: Thank you, that would be great!

C: You know, it occurs to me. Just a couple of days ago, the Bible we leave out on a stand in the chapel turned up missing. Perhaps you would like to purchase a Bible that could replace that one.

P: Oh that would be perfect. Can you help me with that?

C: Of course.

P: See, I want to keep the Bible you gave me. It is really important to me.

C: How so?

P: It helped me in an area I was really struggling. I was … struggling with the verse where Paul says more than anything he wants to be with the Lord (I struggle to recall just where she is referring to), and I was wondering if I had the right to want to continue here.

C: To continue to want to live in this life?

P: Exactly. I asked for the Bible because I didn't know I was going to be admitted and didn't have one with me. When you gave it to me, one of the medical students was there. Because he saw that, he asked me what my favorite verse was. I told him I didn't know, there are so many. Then he shared with me a verse he likes— "But I know the plans I have for you," says the Lord, "Plans for good and not for evil … (pause)

C: ... to give you a future and a hope"—from Jeremiah—it is a great text. (I couldn't help but remember being given this same verse on a get-well card while going through chemo and it being meaningful.)

P: Yes, yes. And then later I couldn't remember where it was so I was looking for it and I came upon the verse from Jeremiah 28 (actually Jeremiah 32:27): "I am the Lord, the God of all flesh, there is nothing that I cannot do." I put these verses together. God is the God of all FLESH—and he plans for us to have a future. Then I knew it was okay to want be here.

C: For you to want to live.

P: YES! To want to live … I have you to thank! (Now that is a humbling thought—for the mere act of bringing a Bible.) The medical student saw you give me the Bible … then he felt free to share with me. You know, for a while they didn't know if they were going to be able to do the transplant. I was so sick, my liver was failing. They said they were going to move me off the list, well not off the list—but on hold, you know, to see if I could get well enough for the transplant. I wasn't sure. I just wasn't sure it was going to happen. I asked them to let me go home for Christmas—that I would come back after, thinking I wasn't on the list. My church had a prayer vigil for me—everybody went. It was so meaningful, so powerful. I went home on Saturday ... on Monday, I got a phone call ... "Jeanne, how are you today? We have lungs for you." The helicopter landed right in my neighborhood and I was at the hospital in 35 minutes. And now here I am!! New lungs and a new life.

C: You share an amazing story.

P: It has all been a miracle.

C: You are grateful for the miracle?

P: It is so wonderful. They didn't think they were going to be able to do it—and yet, here I am.

C: I am so glad you are doing so well now.

P: Thank you.

C: Would you like to have prayer?

P: Oh yes!! Please pray.

C: Besides prayer for continued strength and healing, what would you like to pray for?

P: For thanksgiving for my new lungs, and for the staff here and the people of my church.

C: Okay. Let us be in prayer. Loving God, we give you thanks that your plans for us are for a future and a hope. Especially today we give you thanks for Jeanne, for her faithfulness and strength. We give you thanks for the miracle of her new lungs, and for all who have cared for her during this process … the nurses and the doctors here, the people who have prayed for her, the medical student who shared with her. We ask now that you bless her with continued strength and healing so that she might return home and get on with her life. We pray all this in Jesus' name. Amen.

P: Amen. Thank you.

During the prayer I hear someone come in and then leave. I am aware that this person is waiting to come back in. So I look around to see and invite the man who is waiting to come in. At first I guess that he may be her husband, but it turns out that he is a friend.

Group Discussion

The final verbatim in this section introduces another discussion model, this one used in the spring quarter of the CPE program. Here, a resident presents the clinical interaction but includes no analysis of her own. Instead, she listens for most of the session as her colleagues and the supervisor each take turns responding to a set of questions by placing themselves in her position and in the patient's position and trying to say what they think that individual would have said in response to the question. They then respond to other questions in their own voices, saying what they as fellow chaplains consider key themes emerging from the visit. The goal is not simply one of wearing others' shoes but of helping the presenting chaplain to step back from the event and observe the interaction as an outsider, rather than as a participant.

Here are highlights from the classroom session, with questions in bold. Each bullet represents a different colleague's response to the question. I conclude with a brief discussion of the process from the perspective of the anthropologist.

Key Message of the Encounter (each couplet represents a different person in the classroom session taking the perspective of both the patient and the chaplain)

- Patient: Thank you for helping me to resolve the conflict of "Thy will" and "my will."

  Chaplain: I am humbled and happy for you.
- P: Having been so utterly vulnerable, I am grateful for big and small mercies that all seem to be rolled up into one experience of grace, and you seem to be someone who can understand such an experience.

  C: I do think I understand at least the tip of the iceberg, and I am humbled and inspired by such an encounter with grace.
- P: I'm so grateful for the miracle of the lungs and to learn that so many people like me…they really like me.

  C: I'm grateful too, to hear this patient's amazing story at this particular time of my life and chaplain experience.

- P: The past few weeks have been an overwhelming encounter of proximity with the divine, and now that I realize that I can and shall be here a while longer, I want to share this sense of nearness with others.

  C: I am so happy for the patient and am humbled/in awe of the ways in which the Lord works.

Dynamics of the Key Messages (Theories of Psychology)

- Mania and empathy
- Exuberant feeling and identification with patient
- Mutually reinforcing euphoria, reflecting a mixture of profound awareness and selective inattention
- Childhood joy
- Tempered, low-grade hysteria

Biblical/Scriptural Associations

- The parting of the Sea; the idea of being a seemingly hopeless situation and finding deliverance/the promised land
- Zaccheus and an offer of grace from Christ; a feeling of gratitude that makes her want to give back what she has received
- The role of Andrew the disciple, who was in the shadow of Peter, but at some critical moments recognized God's grace (especially with reference to the medical student who recognized the symbol of the Bible and then connected with the patient)
- Samaritan woman at the well, whose encounter with Jesus so energized her that she became an evangelist to her people(s)
- Magnificat, for both patient and chaplain—the idea that God looks upon the seemingly lowly and works with/through them in profound ways

Theological Associations

- Deliverance
- The intricacies of the will of God (plans for you/Jeremiah/Paul)
- Theodicy and community and human agency in God's intervention (framing the transplant as a question of theodicy—one person's gift is another's loss—how to reconcile? Community as one way to do so…)
- Child-like / mustard seed faith is honored as well as the provision of someone to rejoice with
- Soteriology and simplistic faith, and patient grace

Discussion

The first question tests residents' ability to distill patient encounters to one central, overarching message. They work to see both broad themes and narrative specifics at the levels of religion (e.g., grace, providence) and specific emotions (e.g., humility, gladness). Second, the topic of the dynamics of the visit borrows from theories in the psychology of religion to elucidate the overall tenor of the encounter. It is important in the sense of understanding how the chaplain impacts the phenomenology of the supernatural for the patient and how the human dialectic may generate a distinctive sense of community within the clinical space.

Third, the matter of scriptural associations recognizes the evocative power of the Bible and its imagery for chaplains as they go about their work in the clinical space. It is designed not for residents to attempt to find perfect parallels or reenactments in the text but motifs that connect the past with the present in order to get a sense of supernatural continuity with humans in moments of stress and hardship. When using this didactic methodology, residents often look for indications of divine faithfulness to humans and provision in times of need; they are not to scour the Bible for proof texts, although the possibility of data mining and other misreadings is evident, particularly in cases such as this one, in which the Bible is such a significant component of the pastoral visit.

Finally, the segment on theological associations emphasizes the clinical manifestation of key doctrines from the religious tradition under consideration. Residents look here to philosophical theology to categorize what they see as the dynamics of God at work in the chaplain's interaction with the patient, stressing how particular divine attributes are manifested in the biomedical space. Here the cohort noticed what was for them the refreshing and uplifting nature of a positive clinical outcome and the importance of giving thanks to God for healing through word and deed. They also noted the woman's epistemological struggle with her own desires in light of her sense of supernatural plans and the ways in which the two could come into dialogue in order to reach a greater sense of clarity and direction alongside biomedical treatments.

IV. PSYCHIATRY

INTRODUCTORY REMARKS

The inpatient psychiatric unit presents a particularly important set of unique issues and challenges for the chaplain resident, and as such, it offers important insights into the place of religion

in the modern U.S. hospital. Scholars of social medicine have long been interested in clinical mental health settings and have written about such topics as mental health and war veterans (Rivers 1924), patients as strategic actors (Goffman 1961), chronic psychiatric patients at the interface of inpatient and outpatient medicine (Estroff 1981), financial and space constraints as determinants of care (Rhodes 1991), the competition between psychoanalysis and pharmacological psychiatry (Luhrmann 2001), and the asylum as a social instrument designed to produce certain types of persons (Foucault 1965). The relationship between religion and mental health, meanwhile, is a mainstay of the subfields of transcultural psychiatry and the anthropology of religion. Here, researchers have shed light on such topics as shamanism (Eliade 1964), spirit possession (Lévi-Strauss 1963), exorcism (Evans-Pritchard 1976), charismatic healing (Csordas 1994), mysticism and psychosis (Obeyesekere 1981), and schizophrenia and organized religion in periods of social upheaval (Scheper-Hughes 2001). Here I am particularly interested in the enculturation of the Western religious specialist in a therapeutic unit struggling to find an appropriate balance between narrative and pharmaceutical modes of clinical intervention.

Overview of the Unit

This is a locked inpatient unit. It is smaller than in previous years, as more profitable units (notably cardiology) have reduced the number of beds available. As a result, there is no longer a separate geriatric unit; mood and thought disorders are also combined into this one unit. There is a mix of single and double occupancy (single-sex) rooms. Windows are glazed, adding to the unit's sense of separation from the outside world.

Socioeconomically, the unit tends to house more low-income and unemployed individuals from the inner city, as patients with better insurance plans typically go to more posh suburban centers. There is a modest amount of ethnic diversity here and an even gender ratio. Some are admitted for just a few days; others are present for several months before being discharged. The length of stay frequently reflects more the (excellent) social worker's challenges in securing long-term placements for patients than biomedical or social needs provided by the hospital. That said, there are a number of so-called "frequent flyers" who circulate between this unit, other locked units in the region, step-down units in the community, and other locations, such as a relative's house or the street.

Depending on the patient's condition, he or she may be expected to participate in a range of daily living and social activities coordinated by occupational therapy. The system reflects various levels of restriction and opportunity, depending on the person's current condition. Those on good behavior could get permission to go on chaperoned smoke breaks to one of the hospital's interior

courtyards. Patients on suicide watch, persons with psychotic tendencies, and those on disciplinary restriction remain in their own rooms or, in exceptional cases, in the padded cell,[40] whereas others attend group sessions throughout the day to promote social interaction, from cooking classes to board games. There is a strong emphasis on taking responsibility one's basic needs—getting dressed in street clothes, making the bed, grooming, and conversing with others. Still, there is a fair amount of unstructured time. Some had frequent visitors; others, none.

Nurses and occupational therapists are the most visible staff members on the unit. Physicians are rarely present on unit, except for residents in training. There is little talk therapy offered; the biomedical emphasis is strongly geared toward medication management.

Dynamics of Chaplaincy on This Unit

It is easy to get the impression that chaplains manage many of the counseling duties once managed by psychoanalytically oriented psychiatrists—listening, conversation, and mirroring in close one-on-one interactions. The resident also leads weekly spirituality discussion meetings for patients who wish to attend and discuss a general topic (e.g., love, hope, friendship, forgiveness) that is not specific to any one religion. It is designed as a forum for patients to talk, express feelings, desires, worries, and thoughts about world inside the hospital and beyond it, and to find points of common reference with other patients.

More than on any other unit, chaplains have close, frequent interaction with other staff members and routinely receive referrals from physicians. There is a general recognition among staff members that religion is an important factor for many patients on the unit and a willingness to turn to the chaplain as a legitimate, valued member of the therapeutic team. Residents consult medical colleagues to get a sense of the patient's condition in general and to be on the lookout for recent changes in medications that may impinge upon their ability to communicate.

CASE 10: NOT QUITE ON THE SAME PAGE

Background

Judy has been a patient on the inpatient psychiatric unit for some time. On her chart, she identified the following members of her family constellation and significant relationships: her mother, who recently committed suicide; her father, who recently experienced a heart attack; her brother, who was recently killed in Iraq; her fiancé, who was recent diagnosed with a liver disease; and her brother's children. The patient comes from a middle-class background. She reported that

[40] To my knowledge, the cell was used only once, briefly, during my two years of fieldwork.

her mother was a psychiatric nurse, and the patient is a medical laboratory technician. She is presently experiencing depression, auditory hallucinations, self-harming ideation, and troubling dreams.

The patient's religious background is Roman Catholic. She reports that she is not particularly observant but that her religious formation significantly influences her worldview.

The chaplain met privately with the patient in her room, with the door ajar. She is neatly groomed, dressed in street clothes and house slippers and sitting on her bed. She presents a friendly, attentive affect. She requested this pastoral visit to discuss her concerns around her mother's suicide. One of the staff nurses introduces the chaplain to the patient and then returns to her duties.

The Encounter

Patient: I have some questions that I need to ask you.

Chaplain: (pulling up a chair to the bedside) OK, I'll try to help you find some answers.

P: There's been a lot going on lately. The main thing is that my mother killed herself. But before that my brother was killed in Iraq. And my father had a heart attack about a week or so after my mother killed herself. I've been having these dreams that my mother is in Hell because she killed herself. And she's coming to me in my dreams and she's angry at me and she's telling me that I should hurt myself.

C: That's a tremendous amount of pain and loss for any person to experience. To get us started on your questions, let's see if I can help you understand how Christians generally look at suicide.

P: OK.

C: Christians understand that going to Hell means being cut off from God forever because of our own choices. For an action to be serious enough to separate us from God, we have to know that the action is wrong and we have to choose to do it anyway. And we have to have the freedom to make that choice. If you decide to punch me in the nose, and you know it's wrong and you choose to punch me in the nose anyway, then that's a sin. But if someone puts a gun to your head and tells you that he's going to shoot you if you don't punch me in the nose, and you punch me in the nose because you're afraid of him, then that's not a sin because you didn't have a free choice. When it comes to suicide, people usually don't have a lot of freedom. Most people who commit suicide aren't thinking clearly because they are in so much

physical or psychological pain. They just want the pain to go away and they can't see any way to get rid of the pain except to end their lives.

P: After my brother was killed, my mother said that the pain was just too much. Every time she looked at his kids, she was reminded of him and how he was gone. It was just too much for her.

C: That's what I mean about the pain getting to be too much. We Christians believe that persons with a long-term or short-term mental illness are sometimes not able to make free choices or good choices. Suicide is definitely not a good choice, but the person who kills herself is usually not able to make good choices because of the pain.

P: My mother was a psychiatric nurse for years. Maybe we didn't pay enough attention to her after my brother was killed. We thought that she would know how to take care of herself.

C: Sometimes the people around us do such a good job of covering up their pain that it's hard to notice. You know, I read somewhere that psychiatrists have the highest suicide rate of any branch of the medical profession.

P: It seems like we were not enough for her to stick around for.

C: I can understand how you would feel that way. Sometimes people who want to kill themselves stick around for the sake of the people who love them. But sometimes the pain gets to be so much that it overwhelms the love.

P: Now I'm having these dreams and in my dreams my mother is in Hell and that frightens me. You know my Church used to teach that if you killed yourself, then you would go straight to Hell, and you couldn't have a Mass or be buried in consecrated ground.

C: Well, what I've told you about how pain can take away our freedom to make good choices is not in any way against Catholic teaching. The Church gives the person who kills herself the benefit of the doubt. It's still considered a sin of despair to kill yourself, but it's just one action in a whole lifetime, and I don't believe that God will cut us off for one stupid action that comes out of being in horrible pain.

P: I've been having these dreams that my mother is in Hell but she's coming to me and she's angry at me and she's telling me that I should hurt myself.

C: I'm not a psychologist and I'm not experienced in interpreting dreams. That's something you probably should take up with your therapist. But let me give you a

layperson's take on the dreams. I believe that dreams come from the inside and not the outside. Dreams can be a warning flag for us. Think of them as spiritual and psychological toothaches. They can show us where we need to work on healing and forgiveness. In my own experience, people that I'm angry with show up a lot in my dreams. All that work of healing and forgiveness takes time.

P: I wish I could just get it over with.

C: I feel the same way sometimes but it doesn't work that way. It's a process and you're at the beginning of the process. Healing and forgiveness take time. Right now maybe all you can do is tell God that you want to forgive your mother for leaving you but that you can't do that yet. I think God is happy with that. And as long as you're here in the hospital, I would be happy to work with you on the spiritual part of the process.

P: That would be nice.

C: Sounds like a plan. I'll come back and see you again. Would you like to close with a time of prayer?

P: Yes, I would.

(We end with a brief pastoral prayer.)

Chaplain's Reflections

In this early encounter on the unit, the new resident contends that "mental disease calls into question the accuracy of the patient's narrative and raises the possibility of delusion. Pastoral care can involve exploring the relationship between spiritual theology/praxis in the context of chronic mental disease, starting with the immediate issues. It gently asks the question, 'Where is God in the life of the broken mind?'" He is aware of the difficulty of interpreting patients' words on the psych ward but demonstrates a limited understanding of various types and categories of disorders ("mental disease") and unwittingly tries to make a medical diagnosis of the patient's condition ("possibility of delusion"). He attempts to be culturally and politically sensitive with his descriptive terms (a "broken" mind) yet presents them in a manner that is neither biomedically nor pastorally robust and is more poetic than clinical. Further, the tone of his reflection suggests a significant distance between the patient's emotional state and the sterile, intellectualized voice he uses in his reflections; this narrative strategy is common in early verbatim reports, as residents attempt to demonstrate objective interpretative acumen in ways that frequently discount significant topics of clinical pastoral interest.

This is not to say at all that the resident ignores the religious component of the patient's situation in favor of a scientific explanation of her current state. Indeed, he frames the topics of "anger, guilt, rejection and grief" as theological issues yet struggles to understand how the spiritual and the biomedical relate to each other, in this case construing these four issues as exclusively religious, rather than as potentially also psychological, emotional, or cognitive phenomena. It is significant that he interprets the woman's struggles through his own religious tradition, where "themes of Divine outreach and compassion, forgiveness and reconciliation are significant, as are Biblical traditions of engaging God through lamentation and outcry in the face of fear and loss," rather than seeking a common hermeneutic platform with the patient or trying to see the situation charitably through the patient's theological position. While he acknowledges that "her religious tradition is an immediate source of anxiety," he dismisses her viewpoint as indicative of "a popular religion that often distorts the authentic expression of Christian theological traditions and is more influential that the orthodox tradition." In his mind, her doctrinal position is flawed and insubstantial in comparison with his own, and he presumes that logical argumentation and deductive reasoning can clear up these misconceptions and can thereby set the patient on the road to recovery. Such a top-down approach gives the patient no space to discuss why she has come to the views that she has or to work through the social or physiological implications of her beliefs; it continues to leave her in a passive, disempowered role.[41]

A key task for residents is to try to get a sense of the role of the supernatural in clinical encounters and to articulate this activity for peers to critique. This chaplain explains that "God is at work motivating the patient to seek a greater clarity and reassurance from her religious tradition. God is also opening the door to a fuller integration of her spiritual and psychological lives." It is striking to observe the confidence with which the chaplain presumes to know how the supernatural is at work in this encounter. This too suggests inductive reasoning; the resident suggested that because he experienced various struggles in the past that seemed to him akin to what the patient was encountering, the same resources that worked for him should also work for her, thus making an enormous diagnostic leap that privileges his own therapeutic journey as normative and disregards the unique needs and life circumstances of the woman sitting across from him as a distinct individual. It

[41] This mode of intervention, and the subsequent analysis, are intriguing also because, as the group only later learned, this chaplain was himself for many years Roman Catholic and fervently embraced the image of a passive laity before turning to his current Protestant tradition, one that stresses a questioning, theologically active believer that does not simply accept *in toto* the edicts of clergy. It is revealing that he never pauses to wonder how his own religious tradition and religious journey might have affected the patient's interpretation of her predicament.

also makes large and, to some of his peers, untenable assumptions about the necessity with which the supernatural functions from one life situation to another.

Group Discussion

While the peer group was able to raise some important topics in their discussion of this case, their interpretative skills were limited at this point in the program. They approached their colleague's interaction and his comments mainly from the perspective of what they as individuals liked or would have wanted to hear if they had been his patient. They also drew upon popular media images of mental health inpatient units, most of which are exclusively negative in terms of their portrayals of both patients and staff members as militant or incoherent, to frame their comments. Most focused on the intellectual content of the resident's words and highlighted the gap between where the patient stood in comparison with the resident's theological and psychological coordinates but did not offer any substantial alternatives for how he could have interacted more productively. That is, they tried to be constructively critical and acknowledge the parts of the conversation that were promising while seeking to demonstrate their interpretative capacity as residents but came up short on both accounts. They were more productive in their attempt to get a sense of how the patient's concerns impacted him personally and what issues they raised in his own life. Why was this seemingly sensitive person taking such a scholarly, sermon-like approach to this woman? Was she "pushing some of his buttons?", as one peer wondered. Why was he seemingly so far from the patient's grief and uncertainties? Together, they recognized that logical argumentation wasn't necessarily what patients wanted or needed in the clinical space, especially on inpatient psychiatry. They agreed that there was very clearly a religious component to this patient's illness that biomedicine was not well equipped to address, but they were unsure about how the chaplain might fit more productively into her therapy.

Finally, in terms of his own performance and its effect on future possible visits with this patient, the chaplain believed that he "created a healthy comfort level" with her and "was able to offer her comfort and reassurance from her own religious tradition that God has not condemned her mother for taking her own life. I was also able to acknowledge her feelings of anger, grief, and rejection toward her mother." Crucially, he seemed to mimic the biomedical tradition of discharge planning with the following suggestion: "I experience a certain amount of anxiety around interaction with this patient because she presents issues for spiritual care that require long-term efforts. My pastoral care needs to address the question of how to continue her spiritual growth after she leaves the hospital." The group challenged his concern for the woman's spiritual and psychological welfare outside the hospital, not because such intentions are not noble, but because they fall outside the scope

of a hospital chaplain. The supervisor in particular emphasized the need for residents as hospital workers to learn to "let go" of patients when they leave the clinical space and to restrict their interaction to the hospital proper.

CASE 11: ON TRUST (AND ANTIPSYCHOTICS)

Background

Jonah, meanwhile, seemed like the antithesis of Judy. Young, devilishly handsome, popular with his undergraduate peers, and reared in a wealthy New England family, he could easily have been the prom king, high school quarterback, and senior most likely to succeed. His parents were both influential physicians, and his younger sister likewise showed great academic promise.

In our initial conversation a day earlier, Jonah recounted his dissatisfaction with the care that he was receiving on the unit and wanted to speak with some sort of advocate who would help him in his relations with the medical personnel. Likewise, he seemed acutely interested in issues of spirituality, mysticism, and transcendence, but I wasn't sure whether this apparent hyper-religiosity was actually meaningful or was simply unproductive, a by-product of his unstable neurochemical status. I thus found myself in a rather curious position of potentially mediating between several parties, some real and some metaphysical or perhaps imaginary, concerned to earn Jonah's trust and to investigate his plaint but also intent on listening to others' perspectives to see what sorts of reconciliation might be possible.

I recalled the advice of one of my chaplain colleagues as I thought about how I might engage Jonah on this upcoming visit. He believed that it was important to engage people at the level of longings and frustrations, in addition to whatever else we might discuss. This dialectical posture could be difficult under most circumstances in the hospital, if not also in the broader U.S. society—could I really expect a dashing male college student to open up about his emotions to another male, a stranger?—but could be downright dangerous on this unit. No, I didn't fear for my physical safety with Jonah, but I was extremely concerned about fanning his emotional flames and thus exacerbating his condition. Nonetheless, he has asked to speak with a religious figure, so my concerns were allayed somewhat by the expectation that he would bring topics to the conversation without much prompting.

As it turned out, there was plenty of conversation to keep the two of us, his mother, three nurses, and a psychiatric resident occupied for a good half hour. When I arrived on the unit, Jonah was in his room with his mother and the charge nurse:

The Encounter

Patient: Here, here's Pastor Will. Let him come in here.

Head Nurse: Jonah, sometimes it's a problem if we have too many people in here.

Chaplain: Hi Jonah, I—

P: No, I asked him to come here. And sometimes it's a problem if we have too few people in here.

HN: Maybe it would be better if the three of us just talk for a little while.

P: Well, maybe it wouldn't. I don't trust you. I don't want to be in here with you.

HN: OK, well maybe your mother and I should talk for a few minutes.

P: (getting up) Sure, that's fine. You two talk, and I'll go out here with Pastor Will. You don't mind, Pastor Will, do you?

C: No, that's fine with me. (walking out with Jonah; turning back to the nurse, softly) About 5-10 minutes?

HN: Sure, that's fine.

C: (to Jonah, as we enter the main lounge area) Where would you like to sit?

P: Oh, I don't care. (walking around corner) Pastor Will, I'm scared. I'm scared of the people here.

C: The staff, you mean?

P: Yeah. I know they can't take care of me. I know they're not going to make me better.

C: (motioning to chairs) Maybe we could sit here?

P: (looking into kitchen/activities room) Oooh, muffins. Let's get some muffins! (turns and heads directly for the pan and speaks to occupational therapist) I'm getting two muffins, one for Pastor Will. (to me) Here, which one do you want, the harder one or the softer one?

C: Oh, whichever one you don't want.

This brief initial segment presents a wide range of issues for a resident in the first month on the psychiatry unit. There is a sharp tension between various parties and the ambiguous place of the chaplain within the unfolding therapeutic drama. I entered the scene marginally familiar with the patient and aware that he had requested a visit; beyond that, I was blind to the situation at hand. Or, perhaps I should say, I did not speak with nurses or other hospital colleagues before meeting Jonah. Over the course of the previous year of training, I had decided that it was usually best not to come

armed with outside opinions and perspectives on the patient's situation; I wanted to hear from that individual directly.

Usually, a patient's request to speak with a chaplain causes no logistical problems: the chaplain arrives, and the two speak. In this instance, I realized quickly that this event was different. Jonah, his mother, and the charge nurse were involved in a significant confrontation, and I suddenly found myself part of their narrative, unwanted by some yet demanded by others. This power struggle between patient and nurse put me in a difficult position; as a care provider, I was absolutely committed to assisting Jonah in any way that I could, yet I was also mindful of the fact that the charge nurse was a person of significant influence and barely knew me, the new guy on the unit; as such, the right or wrong move here could have significant repercussions for subsequent access to patients on the unit. I also realized that the heightened emotions in the room meant that the question of timing was particularly important. Was it better to come back in a few minutes? Should I attempt to intervene, to mediate the situation, in an attempt to resolve a stalemate? Or, as the nurse suggested, would another body simply make the moment more volatile? And what about the mother—where was she, in the midst of her silence?

My arrival was fortuitous, inasmuch as it gave Jonah the opportunity temporarily to move away from the tense meeting in his room to converse with someone whom he appeared to trust. Such availability in itself could be therapeutic, for the simple act of redirecting attention, particularly that of a manic patient, could have a calming effect and could open space for dialogue that is meaningful and productive. For me as a person, the joint decision between Jonah and the nurse was actually a relief, because I could avoid taking sides while maintaining a sense of usefulness and relevance to the situation. Likewise, I was still new enough on the unit to feel a bit uneasy whenever a patient became agitated, because I didn't know how he might react if pushed too far.

Our subsequent stroll to the common room provided me with some important insights into Jonah's current state. He revealed a key source of tension: fear and mistrust of the staff. Mania for Jonah did not in that moment appear to be a flight into the realm of fantasy; his emotions were strong, but he was still able to reflect on his state of being. He was able to articulate an awareness of the fact that he was facing health problems and that the therapeutic environment of the unit was not conducive to his recovery. Interestingly, his comment "I know they *can't* take care of me" (my emphasis) suggests a seasoned awareness of what does and does not work for him in terms of treatment.

But where did I, the religious specialist, fit into Jonah's world? He apparently trusted me enough (or did not see me as threatening enough) to share his feelings with me. Still, wasn't it

curious that a smart, imposing, athletic male college student would tell another youngish male, a near stranger, that he was scared? That he was sick and needed help but wasn't getting it? These are extraordinary revelations of vulnerability for a person from such a demographic group. I was trying to figure out what this might mean in terms of the nature of medical intervention on such a unit. Yes, Jonah had been admitted primarily for physicians to tweak his medications, but was that the sole mechanism of treatment? I wondered if this hospital's psychiatric unit was a purely biomedical one, a place that offered pills and some social activities but little in the way of dialogue, self-reflection, or psychotherapy. I wondered if this patient might be eager to vent his frustrations about particular staff members, or more generally about the therapeutic paradigm of the unit as well. Yet why was he sharing such reflections with the chaplain? Was this an oblique request for me to play the psychoanalyst, in addition to whatever religious or spiritual elements I might bring to the encounter? Would this the first of many requests to inject back into psychiatry what pharmacology had stripped away from the treatment of the brain?

Our time alone for conversation was briefer than either of us had expected. Just as we were about to sit down, one of Jonah's nurses approached him rather casually to inquire if he had had his second daily dose of medication; he replied brusquely that he had not, because she had not given it to him. Upon her suggestion that he do that now, Jonah reverted to his earlier, highly animated self:

P: No, I'm not going to take it now. You were supposed to give it to me at 1:00.
(he pulls out his antique pocket watch) It's now 3:34. Too late, you lose.
Floor Nurse: It's ok, you can still take it now.
P: No, you can't get anything right. I don't need it now, and I'm not going to take it.
(mother and head nurse approach; Jonah stands up)
HN: OK, Jonas, let's take your medication.
P: My name's *Jonah*, not Jonas.
HN: Sorry, Jonah, I made a mistake.
P: You're right, you did make a mistake.
HN: OK, Jonah, will you take your medication now?
P: No! *FN* screwed up. (to FN's face) You can't get it right. You can't do anything right. (to HN) I'm not going to take it.
HN: Yes, you're right, you should have had the medication at 1:00. We made a mistake.
FN: He needs it three times daily, so we can space it out—

HN: No, it's important that he have it on time.

FN: Here Jonah, just take the pill, it's ok. I'm sorry.

P: No, I'm not going to do it. Sorry isn't good enough! It's too late for that. You screwed up. I don't accept your apology.

As the situation unfolded, I learned more factual information about Jonah's relationship with the staff and began to understand more clearly why he felt antagonistic toward specific clinicians. He felt neglected and betrayed; his conception of necessary and proper treatment did not align with the model of care deemed acceptable by the floor nurse.

What was more difficult to gauge were his comments in light of the delay. At least in his excited state, Jonah appeared to have very exacting standards and placed a high premium on precision and regularity. When these standards were not met—either by another person or, perhaps, by himself—vicious recriminations followed. Jonah did not appear to be someone who forgave easily, and when approached by several persons at once, he became more stubborn and more histrionic.

These were some of the thoughts that raced through my mind in the moment and upon subsequent reflection. Such ruminations, however, were merely at the intellectual level. Again I asked myself what Jonah's words and emotions meant for my work as a chaplain. What was I, *the chaplain*, supposed to see and hear in this situation? What was the best way for me to respond? If I sided with the medical staff and encouraged Jonah to take the medication, I ran the risk of annulling the trust that he had found in me, even if the moral authority of my position might have helped bring about the desired biomedical outcome and stabilization in Jonah's mental state. However, I was in no position to speak authoritatively on the chemical aspect of Jonah's condition and would have looked like a charlatan if I did. I wanted to hear from both sides alone to get a better sense of the picture and to explore options for solving this and future potentially difficult situations, yet I felt that I would have little success attempting to re-segregate the various actors.[42]

But would I be perceived as cowardly if I did nothing? An unnecessary, perhaps even unwelcome, piece of furniture? I was at a loss for words and hence felt quite powerless—discourse being the main toolkit of chaplains, particularly on psychiatry—yet I was not about to abandon Jonah to face the situation alone. Perhaps I could not find anything helpful to say. Perhaps there *was* nothing helpful for the chaplain to say at that moment. Yet perhaps my presence did some good. Perhaps the act of standing at Jonah's side, silently yet intently, reminded him that he was not alone,

[42] In hindsight, I wish that I had tried this option, if only to calm Jonah and to mitigate what may have felt to him like a gang attack.

that there were in fact resources available to him. The calm yet supportive presence, I recalled from conversations with my CPE peers, could also act as a stabilizing force, a buffer against wholly unchecked emotions, so long as a situation was relatively short in duration and was one in which silence could be a useful distraction. I also realized that silence could be useful inasmuch as it kept at least one voice out of the discursive chaos of the moment and, potentially also, in Jonah's mind.[43]

Yet.

While this segment highlights issues of order, regularity, and compliance, it also demonstrates an intensely human, moral side: it is a discourse about failings, blame, apologies, and forgiveness. The head nurse makes and acknowledges mistakes, both for her own actions and those of the floor nurse, yet these apologies are rebuffed by a young adult frustrated and increasingly hostile to their overtures. There existed in this moment the possibility for reconciliation, for growth and progress, yet Jonah would have none of it.

Yet.

Should I have told Jonah to accept the apologies of others, to use the moment for a moral lesson on the importance of forgiveness? Hardly. But why not? Among other reasons, it was a question of timing. I was unable to get any clue about what, if anything, Jonah wanted from me at this moment. No doubt he did not want me or anyone else to make demands of him. Perhaps I should have asked what Jonah wanted. I could have asked him to articulate his view of the situation and his sense of a way forward. Did he see the situation as permanently irreconcilable, or did he have a reasonable solution and was simply waiting for someone to treat him like an adult?

My as-yet minimal understanding of bipolar disorder gave me little sense of the effectiveness of trying to reason, or even dialogue, with a person in such a mental state, but my gut instinct was that, given the emphasis on the medication, such talk of forgiveness and reconciliation would at best be an anodyne and would do little to resolve the issue about the pill in the nurse's hand. I would have loved to have pushed the pause button on the scene, excused myself to the library, and spent the next three days boning up on manic disorders before returning to perform my role, but such a luxury was not available to me. Or rather, I should say that I could indeed have left the situation and hit the books, eyes firmly on the future, yet such a move hardly would have done anyone else any good.

Returning to the conversation:

Mother: Jonah, it's ok. You said you wanted it earlier …

[43] It is worth reflecting on the affective contrast between the religious specialist in this scene and the dramatic, even hypnotic, demeanor of shamanic healing rituals described by Lévi-Strauss and others.

P: Well now I don't want it. If you want to give it to me, you're going to have to put me in the isolation room and give me a needle.

M (to FN): Can I give it to him? (to Jonah): Here, will you take it from me?

P: No, I don't trust any of you. The only people I trust are my mom and Pastor Will here.

FN (looking to HN): I suppose we could give it to him in injection form …

M: It's really important that he have things on time.

P: Yeah, and you screwed up this morning as well! I asked for my medication at 09:00 and you said you would give it to me at 09:00, but you didn't give it to me until 09:17!

Another Nurse (approaching): Jonah, Jonah, could you take your medication?

P: No, not unless you give me a blood test.

AN: But Jonah, you've been doing so well …

P: Tell you what, I'll take the medication by injection if you give me a blood test. *HN* can give me a blood test …

HN: No, I can't do that. I'm not allowed to—

P (motioning with his hands): Wait, everyone, time freeze! (silence) There, I'm all better! See, I don't need the medication after all. I'm perfectly fine. *FN*, I love you (gives her a hug). *HN*, I love you (hug). *AN*, I love you (hug). Look, it's a miracle! Here—Pastor Will knows all about miracles. (takes my arm and waves it in front of the group) See, miracles everywhere! Everyone touch Will and feel the miracle (takes my wrist and has my hand touch each person in the group in turn).

There are many significant issues here, some of which bear directly upon the role of the chaplain, and some that are ostensibly quite peripheral to my work and would not usually merit my attention, were it not for the fact that I was standing right next to the patient throughout the encounter. Perhaps the most obvious theme is that of power, as Jonah battles with the three nurses and his mother regarding the medication. In one sense, his reactions can be seen as perfectly rational, if rather juvenile: both he and his mother attest to his desire to take the pill—this is not an issue of compliance or of treatment rejection—but, from Jonah's perspective, an issue of Hammurabian commitment. So long as the nurses perform in a manner acceptable to the patient, he will submit to the pharmaceutical regimen. When they neglect their responsibilities to him, there is a price to pay. He will take the medication, but there's a cost: the medical staff must go to additional lengths to treat the patient. Jonah uses recalcitrance to exact confessions and apologies; then he

demands the drug in injection form, then a blood test. The more they cajole, the more excited, the more stubbornly outrageous he becomes.

This intermingling of authority and desire emerges in additional ways. Jonah appropriates the medication as a bargaining chip, a leveraging device, inscribing the pill with an additional ontological status. In the process, it becomes an object of multiple desires: at some cognitive level, Jonah recognizes the medication as helpful for him, and as such he is invested in its success. Likewise, the nurses become increasingly invested in the fate of the pill: its ingestion can testify to their prowess, their legitimacy as care providers, and to their absolution in Jonah's eyes for their sloppy care. As the chaplain, my investment in the pill was oblique; I trusted the physicians—and for that matter, Jonah and his mother—enough to believe that the drug would benefit him. I also sensed that his taking the pill would bring him to a state of mind where, as chaplain, my interactions with him would be more productive, yet memories of readings from Foucault and Goffman made me reluctant to join the biomedical "team," even if it might make my work easier, in part because I was more than a little bit annoyed myself at the prospect of having to clean up others' mistakes in order to do my job effectively. In that respect, the frustrated part of me took secret, modest satisfaction in watching the nurses squirm.[44]

That said, what I failed to recognize at the time was precisely this moral undercurrent to the drama. Overwhelmed by the emotional energy and theatrical novelty of the moment, I was distracted from a calmer, more analytical ability to look beyond the shouting and recriminations to see an important opening for me as a religious practitioner. Just as Jonah subtly but skillfully parsed the moral and pharmacological components of the treatment process, I too should have distinguished these two levels and intervened the moral one, the realm where I as a chaplain could legitimately claim expertise and authority. I did not have to engage either the patient or the others at the level of the medication, but I could have named Jonah's penal strategy aloud—I could have mirrored it back to him.

Given his frame of mind in his last comments, however, such an intervention might have had little practical effect. Jonah was ostensibly rational enough to manage part of the interaction to his satisfaction, but what about the rest of it? It would be easy to dismiss his "miracles" monologue as a clear sign that he needed his medication, that he had lost control of his capacity for decision-making and proper social behavior, and that only pharmacological intervention would restore him to health. I wish to suggest, however, that this interpretation alone neglects the agency that he has shown

[44] I certainly derived no such pleasure at the mother's anxiety, however, for as far as I could tell, she was certainly not culpable for this sorry state of affairs.

throughout this encounter. Questions of morality aside, Jonah is smart. Very smart. I knew him well enough to recognize that he has little patience for ineptitude and suspect that he realized that he was more intelligent than the nurses before him. He was also, I guessed, game for a bit of playful chicanery as a social commentary on the drama unfolding before him. If this was mania, then it was mania with a purpose: namely, to mock the nurses and, by extension, their therapeutic modality. I suggest that Jonah does not give his mother or the chaplain a "love hug" because, while he was ostensibly frustrated at them as well, they were not directly part of the biomedical enterprise and were competent—trustworthy. True, I became a handy, if unwilling, prop for his antics. I want to believe, of course, that I was the momentary object of his attention because of the symbolic usefulness of my role for his speech, rather than what he actually thought of me as a health care practitioner, but perhaps I too was being dismissed as dim.

The conversation continues a bit longer before coming to a close. One of the medical residents enters the conversation and tells Jonah to take his medication, and he responds with an even more dramatic bargain: "I'm only going to take it if you put me in the seclusion room and tie me down and force it into my arm." When presented with an ostensibly genuine power figure, his discourse returns from the magical to the pragmatic, yet it also continues the motif of non-cooperation and cultural criticism: if they want him to play the psychiatric sick role and take medication, then he would do one better. They would have to relate to him as a stereotypically wild, unmanageable madman, a dangerous outlaw who could only be controlled by dramatic, physical constraint. Here is perhaps the most dramatic diagnostic challenge yet: If I'm as crazy as you think I am, prove it. Use the scientific method and verify your claim.[45] If you can't, or if you won't, then maybe I'm not actually as sick as all of you have made me out to be. Look—I'm calling for a blood test to assess my condition, but you tell me that it's "not open to negotiation." I'm giving you an opportunity to regain your credibility and my trust—I'm offering to play by the rules and methods of biomedicine—but you aren't up to the challenge.

Medical Resident: OK, Jonah, why don't you …

P: No, I'm sick of this shit! I don't trust any of you. Nope, conversation's over. Thanks.

MR: OK, Jonah, why don't you go to your room for ten minutes and then we'll talk.

(circle starts to move toward Jonah's room)

P: Fine, I'll go to my room, but I'm not taking the medicine.

[45] The patient had taken a number of science courses in his degree program and had also worked as a laboratory research assistant and so was quite familiar with the basics of the scientific method.

The discourse has devolved into monotony. In the hierarchy of the unit, the doctor's presence effectively silences the nurses' voices and further limits my own; both the medical resident and Jonah agree that the interaction has become pointless and hence bring it to a close, leaving the central issue of the medication unresolved.

After Jonah returns to his room, I take the opportunity to debrief with the head nurse, both to hear her thoughts and as a way of introducing myself to her:

C: Has he been having trouble with the staff?

HN: (as though I'd just hopped off the boat) He's *manic!*

C: Yes, I recognize that. He had mentioned to me that, in addition to the medication issue, he has been having a difficult time with some of the staff.

HN: (indignantly) Well, he has.

C: Look, I understand that there are some things that manic patients say that we can't take seriously. If he says that he's not getting his medicines and he isn't, that's a problem—

HN: No, you're right. It's just been a difficult relationship with him. (We both turn to hear Jonah yelling at his mother in his room.) It's too bad you were called to this; you didn't need to get involved.

C: I came because J called to the pastoral care office and—

HN: I know, I know. Now just isn't a good time to visit.

C: Tell you what: I'm here until about 5:00. Maybe if I come back around then and just pop my head in his room?

HN: Sure, that would be fine.

C: OK, I'll do that. Thanks for your help.

HN: Sure.

This concluding segment highlights a number of important issues and challenges that chaplain residents face as they attempt to establish their identity and legitimacy among staff members. Ideally, a resident will meet the head nurse in her office for conversation at the beginning of the residency year in September, and she will subsequently have the opportunity to observe a resident in action during non-crisis moments to get a sense of the chaplain's affect, technique, demeanor, and so forth as a way of building a sense of collegiality, helping the resident to identify challenges and opportunities unique to that floor, and often introducing floor nurses and other staff to the chaplain.

This being a hospital, however, the ideal often remains just that. In our conversation with Jonah, the head nurse has little by which to gauge my prowess as a care provider. She may or may not have seen me talking with him before the floor nurse approached with the medication, in which case her first image of me at work was essentially that of a mute wallflower—stable but useless. It was for that reason that I sought to establish my credibility as a perceptive apprentice with an investment in Jonah's welfare and also to demonstrate that I was striving to develop an awareness of the dynamics of the unit. The phrasing about Jonah's relationship with the staff, for instance, was intentional: CPE training emphasized repeatedly the value of listening to each person's point of view, rather than inferring from others' comments; I wanted to hear her voice, even if the question came across as naïve, rhetorical, or implicitly critical of her management of her subordinates.

This reconnaissance reflected additional priorities beyond questions of power and authority. Her comments about the appropriateness of visiting and getting involved reflected an element of regret that I had to be exposed to such a complex situation as a novice, but I think it also reflected a certain level of frustration at my presence, because I was yet another person in the room, yet another stimulus to distract patient and practitioner from the task at hand. The images of the chaplain as potentially helpful but also a potential nuisance were common ones during the beginning of CPE training. In the trauma bay, and particularly during codes on ICUs, chaplain residents could be useful to the medical staff through a division of labor: the chaplain would tend to the family and friends in the waiting room while they tended to the patient's body. In Jonah's case, the situation was different: there was no physical separation between patient and family, and the chaplain resident could plausibly be viewed as simply in the way, though as we saw, the interpersonal dynamics suggested a more complex reality.

On the other hand, I happened to be present during a rather vulnerable and embarrassing moment for the unit's staff, and that gave me leverage. Had I been the chief nursing officer of the hospital or an outside auditor of the unit, the head nurse would have been reprimanded for negligent patient care, and she knew it. My determination to check on Jonah later in the afternoon reflected a genuine concern for his well-being and my commitment to be available for him, but it was also a way claiming my right to be an active partner in the work of the unit. I would not write up this incident and forward it to hospital management, but neither would I allow my office to be sidelined.

Chaplain's Reflections

What on earth was someone like Jonah doing on a psych unit? What on earth was someone like him doing on *our* psych unit? He didn't fit one of the archetypal profiles of patients I was growing accustomed to meeting, and I needed to remind myself more than once that illness—

particularly mental illness—often looks quite normal by many socioeconomic indicators. It was also more than a bit strange to encounter a fellow student as a patient, someone several years my junior, not because young people don't experience depression or mania (they do), but because the relative lack of young adult patients at the hospital had, in terms of my work as a chaplain, caused me to associate illness and misfortune with patients who were older than I. Yet there he was, portable DVD player in hand, oscillating rapidly between trying to convince the staff that he was a surgeon late for an operation, that he planned to drop out of college to discover the fundamental truths of the universe, and that he was searching for the one person who would understand him.

Was there counter-transference here? Some. I tried to slip myself into the patient's shoes, to understand his world and his referent points, yet I struggled to keep my own undergraduate journey in its proper place and not to juxtapose it onto Jonah's. Realistically, though, I knew that he was the sort of person that I could easily meet and relate to outside the hospital, and that admittedly aroused within me a certain type of urgency, a certain longing for success, that was different from that which I felt for other patients on that unit.

In terms of social factors impinging upon his case, what stood out most to me was that even though Jonah was an adult, the staff treated him very much like a teenager. They spoke with him as one would a disobedient child, and it seemed as though they were not sure whether to address him as inherently healthy or as inherently sick. I sensed a degree of impatience in this scene, as though his upper-class background and status as a college student may have caused some of the staff to see him as spoiled and overly demanding or exacting. Likewise, I'm still not sure what role gender played in this exchange, but I had the sense that Jonah was more comfortable with male authority figures and caregivers than female ones.

Group Discussion

This verbatim provoked an interesting dynamic between residents, who generally sided with my interpretation, and the director, who contextualized the issues and provided alternative images of how chaplains can engage in behind-the-scenes work to promote patient welfare. My peers were particularly concerned about possible ethical issues in this case, both with respect to patient autonomy and in terms of the role of chaplains as advocates for the afflicted when they receive sub-standard care. One colleague described the chaplain's situation as one of "opportunity but little power" and sympathized with the reluctance to challenge medical staff in a public setting. The resident on psychiatry the previous year spoke rather ruefully of practitioners on the unit, arguing that they routinely undermined and dismissed the chaplain. He argued that chaplains "have little

power, but we shouldn't give that away." Even he, however, seemed somewhat at a loss as to how to be an effective advocate in this situation.

The supervisor, meanwhile, sought to strike a balance between the appropriateness of the "righteous indignation" that the cohort was demonstrating in the face of poor treatment with some of the harsh realities of clinical psychiatric care. He argued that patients with serious mental illnesses may at times require interventions that may seem inhumane and suggested that, in his experience, this struggle to find the right type of treatment can lead to unpredictable and complicated forms of social interaction. In essence, his message was in line with much current pharmacological psychiatry: patients may need to be medicated against their will; chaplains deal with spiritual matters and don't understand much about the somatic elements of the human person and so should proceed with great humility in such situations. His explanation that manic patients may sometimes appear "hyper-religious in ways that aren't necessarily productive, but at other times, they may be able to do that in a meaningful way," and that chaplains should attempt to engage them at the level of longings and frustrations, seemed appropriate and helpful to the group. That some were frustrated by what they saw as his message to stand aside and let medicine "do its thing" brought a clarification. He explained that chaplains can function as "a kind of witness of the community at large" and that, while they are not in a position to discuss topics like dosage levels with medical staff, they can and should speak up (for example, through one-on-one conversations or, if necessary, incident reports) when patients do not receive the care that they have been promised due to neglect or incompetence.

CASE 12: THE JEALOUS NEIGHBOR

Background

The chaplain is referred to Leticia Boyd by her attending psychiatrist during one of the care team meetings. Dr. Blumfeld thinks that it might be helpful if he speaks with her because of the religious character that Leticia attributes to her experience of mental disease.

The patient is a 43-year-old African-American woman with a history of psychosis dating back at least eight years. She reports auditory and visual stimuli in the form of a "demon" that speaks to her frequently and sometimes appears to her in physical form that only she can see. Further, she states that the demon sometimes speaks to her through her mind (i.e., in thoughts and ideas) and at other times she hears it speaking externally. She attributes responsibility for her mental disease to this demon, which she believes was set upon her by a vindictive neighbor jealous of her musical abilities and eager to see her fail to realize her potential.

The patient reports that the anti-psychotic medications decrease the intensity and frequency of her encounters with the demon but do not completely drive it from her. She reluctantly accepts her diagnosis of schizophrenia but adamantly maintains that the underlying cause of her mental disease is the demon. She reports that she has consulted numerous spiritual resources such as occultists and deliverance preachers to cast out the demon, but without success. She has also sought out broadcast and mail order faith healers. Presently, when not hospitalized, she participates in daily prayer meetings at a Christian "deliverance" church whose pastor public claims to have himself been delivered from demon possession in his early adulthood. Leticia appears to take hope for her own spiritual and psychological liberation from his testimony. She states that all other activities and relationships must be built around her participation with this faith community. The patient is averse to any day hospital or clubhouse program that would prevent her from attending these daily noon prayer meetings.

By her report, several persons are significant in the patient's family constellation. Her closest family member is her maternal grandmother. Her mother died last autumn from ovarian cancer. Her father is in contact with her only intermittently and does not appear to provide meaningful emotional support. She states that she has several half-siblings but does not have a close relationship with them. She also mentions her close friendship with "Zola," the initiation of which coincided with renewed intensity of her experience of demonic oppression.

Before her illness gained its current intensity, she was employed as an office cleaner and reports that she enjoyed the work. Her socioeconomic status is working class, with no formal education beyond high school. Her primary interest and avocation is music. She states that she would like to return to work as a cleaner, perhaps even at this hospital, but that her primary focus right now is exorcism.

When the chaplain arrives for our conversation, Leticia is lying in her bed reading the Bible. She has arranged the furniture in the room so that the nightstand, bed, and desk are all in a straight line. She is an attractive woman who appears younger than the reported age.

The Encounter

Chaplain: Hello, Leticia. My name is Nick Derby, and I'm the chaplain for the psychiatry unit. How are you today?

Patient: I'm doing OK.

C: (she has her Bible open) I see that you're reading one of my favorite books.

P: Yeah.

C: I was speaking with Dr. Blumfeld and she mentioned to me that you might find it helpful to talk with me.

P: Yeah. You see I'm fighting this demon that somebody's put on me.

C: Wow. That sounds pretty rough. Would you like to tell me about it?

P: Well, you see this woman Marcy—she lives next door to me—she's jealous of me. You see, I know music and I'm good. I could go to New York and get into the business but she doesn't want me to succeed because she's jealous. So she put this demon on me. And it comes to me. The first time I felt it, it was like it pressing on the back of my neck and saying, "I ought to kill her."

C: So the evil spirit talks to you?

P: Yeah. Sometimes I hear it in my mind, Pastor Jeremiah says that the demon lives there. He says that demons live in our mind. But sometimes I hear it outside also.

C: Does it frighten you when the evil spirit talks to you?

P: Sometimes. But mostly it just gets me upset. Sometimes it brings up things that happened to me in the past. I'm not a bad person. I've never been much for getting into trouble or doing bad things. But there are some things in the past that I've done that weren't good. And the demon just brings those things up in my mind.

C: So the demon reminds you of things that you would rather forget?

P: That's right.

C: I'm sure that you're not a bad person, Leticia. And what's past is past. But let me ask you this: these bad things that you have done in the past, have you asked God to forgive you?

P: Yes.

C: And do you believe that God has forgiven you? Have you been able to accept God's gift of forgiveness?

P: Yes, yes I have.

C: It sounds to me like the evil spirit wants to shake your faith in God's forgiveness or make it hard for you to forgive yourself for your mistakes.

P: Yes, it does. My mother died last year. She had cancer and she kept it a secret.

C: That must have been very painful for you to lose your mother.

P: It was.

C: Do you have other family besides your mother?

P: I have my grandmother. She lives in the house with me now since my mother died. I take care of her when I can.

C: Do you have any brothers and sisters?

P: I'm the only child with my mother. I have some half-brothers and half-sisters with my father but I'm not really close to them. I have some cousins in New York. Do you know Pastor Jeremiah?

C: No, I don't know him. Is that your pastor?

P: Yes, he's the pastor at Harvest Deliverance Church over on Oakville Boulevard. I heard about him from this woman I know. I should make you a copy of his tape so that you can hear his preaching and see if you like it.

C: That would be nice. I would like to hear that.

P: Pastor Jeremiah says that he had a demon put on him when he was young, and that this woman took the demon off him.

C: How long have you felt that this evil spirit is oppressing you?

P: Marcy put it on me back about eight years ago. The doctors tell me it's schizophrenia. They tell me that it's a chemical imbalance. But Pastor Jeremiah says that demons can cause mental illness. You see, Marcy sends this demon to watch me and get in my head and then report back to her what I'm doing and thinking. When I first started hearing the demon, it had her voice. But now it has its own voice.

C: So now the demon you hear has its own voice?

P: That's right. I have this friend of mine, Donnie. He took me down to Al's Occult Shop on 17th Street. Do you know the place?

C: I have seen the place from the outside but I've never been in there.

P: You don't need to go in there. Donnie was trying to help me. He took me there to get some magic powder to chase away the demon. But it didn't work and I had to go into the local hospital. My grandmother got mad at Donnie for taking me there. But he was just trying to help. She threw away the magic powder while I was in the hospital.

C: I'm not surprised that it didn't work. Magic powders and potions don't usually work.

P: One of the doctors here—the fat lady with the brown hair and glasses …

C: Dr. Blumfeld?

P: That's right. I told her about Al's and she told me that she had once been in there but it made her feel creepy. That's because she didn't belong in there. But I knew she would understand and I could trust her because she had been there. Then this lady I know goes to Pastor Jeremiah's church and she invited me there. So I go there every day at noon for a prayer meeting. And I go to the Sunday night service. He has a morning service but I don't go to that one. I go to the evening service. You should come to hear him sometime, maybe bring your wife.

C: Maybe I could do that sometime. You know, Dr. Blumfeld really respects your religious beliefs. That's why they asked me to stop and talk with you.

P: That's good. They tell me I have schizophrenia. It's a chemical imbalance. But I know it's this demon that Marcy has sent on me that's causing it. The drugs they give me, they help. I don't hear the demon talking as much. But they don't make the demon go away completely. So I read my Bible and I pray. I read Psalm 51.

C: That's one of my favorite psalms. I pray part of it every day: "Have mercy on me, O God, according to your steadfast love. According to your abundant mercies blot out my transgressions. Wash me thoroughly from my iniquities, and cleanse me from my sin." Do you know the story of how King David came to write that psalm?

P: I don't think so.

C: (I tell her the story of David, Bathsheba and Uriah, and David's confrontation by Nathan.) The psalm is David's prayer asking God to forgive him for his sins. He asks God to help him change his life.

P: I like that.

C: I think that reading and praying the Psalms are very helpful when we are in a spiritual struggle. And I think that being part of a faith community like Pastor Jeremiah's church is helpful also.

P: The demon doesn't like it when I go to church. He talks louder when I'm on my way to church. He causes me to fall down. I hear him say that he ought to kill me. I don't hear him as much when I'm in church.

C: Sometimes an evil spirit will try to push us away from doing those things that are healthy and healing for us. I think one of the things that happens when we have a mental illness—whether it's caused by an evil spirit or by a chemical imbalance—is that we get so focused on ourselves that we withdraw from the people and activities that can help us in our struggle. So if this evil spirit that you hear tells you to stay

away from people who care about you, or activities that you enjoy, I think you should try to resist his pushing. It can help you to resist if you just spend time with other people and do things that you enjoy, like your music.

P: Right now I'm not doing anything about my music. I'm just focusing on going to church every day and getting myself free from this demon.

C: I think it's good to focus on your healing, but I want you to think about this: if you stay away from the things that you enjoy and that bring meaning to your life—like your music—then that evil spirit is winning. Your musical talent is a gift from God and I think it would be a mistake for you to let the evil spirit get in the way of your using that gift. If you use that gift, then you will grow as a person and God will be glorified. And that will help with your healing and weaken the power the evil spirit has over you.

P: OK. I think I'm going to be able to go home tomorrow. But maybe I could come back here and talk to you some more.

C: That would be OK with me. I'm here Monday through Friday and I would be happy to see you here at the hospital. And Leticia, if you need to come back to the hospital as a patient here on the unit, I want you to know that's OK. That doesn't mean that you have failed. Healing and liberation take time. I'm sure it's hard to be here on the psychiatry unit sometimes. But there's one good thing about being here. You're safe here and no one will harm you here. So if you're on the outside and you start to feel like the evil spirit is too much for you ...

P: Like it's too much to bear.

C: Exactly. If you feel you're not strong enough to fight off the evil spirit, then you can come back here.

P: I know.

C: Would it be alright if I offered a prayer for you?

P: Sure.

C: (I had chosen the following prayer entitled "For the Mentally Distressed" before my initial meeting with Leticia. I chose it because of its reference to evil spirits.) Mighty God, in Jesus Christ you dealt with spirits that darken minds or set people against themselves. Give peace to those who are torn by conflict, are cast down, or dream deceiving dreams. By your power, drive from our minds demons that shake confidence and wreck love. Tame unruly forces in us, and bring us to your truth, so

that we may accept ourselves as good, glad children of your love, known in Jesus. Amen.

Chaplain's Reflections

The resident explains that he chose this particular encounter for presentation chiefly because it highlights a sharp gap between his own metaphysical worldview and that of the person for whom he offered pastoral care. "I do not believe in demonic possession," he told his colleagues, "and I certainly do not believe that mental illness is caused by demons." One of the key challenges for him was thus how to acknowledge the patient's beliefs as significant to her sense of self and worldview in light of both his own theological and nosological schemas and those of the attending physician, who described Judy's explanatory model as "her own way of coping and therefore not totally pathological. The patient cannot conceive of something inside herself causing her mental illness; attributing the source of her schizophrenia to an external source seems to make it more bearable." In this verbatim, the chaplain recognized the difficulty of being simultaneously honest to himself and increasingly sympathetic to biomedical explanations while "respecting" the patient's model and struggling to figure out how to contend with it as a religious specialist.

Part of the difficulty for the chaplain was finding some sort of common point of convergence, either narrative or cognitive, at which to meet the patient. In his words,

> I admit that Leticia's worldview and presentation left me feeling like a rider on a runaway horse. Her conversation was often scattered and erratic and delivered at a staccato pace (much more than an inanimate transcript might convey). I had a hard time formulating what I hoped would be helpful, appropriate responses to her statements. I also found it difficult to relate to parts of her conversation because it seemed to me (from my worldview) that she was not describing reality. On the other hand, she was describing her reality.

This vivid description of the phenomenology of interacting with the patient highlights the gap between the experience of wanting and trying to be helpful and the experience of simply trying to keep pace with the patient and find some semblance of plot or narrative structure to her discourse. Despite these formidable dialectical challenges, the resident believed that God was at work in their encounter and absolutely agreed that religion, in some fashion, was central to the patient's search "for healing and liberation." She was able to articulate in their conversation some "clues to spiritual and psychological issues of self worth and her vision for her life, as well as her sense of loss over her mother and conflicted relationships with other people in her life." The chaplain found himself

increasingly touched by the "poignancy of her search for wholeness and meaning" yet was "troubled" by her "naïveté" in identifying resources for healing, such as Pastor Jeremiah and the Harvest Deliverance Church, which he viewed as a resource that "may do more harm than good" because it perpetuates the concepts of spirit possession, spiritual warfare, and exorcism as bona fide realities of the lived world.

7

DISCUSSION

We return now to the central question that animated this study: What are the social, epistemological, and phenomenological effects of depositing a religious specialist into a research-intensive teaching hospital in an inner-city U.S. metropolis for purposes of training and service? What general conclusions—if any—can we draw from the residents' accounts and their encounters about the consequences of their work for themselves and for patients, family and friends, clinical staff, and the institution as a whole?

In this chapter, I investigate the topics presented in chapter 1 through an analysis of key facets of the pastoral encounter of chaplains with their interlocutor(s), from initial glances and verbal exchanges to the use of various techniques to the end of the clinical interaction and then subsequent reflection and discussion by the chaplain and the cohort. I utilize data from the previous three chapters to demonstrate how the various components of clinical interactions illuminate both prosaic and extraordinary components of narrative exchange in the name of religion. Topics that I shall address include rationality and belief, the social management of morality, the relationship between sacred and secular epistemologies, the phenomenology of the unknown, embodied and noumenal manifestations of power, the nature of social proximity in liminal spaces, and cognitive and affective implications of death for reflexivity in cosmopolitan biomedical settings.

WHO/WHAT SETS THE AGENDA OF CLINICAL PASTORAL INTERACTIONS?

Introduction

Clinical pastoral care is a distinctive form of narrative interaction that fosters a certain form of personhood through reflexive self-awareness in the biomedical setting. It presents a unique set of activities for religious specialists in hospitals, in which the chaplain does not seek an active role in interactions with patients and others. Residents do not aim to render the patient passive or mute in order to instruct or proclaim. Rather, CPE presupposes that each patient has a sense of what troubles her and teaches students to follow the patient's lead, at least initially, in the exploration of these

issues. This stance has significant implications for the comparative value of narrative, and particularly patients' own understandings of their bodies and selves, as legitimate sources of clinical data. This is particularly evident in trauma cases (Cases 1-3), when the individual himself requests a chaplain (Cases 6, 9, 10-12), and when someone has paged the chaplain on another's behalf (Case 8). When the chaplain visits someone who is not expecting a call (Cases 4 and 5), the sense of agenda may be less immediately obvious to the patient, yet the opinion of CPE is that most individuals will, at a minimum, welcome the chance to express their thoughts and reflections with a sympathetic audience and may, if given the chance, uncover topics that could benefit from discussion.

The Intentional Lack of an Agenda?

Explaining his mental preparation for visits to new patients, one resident argued that "We don't know how things should unfold. We embraced our doubt, and in our mutual openness, the distinct line between the patient's pain and our pain is lost, there is just pain … or joy … or fear … or experience without a particular label." For him, the key to clinical encounters was radical openness to receiving from the patient, rather than simply (or necessarily) administering something in response to results from a diagnostic test. He tried not to enter into a clinical interaction with someone with the presumption that something was amiss from a religious, emotional, or social perspective. Similarly, he did not assume that, just because someone was in a hospital, she would necessarily be frightened, for example, or that she would want to be discharged as soon as possible. He tried, in other words, to assume nothing.

One of his colleagues, meanwhile, was rather less serene and expressed concern about the link between narrative modesty and palliation. "Sometimes I'm unrealistic about how many such random initial visits ought to metamorphosize into meaningful pastoral encounters," he explained, for "often I get so caught up in what I will say in response to a patient or family member that I tune out to what the person is actually saying. Sometimes I still gravitate toward fixing things rather than staying in the present moment with the patient or family member. Silence discomfits me." This resident, still in his initial unit of the program, struggled with senses of relevance and the desire to accomplish something concrete for the patient. He tried to find a role, a purpose, a rationale for being in a stranger's bedroom. Initially, he viewed his work through what he saw as a biomedical model of clinical practice: a practitioner is only present in a patient's space if something needs or ought to be done. He also viewed the pastoral encounter somewhat romantically, in which a successful encounter would be "meaningful"—intense, profound, and life-changing.

One of his colleagues, even at the end of the second year, confessed that he continued to struggle with chaplain-initiated contacts and information gathering. He felt that he often did not

identify "enough pertinent details" about a patient's status in his conversations and was consequently "serving the person poorly." He had come to accept the reality that a number of actors would only speak in response to questions and acknowledged that "some folks simply do not have large existential crises on their minds and really don't need anything from me." For him, this tension revealed an important ethical issue. If there was something wrong with the patient—if she was experiencing some grief or distress that the chaplain could ameliorate—was it the chaplain's duty to try to pinpoint the problem, to unearth, to bring to consciousness? He believed that the answer was yes but felt that he could not make such issues his own mission if the patient was unwilling to discuss them further.

It is important to recognize that there is no standard battery of questions that chaplains utilize to diagnose an individual. Rather, they operate under the presumption that *if* there is something wrong that the patient would like to discuss with them, and *if* the chaplain can set the right tone of trust and concern for the encounter, the issue(s) will either spontaneously rise to the surface—or at least the two will be in a position to explore potential topics together. Some of the residents nonetheless identified a few basic questions to have on hand, in case particular narratives seemed unclear or appeared to lack a connection to the person's state of being—situations in which the chaplain sensed something amiss and perceived the patient's desire for engagement. One resident's list included such topics as the number and quality of visits from friends/family, senses of loneliness, coping mechanisms, desire for prayer and/or follow-up visits, thoughts about the future, and topics for prayer. Similarly, he stated that he had learned a number of "tricks to keep the conversation going—everything from 'uh-huhs' to questions that stimulated further reflection."

Affliction as Stimulus and Rationale

Pastoral conversation occurs in a wide variety of settings in the U.S., from parish offices to prisons to aircraft carriers to factory floors. What components of the research-intensive urban teaching hospital contributed to the topics that emerged for these residents? Near the beginning of the program, one colleague suggested that pastoral care in the clinical setting "tends to be more focused just by virtue of the setting," and that "personal illness and/or impending death tend to give some people the desire to discuss life issues more readily than those one might encounter in parish ministry." This was a common sentiment; residents tended to view discourses as framed chiefly by the issues and maladies that individuals brought into the space, rather than the ideologies and idiosyncrasies of the clinical setting.

Because the hospital is supposed to be a place of healing, many patients and most new residents sensed that there should be some sort of meliorative element to a pastoral conversation—

some problem to be addressed or brought to light. Once again, this should not surprise us, given the expected nature of patient-physician interactions: subjects do not meet in the clinical space primarily for the purpose of discussing mutual fund valuations, liturgical rites in medieval France, or software design, but rather topics like blood pressure, surgical options, and pain management. But chaplains? Why would a patient talk with a religious specialist in the clinical space? The manners in which individuals convey sentiments to residents, and the cultural norms by which they act, may vary widely (cf. Cases 2, 4, 12). Patients and chaplains may have much in common in terms of personality or life experiences (Cases 1, 2, 9) and may find conversation flowing readily, as though they were long lost friends, but in other situations, differences are sharp and may seem insurmountable. It may be obvious to chaplains why they are present with a particular patient and what they hope to accomplish through dialogue, but as we saw in Case 11, the resident may not always know what role he is to play in an interaction, and the patient/family may not be entirely sure why the person is there either (Case 3). I do not wish to reduce the concept of the clinical social dialectic simply to a meeting between A and not-A—though this is an important component of many pastoral exchanges, particularly when sick meets well, rupture meets continuity, and bedridden meets ambulatory—but rather to suggest that there are subtle social and epistemological perimeters within which exchanges occur. The substance of these narratives may become apparent only gradually, but at first glance, it appears that there must be some common issue or goal that guides the interlocutors if the exchange is to be considered meaningful.

As we have seen, this issue is typically the phenomenology, if not also the ramifications, of disease and injury, as related to religious convictions. Although they may not always be consciously aware of it, chaplains' roles as discourse specialists in the hospital positions them uniquely and powerfully as reminders of the role of narrative interaction with patients for treatment planning, embodiment, and the social-environmental component of intervention in the name of restoration. To the extent that inpatient medicine, psychiatric or otherwise, is such that "the narrative of a person has become a case study of a body" (Luhrmann 2001:88), pastoral care sees part of its cultural rationale to highlight larger lived issues in which bodies are situated (cf. esp. Cases 1-4 and 12).

Death is likewise a common stimulus for pastoral conversation with patients; this too has important ramifications for social cognition in the hospital setting. In his review of Arney and Bergen's *Medicine and the Management of Living*, Young highlights for consideration their argument that Western medicine has experienced a dramatic shift in focus; "life has replaced death 'as the great beast in need of taming,'" where medicine "has become a 'tamer of life' instead of a 'warrior guardian pitted against death'" (1987:111). What are the implications of such a shift—to

the extent that it is a valid assessment—for clinical religious practice? I suggest that death is still the great enemy of medicine, and that death has never been tamed, much less domesticated; if anything, it has been displaced.[46] Metaphors aside, as more and more formerly fatal diseases are brought under relatively stable (if chronic) control, this shift has ostensibly generated a mindset that has encouraged biomedicine's reach into more and more afflictions for a variety of scientific and political economic reasons. This can, I suggest, have important implications for the types of topics that arise in hospital discourse. Pastoral conversations at my field site were indeed shaped by the nature of what biomedicine could and could not fix, prevent, or minimize, just as these interactions were almost certainly influenced indirectly by the warnings and admonitions that biomedicine provides to patient and chaplain alike in everyday life (cf. Cases 1, 3, 10).

Hunter points to one of the ironies of technological advances in hospital medicine with respect to clinical discourse and, by extension, the effects of clinical cultures on pastoral conversation. While she acknowledges the benefit that high-tech devices often provide for patients, she argues that "the proliferation of technology used in the diagnosis and treatment of disease has driven the physician farther and farther from the presence of the patient" (1991:xix), suggesting that such mechanical devices may undercut—if not displace—the value of narrative discourse as a means of knowledge exchange. The availability and enthusiastic, widespread use of the latest technology at my field site indeed gave many patients and others senses of distance, if not estrangement, from some of the biomedical staff in a way that often stimulated patients' conversations with chaplains.[47] In addition to religious and interpersonal issues, residents frequently found themselves listening as patients talked about their experiences with biomedical treatment—what worked, what didn't, who was kind or rude to them, their feelings about discharge and the food and setbacks and yet another blood test in the middle of the night when they'd really rather just stay asleep. As we saw earlier, some of these conversations generated helpful, non-confidential insights that the chaplain could pass along to clinical colleagues to improve the patient's treatment regimen (Cases 4, 8), but in other cases, the information reflected less tasks that should or could have been done than insights that held

[46] Indeed, Christianity's claim that through the cross and tomb, Jesus not only *tamed* death but *conquered* it makes the argument that biomedicine has tamed death seem curiously anachronistic. One could argue that the goal of human medical practice has never been to overcome death itself but rather to prevent early deaths.

[47] In one particularly striking encounter, one of my colleagues spent a considerable amount of time with a patient who felt pressured by the medical staff to undergo a series of invasive procedures, even though it was not clear to her how the procedures would occur, what she could expect to gain, or what her other options were. This lack of informed choice presented significant ethical challenges, but also important social and cultural opportunities, for the chaplain to mediate technologically savvy practitioners and anxious, uninstructed patients.

the potential to make the listener a more skilled and subtle practitioner, attuned to the nuances of various interventions and their comparative impact on individuals (Cases 3, 7, 9, 11).

The life journeys of both patient and chaplain contribute to the ways in which they interact, what topics they raise or avoid, what they hear or miss in conversations, and how they process information. Previous encounters with hospital settings (Case 8) and religious leaders (Cases 10, 12) can provide absolutely crucial insights into the ways in which patients discuss their struggles and comply with or resist various forms of treatment. The gap between reality as perceived by various participants and the narrative expression of this perception may be huge (Case 11) or minimal (Cases 2, 6); this too is a factor that chaplains learned to weigh as they interacted with patients and particularly as they presented the verbatims to their peers for group analysis. One could even say that an implicit goal of CPE is to teach residents to expect disjunctures between experience and its expressions, not necessarily as indices of sin or chicanery, but simply as reflective of broader social norms and cognitive biases. Such possibilities resonate with Bruner's argument that "experience structures expressions, in that we understand other people and their expressions on the basis of our own experience and self-understanding. But expressions also structure experience" (1986:6).

Residents gradually realized, however, that there were other, often more practical, factors that contributed to the tendency for chaplains to speak with patients within this medical center. I was struck by the following quote from Luhrmann's research, which could easily have been (and probably was) uttered at my field site as well. "'Psychotherapy,' a psychiatric scientist said to me once in irritation, 'is what ministers can do. We are doctors' … the overwhelming reality was that insurers would not pay for the length of hospitalization that would make psychotherapy possible inside the hospital" (2001:250). I found that clinical staff on psychiatry seemed to understand and appreciate that chaplains spent a good deal of time in conversation with patients, talking about religious and other issues, and most of them saw this work as valuable to the care of the patients and to the welfare of the unit as a whole. A few of them also recognized that hospital chaplains were significantly less expensive to employ than either psychoanalysts or psychiatrists of whatever school. On large non-psychiatric units, meanwhile, it was less obvious to residents that the clinical staff viewed their narrative work as talk therapy or as salient to the broader therapeutic goals of their unit; this may well have had an impact on referral rates and the likelihood that discourse in general was viewed as a potentially useful therapeutic endeavor. Staff on trauma and many of the ICUs, who had frequent and sustained contact with chaplains and could observe them in action, were far more likely to understand the meliorative aspects of their work, whether or not religion was discussed explicitly.

Likewise, residents noted that over the course of treatment, some epistemological questions will assume less urgency than others in the clinical setting. In their study of the social and psychological correlates of prayer, Ulanov and Ulanov suggest that

> [When we] enter the community of all who pray … we enter their lives now from their point of view instead of exclusively from our own, and as a result we are introduced increasingly to God's point of view …. The question of causality (did our prayer do this for them?) dissolves in this increasing current of God's interconnectedness with all of us and our intensified awareness of it in all the parts of our lives. [1982:96]

For them, as for many of the residents in my program, there was frequently a shift from exclusively or predominantly egocentric topics toward larger issues—relationships, other persons, and other situations and phenomena beyond those noted in the patient's chart. Some such narrative shifts may be expected if, for example, an iatrogenic infection is cured or a breathing tube is finally able to be removed. However, there was also an oblique sense among residents that such a broadening of a person's horizon, for instance, to be able to acknowledge and express concern for others' struggles in the midst of one's own could be seen as healthy, if not also spiritually mature or pious (cf. Cases 3, 9).

A final topic here considers the role of religion in the development of conversation topics. The mere fact that residents are religious specialists suggests that spiritual topics should be significant components of these conversations, yet this was in fact not always so. When individuals expect the chaplain to introduce religious topics and they do not do so immediately, this can create cognitive dissonance (cf. Cases 3, 4, and 5). There are many reasons why religion may not emerge quickly or even at all in an encounter, beyond the notion of patient-led agendas. Residents themselves might, for example, be reluctant to raise the topic or might initially struggle to do so in a non-threatening manner. Near the end of year one, for example, one trainee remarked that he only gradually became comfortable initiating and responding to questions about religion and spirituality when interacting with patients. He confessed that he still needed to refine his techniques but was able to discuss God with strangers without feeling like a proselyte or fraud. Likewise, he noted that he felt much more relaxed and legitimate in his ability to offer prayer to individuals and groups, particularly in moments of crisis. For him, taking the lead during these segments of conversations led him to conclude that such initiative "draws [patient and chaplain] closer together, increases our levels of trust, and makes further interactions more meaningful."

Other Considerations

Chaplains serve, at least in theory, at the pleasure of the patients. Patients or family members who consent to biomedical treatment upon hospital admission sign no similar consent for religious intervention; implicitly or explicitly, they are supposed to choose whether or not they will engage the chaplain.[48] It is in no way considered problematic if a patient declines to interact with the religious specialist, in the way that it would be exceedingly problematic if he refused to interact with, say, the nursing staff, physical therapists, or phlebotomists.

This protocol is significant in that it provides an important glimpse into the nature of leader-patient relationships in the clinical space. This format regarding pastoral interactions is suggestive of a consumer mentality yet is certainly not in all cases reducible to an economic supply-demand transaction and in fact masks significant and often unconscious issues about institutional religion. It is true that residents have no direct enforcement mechanism for making a person talk or divulge information. In the eyes of some patients, chaplains possess significant moral and cultural authority (cf. esp. Cases 1, 10, 12), such that they either want to or feel that they should discuss certain topics with the chaplain, but these internalized norms are by no means universal (Cases 5, 7).

When patients, family members, and others do engage a chaplain in conversation, residents attempt explicitly to avoid technical (i.e., non-scientific and non-theological) jargon and try to align their discourse style with that of the other person(s), so that the afflicted do not feel overwhelmed or disempowered. At the same time, residents are taught to avoid a generic, paternalistic approach to spiritual support that infantilizes or presumes low theological literacy. As one resident explained in the second quarter of the program,

> When I am aware of the spiritual tradition of a patient, family, or staff member, I try to honor their belief in the way that I pray for and/or encourage them. I do not encourage a person who does not believe in God to "just trust Him" because that would be disrespectful to that individual. I do use a Bible as a resource with those who profess a belief in it, but not with those who do not. I also allow prayer to be the choice of the patient, family, or staff member.

It is worth noting some points of dialogic overlap between chaplains and other religious specialists studied by anthropology. Discerning family power structures and working with them—

[48] If a resident genuinely feels that a patient is withholding crucial information that could impact the latter's immediate physical welfare, he may consult the CPE supervisor and/or medical staff attending to that patient to determine an appropriate plan of action.

not ignoring the patient by any means, but not necessarily presuming the Western bioethical position[49] of the imperial patient as normative—is an important task for hospital chaplains as well. This was crucial when the person was an infant (Case 6) or a child/teenager with family present (Cases 3, 5), but it was also important when working with adults when others were in the room (Cases 2, 7, 11). Logistically, culturally, and ideologically, residents sought to identify values, needs, priorities in order to incorporate these variables into their clinical interactions.

THE CHAPLAIN AS DIAGNOSTICIAN

How do religious specialists come to think in the clinical setting, particularly in light of maladies, disruptions, change, loss, and potential or actual interventions that are framed according to biomedical taxonomies? How do chaplains' theological beliefs cause them to view such phenomena, and how do clinical scientific norms and presuppositions shape their perceptions of evidence, causality, interventions, and modes of knowledge accumulation? How do they come to determine what can and cannot be amiss in a given situation? These are some of the key questions that guide this section of the thesis.

Some Starting Points for Knowing

Not long after beginning the program, one of my colleagues suggested that "as a pastoral care provider, my calling is to seek faithfully, respectfully, and sensitively, in partnership with the person to whom I offer pastoral care, to discern how God is working in and through his or her existential realities, and to cooperate with the divine initiative." This statement reflects a number of basic epistemological convictions common to most of the residents in my program. First, the supernatural was present as an active participant in healing dramas in the clinical space. Second, diagnosing was a collaborative exercise between chaplain and patient; it was not something imposed by an active clinician on a socially passive, mute patient. Third, the statement makes no mention of specific causal mechanisms but instead appeals to the rather vague term "divine initiative" as a central rationale for clinical pastoral interactions. An important training goal for residents was thus to

[49] The reader may note the relative absence of normative proclamations here. This is not an oversight: at my field site, questions about the appropriateness of various medical treatment options were almost without exception referred to the hospital's bioethics committee, rather than to chaplains. While CPE residents occasionally sat in on such meetings, it was clear that neither family members nor medical personnel looked to pastoral care for guidance when specific therapeutic decisions had to be made. I found it striking that many patients and family members readily welcomed the work of chaplains in moments of grief and interpretation but rarely turned to them for advice. This separation of duties holds significant potential for the understanding of religion as a source of power and oversight in the clinical space but is one that I was not able to address in detail during my time at this hospital and so can but acknowledge its presence at this point.

develop an appreciation of these factors, in light of how the patient *perceived* the divine to be at work, to begin to understand important issues in a particular case.[50]

There are other basic considerations that underpin attempts at understanding. First, for these residents, the divine could not and did not work in a manner contrary to that set forth in sacred texts and orthodox theological treatises. An event might well meet with divine disapproval or would not be authorized or stimulated by supernatural agency, but every situation could reflect some attribute of the divine or could serve as the basis for religious insight. Second, the program implied that residents, if not also patients, could and should make use of experience and reason in the search for understanding. In this sense, apophatic knowledge became a common first step in interpretation: it might not be possible to discern clearly what the supernatural was doing or was trying to do, but they could appeal to historical resources to suggest what was *not* occurring. Stating that God was working in and through existential realities nonetheless left wide berth for the supernatural in illness experiences; for this chaplain, the key was to attempt to see the extent to which a patient's life, in the broadest possible sense, was aligned with what the resident perceived to be a larger, and ultimately good, divine plan for creation within history.

Beyond metaphysical questions about the supernatural, what are the credentials by which an individual claims to know another person (and, for that matter, herself) in the hospital? It is crucial to our analysis to get a sense of whether or not a given individual has access to both the data contained in the object under consideration *as well as* the meanings and implications that the object is thought to hold. Such issues point us toward hermeneutics and the extent to which an individual can assume or obtain access to such data as a result of her own constitution and activities.

For another resident, clinical knowing involved the development of interpersonal skills and fortitude. After the autumn quarter, she felt that she did more "visiting" with patients than "actual assessing" and "ended encounters too quickly when it seemed the patient was 'showing me the door.'" Conversations that did not go beyond the "surface" led her to assumptions "that were not necessarily true in retrospect, such as a person being in a fragile state." Significantly, though, her admission that "I have learned that my own emotional and/or physical state at the time of these visits

[50] Systematic theologians will be quick to ask about the role of revelation in such epistemological activities. Does knowledge of the supernatural come wholly through human initiative, wholly through the actions of the divine, or through some combination of the two? I infer from my data that residents believed that individuals in the hospital were all capable of receiving and understanding divine communication and that, if God so chose, genuine supernatural messages would be rendered in a manner intelligible for the human brain to comprehend, provided that the person was open to receiving the information as it was intended to be understood. Chaplains never discussed these issues explicitly during the program, however, and so it is not possible here to state conclusively what they believed about the metaphysics of such processes.

was a factor, but I did not take the time to question my responses" suggests that she was trying to be attentive to the program's call for reflexivity and had embraced the idea that knowledge accumulation depended as much on the receiver as the sender.

In his discussion of Kantian versus Heideggerian epistemology, Taminiaux sees pure reason as a primary credential of knowing, which is "conceived as a pure prior relation to beings which determines the Being of beings" (1985:56). Crucially, however, Taminiaux argues that pure reason is *finite*. In order to gain access to insight into another being such that this access can be translated into meaningful and comprehensible knowledge, he argues that we must consider reason as finite intuition plus "a *mediation* that alone can universalize the immediate contact … this is the role of the understanding" (1985:57; emphasis added). Due to the finite nature of understanding and intuition, their collaboration—their synthesis—is pure imagination, "the fundamental faculty of the human soul, which *a priori* serves as the foundation of all knowledge" (1985:57). Such a system resonates well with this chaplain's remarks, whereby residents gradually learned to mediate their own knowledge by their intentional and socially and spiritually developed devices of understanding.

Other reflections add additional insights to this basic clinical model. One colleague suggested that some assessment is "more intuition than technique" and looked for clues such as family and friend support networks, the patient's perception of the medical situation, and the person's "ability to use their faith experience" to aid her reasoning processes. They helped her to understand, for example, that "hearing the words 'I am fine' are spoken frequently when such clues suggest otherwise. In such cases, I find myself pressing a little to encourage conversation," yet she also acknowledged that "there are other times when the words 'I am fine' seem truly genuine and reflect a healthy integration of the person's hospital experience." For her, pastoral insight proceeded from the assumption that a person's real state of being reflected a combination of spoken words, relationships, perception, and ability to draw upon religious resources.

To these words I add another's, who explained that "seeing sorrow in other patients has made it easier for me to understand how certain diagnoses, procedures, etc. could be trying for folks, and this second-hand awareness has been helpful when ministering in the hospital." This student found himself increasingly "comfortable and efficient consulting with staff (especially nurses)" and spoke up during discharge rounds when dealing with complex cases. These activities helped him "to develop a better conception of the emotional, physical, and cognitive struggles common to various patient populations."

What was it like to attempt to collect and compile such information during a clinical encounter? One resident confessed that she "needed the wisdom of handling and juggling so many

variables simultaneously and to appropriately administer timely messages of hope [through] 'presence' more than [through] words. Now, I realize my need to be more sensitive about times to speak, or to remain silent. I was challenged to listen and discern the motion, movement, or stillness of the moment." This chaplain in particular had a vivid faith and talked openly about her sense of the divine in her life as a source of guidance and insight, but in terms of her clinical work, she gradually embraced new listening techniques as necessary.

This statement points to additional challenges of patient-driven discourse. One of her colleagues sensed a "potentially large tradeoff between diagnostic accuracy and patient-driven conversations, [where] I can only know as much as the individual is willing to share with me, and I cannot force anyone to share. Perhaps I'm expecting too much from them—and myself." This resident's desire to do his best did not reflect a desire to solve cases or to attempt to uncover every possible bit of information apropos to a patient's situation, yet he struggled with such interpersonal limits and the realization that not all of his encounters would be maximally efficient or effective.

This reflection also points to a broader narrative conundrum in terms of information collection, namely potential points of rupture along the trajectory from original event to reception by the patient's pastoral audience. Confronted with raw data, Ricoeur suggests that there is often a preliminary desire to situate the particular within a universal law or norm and simultaneously to "oppose practical contingency to logical or physical necessity" (1984:97). He continues: "historical causality is a relation of one particular to another particular, through the medium of retrospective probability" (1984: 97-8), in no small part because "historical knowledge, resting on the testimony of others, is 'not a science properly speaking, but only a knowledge by faith'" (1984:98).

I suggest that in pastoral conversations, there is a tension between the idiographic and the nomothetic, rather than simply the presence of one or the other. Most, if not all, patients in the case studies tended to see their experiences as historically and socially unique. From the perspective of CPE, their journeys deserved to be narrated and treated as unparalleled. These budding practitioners sought to approach each individual with dignity and to avoid reducing them to anonymous points on trend lines, yet they also found themselves looking for motifs in patient narratives, in part to manage their own uncertainty in conversations. Particularly because they had access to biomedical staff members' explanations of illness etiologies, chaplains tended to be less concerned about the accuracy (or perhaps the mechanistic content) of patient beliefs regarding causality than in the implications that such beliefs had for individuals' senses of well being. They gradually came to realize that some patients withheld information, forgot, or intentionally misled in pastoral conversations and took these possibilities into account in attempts to gauge a person's spiritual and emotional status.

The reality was that residents did become more efficient observers over the course of the program, in part due to necessity. There was a huge and near-immediate filtering process that occurred in their work, particularly in the trauma bay, as students learned how to gauge a person's state in a few sentences, gestures, and glances. One resident described this aspect of the work as "a profound, radical type of social encounter, arguably unlike any other. It's sort of like being stuck with another person in an elevator car inside a burning high-rise and getting a 15-second summary of their life." Yet unlike some of the trainees studied by Luhrmann, one of whom commented that "after a year of seeing people and doing countless admissions, two to five or more a week, you walk into a room, you see how they address you, and you're already thinking the diagnosis" (2001:36), chaplains at this hospital had neither diagnosis nor classification at the front of their minds as they sought to understand an individual's situation. This was not because residents were inattentive or lacked interest in identifying key topics for conversation, but because they did not see themselves foremost as problem solvers. Their work was not to fix misfortune but to comfort, mirror, and enlighten, and searches for understanding proceeded accordingly. Absent were military metaphors about locating an enemy or waging a battle against some entity (cf. Sontag 1978). To the extent that the act of diagnosing, like naming, gives the actor power over his object, chaplains lacked power over the literal or metaphorical entities that afflicted patients.

Religious Knowing and Biomedical Knowing

Medical anthropologists have been particularly keen to elaborate the ways in which biomedicine cultivates certain ways of knowing in light of the latter's edicts about what issues and conditions can be amenable to scientific intervention. Young, for example, argues that "before medicine can move patients from disorder to order, it must first discover the meaning of "order"—the secret of how organism is connected to environment, desire to gratification, individual to group." The development of nosological systems has, he suggests, gradually led to the concept of the "'managerially optimized life," i.e., a "calculus of optimal trajectories with analyses of deviations from these trajectories" (1987:109). Such taxonomies then generate particular modes of analysis and diagnostic techniques for determining what is amiss and what must be done to return both the individual, and by extension this person's larger social network, to a state of equilibrium.

Young extends this argument to suggest that "the medical gaze extends to every nook and cranny of our lives" and that biomedicine is increasingly transforming formerly moral problems into medical ones (1987110-1). To the extent that this is true, does this mean that biomedicine, by attempting to colonize territory once under religion's domain in the West, has also colonized the religious diagnostic consciousness (cf. Comaroff and Comaroff 1992)? In terms of our clinical

interests, does religion lack the power to stem such territorial invasions (or, for that matter, to retrieve anything from medicine's purview)? Young summarizes Arney and Bergen's shift toward a new type of logic in the following manner:

> Knowledge of a moral problem "is complete once we know it is wrong." Medicine, because its problems are essentially technical, has an insatiable thirst for knowledge: a "technical problem compels analysis and requires detailed knowledge of its fine structure." Further, moral problems tend to work by excluding people: "one might be inside moral laws or outside them." But in the new medical logic—where all aspects of life, however innocent and private they may seem, are brought under medicine's gaze by the principle of preventive optimization—everyone lives on the inside …. [1987:111]

The idea of preventative optimization is hardly new; indeed, one could argue that it is the basis of most forms of religion, in particular those that emphasize immanent deities, the quotidian interaction of natural and supernatural, and some sort of afterlife contingent on actions in this world. Chaplains at my site were concerned about preventing as well as restoring, yet resource limitations were such that most necessarily focused their attention on stabilizing and left long-term preventative exhortations to their colleagues in parish and related settings. Likewise, the fact that these religious specialists were employees of the hospital itself makes it difficult to suggest that a purely secular medicine directly oversaw all aspects of morality within its own walls.[51]

At my field site, chaplains took as given their biomedical colleagues' statements about the reliability and legitimacy of laboratory and other somatic diagnostic techniques. Such information was one component of their analysis, yet they focused most of their attention on narrative accounts and non-verbal cues such as facial expressions and non-medical artifacts in the room (e.g., sacred texts, cards, flowers, pictures) to develop an understanding of a person's situation. This divergence between pastoral and biomedical investigative techniques[52] points to a further tension between

[51] Administratively, the director of pastoral care at my field site reported directly to senior (non-medical) hospital management. The work of chaplains was, as we have seen, influenced by biomedical concepts and practices, yet it was secular hospital bureaucrats—not physicians or scientific researchers—that oversaw the department's funding and access to other resources. Permanent chaplains were each responsible to leaders from their own religious denominations (e.g., bishops, executive presbyters) in terms of maintaining their clergy credentials, but these persons had no oversight of the department's affairs.

[52] I purposely avoid the label "divination" here, not only because chaplains never used the term, but also because it does not accurately reflect the methods or concerns of these practitioners. The reader will notice that I have used the term "diagnosis" and its cognates to refer to their work; I am not thrilled with this term either, chiefly because it suggests biomedical connotations that likewise do not capture chaplains' activities, but utilize it because chaplains at

dialogical and technological mechanisms of knowing within the hospital space. On one hand, the laboratory equipment is viewed by many as more reliable than narrative, the main epistemological technology of chaplains, and yet the devices and allusions to the spoken language remain pluripotent throughout treatment journeys. What, then, are we to say about issues of accuracy and reliability, particularly in light of my references to Wittgenstein in Chapter 1? Biological test results were not irrelevant to residents' pastoral encounters, particularly on psychiatry and neurology, but given the fact that most patient narratives did not include such topics with chaplains, the most we can say from the perspective of pastoral care is that biology can be a symptom of difficulties apropos to pastoral consideration, but so can family relationships, past struggles, squabbles with the charge nurse, concerns about unemployment, and of course the person's relationship with the divine.

Permit me a brief word on the relationship between the diagnostic tools of hospital chaplains and those of other religious specialists working in healing domains. While residents were expected to learn as much as possible about various religious traditions, there is no equivalent of the DSM for chaplains to consult.[53] Despite the predominantly Protestant makeup of my cohort, with strong Trinitarian beliefs in the concept of an imminent Holy Spirit, there were no spirit assistants (of the type described by anthropologists of religion such as Boddy) who accompanied these religious specialists on their rounds to provide guidance. There was no spirit possession in this profession, just as there were no séances, hallucinogenic substances, or other supernatural divinatory rituals utilized by many other religious specialists for purposes of "the analysis of the immediate problems and interests of individuals and subgroups" (Turner 1968:441). Even within the denominational traditions represented by these cohorts, there were no specific reports that I encountered of residents' being guided by God or having special insights revealed to them in the course of their clinical work. I was unable to get a sense as to whether this is because residents believed that revelation could happen but did not for them, because they did not believe in it as a regular/routine part of pastoral care, because it was never emphasized as a legitimate tool according to CPE, or perhaps because there was a sense that revelation would not hold much weight as an epistemological device in clinical rounds.

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my site (and in a number of academic publications) *did* use this term to describe the information gathering element of their clinical activities.

[53] There are, of course, countless guides available to chaplains, including the well-regarded *Dictionary of Pastoral Care and Counseling* (1990), but such volumes are reference works, not classification tools. True, a chaplain could in theory "diagnose" a person's beliefs as inconsistent with the formal teachings or confessions of the patient's religious tradition—we saw a bit of this in Case 10—yet these chaplains had no interest in playing the role of Inquisitor. "Heterodox" religious beliefs were not pathological in residents' eyes, so long as they were considered *ethically sound* and *life affirming*, concepts that were admittedly not clearly articulated in the program.

On Not Knowing; Diagnostic Uncertainty

Toward the end of her second year in the program, one resident reflected, "I walk more in the authority of a chaplain and have become more assertive as such because I am gaining more insight into patient assessment." Such sentiments should not surprise us; all of the students expressed similar thoughts about feeling more confident and self-assured as they refined their ability to ask relevant questions and listen discerningly. Still, there was a clear sense among students that they would not master every component of patients' diseases and injuries during their time in the program. There were likewise a wide range of practical limitations to understanding for chaplains. Many on ICUs were intubated or not fully conscious, making even non-verbal interaction difficult. Dialogue was also frequently short due to the severity of the patient's condition or particular medical procedures, and hence any clear sense of the person's status was difficult, if not impossible.

Thus the questions: What are the cultural and ideological consequences of having practitioners at a teaching hospital who freely acknowledge that they do not have a need to know or solve every problem that arises? What can we say about the ways in which residents view themselves and their own limitations, in terms of the effect that this has on them as people, clinicians, and social subjects? On a related note, what are the consequences for patients and other clinical staff of utilizing ways of knowing in the clinical space that aren't readily empirical or verifiable?

One particularly idealistic chaplain noted midway through the training that she had become "more comfortable with knowing that I do not have all the answers and that I do not need to" yet admitted that one of her weaknesses was "accepting the fact that I cannot wave the magic wand and accept my limitations as a human being. Oh how I wish everyone could 'live happily ever after' as the fairy tales tell us." Another resident came to similar conclusions, albeit from a more theological perspective: "Even though I have often felt the need to give answers to questions I do not find it difficult to invite patients to consider [the possibility that] there is no answer. We have not been promised to get answers from God, [but God] did promise to always be with us."

This statement points to an important belief about chaplains' understandings of their own work. They were rarely if ever able to offer concrete solution to existential questions, but that did not mean that their patient encounters were therefore pointless. From this resident's perspective, the mere presence of a religious specialist could be a reminder of divine presence, even in the absence of answers. Similarly, one of her colleagues explained that "in and of myself I am not going to be able to meet [a person's] need(s), nor am I going to be able to provide them with answers to their particular dilemmas. I am to be present with them in the midst of their particular circumstance … I

am a listening ear when needed. I am a non-anxious presence in the midst of the chaos of others' lives."

These ideas return us squarely to issues of power and control that we have discussed elsewhere. Is the interpretive enterprise, whether or not in the form of a dialectical exchange—ultimately interested in solutions, conquering, and overcoming? Is the role of exegesis to embrace the mysterious and the unknown, only to overwhelm it? Crapanzano would like us to believe that "we are of course unwilling to limit our symbols, our data, our documents, to mere tokens of recognition and exchange" (1992:227). But is this accurate in the case of clinical pastoral interaction? Particularly in Cases 1, 2, and 6, it seems that, so long as someone can manage a minimum sense of control over the unknown, a situation need not be threatening and can allow contentment with some forms of ambiguity. Consider the following vignette:

> The other day, as I was sitting across from a patient, he suddenly interrupts himself to ask me, "What happens when you die?" My discomfort with not having an answer was overshadowed by a strong intuition. So I waited a second, the intuition came again as some *insight* that he didn't seem to want an answer; he just wanted some emotional articulation, outlet or catharsis of some kind. He is an older man; I took his hand, and he began to cry almost silently but copiously, large tears actually spattered on the hospital bed-table.

Offering space to verbalize uncertainty can reflect the pastoral conviction that large questions still have a place in the phenomenology of the hospital experience. Such work acknowledges that ambiguity is present, is valid, and deserves naming. At its best, this resident and his colleagues believed that such actions could introduce greater humility into the therapeutic enterprise and into the lives of patients.

Wittgenstein may be able to shed some light on these phenomena. He argues that both belief and doubt stand at a crucial conceptual and practical distance from knowledge, where the last presupposes the absence of error (*OC* 8). At the outset, he focuses on the place of propositions within socially contextualized language and argues that contingents—objective determinants and proofs—are necessary in order verify or discredit a particular statement (*OC* 2, 5, 15, 298, 426). He readily acknowledges the presence of rules within cultures, yet he is equally quick to point out that such rules presuppose what he calls "normal circumstances" and, by extension, exceptions and indeterminacy (*OC* 27-8, 473; cf. Cases 2, 6, 11). Important for the work of chaplains is his claim that individuals "do not learn the practice of making empirical judgments by learning rules"; they are

taught "*judgments* and their connexion with other judgments. A *totality* of judgments is made plausible" to them (*OC* 140). The fact that persons are taught rules and standards in the attempt to achieve predictability and accuracy nonetheless means that they must contend with intuition and the freedom—if not the unconscious desire—to trust one's inner self, particularly when the alignment between the observed and the theoretical is poor (*OC* 34) and when moving, through independent questioning, from the weak beliefs of the child to the stronger beliefs of the independent adult thinker (*OC* 144), a process that for many stood at the heart of the hospital experience (cf. esp. Cases 1, 3, 5, 6, 9).

For Wittgenstein, belief and certainty are ultimately social enterprises, where the viability of an epistemological proposition is subject ultimately to its grammatical elaboration[54] (*OC* 40-1); this stands in addition to whatever ulterior motives persons may hold for their affiliation with a particular belief (cf. Hunter 1991). Initially, Wittgenstein's thoughts seem inconsistent here. On the one hand, he rejects the notion of certainty as a purely a social fabrication (*OC* 56), a viewpoint that most of my peers and I came to embrace in a great many circumstances. The great problem for him was that few find themselves in a position of complete doubt or certainty and, at least in the West, gravitate toward what they consider adequate tests of validation to comfort themselves (*OC* 66, 110), even as some could acknowledge that propositions "are not all equally subject to testing" (*OC* 162), with no clear boundary between them (*OC* 454), and that testing (*OC* 164) and justification (*OC* 192) must eventually come to an end.[55]

Nonetheless, such criteria are important for distinguishing *mistakes*, which are typically rational and reinforce a socially standardized truth known and embraced by the speaker, from *irrational beliefs*, which can reveal false premises behind a given belief (*OC* 73-4), for "the *truth* of certain empirical propositions belongs to our frame of reference" (*OC* 83; original emphasis) which may privilege elegance, simplicity, or creativity over less subjective approaches (*OC* 92). Thus, on the other hand, he proclaims, perhaps ironically, with these chaplains that

> All testing, all confirmation and disconfirmation of a hypothesis takes place already within a system. And this system is not a more or less

[54] Wittgenstein uses *wissen* almost exclusively when discussing knowledge. This choice is no doubt strategic: it suggests a higher standard for certainty than does *kennen*, the more straightforward form of knowledge that emphasizes memorization and synoptic familiarity over analytical comprehension. *Wissen* should behave in such a manner that the fact in question is taken into a person's consciousness but is often complicated by imagination (*OC* 90).

[55] Wittgenstein later resurrects his familiar refrain from the *Philosophical Investigations* that "At some point one has to pass from explanation to mere description" (*OC* 189). Indeed, the language-game is possible only if it presupposes synchronic, if not also diachronic, certainty about particular facts (*OC* 446, 617, 645-6).

> arbitrary and doubtful point of departure for all our arguments: no, it belongs to the essence of what we call an argument. *The system is not so much the point of departure, as the element in which arguments have their life.* (*OC* 105; emphasis added)

Wittgenstein distinguishes between the certainty that arises in language-games from that generated by other analytical technologies, both within a given culture and cross-culturally (*OC* 108, 609, 611), such that it becomes nearly impossible to speak of a single certainty; there appear to be multiple certainties, depending on the stage of information transfer in which individuals find themselves, constantly interacting with doubts, which likewise form a system (*OC* 126).

A practical consequence of such a process of moving from doubt, to certainty, then to knowledge, and finally to truth is that "the reasonable man does *not have* certain doubts" (*OC* 220; original italics). Though this species may not harbor certain doubts for a variety of reasons, such as necessity ("I can't help believing …" (*OC* 277)), apathy or contentedness (*OC* 344), time constraints (*OC* 343), or imagination (*OC* 442), I believe that Wittgenstein is arguing that the critical thinker has at least a limited ability to doubt *at will* (*OC* 221). If this is true, then it seems that it must also be the case that his reasonable man must also possess a certain ability to believe at will, above and beyond the extents to which "a language-game does change with time" (*OC* 256, 336) and that the persuasion noted above can likewise be directed at others (*OC* 262), just as it was between residents in their didactic sessions.

A more difficult question revolves around the necessity and situational nature of a given belief. While on the one hand he argues that a person should be considered unreasonable either if she believes something despite scientific evidence (*OC* 324), or (implicitly) because of divine revelation (*OC* 361), he also disputes the suggestion that reasonable actors should necessarily draw the same conclusions (*OC* 325, 629), primarily because Wittgenstein believes that we must understand the broader context before making a final judgment (*OC* 326, 334). Even so, Wittgenstein regards certainty as "a form of life" (*OC* 358), suggesting that it can become an M.O. at any point in time, quite possibly to the detriment of future epistemological odysseys—though it seems that a certain measure of it is clearly necessary for ongoing language-games in which subjects participate in the meantime (*OC* 369-70), in the clinical space or elsewhere.

MORALITY, CONFESSIONS, AND CONFRONTATIONS

Morality and confessions retain a significant place in U.S. hospital cultures. Though the aims and processes of moral oversight have evolved over the last three centuries, Foucault's (2003) reading of the clinic as a confessional space has remained a popular way of conceptualizing issues of power, guilt, and condemnation among the afflicted. There seems to be an assumption that clinicians readily assume the position of moral hangman and judge patients because of actions they have taken (or have not but should have) to lead to the compromised physical state. Biomedical practitioners, so the argument seems to go, have increasingly subsumed roles that were earlier the purview of Roman Catholic priests, with their formal Sacrament of Confession.[56,57]

In earlier days, as we recall, a confession or admission was frequently thought by religious figures and many laypersons to precede—to be a precondition for—healing. Gradually, however, scientific progress decoupled physical and the spiritual elements of causality, particularly as the preparation of the soul for death became less paramount an activity within the clinical space, even though such mentalities lingered in the ideological makeup of the clinical space, thus reflecting a peculiar confluence of Weber (2001) and Foucault (2003) on the relationship between accountability and perceptions of various forms of oversight and their consequences for an individual's social status and progress. Indeed, shame and scorn of various types continue to be present as topics of concern in

[56] There is also the broader question of the term "confession" itself. Richardson explains that "in the ancient church *confessio* meant the profession of faith made by a martyr (or 'confessor', who had withstood persecution for his faith) …. The word thus came to mean a firm declaration of religious convictions with or without reference to persecution …. It could also have a still more general sense, namely the biblical sense of praising God, e.g., Augustine's *Confessions*." At the time of the Protestant Reformation, confessions "were not intended as alternatives to the ancient ecumenical creeds (the Apostles' or the Nicene) but rather as statements of how the traditional creeds ought to be understood …. They were confessions of the church rather than of individual theologians." Examples include the Augsburg and Westminster Confessions, and Protestant churches that utilize these formulas are known as "confessional" churches (1983:116-7). Etymologically, these confessions of faith should not be confused with either (1) the Roman Catholic Sacrament of the Sick (a.k.a. Anointing of the Sick or Extreme Unction), for individuals "whose bond with God and the Church has been weakened by illness or physical incapacity" (McBrien 1994:836); or (2) the Roman Catholic and Orthodox sacraments of reconciliation (or Penance, Latin *paenitentia*) suggested rather loosely by the use of the term "confession" in most medical anthropological literature, which tends to conflate the public act of reconversion to the church and the inner act of turning again toward God (Martos 1983:435-6). For that matter, it is important to note that the sacrament has for some time been called the Sacrament of Reconciliation.

[57] This schema of course completely neglects the work of Protestant ministers who viewed sin and forgiveness with great importance but did not elevate the process of articulating misdeeds to a fellow human—even an ordained clergyman—as rising to the status of sacrament, thus reflecting a more circumscribed role for religious figures and hence a less mediated (and arguably more individualistic) relationship between human and divine. Such a distinction assumes added importance in the U.S., given the large role that Protestants (and, for that matter, other non-Catholics such as Jews) played in the construction and ideological oversight of many hospitals prior to the 1980s. It should likewise be remembered that Luther and other Protestant reformers insisted that divine grace was immediately available to penitent believers through justifying faith, not through the necessary intermediation of clergy with a formula of absolution or a set of juridically oriented penitential books (McBrien 1994:839).

at least one U.S. hospital. As we have seen (cf. esp. Cases 1, 4, 8, 11), there was a complex dialectic at this hospital between religious and biomedical knowing in terms of moral issues and ways of determining abnormality, deviance, and pathology. These encounters invite a reconsideration of clinical morality, particularly in terms of the loci of power and the role of religion in processes of estrangement and reconciliation.

Correlations, Causality, and Culpability

One may be forgiven for getting the impression from the verbatims that sin, if not dead, is but a faint shadow of its former self within the hospital. In most of the cases, the issue never arose at all, or did so but obliquely in the resident's reflection. Why? The ideology of pastoral non-judgment was one major factor. Despite the fact that each resident came from a particular religious tradition and was informed by denominational views about what counts as proper and improper behavior, the training program expected that residents would attempt to consider a broad range of factors that might have contributed to the patient's condition;[58] this gradually led students in my program to consider the possibility of a *lack* of a *necessary* causal connection between the biomedical event and the patient's own actions. A very high bar was set for chaplains for the notion that a thought or action that breached some religious code directly generated or elicited putative bodily punishment.

Still, in terms of assessing beliefs and behaviors during the hospital stay, residents quickly learned that the use of certain medications and procedures implied afflictions that carried social stigma and hence could generate condemnatory beliefs and attitudes among clinicians and others. This was particularly true on trauma, neurology, and stroke rehabilitation, where it was routinely difficult to know a person's complete medical or social history and hence his or her own contribution to the presenting malady. For example, there was never any suggestion in Case 2 that Ranu's sudden collapse and death were the result of "sinful" behavior or divine retribution for some past wrong. His family members made no confession of guilt regarding his health, and neither the chaplain nor anyone else attempted to extract one. The chaplain did not remain in contact with the family in the days and weeks following the event and so never knew what conclusions his relatives back in Africa may have drawn or, for that matter, what (if anything) the hospital's lab found. Perhaps the coach worked him too strenuously. Perhaps Ranu pushed himself too hard during training when he in fact knew that he had a cardiac condition. The boundaries of the chaplain's workplace made it essentially impossible for her to pursue the sort of social continuity-generating activities of many other religious

[58] One sees parallels between this ideological influence and that of psychotherapeutic models of illness versus the biomedical model, where these differences ultimately "help to produce different moral sensibilities about mental illness" (Luhrmann 119) according to their respective nosologies.

specialists or to get the sort of longitudinal picture seen by, say, Evans-Pritchard's witch doctors (1976), thus restricting the jurisdiction of her societal credibility and influence.

How, then, do chaplains conceptualize causality in their clinical interactions? Residents in my program certainly thought about the underpinnings of affliction, even though these topics were largely uncoupled from condemnation. The heavy epistemological emphasis on narrative in residents' work provides a partial answer. Causality, for chaplains, was predominantly assessed through conversations—stories that recounted past events from particular perspectives that reflected both the cognitive and dialogic biases of the narrator—and were as such factors that mitigated residents' tendencies to blame or shame.

This is not to say, however, that individual volition or the concept of causality itself were irrelevant considerations in clinical pastoral care. Consider, for example, Ricoeur's reading of Popper: "the underlying thesis is that the *polysemy* of the word 'cause' is no more an obstacle to the rule-governed usage of this term than is that of the term 'to explain' …. The problem is to regulate this polysemy, not to conclude that the term must be rejected" (1984:125). Likewise, he suggests that "to the extent that the model of rational explanation makes the theory of history intersect with the theory of action, the problem is to account for those reasons for actions that cannot be attributed to *individual* agents. Here, we shall see, is the critical point for any 'narrativist' theory" (1984:130; original italics). To the extent that admissions of guilt still find a home in the hospital, it seemed at my site that biomedical staff were primarily interested in confessions as they related to presenting somatic issues, whereas chaplains found confessions relevant chiefly in terms of a patient's relationships—with himself, loved ones, society, and the supernatural. I suggest, however, that there were also points of overlap in matters of causality, narrative, and agency. It may be helpful here to think of confessions in terms of Venn diagrams that distinguish maladies that are purely biological and in no way reflect culpability on the individual's part (e.g., random gunshot victims), maladies that are purely spiritual yet have no immediately perceivable somatic manifestation in the hospital (e.g., greed or lust), and maladies that are some combination of the physical/environmental/genetic and the spiritual (e.g., alcoholism, obesity,[59] and perhaps STIs).

Such a schema nonetheless presents challenges for the division of labor and perceptions of accountability. Luhrmann points to the problem of intention in psychiatric illnesses and argues that the broader U.S. culture reflects "religious traditions that condemn intentional suffering and medical practices that bracket intention away" (2001:274). I sense that the chaplains in this program would

[59] Or, to use the older and decidedly less fashionable term, gluttony.

have largely accepted the first part of this statement but rejected the second. While residents in my program were unevenly committed to the doctrine of free will, and while they were aware of various somatic and societal forces that nudged individuals to make certain life choices, they held firmly to the notion that patients were not wholly passive objects of cultural or biological dictates. These chaplains were unwilling to accept the argument that all behaviors and choices could be reduced to neurochemical activity or genetic predispositions (nor, for that matter, did they encounter any biomedical staff who suggested that this was the case). As one of the chaplains on neurotrauma-neurosurgery, I developed the sense that it was indeed difficult to speak of the intentionality of some patients, due to degenerative conditions that they faced. I might have been romantic in thinking that there was still a measure of conscious intentionality in their narratives, but through my discussions with my peers and supervisor, we came to the conclusion that it was therapeutically preferable to err on the side of full personhood than to risk biomedical reductionism or paternalistic religion in our dealings with patients. Residents felt that patients should want to get well, take an active, participatory role in their own treatment, and seek to avoid the intentional or unintentional affliction of others, and they believed it was important to convey to patients that they believed that they were capable of such agency, despite their maladies.

However, this still leaves unsettled the question of the moral status of biomedical knowledge and its relationship to the work of chaplains as religious specialists. Luhrmann offers a provocative argument about current understandings of causality and the scope of clinical intervention as a possible way forward:

> The psychoanalytic theory of mind will never anymore be understood to provide the explanatory foundation of mental illness, because that foundation, as it is culturally constructed in this age of electron microscopes and genetic analysis, lies beyond personhood, in biological microstructures that escape uniqueness. There is a quality here of the deepest and most real. It has a moral quality: that this knowledge is what really counts, what really makes a difference, what in the end creates the greatest good for the greatest number … for many young psychiatrists, at least in residency, the moral authority of science outranks the moral authority of helping people one person at a time. [2001:181]

It is profitable to compare this outlook with that of chaplains, many of whom were acclimated to thinking in terms of groups and collectives in congregational settings prior to CPE, only to find

themselves thinking predominantly in terms of individual cases in the hospital. Utilitarianism, particularly the sort described by Luhrmann, was largely an abstraction for residents' day-to-day work, not because these residents did not want to help as many people as possible, but because they viewed individuals as unique persons that should be approached one case at a time. For them, the psychoanalytic theory of mind also had its limitations for mental and other illnesses, not so much because religion also looked to microscopes and genetics for moral guidance in lieu of Freudian theories, but because religious moral foundations ultimately rested on cosmological systems that sought to acknowledge the spiritual, affective, and historical idiosyncrasies of the individual while situating them within larger metaphysical frameworks that transcended scientific theories and human reasoning in general.

Still, the questions of which attitudes and behaviors should be rejected, and how, resist easy formulations in the hospital. In an earlier monograph, Rieff argued that "evil and immorality are disappearing, as Spencer assumed they would, mainly because our culture is changing its definition of human perfection. No longer the Saint, but the instinctual Everyman, twisting his neck uncomfortably inside the starched collar of culture, is the communal ideal, to whom men offer tacit prayers for deliverance from their inherited renunciations" (1966:8). It is difficult to defend this claim based on my data, despite the seemingly accelerated biomedical drive for human perfectibility and broader social norms about consumption and restraint in the names of bodily maintenance and refinement. Cases 3, 9, 10, and 12 all consider explicitly issues of evil, brokenness, and restraint in society in relation to biomedical treatment and the last three in particular looked to religion for ways to help them find recovery. For these patients, it was not renunciation that they hoped to escape so much as the repressive drives of others, whose own worldviews and actions sought to limit their flourishing.

Compare this line of reasoning with Young's analysis of Arney and Bergen's thesis that those "who stray from normalized trajectories run the risk of being simultaneously afflicted and deviant. People whose unrestrained individualism has brought disease and misfortune onto their own heads are conspicuous figures in the new medical discourse" (1987:110). Here we find the opposite problem to both Rieff and the somatization hypothesis. Individuals, they suggest, can and should control their own individualistic desires according to biomedical norms, and when they don't, they can expect judgment from scientific clinicians and labeling as persons who are sick in a double sense of the term: they are both biologically unwell and irresponsible, in need of technological management. Chaplains did not view individualism, much less uniqueness, as abnormal or pathological; they were interested in how a person's individualism manifested itself in social settings

and the effect that it had on relationships. One might even say that the social uniqueness of the chaplaincy role made residents all the more sympathetic to the struggles and needs of the seemingly (or actually) marginalized.

Therapeutic Confrontation? Rationales for Moral Intervention

Granted the philosophical and ideological positions articulated in the last section, chaplains still wrestled with how to approach causality as a rationale for pastoral intervention.[60] Indeed, chaplains reflected with patients and with each other on such topics as the brokenness of the world, communal violence, and structural inequalities (cf. Cases 3-5, 9, 10). They acknowledged in their reflections that some patients were at least partially to blame for their afflictions but rarely felt that they should condemn patients to their faces. Some of this reluctance to condemn reflected the non-judgmental ideology of the program, but I suggest that this protocol existed for reasons beyond Biblical interpretation[61] or a wishy-washy theology that sought to focus only on the positive. Moral judgment was, I argue, contraindicated in most cases in terms of promoting recovery—physical, emotional, or spiritual—whether or not such critiques were warranted. Likewise, from the perspective of narrative psychology, judgment tended to suffocate discourse and left the patient little room to respond or contemplate alternatives for the future. Instead, residents sought more productive ways of encouraging reflection that would foster positive change.

It is important to stress that chaplains believed that patients were capable of changes of behavior and outlook. Protestant chaplains in particular were likely to cite free will as a foundation for such convictions in the possibility of moral, ethical, and psychological growth and emphasized forgiveness and reconciliation more than discipline and punishment. Consider the following reflection from one first-year resident:

> I also need to work on more entry places in a conversation when the first response is "I am fine." The challenge, again, is that balance between privacy and support. In cold calling I believe I err on the side of privacy, giving up too quickly. I take "no needs" at face value and many times one more opportunity is all it would take to allow someone to have a conversation that could be helpful to them.

[60] I am tempted to suggest that before a meeting with a chaplain, some individuals at my field site might have been inclined to view institutional religion through the lenses of the panopticon and guilt but were less likely to do so, if at all, after pastoral contact. Once again, most of the chaplains didn't wear visible religious clothing, so it would have been harder to make the claim that patients and others saw embodied religious authority as a ubiquitous presence in the clinic. More research is needed to validate or reject this hypothesis.

[61] For example, "Do not judge, so that you may not be judged" (Matthew 7:1).

For this trainee, the question is neither whether the person is guilty of some act or has the capacity to contribute to healing. Rather, it is that patients may be unaware of actions that contribute to their hospital status or are reluctant to discuss them with a stranger, religious or otherwise. The desire to respect the patient's "privacy" kept her from more thorough questioning, yet she suggests that not all statements should be taken literally and may require a bit more determined prodding from the chaplain to open up topics that a patient might not initially think to address.

While such situations may lead to what might be considered an empathic confrontation from the chaplain, this was not the only possible outcome. Denial and artifice could cause narratives to become pathologized (cf. Cases 8, 11). Doubt about the accuracy of a patient's statement could lead a chaplain to take a more authoritative stance toward the individual and see him in a different light. For instance, one resident explained that she occasionally confronted a patient because "it seemed to be the best course of action to take at the time. The few times I did always were fruitful in that it got the patient to look at him-/herself and their choices honestly." She found that the person usually opened up in response, and "the conversation would take on a life all its own" in a way that she believed "was appreciated by the patient and myself as well. One gentleman simply broke down sobbing, 'I needed that, I needed that.'"

That said, there was a variety of opinions among the residents on the notion of being a sort of supervisor-overseer of a patient or other human beings in general; some seemed to relish the role, while others did so only reluctantly. Part of this variation stemmed from different models of leadership discussed earlier (e.g., facilitator, shepherd, companion). One resident explained that in his early patient contacts, he himself had "felt a keen need not to offend anyone," and that while he considered his listening skills quite good, his "willingness to initiate and engage in frank discussion about religion with patients was rather tenuous." A few months later, however, he reported that he had become

> far more comfortable asking questions about a person's relationship with God; reflecting with patients on the possible spiritual implications of their illness; challenging individuals when they express a theological position that is inconsistent with the notion of God as a source of hope, mercy, and healing; praying with patients and family members, both in moments of crisis and in moments of waiting; and expecting that my prayer companions will contribute petitions and reflections—and maybe even a thanksgiving or two—to our collaborative communication with God.

Such a shift should not surprise us, given the pedagogical nature of the program. In his mind, confrontation was not about wielding power, but about fostering a healthy sense of agency for patients. Whether his patients saw these overtures benevolently is, however, another question, one that I was unfortunately not able to investigate during this period of fieldwork.

Another student, meanwhile, found himself struggling with how to be confrontational "in appropriate ways." He was comfortable challenging his peers in the classroom setting and saw such work as crucial to his own personal development. With patients and family members, however, he confessed that it "depend[ed] on the situation." He felt more comfortable raising objections in an "established relationship" of trust and familiarity and when the social situation was stable on the unit. He found staff confrontations "more delicate," for he explained that he was not in a position to challenge his biomedical colleagues on issues of science but could raise patient-related questions about such topics as visitor access, doctor-patient communication, and pain management.

What conclusions can we draw about the ways in which these chaplains viewed subjects and their uses of their physical bodies? Rieff argues that the U.S. culture developed, "as its general technique of salvation, assents to moral demands that treated the sensual part of the self as an enemy. From mastery over this enemy-self there developed some triumphant moral feeling; a character ideal was born …. The dialectic of perfection, based on a deprivational mode, is being succeeded by a dialectic of fulfillment, based on the appetitive mode" (1966:49-50). Case 1 addresses the issue of sexuality and what we might call bodily appetites (or, to borrow an arcane theological term, concupiscence); Cases 4 and 5 do so in other ways, through discourse about illegal drugs and nutrition. Cases 8 and 11 touch on these issues through pharmacology and symptom management. If there is an overriding moral message in these cases regarding the status of the body, it is that the somatic self is a resource that should be managed wisely, like any other device or good. It should be utilized in a way that does not generate harm for others (cf. Case 1) or for the self (Cases 4, 5, 8). Similarly, medical care should aim not toward perfectibility but toward proper, timely care, particularly so as to minimize future problems (Case 11). The notion that more is better is one that residents decisively rejected as antithetical both to the welfare of the individual patient and to the just distribution of limited resources in the broader society. Most of them realized, however, that theirs was not the prevailing ethical norm of either the institution or the broader culture.

In other cases (cf. 1 and 10), it was the patient who raised issues of sin, guilt, and punishment with reference to the body. It is interesting to note that in both of these exchanges, the resident was taken to task by the supervisor and peers for overly legalistic answers that seemed to keep questions of culpability purely at the intellectual level, rather than introducing the level of affect. He was not

wrong in their eyes for attempting to address the patients' concerns, but particularly in Case 10, he was scolded for doing so in a manner that was not considered therapeutic. My colleague absolutely did not seek to revel in another's spiritual pain or seek to fan shame, yet it is entirely possible that he, as a Protestant, did not provide what these two Roman Catholic patients seemed to want, namely an illocutionary proclamation of the forgiveness of sin or a set of penance exercises (such as the Rosary or novena performances). The psychiatric patient in particular did not appear interested in theological logic or spiritual self-sufficiency; she had made her confession and wanted—perhaps expected—the religious specialist to perform the standard ritual. When he did not ritually proclaim her forgiven—when her schema of confession did not obtain—the interaction was incomplete from the patient's perspective.

This exchange points to a larger, and to my mind under-theorized, element of moral confrontation in Western hospitals, namely the social, spiritual, and psychological aftermath of confessions in the clinical space. In her review of McGuire's *Ritual Healing in Suburban America*, Luhrmann criticizes the author for a misreading of Tambiah's notion of the performative efficacy of ritual language, suggesting a misalignment between this theory and the field data that she collected, in which symbolic action *did* appear to have concrete therapeutic consequences (1990). At my field site, chaplains did not believe that their utterances held magical potential, even in situations in which they saw themselves as conduits of the divine. Words did not *cure*, but they could *heal*. That is, a sense of emotional release could emerge for patients through both verbalizing their own thoughts and receiving words of encouragement that the religious specialist provided, whether those words came in the form of a formula such as the recitation of a passage of sacred text (Case 8), prayer (Case 6), or everyday conversation (Case 1). Chaplains believed that they possessed neither monopolistic access to the sacred nor exclusive right to narrate religious concepts in the clinical space for therapeutic ends. Unlike religious specialists described by Lewis (1971) or Lévi-Strauss (1963), residents saw their roles as facilitators of contact with the divine, not gatekeepers or mandatory intermediaries, and in this sense viewed themselves not as guardians of an esoteric corpus of formulae or moral high priests but as modest witnesses to the struggles of strangers that placed the onus of efficacy and moral condemnation on the personified deity.

Indeed, the therapeutic issue of doctrine and the stranger presents a number of challenges for pastoral confrontation can be seen as a *via media* between confessionals of old and secular psychoanalysis. There is the potential for a moral base, a moral tradition, when the patient/family/friend and the chaplain are in alignment about what that tradition should be (e.g., Protestant, Jewish Orthodox). The more theological overlap there was between care provider and

recipient, the more that issues of morality (guilt, forgiveness, sin, grace, etc.) could be discussed openly and authoritatively in conversation. When there was relatively little specific theological overlap, and/or in early stages of a conversation, when both sides sought to gauge the other's position and agenda, there was likely to be more emphasis on understanding and the articulation and mirroring of emotions. Initially, then, chaplains came to expect a significant focus on unstructured conversation and the narration of recent events, and only then a possible move to questions of meaning, the search for understanding and assessment of the person's narrative understanding of the situation, including questions of morality and blame.

Some Additional Challenges

Instructing residents not to judge patients or others in their clinical interactions does not, of course, mean that judgment will not happen in some form or another. Chaplains initially struggled to distinguish between religious diagnostics and religious confessions in terms of information transfer and therapeutic ambitions (cf. Cases 4, 10). Yet where does this leave the work of the chaplains as therapists? If biomedicine seemingly has a tendency to judge, or at least to explain away certain behaviors and activities as a result of the patient's underlying biological (neurological and/or genetic) behaviors or drives, and if, from the point of religion, a deity or deities still exercises judgment over the thoughts and actions of humans, then what is the chaplain's role in terms of healing and, in particular, reconciliation? More to the point, what is the connection between confrontation, confession, and mediation? And, ultimately, what is the connection between confrontation, confession, and therapy? These questions raise profound issues of justice with reference to clinical cultures and highlight the ambiguities of the types of rejuvenations that are expected, or at least desired, from patients and practitioners alike in the clinical space.

For these chaplains, all of whom genuinely wanted to see improvement in the well-being of their patients, another key challenge was to determine, as one resident said, "whether or not my interactions with patients have been about them or me and my need to help/serve." If pastoral confrontation is finally about helping believers to live in fidelity with their own religious traditions, in light of biomedical findings and suggestions, then as this same chaplain found, such an outcome can only begin to occur if she can "recognize the intrinsic value of every human being I encounter. It is only then that I am able to genuinely come alongside a person and attempt to meet them where they are, not where I think they should be."

This resident was not alone in such tendencies. One of her colleagues explained that

> There are times when a big part of me wants patients to accept my vision of God, my way of doing theology, yet there is simply no

> reason why the Other must be cast in my image. Yes, I challenge individuals if I believe that their beliefs misrepresent God's goodness and close the door to possibilities of reconciliation, but it's not my job to try to convince a Calvinist to abandon predestination or to suggest to a member of Opus Dei to put the Pope in a more reasonable perspective. This openness to difference is perhaps most difficult when an individual holds what I consider racist, homophobic, sexist, etc. views; in such cases I try to focus on the goodness and justice of the Divine without embracing or sanctioning the exclusionary.

It is easy, in light of such comments, to get the impression that chaplains ultimately tell people what they want to hear. With the possible exception of Cases 7 and 10, patients here showed no interest in an angry God or an unforgiving deity that had no time for their plight. I argue that this hospital was likewise uninterested such a being within its walls. At the same time, there was little space at my field site for ancient Roman or Hindu gods—deities who exhibited both good and bad attributes. Patients wanted to be comforted through their interactions with chaplains and to know that goodness would win in the end (whenever that might be). Either God was (ultimately) loving and compassionate, or there was to be no God at all in the clinical space.

Given these reflections, how should we interpret Rieff's contention that "coercion and the renunciation of instinct a[re] indispensable elements in all cultures" (9)? It is certainly possible that some saw chaplains as coercive figures in the clinical space, icons of larger social systems of power and constraint (cf. Case 7), though the fact that several patients appreciated the pastoral visit (Cases 1, 6, 9), coupled with residents' remarks about initially being associated with death and bereavement care as chaplains, rather than with judgment and exclusion, suggests a more complex picture of social religion in the U.S. than was the case even a couple of decades ago. It seems entirely likely that memories and imagination both played a role in perceiving—if not stereotyping—chaplains; those who wanted to see these religious specialists as closely aligned with other social elites such as physicians and surgeons were likely to do so, just as those who viewed chaplains as benign grief counselors would find that as well. It was possible to see chaplains as authoritative figures with an institutionally granted entitlement to confront and condemn, just as it was possible to see in them as saints, bureaucrats, or garnish.

Phenomenology of the Dialectic

> When I enter a dying patient's room, or a very sick patient, even if I have never met the person, often we come together completely in the moment we join hands and look in each other's eyes. What is this? It is startling. I have begun to let go into it, and relax in the question. Nothing has to be said; on the other hand talking is fine, especially in the awareness of the ultimate connection. In this space we have no agenda, we don't know how things should unfold. In our mutual openness, the distinct line between the patient's pain and our pain is lost, there is just pain … or joy … or fear … or experience without a particular label. We bear witness to each other's feelings, and in this there is some kind of mutual healing. There is some exchange. Something comes through, and the one to be healed becomes a healer, while for the healer there is healing.
>
> — First-Year Resident, Fall 2004

One of the most significant challenges for CPE residents was to find a workable balance between allowing in enough sensory data to be fully present as a compassionate dialogue partner and letting in so many sensations that they became overwhelmed and incapacitated, unable to process information or to respond in a therapeutically useful manner. They believed nonetheless that their openness should be motivated by some higher principle. As one resident confided, "My understanding of the pastoral role has evolved into the belief that the most important aspect of what I do is to be a human conduit of divine love. Pastoral care, I believe, is essentially about helping a person to feel loved. Our duty is to see and treat people in the manner that we can attempt to imagine God would."

Perhaps not surprisingly, this statement resonates closely with Wedenoja's description of syncretic religious practices: "There is likewise a premium on love and altruistic behavior, in contrast to selfish individualism, as components both of prevention and of assisting the healing process" (1995:93). Koss-Chioino argues along similar lines that "radical empathy" can create an "inter-subjective space where individuals, whether acquaintances or strangers, enter into intimate relation with each other" in healing relationships to such a degree that individual differences "are melded into one field of feeling and experience" (2006:655-6). These concepts are significant to our debate for a number of reasons. She argues that those who seek healing within the ritual paradigm

tend to see their illness in terms of the world of the sacred, and the interventions of religious practitioners "comes not from the healer him/herself but from the realm of spirits, God or gods or other extraordinary beings." She explains that the practitioners she encountered "did not identify themselves as 'healers,' but rather as the vessels through which healing forces were summoned and transmitted to and from supplicants. They say that they 'lend their bodies' to spirits" (2006:656). Through a variety of contact mechanisms, healers "experience spirits in ways that are both personally meaningful and at the same time open onto a new kind of relationship with all Being" (2006:657).

This model of intervention, familiar to many accounts of religious healing, bears partial resemblance to the experience and perceptions of chaplains at my field site. In some cases (esp. 1, 3, and 6), the resident demonstrates a sense of concern for and proximity to the suffering other to the point of a partial loss of self-identity. In the first and particularly sixth narratives, there is a palpable sense of the supernatural at work. However, despite the resident's sense of being a conduit for divine love on the neonatal unit, she did not intend this statement to imply that she or her colleagues possessed preternatural powers to transmit superhuman forces to the somatic sphere. She could model divine attributes, in other words, but at least in her eyes, her presence lacked metaphysical content. The manifestation of a particular affect may thus hold salutary potential for a patient's or family member's emotional and spiritual stamina along an illness trajectory, but this in itself cannot be taken to imply that the demonstration (or even communication) of regard has direct causal impact on a disease or injury, in the absence of the patient's reception of and reaction to such an offering.[62]

Despite ostensibly noble intentions, phenomenological proximity between chaplain and patient at any ontological level was by no means something that could be presumed, as we saw in particular in Cases 3, 5, 7, and 10. Several possible reasons come to mind. On one hand, except when a patient had a disease or injury of the reproductive organs, gender was rarely noted as a barrier to conversation or a sense of trust in residents' interactions; economic status likewise garnered little discussion. Issues of ethnicity and age, however, did. Ethnic relations were outstanding between the chaplains themselves, but there was a clear awareness that there were substantial ethnic tensions in the hospital on a variety of levels in ways that made open, honest communication and the sharing of experiences difficult, regardless of the parties involved. One resident felt comfortable reaching out to persons "of any and every ethnic group," yet he realized that others "may not necessarily welcome

[62] This, of course, leaves open the question of secondary causality through biomedical interventions. Either way, there is at present no means to test for supernatural influence through either direct or indirect clinical mechanisms. We cannot, in other words, say whether the effusion of something called divine love itself holds curative or restorative powers.

the presence of a white male chaplain, and I must consequently be patient if I am to win their trust." He explained that he occasionally felt "under scrutiny by some African-American family members in the ED/trauma bay, particularly when test results are slow and when I cannot let them see their family member(s) immediately." Nonetheless, he concluded that in most of these cases, family members were not angry at him but were "simply anxious and scared." Similarly, one of his colleagues and a lifelong resident of the city, explained that she "purposely ignored stereotypes concerning people I met. Instead I attempted to attend to their needs. There were those who obviously did not want pastoral care from me as a woman, or as a Black woman. Their pain and/or suffering became the priority and enabled me to overlook any presumed prejudices on their part." Conversely, she noted that "there were also others who acknowledged these differences, and yet chose to have me be their comforter because their pain was so great. As one Catholic gentleman said as he and his family stood around his dying wife, 'You're not a priest, but you can pray, right?'"

Empathy, Listening, and Narrative

Dialogue served a wide range of diachronic functions of self- and other-formation in CPE, not only through the experiences of encountering and remembering, but also processing, relating, formulating, and responding. Indeed, phenomenology of discourse was one of the key components of the clinical experience for these religious specialists.

Consider the following reflection:

> I continue to work to listen with an ear for the feelings behind the words …. I am working on developing a deeper level of hearing which will enable me to more effectively move conversations from data to feeling. I continue to find it a challenge to help those patients who comfortably talk at length about the specifics of their care and hospital experience, but who would be better helped by sharing how that experience affects them.

For this resident, words conveyed meaning, both in terms of what was said and what was left unsaid, but she considered the delivery of the lexemes themselves—tempo, cadence, volume, enunciation—crucial to understanding patients' reactions to what was happening to them. Pastoral empathy reflected for her a linguistically counter-cultural, even counter-intuitive process in the hospital: it sought to foster reflexivity through the dialogical articulation of experience, not as a confession, but as a balm. Such acts of listening were designed to recognize (in the Hegelian sense) the importance not only of patient feedback in therapeutic processes but also the implications of such processes for the person's sense of selfhood and sense of connection to others, both human and divine.

Chaplains learned to talk openly with each other about feelings and emotions, but for most patients, family and friends, and even medical staff, this frankness could be difficult or threatening at first, unless these persons were familiar with this mode of discourse. Such unclear expectations could, if not explained by the resident to her interlocutor, easily lead to a disjuncture between what the chaplain thought that s/he should try to accomplish, what a good intervention looked like, and what the other person(s) expected or desired (cf. Cases 5, 7, 12).

Compare now these ideas with those of Lacan: "Analysis is becoming the relation of two bodies between which is established a phantasmatic communication in which the analyst teaches the subject to apprehend himself as an object" (1981:68). To an extent, this description captures the aim of clinical pastoral conversation as well. *Teaching* is probably too strong a word for chaplains' encounters, given the fact that most were short, one-off meetings, but there was clearly a strong aspect of helping patients to embrace the affective components of their misfortune through appeal to narrative. In some instances, like Case 1, this involved encouraging the person both to step back from his own experiences to view them from a new angle, and to consider different interpretative and affective approaches to current and future relationships in the name of healing. Similarly, the chaplain sought to help this patient to reconsider religious beliefs and the lived experience of these beliefs in order to evaluate which beliefs were helpful or productive and which were not.

There are other ways in which words were used in tandem with phenomenological processes. One resident explained her use of sacred texts and other works of theological literature to assist in the articulation of phenomenological sensations. She noted that it could be appropriate for the chaplain to offer interpretative insights or ideas into particular passages, but she believed that it was "always preferable to ask the recipient what they perceive the message from God to be." Such topics often introduced imagery and metaphor into the pastoral conversation in ways that could, when successful, help the patient to recognize and experience a supernatural presence in a clearer, more substantial (and presumably more positive) manner.

This dialogic methodology resonates with Mattingly's work in occupational therapy. For her, one of the central questions of narrative in the face of uncertainty is how to bridge the gap between perlocution and illocution. This goal can be particularly salient in terms of satisfying the *healer's* need for order. At the same time, "healers may draw upon narrative to encourage powerful reframings of illness that actively [or, I'd argue, passively] change the sufferer's perception of his own body and personal experience" (1998a:14). Likewise, she argues that

> stories and snatches of stories become a predominant means by which the clinical problem is reframed to include the patient's experience of

> his body and his renegotiation of the social world given this new body. It is in this sense that storytelling does essential referential work. It allows therapist and patient to *refer* differentially, subtly recasting a physical problem into a phenomenological one. [1998a:66]

The one caveat I would add to this comment based on my fieldwork is that it is not necessarily obvious how the reframing of bodily experiences, particularly through the lens of religion in an ostensibly secular healing space, equips a patient forthrightly to renegotiate social worlds. Such interpretative apparatuses may foster a sense of empowerment by which to challenge hermeneutic minimalism, however. Case 11 is a potential, though obviously complicated, example of this thesis. Case 6, meanwhile, highlights questions of narrative and bodily interpretation in relation to the hospital culture for the patient's family, but here significant beliefs and stories predated inpatient treatment and arguably prevented the infant's illness from being anything other than a phenomenological issue; the baby's body was never an exclusively or even predominantly literal being—it was *always* a metaphor-laden entity in the social setting in which it existed.

A couple more points deserve mention here. Reflecting on the demands of close listening, one resident explained that often, as patients shared their stories, "I am not able to stay with them emotionally but move on to other subjects that are less intense … I find that all I want to do is to wave the magic wand and have my patients feel well." For her, phenomenological openness to the other could lead to overwhelming demands on the resident in terms of her ability to be fully present multiple times for multiple diseases and illnesses over the course of a given day. A resident may be asked to share in the experience of, for example, having chemotherapy, losing a child, being shot, and breathing through a stoma before heading home for the day. There are dangers of emotional burnout through over-identification, even as patients and others looked for compassionate persons with whom to share their sentiments and sensations.

Identifying with processes of wounding and healing can lead a healer to become, in Kirmayer's view, "'inflated,' filled with the delusion that it is he who does the healing and not some supra-individual or transpersonal process acting through him." Likewise, it can be easy for healer and patient to become "lost" in the symbolic, often unconscious, level of their relationship—despite the fact that it is in this "liminal space, at the edge of awareness, in myth, dream and reverie, [that] the images of gods and goddesses do their work of healing and illumination" (2003:256). At my field site, it was easy for residents to forget that clinical encounters could (and perhaps even *should*) be religious encounters for them as well. This is not to suggest that the residents were quick to take

credit for helpful outcomes, but it seemed that many of them struggled with their own sense of the place of the divine in their clinical interactions (cf. Cases 5 and 9). This was perhaps due to the surfeit of data to which they were supposed to be attentive, but it could also have been the case that they sometimes genuinely felt abandoned by the supernatural or were convinced that the divine was absent. One gets the impression that they may have been led to feel wholly responsible for the spiritual content of clinical encounters, rather than being a partner or servant of a deity ultimately in charge of the course of events.

Ricoeur considers other elements of the phenomenology of interlocution. He cites Louis Mink's argument that "the phenomenology applied to our capacity for following a story is not debatable as long as we have to do with stories whose outcomes are unknown to the listener or reader, as is the case when we are following a game … history appears once the game is over" (1984:157). Narrative, in other words, presents both speaker and listener with multiple phenomena to be apprehended at each point in a given exchange. For chaplain and patient alike, stories were rarely linear (cf. Cases 5, 10, 11) and often included historical elements along the therapeutic trajectory that mixed episodes and the phenomenological components of episodes without a clear sense of finale, denouement, or even climax. Such convoluted recitations could prove therapeutically useful for patients, inasmuch as they provided a sense of emotional release and raw materials for a future, more coherent, account of their experiences, yet this ambiguity could also be phenomenologically exhausting for the chaplain, who was often expected to identify motifs, sub-plots, antagonists, and other dramatic elements while being spiritually supportive and emotionally stable.

I turn to Luhrmann for a final word on narrative and empathy, one that potentially complicates our understanding of the work of chaplains as dialectical partners. She suggests that

> Empathy often implicates morality … to empathize—at least beyond the toddler stage—*is* to judge. To empathize is to assess someone else's circumstances and character, to interpret that person according to one's profession, one's society, and one's own personal history; to infer, on that basis, what that person feels; and, inevitably, to make a judgment about the rightness or wrongness of what has happened. [2001:280]

How well does the concept of the empathic, non-judgmental chaplain hold up against such a critique? I suggest that the concept of non-judgment for these residents meant *don't judge, but if you must, don't reveal your judgments. Treat all persons with dignity and respect, regardless of their actions,*

and presume that even those who have committed heinous acts and manifest no remorse may in fact be ambivalent, or even contrite, about their deeds. To the extent that empathy presupposes some measure of identification with the other, pastoral empathy with covert judgment could conceivably manifest itself as a form of discursive self-judgment. It was not easy, for example, for one of the residents to be asked to provide pastoral care to a husband who had killed his wife and child and then attempted suicide. She was repulsed by his deeds and wanted to stay in a zone of rejection but was duty-bound to engage him. To the extent that her acts of sincere listening and patient, non-anxious presence could be considered components of empathy, it seems that pastoral care at this hospital reflected something approaching aperspectival charity, one that acknowledged wrongs but still left room for dialogue and for the possibility of identification with the other, if largely through imagination. To the extent that this sort of empathy judged, it did so without the sentence of social exclusion or ridicule.

Experience and Imagination

This brings us to the topic of familiarity in pastoral care. As we have seen, CPE's emphasis on reflexivity and on the testing of clinical techniques in the classroom setting are designed to promote phenomenological nearness back on the units, and in many respects, residents found these methods useful for improving their skills. The fact remained, however, that no amount of life experience could give any one resident personal experience with all of the maladies that they would encounter as practitioners.

What are the implications of such limits for relating to the other in a therapeutic capacity? One resident explained that she occasionally used "appropriate self-disclosure to help my patients know that they are on familiar grounds that others have walked that path and more specifically I have also walked that path," yet she cautioned that she tried to be careful "not to assume my experience of an event will be the same for them. For that reason, I must admit that it is not always easy to know when a patient would benefit from a particular disclosure. I am still working on that." A colleague confessed that it was often difficult for him to imagine what a patient or family members were experiencing, "in no small part because many of the issues of suffering that arise revolve around relationships that I don't inhabit—having children, a spouse, siblings, lovers, etc. Hard as I try, it is still difficult for me to be entirely present when a woman loses a fetus, not only because I am not female, but also because I have never attempted (or had any interest in) procreation." His rejoinder? "I do know something about loss and failure, however, and I try to draw upon these moments to be more emotionally present/compassionate for such individuals." He gradually came to believe that

most patients were in fact patient with chaplains whom they trusted and when they did not expect—or even necessarily want—someone else to *presume* to know what their experience was like.

EXISTENTIALISM, HERMENEUTICS, AND MEANING

Some Rationales and Goals for Pastoral Interpretation

Searches for meaning and purpose occupy a unique place in the broader repertoire of pastoral care. Interpretative questions do not arise in every encounter, yet when they do, there are often a variety of issues at stake. In some cases, for example, the search for meaning may serve as a coping mechanism, such that even if a concrete answer is not found (or constructed) in the present, the process of looking can itself be therapeutic.

In his analysis of Roman Catholic charismatic healing, Csordas describes the work of healers as "holistic" and emphasizes intervention on three levels: physical healing of bodily complaints, "inner healing" of emotional angst, and "deliverance" from the effects of evil spirits and demons (1988:123). All three of these levels of intervention relate to the work of chaplains at my field site and to the role of interpretation in facilitating relief. I shall not say much about physical healing in this section but am keenly interested in his notions of inner healing and deliverance, both of which appear to be present in the case studies (cf. 1, 6, 8-10 for the former and 12 for the latter).

The search for meaning with hospital chaplains usually sprang from negative or problematic outcomes. Good outcomes were likely to be taken for granted or as confirming something desirable—a just and ordered universe, a benevolent deity, luck, and so forth—that needed no further analysis. Patients and family were often willing to give thanks for a successful surgery or problem-free delivery, but they did not appear particularly inclined to analyze the experience or search for meaning, unless there was a seemingly miraculous recovery from a near-death experience, and residents were routinely busy enough with patients mired in suffering and doubt to devote time or energy to happy outcomes. This is not always the case (cf. Case 9), but such work was exceedingly rare for these chaplains.

Psychological anthropologists in particular have provided important insights into links between semiotic practices and affliction. Luhrmann, for example, suggests that "the psychoanalyst sees the tragedy of human lives, which is one reason we have thought of psychoanalysts as the priests and rabbis of a secular age. Here the bottom-line commitment is to a kind of nurturing, loving relationship with the patient and a belief that self-knowledge is inherently good" (2001:276). Both of these elements resonate with the interpretative work of chaplains. At one level, CPE is firmly

convinced that insight is a good thing, both in itself and within the context of religious beliefs and social commitments. Residents in this program sought to help others to develop greater awareness of their medical condition in relation to, for example, cultural norms and constraints (Case 1), the relative merits of different coping methods (Case 5), pain (Case 8), and neighbors' thoughts (Case 12).

Yet did chaplains intentionally try to ascribe meaning or to convince the afflicted to adopt a particular way of interpreting an experience? As we saw in Case 10, there was an early tendency among some chaplains to do just that—to teach certain (Protestant Christian) hermeneutic methods to patients in the belief that such a set of lenses would help individuals to see reality in a *correct* way—yet this manner was roundly rejected by the supervisor as paternalistic and indicative of greedy theology. He did not suggest that residents should sit passively as patients interpreted life events self-destructively, but he also did not presume that there was a single, correct path that would lead automatically to divine enlightenment and healing.

It was often the case that a search for meaning connoted a plea for moral order and justice. Particularly in the trauma bay, where countless subjects manifested the effects of seemingly senseless acts of violence and encountered what appeared to be pointless suffering, many sought assurance. They wanted someone—anyone—to suggest that the world was not coming to an end, that righteousness still existed, and that goodness might still triumph in the end. The persons that these chaplains met appeared (with the possible exception of Case 3) to want to believe that such horrible events could be explained and that they held both cultural and spiritual significance. They wanted to cobble together some sort of narrative account that would help to alleviate pain and to uphold the cosmic relevance of their affliction. These chaplains, convinced that no one should suffer or die in vain, were happy to oblige. *Contra* Rieff's reading of Freud, chaplains were unwilling to "abandon the cultural dichotomy between a meaningful and a meaningless life" (1966:30). This is because one of the key aims of pastoral meaning facilitation was to embed (or re-embed) clinical phenomena in wider networks of significance.

This openness to interpretation and symbolism, both with patients and through reflexive assignments in the CPE curriculum, could nonetheless lead residents to see the hospital in highly symbolic terms, where every event, every encounter assumed interpretative significance. Consider the following statement: "Baptizing a little baby, before we watch him die, I think to myself we didn't need the holy water, his mother's tears are bathing him in sacredness …. From a little child to the last breaths of a century-old woman, in one night, all of life and death has passed me by." This chaplain reflected on her clinical work in terms of its ontological import for her and for the peers

who would subsequently read about her encounters. Interpretation for them could serve as a bulwark against nihilism and absurdity, but also against familiarity. The intentional search for significance strove to contextualize singular events even as it worked to uphold the idiosyncrasy of phenomena as worthy of reflection in their own right, but they could nonetheless lead residents to search for or presume meaning when in fact none was implied—or desired.

The fact that the abnormal increasingly became the quotidian for residents only compounded the challenge of holding at the right hermeneutic distance the potentially overwhelming nature of the sights, sounds, and smells hurled at them. One resident explained that she found something increasingly "taboo" about what she and her colleagues were doing at the hospital, suggesting that they were "unwilling voyeurs on life and death's great atrocities." She continued:

> Back in the trauma bay, I am singing a lullaby to a 46-year-old man with Down syndrome, I am stroking glass tenderly out of someone else's hair. A shattered bone creates an improbable second elbow; men are crying, moaning, and pleading. There are pieces of brain on the empty backboard [from the ambulance transport], and more bloody vomit than I thought was even possible is pouring like *The Scream* from one man's open mouth. A blanket askew reveals feces smeared on shriveled buttocks. There are bloody footprints on the floor like a demented game of Twister, the grisly record of the trauma bay dance.

Why did this resident record these images for her colleagues? What benefit could there possibly be in trying to reflect upon such encounters? Why didn't she simply try to forget them? Her own words provide a clue: "Washing my hands, I feel like Lady Macbeth, desperate to remove the blood that only she can see. Sometimes I am amazed that I can still seem so normal, can actually give [morning] report and walk down the hall and somehow make it home [after an overnight shift]. I'm often praying on those drives, please just let me get there safely, then I can fall apart at last." To an outsider, such words could have shock value, but to her fellow chaplains, they are painfully familiar. Her report may have been a demonstration of toughness to her colleagues—*See! I can handle this stuff as well*—but they also functioned as a challenge to herself—*What sort of person have you become, you who claim to manage the terrors of the night with equipoise? Have <u>you</u> not become Lady Macbeth? Are <u>you</u> not also implicated in the wounds that you encounter? Absolve yourself, if you can!*

But how? Lacan argues that "although the symbol in psychoanalytical terms is repressed into the unconscious, it carries in itself no index whatsoever of regression, or even of immaturity. For it to induce its effects in the subject, it is enough that it make itself heard" (1981:58). The appeal to metaphor and symbolism, at least for these chaplains, often facilitated short-term functioning through macabre irony, but at potential cost to their medium- and long-term coping skills. With biomedical colleagues in the trauma bay, metaphors functioned as stimulants; with pastoral colleagues in the seminar room, they served as confessions in the traditional sense of the term, as pleas to be released from roles of care provider and voyeur. To her, these sights and sounds were evidence of transgression and ridicule that begged absolution.

Yet does the clinical coping of chaplains necessarily presume a measure of guilt?

Such dilemmas point to the complex relationship between metaphor, meaning, and bodily states in the work of clinical religious specialists. In his analysis of metaphorical aspects of health and medicine, Moerman argues that healers "mediate culture and nature" by "enacting *cultural physiology*" (1979:59) in such a manner that the form of medical treatment is an important factor in its perceived success. He argues that the "metaphorical structure" of a healing system is at least as important a factor in a positive outcome as physical or pharmacological elements, especially in nosologies that conceptualize illness as the intrusion of foreign substances that reflect some sort of malevolent intent. This distinction between "personalistic" and "naturalistic" systems emphasizes ritual and metaphorical aspects of intervention in both systems, though they tend to carry far more interpretive weight in the former than in the latter. He explains that medical treatment involving ceremonies led by a shaman, for example, usually includes "a patient perceiving a field of symbols created in whatever manner" in which struggles and intervention occur on behalf of the afflicted person's body (1979:60). Such desires and longings have been described as "enthusiastic activism" and "expectant faith," arguably analogous to the placebo effect in the West (1979:62).

There are several notes of resonance here. With the exception of case 12, residents encountered little personification of disease- or injury-inducing agents in their work with patients, and none was asked (or, for that matter, offered) to battle some nefarious power in order to promote healing. That said, several other cases (2, 6, 11) allude to supernatural forces as components of clinical processes, and patients and family members elsewhere routinely requested prayer for divine assistance in overcoming afflictions. Though we cannot speak properly of chaplains as direct causal agents in the sense described by Moerman, the iconic presence of residents pointed to religious metaphors and other forms of imagery that patients could appeal to themselves as means of re-conceptualizing their plight (e.g., *God is fighting for me, God is on my side*) that could generate

hopefulness and might have had some sort of psychoneuroimmunological or placebo effect as well through the stimulation of the person's faith (see e.g. Koenig and Cohen 2001). Conversely, we saw in the chaplain's account above how her own recourse to symbolism, and particularly to worlds of the imaginary (*The Scream, Macbeth*), gave her encounters a hyper-real quality that, far from comforting her with the idea that she might be approaching the end of a nightmare and would awaken to a pleasant, distant, and safe reality, seemed only to prolong her sense of helplessness and bondage to the painful realities of the present. To the extent that this chaplain's case was indicative of a broader reality for residents, it was that while auxiliary worlds might bring relief to others, they were notoriously less useful for chaplains' own spiritual and cognitive processing.

Mechanics of Interpretation

Clinical pastoral semiotics drew upon a wide range of inputs to facilitate meaning making. Perhaps the most basic of these, as one resident suggested, were the residents themselves. For her, their mere presence could "be seen as a reassurance, tangible evidence of the omnipresence of the Divine." A colleague concurred and viewed her work as "that visible expression of the divine presence of God walking alongside people as they journey through in this world. Particularly for the Chaplain, it is the visible expression of the divine presence of God as people go through sickness, disease, and death of their own or of their loved ones; and as people face traumatic events in their lives." For both of these trainees, the mere availability of a religious specialist in a house of suffering symbolized the nearness of a benevolent deity attuned to life changes and challenges. They saw this spiritual presence as comforting for both patients and family members and residents themselves as practitioners, not only because it gave them a sense of legitimacy as clinicians, but also because, as fellow believers, it provided an overarching sense of comfort that their deity cared.

Second, and whether they were conscious of it or not, CPE residents agreed with their biomedical colleagues that somatic events could, or perhaps should, be seen as forms of communication and potentially intervention. A physician might see in a particularly swollen tongue a symptom of some deeper or more troublesome disease; a chaplain could also be asked to help provide an analysis of such an ailment on a different level of interpretation. A patient might, for example, view her affliction as metaphorical exhortations from the supernatural that could be at least partially decoded with the assistance of a religious specialist (cf. Case 10) or might be concerned about a causal relationship between certain unfavorable elements in the patient's life and the clinical manifestation (cf. Case 12). Significantly, there was often a conviction among patients, family members, and chaplains alike that each individual was cosmologically relevant, significant, or worthy of attention. Bodies did not simply malfunction; there was frequently a message(s)

embedded in such events that suggested some larger purpose or possibility, whether or not it was conceptualized in terms of divine communication.

Kirmayer frames his analysis of the interpretative activities of healers by citing Jerome Frank to argue that systems of symbolic healing include the following components of the "assumptive world" of a particular healing practice: a person defined as a sufferer, a person defined as a healer, a prescribed ritual time and place, symbolic actions intended to transform the illness, and expectations for recovery. When understandings of these components are not shared between patient and practitioner, the parties "must go through prolonged negotiation to define the parameters of an effective clinical encounter," including the ways in which social power and position will impinge upon "the shared understanding of goals and procedure" (2003:249). Given the wide range of cultural models and metaphors for the healer, including "technician or technical expert, an educator, a helping professional, a spiritual teacher, master or guru," he contends that there is a corresponding diversity in expectations for what the provider will bring to the relationship in terms of "boundedness in space and time, the sources of clinical authority, the distribution of power among the participants, the level of self-disclosure and the regulation of affective bonds" (2003:250).

Such variables point to important issues in our case studies. In Cases 1 and 9, the impact of multiple visits engendered a good level of trust between patient and chaplain that allowed the resident to perform a variety of spiritual, psychological, and logistical-informative roles for the patient. In Case 3, the patient and his sibling lacked a clear schema for a religious specialist but were open to her presence due to her sympathetic affect. The mother in Case 2 was receptive to the presence of religion in her life in general but was at least initially uninterested in dialogue with the chaplain because the latter could not bring her son back to life. In Case 7, meanwhile, the patient was not interested in religion but showed some tentative signs of interest in the chaplain's presence until an unsuccessful turn of phrase led to the resident's dismissal from the room. My point here is that there was no obvious parallel at my field site between interest in religion as a symbolic or interpretative system and an understanding of the work of the chaplain. Furthermore, patients often made decisions about whether or not to proceed with interpretation with a resident extremely rapidly—there was frequently insufficient time for thoughtful, thorough vetting before deciding whether or not to incorporate the chaplain into the healing paradigm—though residents very occasionally had a sense of how a patient or family worked to determine whether to include him or her in their therapeutic journey (Cases 6, 11).

This leads us to another important point. Depending on the type of religious-based intervention, Sharp suggests that a practitioner may or may not corroborate the patient's framework

of understanding illness. Treatment might or might not be effective, but the outcome would not likely change the patient's etiological assumptions. If the healer presents a radically different model of illness and treatment, however, then the decision to entertain this therapy could well change the individual's "assumptive world," particularly if the treatment is successful (1994:526). To the extent that chaplains sought to reframe assumptions, it was within strictly defined parameters. Chief among these was the biomedical/religious divide: chaplains never sought to convince a patient that a somatic or medically diagnosed condition was in fact an exclusively religious or supernatural matter. These were not rival practitioners who secretly cajoled patients to forego medications in favor of prayer or ritual but rather encouraged them to be open to the possibility that biomedical phenomena could also provide opportunities for spiritual insight and reflection.[63]

One more item. In his comments about shamanism in Western Amazonia, Brown contends that there is a close parallel here between symbols, language, and the patient's state of suffering, which "constitutes a disordered whole involving different aspects of bodily function" that is gradually "recast … into various manageable domains" through the shaman's actions, all the while encouraged by shouts of encouragement from the participant-observers (1988:113). I have noted in several places the holistic, contextualized tendencies of pastoral intervention, particularly chaplains' concern for patients' relationships with loved ones. What is significant here is that the interpretative mechanisms that chaplains utilize are decidedly different from the ritual theater described by Brown and others. Chaplains are no ringmasters; they do not engage in therapeutic-juridical public performances or encourage participation between patient and audience-compatriots. Social reconciliation, when it occurs, emerges in their work through two mechanisms. In the first, chaplains mediate between parties away from the limelight (cf. Cases 3, 8, 11), talking with individuals separately to clarify and suggest. In the second, chaplains encourage patients to take their own initiative in reconciling differences with those near them (cf. Cases 1 and 9, and to an extent 12). A significant part of this difference in mechanism is due to the liminal nature of the setting: chaplains at this hospital neither knew nor interacted with patients or their circles outside the hospital—this was a large hospital in an even larger city—and was also due to the fact that the chaplain lacked the social authority to play the role of sentencing judge.

[63] Once again, Case 12 presents a more complicated situation. Here, the chaplain largely rejects the concept of spirit possession yet recognizes that the patient sees her illness as only minimally biomedical. The resident struggles to navigate a convoluted path between science, doctrinal religion, and syncretic religious cosmology in a manner that leaves room for the science and doctrinal religion to be efficacious while recognizing that he was unlikely to dissolve the third system through logic and rational argumentation and so would have to frame the first two in a manner compatible with the third.

Interpretation and the Anthropologist

Particularly within the last fifteen years, the question of the socio-political stance of the anthropologist has become paramount in the understanding and interpretation of the words of informants. Crapanzano portrays the situation bluntly: "Insofar as we are shielded by fictions of objectivity, neutrality, and distance, the moral and political consequences of our role provide the determining undersong of our investigations" (1992:4), yet at the same time, "the anthropologist's message of otherness is perceived as a threat to a stable and complacent order" (1992:5). More broadly, he contends that reading and writing are social activities that are inevitably undertaken within the confines of specific social arrangements: "We do not read generally but rather in genre-specific ways, and if we fail to read in these ways … we are considered bad readers, tactless readers … or, like the deconstructionists' reading of philosophy, blasphemously brilliant readers" (1992:9).

Nonetheless, he cautions the discipline to bear in mind the doctrines and presuppositions that undergird interpretive paradigms when selecting an interpretive framework. For instance, psychoanalysis has "what can be called, not pejoratively, a theological structure. It has a privileged body of texts, essentially the Freudian corpus, that determines its boundaries, grounds its therapy and research, and limits what might otherwise be an infinite interpretive regress" (1992:138). More broadly, and controversially, he claims that "without a central, authoritative text, interpretation is always uncertain" (1992:139). For anthropology, this has meant that it has allowed itself to be challenged—to an extent—by the possibility of multiple points of view, most prominently from those it seeks to understand.

It is hopefully clear by now that it was often difficult for me to keep my interpretative roles distinct over the course of this project. Switching between hermeneutic levels within the training program was challenging enough; attempting to switch back into the role of the secular, disinterested anthropologist, critically distant from the texts and theories that informed my modes of understanding as a clinician, has proved one of the most challenging aspects of my research. When I interpreted as a resident, a part of me felt that I was betraying my roots as a social scientist by embracing a religious worldview and presuming that most of the work that chaplains did was genuine, noble, and helpful. When I interpreted as an anthropologist, an even larger part of me felt that I was betraying my pastoral colleagues, maligning them as willing accomplices in the physical and ideological domination of the afflicted. I find little consolation in the thesis that in each case, I was trying to be faithful to the pedagogy of the training program (i.e., CPE or the PhD). The fact that the pastoral care oeuvre and the medical anthropology / anthropology of religion literatures have never been in dialogue to any extent makes this dual process of interpretation all the more

challenging, for I have been unable to find a neat and tidy camp with which to align myself and thus justify my interpretative practices. This is an area of struggle that I suspect will continue to swim in my shadow for the foreseeable future.

ADVOCACY AND SOCIAL JUSTICE ISSUES

Some Rationales for Intervention

In both theological and therapeutic senses, CPE views the hospital enterprise as a mixture of what the patient can contribute to healing processes and what the chaplain may be asked to do on her behalf. Residents were expected to live by a moral code of active social concern for the other and often looked to figures like Jesus, Buddha, and Moses as examples of religious specialists who spoke up for the weak, marginalized, victimized, and neglected. This mode of engagement was easier for some than others, both in principle and in practice: residents who came from liberation or other social justice-oriented doctrinal perspectives tended to embrace these components of pastoral care far more readily than did more conservative denominations that viewed social activism as a marginal component of the Christian faith. One United Church of Christ[64] resident, for example, cited Matthew 25:34-36 as a sort of mission statement for his work at the hospital.[65] In his reading of this text, there was "no inquiry into the theological orthodoxy or the moral rectitude of those being served. Rather there is a simple response to the genuine needs and inherent dignity of the human person." He viewed this "unconditional positive regard" as a basic starting point for pastoral engagement, one that nonetheless left space "when necessary for a prophetic, 'Thus saith the Lord!' addressed to individuals, institutions and communities." Clinical intervention for this chaplain thus did not occur merely at the level of the individual body or person, crucial though that was. Instead, he viewed matters of health and illness as intricately tied to broader socio-cultural, historical, and economic considerations, and for him, chaplains had an important role to play in raising a voice against systemic and structural inequalities within the hospital.

As you no doubt guessed, discourse was one of the chief mechanisms through which chaplains attempted to impact these cultural structures. Yet this returns us to the familiar question: could narrative—for the chaplain or anyone else—ultimately be that influential in an age of

[64] A progressive mainstream Protestant denomination known for, among other issues, the ordination of women, support for refugees and so-called illegal immigrants, and the blessing of same-sex unions.

[65] "Come, you that are blessed by my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me."

biomedicine? Could pastoral narrative realistically shape larger epistemological and ideological visions of therapy within the hospital? With regard to the general potential of narrative in the clinical setting, Hunter responds emphatically: "Narrative shapes clinical judgment. In medical practice, the vast body of knowledge about human biology is applied to the patient analogically through narratives of the experience of comparable instances" (1991:148). "Pedagogically," she argues, "narrative encourages and improves clinical judgment by making possible a kind of practical, clinical knowledge that *mediates* biological principles and the facts of the particular clinical case" (1991:155, emphasis added). I take clinical judgment here in the broadest possible sense, where any hospital employee with any sort of contact with patients and visitors utilizes judgment to discern how to react and relate to the afflicted. In this sense, the narrative work of chaplains holds the potential to be extremely influential in shaping individual modes of relating to the other in the clinical space.

In addition to the cultural potential of narrative at the interpersonal level, Young points to additional functions of language that bear upon chaplains' work as activists at the level of collectives. He argues that discourse

> is a means through which the object world emerges and instrumental action (including knowledge production) becomes possible. At the same time, it constrains what can be known, experienced, or affected. It is this duality, *through which action and understanding are simultaneously enabled and constrained,* that links knowledge to power. In the West, power/knowledge—organized into a grid of technologies operating on the human body—created, and now reproduces, a distinctive human subject. [1987:113-4]

Many will argue with the thesis that object worlds emerge exclusively or primarily through language, but this ontological claim, combined with the notion that language can manipulate and/or fashion the knowable world—and the subjective identities of its inhabitants—holds enormous implications for the place of religion in biomedical cultures. In its work in both illumination and policy analysis and lobbying, it is important to see how chaplains contribute to such "power/knowledge … technologies" that seek to fashion distinctive persons and collectives in the hospital setting.

Advocating for Individuals and Families

A second-year chaplain described his vision of pastoral care as "a voice for the intubated and the unconscious, a shoulder for the weary, and a resource for the scholar." He found that through the CPE process, he was "developing a passion for defending the weak." Even in an age of participatory

medicine, where patients were supposed to have a greater say in the trajectory of their own care, his impression was that sometimes they could benefit from the assistance of others, especially if they were unconscious, intubated, schizophrenic, spoke no English, or otherwise experienced difficulties articulating their needs. Some examples of residents' use of dialogue to promote therapeutic outcomes for family members included collaboration with social workers to coordinate home stays for family members traveling from long distances who could not afford hotel accommodations, asking unit secretaries to order food trays for families, advocating in particular cases for more flexible visiting hours, ensuring the communication of important social and religious messages related to a patient's care between various medical teams and shifts, and seeking to address perceptions of a lack of concern or care by physicians toward family members on various units.

There were challenges to such a socially engaged stance. On psychiatry, patients occasionally tried to convince the chaplain that there was nothing wrong with them, in order to get the chaplain to campaign for an early discharge, a task that residents quickly learned to circumvent while seeking to remain sympathetic to the patient's frustrations about their lack of freedom on the unit. More broadly, residents learned that not all patient requests were feasible and not all medical staff members dictators. As students encountered more and more patients and came to know biomedical clinicians on a particular unit, they gradually came to distinguish between idiosyncratic personalities and systemic problems that could benefit from thoughtful discussion.

These and other forms of intervention reflected a mixture of resistance and diplomacy. They were significant because they reflected a domain in which chaplains realized that they could have a concrete and positive effect on patients' well-being. Consider the following reflection from one chaplain toward the end of her residency:

> I have grown in my ability to advocate for the family with both law enforcement and nursing staff in the area of appropriate viewing of deceased patients. After several less-than-optimal family viewing experiences in hallways and the morgue, it has been gratifying to be instrumental in facilitating more desirable viewing experiences. I have stepped up the sassy side of myself with staff and police officers to advocate for families. This has felt good. I will always carry with me the image of a very young wife falling into[66] the glass window of

[66] i.e., falling up against, not through.

> the morgue in her grief. Every time something better can be arranged it seems a triumph.

This resident found it both important and satisfying to speak up on behalf of those who did not know the logistics of the hospital cultures and who seemed to her in too vulnerable a position to be active, informed consumers of clinical care. As she suggested, it was not easy for this timid, suburban mother of three to learn to confront members of the inner-city police force or to negotiate aggressively with senior staff members on behalf of what were often economically poor, minority families, yet the more she realized that she could speak up successfully, the more she understood that she could bring about positive changes in the logistics of patient care, the more she came to believe in herself and in the potential of the office.

It is somewhat more challenging, but just as important, to attempt to analyze chaplains' work mediating human and supernatural parties with respect to the formation of various social subjects and objects. In his analysis of religious mediators, Macquarrie highlights a variety of unique functions of persons who attempt to bridge the conceptual, and often metaphysical, gaps between divine entities and human adherents. He argues that in many of the world's great religions, this go-between person either introduced the idea of the deity to the society in which he lived—through revelation, embodiment, or as a teacher with privileged knowledge—or brought a renewed or heightened sense of the presence of the divine into the daily affairs of the people that suggested the possibility of routine spiritual communion with the supernatural. In his model, these mediators stood between two realities and attempted to relate them to each other in what he calls a "theology of mediation," a theory that highlights the gap between the mortal and divine but suggests that a gulf between eternity and temporality can be bridged through a dialectic of human transcendence and divine availability (1996:145-6).

We have seen a number of these activities in the work of chaplains in the hospital. While it is too strong to suggest that religion would be absent at my field site without the presence of chaplains to point to the transcendent, their interventions raised awareness of metaphysical domains in ways that the private belief of patients and other practitioners could not. This heightened sense of presence could help individuals to reflect on the possibility that the culture in which they operate might not be limited to the verifiable and falsifiable (cf. Cases 4, 8). Moreover, their presence served for many as reminders of moral principles and the significance of theological norms and values as components of therapeutic endeavors (cf. Cases 2, 3, and 9). This was true, I suspect, for both religiously inclined as well as for atheists, though it is possible that the latter saw in the presence of chaplains only

superstition, self-interest, and manipulation (Case 7). Such speculation demands further investigation.

In light of these processes, we must now attempt to assess the extent to which chaplains saw themselves as advocates before the divine. Residents prayed routinely and sincerely on behalf of patients and family members in much the same way that they offered supplications for skill and compassion for medical staff. In one sense, each trainee saw God as more or less omnipotent—as an entity with the ability to intervene on behalf of the afflicted, in manners that might or might not be perceivable, in response to human pleas. This notion of supernatural mediation was consistent with residents' understanding of the world as unjust, corrupt, and decidedly evil (cf. residents' comments for Case 3), one in which brokenness was manifest in a variety of ways and one in which they felt called to act on behalf of both the innocent and the contrite. It was unclear from my time there whether any of the residents saw it as their duty to attempt to win clemency for someone in a divine courtroom, where an angry God presided over the souls of the still living. Such images are indeed consistent with sacred texts and theological treatises on the juridical relationship between God and humans, yet it was not at all obvious that residents wanted to work with (or for) a jealous, vengeful deity. Most seemed to prefer a cosmology in which misfortunes happened or were allowed to happen and in which the transcendent was both quick to forgive and wholly loving, one who would be especially receptive to the cries of religious specialists on behalf of broken bodies and broken societies. The following words from a second-year resident summarize some of this ideological and methodological sense of ambivalence:

> The good news is that I've become more convinced than ever that God is indeed present with us humans in our everyday lives. What is less clear to me is what exactly this means. As a chaplain, I still find myself praying for physical healing, for the miracle, for positive and concrete intervention, according to my own sense of what is best in a given situation, and I expect that God will respond accordingly. Is it wrong to pray for God to spare the life of a teenager who has just been shot? No. Can I expect that my prayer alone will rouse God into action, to do my will? Alas, no, however pure my intention might be. This situation is entirely frustrating for me, and I know that I need to continue wrestling with this one.

Structural Issues/Confronting the Hospital System

Confrontation for chaplains takes a number of forms in the hospital. As we have seen, much of it is programmatic: challenging colleagues during CPE didactic sessions and occasionally challenging patients in terms of their beliefs or outlook, but also challenging the biomedical system as a culture. This confrontation stems in large part from their vision of the hospital as a place of hospitality, a place of welcome to the stranger as guest. This moral-ethical posture at the institutional level emerged gradually but highlighted for residents at my field site the possibility that patient care was not always what it could be, whether through neglect, occasional incompetence, willful injustice, or various forms of structural violence such as institutional racism. Some of the residents in particular argued that the system was as much in need of healing as individual patients, family, or staff members. Such activism presupposed a particular type of leadership, a certain way of making their voices and priorities heard in the midst of an intricate web of ideologies and priorities that was not necessarily hostile to such concerns but was typically too busy to address them systematically.

It is important to note that residents generally responded to events after an issue arose in the clinical space and only occasionally attempted to engage in what we might call *preventative religion*. In this sense, religion seemed to function in the inpatient setting in a manner similar to biomedicine: not preventative but restorative, and only secondarily as enhancing or rejuvenating. Attempts to effect broader social changes in the cultures of the hospital tended to emerge over time, through reflection on multiple patient cases and the challenges that they highlighted. In some instances, students advocated to allow people to have space and time to experience the moment more fully. In other situations, residents appealed for greater sensitivity to physical needs (e.g., religious diet and meal requests, privacy when using a commode, or an adjustment in pain medications). It was difficult for me as anthropologist to discern whether the mere presence of a religious specialist brought out certain positive attributes in biomedical practitioners or caused them to behave in a more morally aware, socially conscious manner than they otherwise would, or whether it took active (narrative) intervention on the part of a chaplain on a specific issue to elicit responses.

One resident's musings about the positive use of power can give some insight to these methodological questions: "Do we residents have any power??? Do I have credibility to make my claims? OK, perhaps this is too strong. Inasmuch as suggestion holds potential, I think that I have been of some use in encouraging my peers to be bolder and more assertive in their work, in defending their own rights as well as serving as advocates for patients and family members." From his perspective, chaplains needed to be prepared to highlight to other clinicians treatment concerns related to ethnicity and race relations, class inequalities, and language barriers, both as these

variables related to the cultures of the hospital and to the broader society that impacted patients' health and well being.

The active pursuit of such work beyond the care of individual patients placed chaplains in a unique space according to traditional anthropological taxonomies of religious specialists. Turner distinguishes between priests and prophets and argues that priests derive their authority from ritual and other service based on a sacred tradition and holds the office either through ascription or achievement. Nonetheless, he argues that if a priest attempts to innovate in radical ways, "he is likely to become a prophet to his followers and a heretic to his former supervisors" (1968:439), a topic to which we shall return in just a moment. He also suggests that the role of priest emphasizes the maintenance of proper social relations in accord with some notion of the common good. Unfortunately, this either-or distinction does not appear to capture either the work of chaplains or their own self-conceptions, but it is useful in that it highlights different aspects of the work that residents did in a sort of dialectical manner, where work with individual patients and family members (i.e., at the micro level) typically emphasized priestly duties of ritual, consolation, and pastoral dialogue, while their work at the macro level of units and other collectives was informed by their priestly activities yet more closely approximated the innovative, and occasionally radical, work of prophets.

Finally, though somewhat dated, Rieff's arguments about the potential of institutional religion to engender positive, meaningful change are also instructive:

> That our inherited moral systems have failed us, that we have been thrown back on our own psychological resources precisely in an era when other resources have been socialized, accounts in a measure for the appeal of Freud. His work was an attempt to strengthen our inner resources against what he considered obsolete cultural systems of inhibitions. Our inherited moral systems have not been either alive enough or dead enough to permit fulfillment of our rising expectations of happiness. Formerly, if men were miserable, they went to church, so as to find the rationale of their misery; they did not expect to be happy—this idea is Greek, not Christian or Jewish. [1966:38]

It would be interesting to hear what Rieff would think of the argument that biomedicine represents a social moral system that has displaced—or at least attempted to outrank—institutional religious systems of morality, either in the clinical space or in society more broadly. The fact that some

patients and family members appealed eagerly to chaplains (cf. Cases 6, 9-12) suggests that they have not been left solely to their own psychological tools to contend with their afflictions, even though residents emphasized the importance of developing "inner resources" for contending with a variety of dilemmas.

Yet this points to an important question: To what extent did hospital chaplains function as secular therapists, attempting to help patients and others cope with the cultures of biomedicine? Could it be that, ironically, institutional religion was unconsciously helping patients to cope with *biomedical* cultural systems of inhibitions in the name of "rising expectations of happiness?" We have seen how clinical religion attempted to help persons to cope with misery through the facilitation of meaning making, yet we have also seen in this segment that many of the residents believed firmly in the concept of a durable, life-sustaining happiness and saw a good deal of their advocacy as driven by the belief that the afflicted in particular had a right—yes, right—to experience nurturing love, trust, patience, kindness, goodness, mercy, forgiveness, and other sentiments that fall squarely under the umbrella term "happiness" in the broader U.S. culture.

Some Countervailing Forces

Given these images of activism, were residents also critical of themselves and their own potential for harm? What did they think about CPE as an ideological system of control and oversight, either of patients or themselves as trainees? At times, it seemed to some of them that they were expected to be more concerned about the long-term stability and the viability of the CPE program and the pastoral care department than they were of the people that they were supposed to be serving. One second-year resident in particular became increasingly frustrated with what he perceived as the shortcomings of both the training program and hospital chaplaincy in general. He had developed one of the strongest and most credible voices in the cohort on issues of social justice, and his peers increasingly turned to him to reflect on these issues over the course of their training. As such, I quote him here at some length:

> Sometimes it seems to me that with all its talk about pastoral care, the CPE movement and methodology is hostile to the notion of chaplains as pastors, as moral and spiritual guides. It seems to have concluded that it is impossible to be a pastor in the chaplaincy context without having that role devolve into paternalism and domination that ignores the authentic realities of the person entrusted to the chaplain's care. Second, there doesn't seem to be much concern about justice in the CPE movement and methodology, except as some amorphous concept

> to be written about in journal articles and preached about at annual meetings. The bifurcation of pastoral care and justice making troubles me.

In response to this reflection, one of his colleagues asked him if chaplaincy was designed to alter structures and institutions, or if it existed merely to give insight into patients. In the discussion that followed, several voiced the opinion that justice was an issue that was often discussed and eagerly theorized but less commonly applied in hospital chaplaincy and in ministry in general. "Are ministers not interested in walking the Selma Bridge?" was one student's evocative contribution. Two of the second-year residents felt that it was indeed possible to raise a prophetic voice within the system, often less against medical staff than upper management, yet these chaplains perceived a significant degree of hesitation on the part of the department director in exercising such a role, and as a result, the students frequently felt stymied in their desire to confront what they perceived to be significant opportunities to encourage social justice in the hospital. The general conclusion seemed to be that while positive, systemic change could happen through the work of hospital chaplains, the CPE program itself was not designed to provide skills to address systems and institutions.

PROGNOSTICATION, TEMPORALITY, AND HOPE

Introduction

Whose responsibility is the future? What is the nature of this responsibility, and what are its limitations? More broadly, how do the healing arts cope with the uncertainty of the subsequent? On one foot, practitioners and patients alike tend to be keenly interested in predicting and influencing the future, yet as Christakis argued near the end of the last century, physicians have increasingly avoided prognostication, "because they did not want to deal with its unpleasant aspects or to think about the limits of their ability to change the future" (1999:xii), often (however tacitly) relegating the topic to chaplains.

There were several possible reasons for this division of labor in the 20th century. First, chaplains had at their disposal a far more flexible spectrum of temporality. Concepts of eternity, and particularly the parousia, gave chaplains far more leeway to present a positive picture of tomorrows than could science, which was necessarily limited by a patient's final death. In the 1600s and 1700s, clergy ministering to the afflicted used the device of prognosis to threaten or warn of eternal suffering for the unrepentant. Though such theology was espoused by hospital chaplains far less

frequently in the previous century, such a history of engagement nonetheless reinforced the authority of the office to speak regarding future matters.

Second, while a chaplain trained in CPE would have been unlikely to contradict a medical prognosis, it is crucial to remember that while statistics became one of the great strengths of the diagnostic and therapeutic enterprises in the 20th century, it presented a potentially severe limitation to predictions about the future. Stated differently, a theology of hope gained momentum precisely in light of worldly evidence to the contrary. Faith allowed patients a credible mechanism for belief in light of unfavorable scientific findings—it left room for the miracle, the seemingly impossible, and the direct intervention of the divine in situations that seemed foregone.

Third, and particularly in the years following World War II, the lag between laboratory progress and therapeutic advances often placed physicians in the unenviable position of being able, if not *forced*, to announce a condition without offering anything helpful in return—something that was never a problem for chaplains.[67]

This final section represents a difficult but central set of issues for chaplains in the midst of clinical cultures that place a premium on determinations of risk, susceptibility, and prediction. Indeed, one could argue that religion's central raison d'être reflects attempts at the prediction and management of the future and commonly reflects roles of faith, prophecy, and trust in a supernatural. Residents at my field site conceptualized this component of their work as attempts to position individual events into larger narrative dramas of redemption and mission (cf. Cases 2, 4, 8). They also looked at historical events to get a sense of what tomorrow might hold for patients and others, acknowledging bodily and epistemological limitations, human autonomy in light of beliefs about divine agency, and the psychology of belief in terms of the likelihood of various forms of recovery.

[67] The reader may wonder about organized religion's participation in the social construction of new diseases, disorders, syndromes, and the like. Further research is needed to examine the extent to which religious institutions resist, reject, or applaud new diagnostic categories, though I suspect that political economics are important factors in official reception of at least some new afflictions. Ontological questions raised by such technologies as in vitro fertilization (IVF) and ventilators have elicited strong religious perspectives at the level of bioethics (see e.g., Inhorn 2003, Lock 2002), though these technologies did not themselves create the conditions that they aspire to alleviate. The role of black churches in the Tuskegee Syphilis Study is well documented (see e.g., Jones 1993), and organized religion has played roles of varying significance in the acceptance (e.g., Tay-Sachs disease; see Wailoo and Pemberton 2006) or rejection (e.g., vaccine refusal; see Wolfe and Sharp 2002). Likewise, some religious organizations have continued to promote certain traits as disorders, long after biomedicine deemed them non-pathological (e.g., the so-called ex-gay movement; see Erzen 2006). The Roman Catholic Church's Congregation for the Causes of Saints oversees the process of adjudicating claims of the miraculous; one could conceivably argue that such work endorses the validity of certain afflictions through its very existence.

Religious Hope and Biomedical Hope

What sort of space is the hospital in terms of risk? The ICU and trauma bay in particular are places where desperate people go in search of hope. They come as patients, and family and friends of patients, searching for interventions that will undo—or at least minimize—damage wrought by bullets, knives, speeding cars, toxic elixirs, gravity, and often raw stupidity. The modern hospital is an institution that is supposed to offer hope: it is a site full of expectation, one where individuals seek to trade despair for uncertainty and uncertainty for optimism. Today, the hospital is a milieu in which the afflicted arguably have both the right and duty to hope; it is a unique culture in which hoping has become a socially conditioned activity that shapes decisions and expectations of patient, practitioner, and family member alike.

This brings us to an important distinction cited frequently in theological writings between this-worldly and otherworldly hopes, fallibility, and the role of death in configuring clinical horizons. Some ethicists have argued for a distinction between subjective hopes (up to and including wishful thinking) and objective ones and conclude that the two should not be mixed (Day 1991), whereas others suggest that whatever its object, hope should be a "fundamental condition of life, a 'state of the soul,'" rather than simply an intellectual exercise (Roman 1975:68). This resonates with the activities at my field site, where several hospital chaplains saw it as their duty to remind those under their charge of divine faithfulness and interventions in the past and to help them to sustain their hope in the present without leading them to irrationality or deception. They understood, with Caspar, that their conception of religious hope was "rooted in time but cognizant of eternity," both "cosmic and eschatological" (1981:140) and was hence one of the key epistemological and phenomenological differences between this type of hope and biomedical ones.

Among various forms of religious hope, Christian hope is unambiguously oriented toward the future, both in this worldly and uniquely in eschatological terms, even as it engages with the present, and it preserves a teleology tightly intertwined with its configurations of hope. This hope presupposes an engagement with the current world as a way of growing, learning, and encountering in order to accumulate new data that may contribute to, but are not the final determinants of, a believer's hope in a given situation and the possibility of experiencing the self in practical ways (Moltmann 1967). Its idiosyncratic intermingling of temporal horizons has historically given it a unique ability to respond to apparent setbacks and frustrations with a flexibility that, while analytically questionable, has arguably been socially efficacious. Consider Moltmann's argument concerning early Christian communities and the revision of their hopes:

> This process of transformation … took place not so much on the ground of an eschatology that had been abandoned because of the delayed parousia of Christ and the disappointed hopes of his nearness, as rather on the ground of an ecstasy of fulfillment which took the *eschaton* that was to be expected and transformed it into the presence of eternity as experienced in cultus and in spirit. It was not so much disappointed hopes but rather the supposed fulfillment of all hopes that led the acute Hellenization of Christianity but also to the acute Christianizing of Hellenism. [1967:157]

Such cognitive flexibility retains its importance for the religiously inclined in this era, I argue, particularly in light of biomedical claims about the promise of life-extending treatments. While science in the U.S. has enhanced considerably knowledge of the natural world and the ability to manipulate it to desired ends, it does not always provide a strictly rational, maximally efficient framework by which individuals can satisfy their thoughts or maintain a steady momentum of hope within the concrete limitations of the therapeutic culture. This is true, I suggest, for clinical practitioners, as well as for patients and family members, to the extent that they are increasingly influenced by what Moreira and Palladino call a "regime of hope," in contrast to a "regime of truth" (2005:57). The former regime, they argue, stands on the claim

> that new and better treatments are always about to come, being tested, "in the pipeline." More specifically, research and development is justified by the promise of finding miraculous cures for debilitating diseases. Such promise entails endless deferrals to stabilize the identity of the therapy, its constituents and effects, deferrals that can be justified in various manners. The following opposition of "truth" and "hope" perhaps best captures the spirit of such deferrals: "We do not know the truth: there is hope." [2005:67]

The latter, by contrast, "is characterized by the view that most medical therapies are less effective than claimed, and this involves the constant returning of new and promising approaches to their original claims, their clinical failures and their ethical downfalls" (2005:67).

This distinction leads to additional questions about the properties of religious and biomedical forms of hope in the clinical setting. If one accepts the non-falsifiability of religious claims about life after death, an omnipotent deity, and divine consistency, then it seems that religious hope could in fact be cognitively *more* demanding than its biomedical counterpart. The former places a greater

cognitive onus on the hoper; there are no tests or studies that will lead a person closer to truth or to certainty. True, the passage of time may yield additional data by which to reconsider questions of meaning and purpose, yet this presupposes an openness to belief revision that is often lacking in manifestations of religious hope. Bearers of religious hopes run the risk of disappointment, for religious hope may be so determined or desperate for a positive outcome that it refuses to approach regimes of truth (cf. Case 6). A death may lead to a certain loss of faith in religious technologies of hope, but the very nature of religion as an epistemic system makes it likely that future acts of hoping will still be robust. Religious hope today may well be a more pragmatic coping method than the biomedical version, despite potential inconsistencies, particularly when a person's resources are limited and yet when an individual nonetheless strives to configure her hopes within the ideological culture of the clinic (cf. Case 8).

Meanwhile, if biomedical hope is indeed falsifiable, then its hope should be cognitively more contingent. Its hope should not be accompanied by any of the underlying faith seen in even analytically robust manifestations of religious hope and should hence prioritize truth over faith or whimsy. Nonetheless, an entirely rational, disinterested hope may be less satisfying from a phenomenological perspective in the clinical setting, particularly in the absence of novel biomedical interventions. This resonates with one resident's comments about his coordinates in the trauma bay as family members envisioned possible futures: "My role was emphatically *not* to cast a panglossian religious spin on events but rather to help ensure their physical safety and to afford them a linguistically and psychologically protected space to process their reactions." This resonates with Snyder's suggestion that thoughtful social discourse can provide "a system for identifying our goals as well as the pathways and agency thoughts linking us to those goals" (2000:32). This mandate to provide hospitality and the possibility of conversation was a key duty of chaplains, in this chaplain's eyes, for it manifested hope as a certain sort of social value in the biomedical space through the ideal of conversation and connection, even between strangers, even in the midst of a dramatic rupture, even "if there is no method for knowing when one has reached the truth or is closer to it than one was before" (Cooke 2004:85).

What, by contrast, are the social and psychological consequences for artisans of biomedical hope when there are no more interventions, when the laboratory truly has nothing else to offer at the bedside? For one thing, biomedicine's great technological advances have arguably weakened the capacity of practitioners such as trauma nurses and surgeons to accept death as a meaningful component of life (Clark 2002). This, combined with Baumann's contention that "contemporary life, at least in the United States, does not provide a context in which reflection and contemplation on

human experiences, such as hope, naturally occurs" (2004:339), suggests an unwillingness and/or inability to engage in the experience of an unfulfilled hope, a turn that in itself can make future opportunities at hoping that much more difficult (cf. Case 2). Ruddick questions why a loss of hope in any given situation has come to be viewed by so many in the biomedical culture as either socially or therapeutically harmful and makes a crucial distinction between (a) states of being without hope for an effective technological intervention and (b) the emotionally fraught condition of being bereft of hope (1999), an existentially noxious state that is socially avoidable yet seems to be conflated with the former in theory, if not also in practice (cf. Cases 5, 7).

Did chaplains at my field site possess a distinct advantage in this realm of medical care? In some respects, yes. Despite their increasing methodological separation from the chaplains, Christakis argues that physicians have often found themselves looking to the techniques of religious specialists in this area of patient care, for "when prognosticating is unavoidable, physicians cope with the difficulty it presents in a number of ways, including recourse to certain cognitive biases, magical ideas, and religious sentiments. Most, for example, develop a ritualistically optimistic attitude when it comes to foretelling the future" (1999:xvii).

Does chaplaincy then reflect a specific sort of religious hope in light of their location within a biomedical therapeutic culture? Can chaplains, through their actions and interventions, claim to be culturally legitimate sources of hope for others? I believe that the answer to both questions is yes, for several reasons. First, to the extent that biomedicine at my field site was itself silent on questions about death, chaplains could, and did, support individuals in their struggles with hope in an empowering way, even in light of the very legitimate critiques of Rorty and others that religious hope acts predominantly as an anodyne, a way to escape time and reality in favor of a simplistic sense of security, rather than focusing exclusively on whatever happiness can be generated exclusively within this lived world (Smith 2005). Second, even if we accept such a view of the world and restrict our attention to the visible and measurable, the chaplain can still prove valuable in light of Rodriguez-Hanley and Snyder's argument about the relationship between discourse and hope: "As social creatures, we need to confide in someone about our dreams and goals. Lacking the opportunity to share our personal experiences dampens, if not completely extinguishes, hopeful thinking" (2000:46-7).

Permit me one more distinction. Chaplains' hopes for good outcomes for patients typically overlap with those of other health providers, yet because their own key techniques of intervention—narrative and empathy—deal only obliquely with presenting biomedical issues, their hopes are rather sharply bisected into hopes in which their own skills allow them to play an active role and those in

which they are essentially reduced to the passive bystander who can appeal to prayer but must otherwise rely on others' abilities for the fulfillment of hopes. Particularly because chaplains do not manifest the somatic expertise of biomedically trained clinicians, or for that matter, the ritual tendencies of spirit possession and dissociation seen in the work of many shamans and witch doctors, those with whom I trained grounded their core hopes in the supernatural as primary agent, rather than in their own abilities or in those of the medical staff (as secondary agents). Such a belief system fits well with Pettit's concept of the buffering effect of hope that can guard the agent against the "tidal movements of evidence and against the demoralization produced by such an ebb and flow" in which "the prospect is manifestly beyond your control"; such a posture allowed chaplains "to sustain a more or less sanguine set of attitudes and to act on other fronts in the way that such attitudes would prompt" (2004:158).

Additional Functions and Implications

It should by now be clear that hope is intricately intertwined with personhood in the clinical space. Positive psychology, for example, has long stressed the adaptive role of hope in cognitive-affective process over the life span (Braithwaite 2004). Hope can bolster a person's sense of agency—or at least an illusion of it (Bovens 1999)—that allows her to continue to engage the world and thereby be shaped by it.

Second, according to Pettit, hope is required "in establishing the sorts of relationships in which we recognize and respect one another as persons—in which we have our status as persons confirmed. Just as collective action requires the capacity for hope, so the mutual acquisition of status within such a relationship is premised on the availability of hope too" (2004:164).

Third, in her research on collective hope, Braithwaite argues that "through parental and peer scaffolding, we are taught the process of hope and learn its social etiquette—how to empower others through the gift of hope and how to empower ourselves through receiving the hope that others offer" (2004:6). Further, "just as individuals and institutions have to prove their trustworthiness, those who offer hope must prove the authenticity of that hope" (2004:9-10). She contrasts collective hope, that which is "genuinely and critically shared by a group," with private and public hopes, where the former is a form of hope held at the individual level and the latter a rather thin, unsustainable variant that spreads easily but superficially, "peddled by spin doctors and uncritically accepted by expectant beneficiaries" (2004:7).

What conclusions can we suggest about chaplains as representatives of religious hope within the biomedical space, in light of these pungent critiques? Braithwaite argues that in Australia, there is missing a "social infrastructure that nurtures optimism and gives the less privileged the confidence

to act on their freedom and planfully pursue their hopes" (2004:10). Nonetheless, when "institutions of hope" exist, or where there are at least devices within social institutions that provide hope, they can function "as spaces for the expression of human need," such that by "investing in the hopes of others, in helping make these hopes meaningful and realistic, a sense of agency and trust in one's own capacities grows" (2004:12). I suggest that for chaplains, who contend with hope on a variety of affective and intellectual levels in nearly every person they meet in the clinical setting, and whose own hopes are influenced by these encounters, this dialectical process is relevant to maintaining a solid core of hope essential to their ongoing ability as practitioners to engage others in hope-related exercises.

One could argue that biomedicine attracts subjective beliefs into its workspace precisely through the nature of its activities and lack of cognitively satisfactory answers to such questions as life after death—dilemmas that typically demand a response in whatever cultural environment they are posed—and because death has been one of religion's traditional areas of cultural expertise, it is logical that biomedicine should attempt to include it within its toolkit. When death occurs, the hospital can become a unique sort of confessional space, one where worry and fear alike lose the object of their focus and credos become a viable mechanism to stabilize the hermeneutical and emotional landscape. A cynic might respond that it is only a matter of time before biomedicine will deploy psychopharmaceuticals or neurostimulators to temper acute, low-level grief in the emergency room (cf. Case 2 on more dramatic levels of affect). I argue that the chaplain's availability allows family and friends to hold and express whatever religious beliefs they want regarding an afterlife and gives them wide berth to explore such topics within hospital walls precisely because these practitioners project religion (and not science), even as they work for biomedicine.

Some Challenges

This is all to say that religious and biomedical types of hope are not mutually exclusive, despite what at times might seem like a rather sharp demarcation between the perspectives of biomedicine and pastoral care. Indeed, there are other points of overlap. In many non-emergency cases in which the possibility of death is not an imminent concern, Ruddick contends that clinical practitioners—I would include chaplains here—become so convinced of hope's own therapeutic benefits that they often support false hopes, often with family collusion, on the assumption of either a placebo-like effect of hope on treatment outcomes or a tacit recognition that some patients will continue treatment even after losing hope themselves, simply because the doctor, parent, nurse, or lover still maintains hope (1999). Similarly, in her study of hope, Good *et al.* explain that American oncology represents a complex admixture of cultural beliefs, sentiments, and somatic realities that

shape consciousness and relationships at the hope-truth interface throughout the therapeutic process. Here, hope functioned as a *modus operandi* and an epistemological filter, an often-dubious rationale for pressing on with interventions that stemmed less from clear-eyed experience than a fear of disappointment (1990).

Is hope necessarily warranted? Or should patients and others in the hospital follow the advice of Hecataeus of Miletus: "Cease to hope and you will cease to fear" (*Fragments*)? Sophocles saw hope as "a human foible" that existed merely to prolong suffering. Plato chastised those who heeded hope's call, calling it a "foolish counselor" (Snyder 2000:4). Caspar argues that the criticisms of Marx, Nietzsche, Freud, and others of religion as an "evasion of reality and responsibility, or simply a childish form of wish projection" are due in large part to the role of hope in religious doctrines (1981:144). Schneiderman, meanwhile, believes that hope in Western medicine today is "almost always promoted for its impact on a single dimension—life prolongation" and speculates that in the case of particularly dramatic illnesses, "the central role of miracles in Christian mythology" may "underlie the contemporary expectation, or at least hope, for medical miracles" (2005:237). From the perspective of care providers, hope for cures—or at least a stable, long life—can have the effect of maintaining "both medical authority and patients' reliance on and expectation of medical intervention" (Eliott and Olver 2002:179). In a subsequent article, they argue that it is a powerful rhetorical tool in establishing the status and legitimacy of medical scientific endeavor, one that sees hope as fundamentally intertwined with the aspirational values of science (Eliott and Olver 2007).

The possibility remains that a chaplain will lead people to have unrealistic hopes in a way that will cause the afflicted to be unduly compliant with biomedical power structures and research agendas. Likewise, practitioners who accept doctrines that interpret any indication of despair as sinful, as a sign of weak faith, or as an abdication of a person's religious duty to be hopeful may cause enormous stress to persons experiencing vulnerability and uncertainty in the clinical space through cognitive and emotional dissonance. Both such views are unlikely to find supporters in either the biomedical ranks or chaplaincy at my field site, though it is entirely conceivable that they would in other cultural settings; this is a question that must await further research.

Such interventions nonetheless point to broader social questions about uncertain futures and the ways in which religion and science interact. Alaszewski and Brown argue that "risk society begins where tradition ends, when, in all spheres of life, we can no longer take traditional certainties for granted. The less we rely on traditional securities, the more risks we have to negotiate. The more risks, the more decisions and choices we have to make" (2007:2). Importantly, they suggest that a

"heuristics of fear" has emerged in response to the recent plethora of questions of biomedical security and risk (2007:9). It seems that such an outlook, to the extent that it represents accurately the state of affairs in biomedical cultures such as my field site, can have a significant impact on the ways in which actors approach questions of bodily disruption and the configuration of hope through science versus through religion.

8

CONCLUSION AND FUTURE DIRECTIONS

MEANWHILE…

Just as my colleagues and I were busy trying to make sense of the clinical relationship between biomedicine and religion in light of lived experiences of disease and injury, a curiously similar sort of process seemed to be underway in another East Coast city.

In the fall of 2005, the town of Dover, Pennsylvania captured national and international attention for a lawsuit (*Tammy Kitzmiller, et al. v. Dover Area School District, et al.*) brought by about a dozen parents against the Dover Area School District regarding the teaching of intelligent design in high school science classrooms. In 2004, the Dover Board of Education voted to require 9th grade science teachers to read the following statement aloud in biology class:

> The Pennsylvania Academic Standards require students to learn about Darwin's theory of evolution and eventually to take a standardized test of which evolution is a part.
>
> Because Darwin's Theory is a theory, it is still being tested as new evidence is discovered. The Theory is not a fact. Gaps in the Theory exist for which there is no evidence. A theory is defined as a well-tested explanation that unifies a broad range of observations.
>
> Intelligent design is an explanation of the origin of life that differs from Darwin's view. The reference book, *Of Pandas and People* is available for students to see if they would like to explore this view in an effort to gain an understanding of what intelligent design actually involves.
>
> As is true with any theory, students are encouraged to keep an open mind. The school leaves the discussion of the origins of life to individual students and their families. As a standards-driven district, class instruction focuses upon preparing students to achieve proficiency on standards-based assessments. (*Case 4:04-cv-02688-JEJ Document 342*, 2005:4)

The request seemed simple enough, from the perspective of the defendants: evolution reflects imperfect reasoning, and students should be alerted to the availability of other causal theories of the formation and development of the universe. They did not, it seems, wish to suggest that science was false or that entities like atoms, cells, and circulatory systems do not exist. Likewise, many of their legal advisors were aware of the precedents set by the Scopes trial and recent events in Kansas regarding evolution versus creationism and recognized the stakes in the case.

Intelligent Design, they argued, was different. This was not a reprise of God versus Darwin (or Nietzsche, Watson and Crick, Copernicus, Galileo, or Charles Lyell), but rather a more sophisticated, and secular, enterprise. The judge in the case, John E. Jones III—a George W. Bush appointee—disagreed. After hearing several weeks of testimony, he concluded that "the religious nature of ID [intelligent design] would be readily apparent to an objective observer, adult or child" (2005:24), that "overwhelming evidence at trial established that ID is a religious view, a mere re-labeling of creationism, and not a scientific theory" (2005:43), and that "ID fails on three different levels, any one of which is sufficient to preclude a determination that ID is science. They are: (1) ID violates the centuries-old ground rules of science by invoking and permitting supernatural causation; (2) the argument of irreducible complexity, central to ID, employs the same flawed and illogical contrived dualism that doomed creation science in the 1980's; and (3) ID's negative attacks on evolution have been refuted by the scientific community" (2005:64). As a result, intelligent design could no longer be taught in the Dover classroom.

I present this brief synopsis not to debate the merits of the case itself but rather to juxtapose it as a cultural and epistemological process to the training and work of hospital chaplains as a way of laying the groundwork for future research. The interaction of religion and science is, I suggest, a unique and complex set of social phenomena that manifest themselves in a wide variety of cultural domains in the U.S., from the classroom to the courthouse to the hospital and research laboratory. These phenomena reflect facets of belief and rationality, narrative, social power structures, and the individual and institutional reactions to the unknown—analytical topics that have stood at the very center of this dissertation.

The analysis of the training and work of hospital chaplain residents has provided important new insights into anthropological understandings of religious specialists, suffering, mediation, and other topics in the clinical space. The time is thus ripe for a broader examination of these topics across the U.S. cultural landscape, to attempt to draw more general conclusions about religion-science interactions as social events.

TOWARD THE BIOMEDICALIZATION OF AMERICAN RELIGION

Introduction

Particularly with the growth of laboratory research, the influence of pharmaceutical and health maintenance/enhancement corporations, and the increasing visibility of health issues in the media, biomedicine is assuming a growing place in American consciousness (Finkler, Skrzynia, and Evans 2003). Scholars have long speculated on the social roles of science in the U.S. and its effects on religious institutions (Lindberg and Numbers 2003), yet predictions about the disenchantment of society have failed to materialize, as believers continue to look to sacred texts, theological writings, and ritual for understandings of the universe and appropriate ways to exist within it (Barnes and Sered 2005). Herein lies an apparent paradox: many of the same persons who study scriptures, pray, and believe in heaven and hell also go to genetic counselors, receive organ transplants, and give their children prescription drugs for ADHD.

Is this age of interactions any different from previous chapters in the science-religion dialectic (cf. Brooke 1991)? If it is, what conclusions can we draw about institutional religions as cultural phenomena in which beliefs, ideologies, and practices are subjected to scientific scrutiny and modulation, and whose adherents increasingly see themselves and their actions through the lens of biomedicine? Has biomedicine been able to leverage the terms of debate with organized religion? If so, then how? Why? And to what effect?

My future research plan is to investigate critically the claim that biomedicine is increasingly challenging, if not siphoning off, many of institutional religion's traditional areas of social influence—ethics, visions of the future, and epistemologies of selfhood—in novel ways, and it examines the degree to which biomedicine's philosophies are modulating religion's conceptualizations of morality, uncertainty, and affliction in light of various responses to these scientific developments. Likewise, it hypothesizes a palpable shift in the ways in which religion and biomedicine relate to each other as ideologies and sources of social control.

This research agenda builds upon the insights and questions that emerged over the course of my doctoral fieldwork and in light of events like *Kitzmiller v. Dover Area School District*. The project contains three interrelated spheres of inquiry: the hermeneutic and phenomenological impact of biomedical clinical practices on religion in local communities; risk, hope, and quantification; and neuroscience and the mind. Taken together, these three spheres hold the potential to restructure American religion anew (cf. Wuthnow 1988).

CPE and Religion beyond the Clinical Setting

The first component of this project analyzes the ideological and interpersonal consequences of CPE training beyond the confines of the hospital. In my dissertation, I focus almost exclusively on religious activities within the medical center; I acknowledge the fact that chaplain residents interact with the broader social milieu in which the hospital is located but do not explore the implications of this interaction for either the residents themselves or for those they meet in supermarkets, choir practice, the post office, and elsewhere. What continuities and conflicts emerge between religious specialists' intervention and practice in the clinical setting and their work in the broader community?

In particular, I am interested in the social consequences of the training of religious leaders under the auspices of CPE's ostensibly homogenizing pathway for cultural understandings of pain, suffering, and recovery (Delkeskamp-Hayes 2003; Engelhardt Jr. 2003). CPE developed in the early 20th century explicitly in response to the physical, emotional, and institutional realities of allopathic treatment (Cabot and Dicks 1936), and its approach to the biomedical management of illnesses highlights broad convictions about compassion, solidarity, and reconciliation common to a wide range of religious traditions (Holifield 1983). Further, CPE is accredited by the U.S. Department of Education, and its professional Association holds almost a complete monopoly on chaplaincy training in hospitals (Department of Education 2008). Thus, while individual religious traditions maintain their own doctrines about disease causality and rituals to alleviate misfortune, persons who wish to work as a hospital chaplain *must* complete this standardized course. This training is required by many traditions for ordination, regardless of the final vocational setting. Presbyterians, Jews, Roman Catholics, Buddhists, Baptists, Muslims, Greek Orthodox and Assemblies of God practitioners, and others are reflected in student cohorts and carry this pedagogy with them into their workplaces.

Risk, Hope, and Quantification

The second component of my project investigates the role of statistics in health and its impact on religious beliefs regarding the future. Here, I consider how shifting visions of prognostication, new risk categories, and experimental/imagined therapies are shaping religious explanatory models of affliction, understandings of the body, and sources of trust.

The popularization of biostatistics has generated considerable social angst about the probability of developing or transmitting various diseases and has shaped perceptions of the likelihood of recovery from illness. Reports about susceptibility genes for Alzheimer's (Lock *et al.* 2007), tests for Tay-Sachs and cystic fibrosis (Wailoo and Pemberton 2006), and studies on high

blood pressure risk (Cappuccio 1997) have configured the body as a conglomeration of potentially compromised outcomes and have led to techniques designed to prevent, minimize, and optimize, all in the name of somatic longevity (Rose 2007). As biotechnology increasingly demarcates the parameters of the possible, religion seemingly finds itself but one mechanism of hope among many, like *in vitro* fertilization labs (Roberts 2006), that offers possibilities in light of bodily limitations. Despite the variable therapeutic success of such technologies, biomedicine's ability to engender surveillance and guidance points to new modes of social oversight and self-management (Foucault 2003) that appear at odds with traditional religious beliefs.

Statistics are likewise found in clinical studies of religion's therapeutic potential. In recent years, hundreds of randomized, controlled trial results have attempted to correlate religious beliefs and practices with quantifiable health outcomes (Koenig, McCullough, and Larson 2002). By framing religion in terms of measurable variables affecting illness prevention and therapy, scientists—often with the enthusiastic support of religious groups—are trying to somatize the purported health benefits of, for example, church attendance, intercessory prayer, and forgiveness. In the process, it appears that biomedicine is becoming an arbiter of religion through its epistemology of the body. Such research draws religion into a domain of hard data in which it is ostensibly ill equipped to participate and yet seemingly must to respond to criticisms of therapeutic irrelevance (Sloan 2006).

The Mind Revisited

The final component of this project examines two related domains of scientific research on the brain-mind and its relation to social religion:

Through a variety of imaging, lesion, and related studies, neuroscientists have developed a range of influential hypotheses about the workings of the human brain that hold the potential to challenge longstanding doctrines of theological anthropology. Correlational analyses of brain activity and religious practices such as meditation have led to new speculation about the nature and content of multiple states of consciousness and have generated proposals about the evolutionary "naturalness" of religious ideas in the satisfaction of human needs for order and explanation (Boyer 1994). Similarly, research on epilepsy and schizophrenia has resulted in novel questions regarding the relationship between neurological activity and purported supernatural forces, distinctions between bona fide and pathological spiritual experiences, and the socio-moral status of such diagnoses (Newberg, D'Aquili, and Rause 2001). These advances have also generated new speculation about the concept of free will and human agency (Ross 2007), and this trend toward the neuro-somatization of morality is breeding novel hypotheses about both the biological bases of social behavior and

actions once thought to reflect sin, evil, and despair (Sinnott-Armstrong 2007). Similarly, increasing biomedical definitions of deviance and the management of such behaviors through pharmacology poses new challenges to long-standing doctrines of guilt, grace, and soteriology (Murphy and Brown 2007).

In addition to these emerging neurophysiological and neuropathological models of consciousness and freedom, biomedicine has also lent provocative new arguments about the modes, contents, and consequences of mental classification. Perhaps most significantly, Damasio (1994) and Hecht (2003) have challenged Cartesian dualism's influence on body-mind relations and have led to a reconsideration of the notion of the soul, with potentially enormous consequences for concepts of embodiment and afterlives.

This appeal for a more fluid, unitary concept of materialist personhood has also led to an analysis of the ways in which the brain forms binary distinctions in response to the intellectual context in which it finds itself. Such studies have illuminated pathways by which religions appear to promote senses of unity and otherness, yet they have simultaneously challenged the timelessness and pneumatic inspiration of such constructs. This neuroscientific hermeneutic likewise questions the moral validity of such religious dichotomies as good/evil, pure/polluted, member/outsider (Douglas 1966) and raises significant questions about the potential consequences of new mental taxonomies for religious explanatory models of illness, concepts of causality, and perceptions of good health.

APPENDIX A: CAPSULE SUMMARY OF CHRISTIAN DENOMINATIONAL POSITIONS ON ISSUES OF HEALTH AND ILLNESS

	Sin and Illness Etiologies	**Divine Role in Illness Causality**	**On Physicians and Science**	**Religion's Role in Healing**	**Priest's Role in Illness and Healing; Pastoral Theology**	**Role of the Church; Notable Figures**	**On Hospitals and Outreach**	**On Suffering**	**This World, Death, and the Next**	**Individual's Responsibilities**
Patristic Era	Sin involved, but not necessarily the immediate cause of every affliction; demon possession a potential cause	Greater stress on Divine sovereignty led to increased stress on God as the ultimate cause of illness	Early on: some rejected secular medicine in favor of miraculous healing or healing by spiritual means; others argued to receive medical care with gratitude; physicians seen by many as servants of God	Some miraculous healing; exorcisms; emphasis on magic (Theodosian Code) for a time; relics	Anointing and laying on of hands; healing via prayers to the saints	Benevolence was important in preparation for judgment	Exhortations to take care of the sick; *Parabolani* during pestilence; first hospitals in 4th Century, including Basileias; all humans possessed human worth & dignity and should be protected, nourished	Expect it; many viewed it as part of spiritual training; corrected specific sins and weakened connection to the present world; increased self-knowledge and dependence upon Christ; not viewed as intrinsically good	Cope with suffering; next life will be grand; many embraced dualism, but most viewed the body as morally neutral; physical health was a good thing, but spiritual health was far more important	View body as part of God's creation but don't cling to life; suicide viewed as an evil; asceticism prized
Medieval Era	No clear indication that sickness was a direct punishment for sin, though ambiguity surrounded the issue	God is involved in the illness process; development of natural law and natural medicine; many viewed the plague as sent by God	Use them, though varying critiques of medics	Saints; relics; ascetic virtues; demonology; presence of the miraculous	Sacraments; healing should emphasize mediation; growth of priestly authorship of lay handbooks for health; confession enters	St. Martin of Tours and other pilgrimage sites; couch healing ideologies in ways that can be understood by laity	Plagues; escaping the wrath of God; Iona as a medical base?; construction of many (proto-) hospitals, which were usually owned by orders	Sanctity possible through illness; flagellation gradually came into vogue	Formidable presence of the supernatural in daily life; syncretism with new converts (folk paganism); emphasize the eternal over the temporal; confession necessary before death	Need harmony with the external world; penance; avoid superstitious practices; repentance always appropriate; prayer; confession required by the 4th Lateran Council

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Roman Catholicism since 1545	Sin is debilitative rather than destructive		Increasingly supportive, though medical practice still part of God's creation	Immanence and the sacraments (as opposed to Protestant trans-cendence); distinguish genuine religious activity and superstition	Sacerdotalism and *medicina clericalis*; deacons; extreme unction	Vincent de Paul, Sisters of Charity, *et al.*	Monastic hospitals, evangelization	Positions varied; traditionally more other-worldly than Calvinism; many argued for the idea of sharing in the suffering of Christ as part of purging process	Tendency to emphasize the spiritual over the physical; Purgatory	Co-creators; care for own body; issues of sexuality and repro-duction big
Eastern Orthodox	OT: sin leads to ill health and disease		Greek tradition: respect for medical profession; Middle Ages: beware greedy physicians!	Christ as the prime healer; some evidence of healing miracles	Sacramental healing; early monastics and ordained as healers; anointing; little emphasis on pastoral counseling, but regular hospital visits were required of priests	Pray for each other; intercession of the saints	Philanthropia and concern for the poor; lots of hospitals, incl. Byzantium and Pantokrator (with chaplains); Monasteries of Sts. Menas and George the Great Martyr	Potentially redemptive	Nemesius of Emesa: human as composite of soul and body that linked physical and spiritual elements; buried dead in expectation of 2nd coming; Christ as victor over death	Personal purity, devotion to God, prayer, clean living
Lutheran	Both natural and from the devil	God may allow/ cause some illnesses	Use them; they're God's instruments	Use prayer along with physicians; some faith healing by charismatics in recent years	Physicians and clergy should work together; emphasized pastoral care	Pietism: hospitals and orphanages but other-worldly; diaconate & priesthood of all believers; Amalie Sieveking and social outreach	Emphasis on this-worldly suffering and need; founded many hospitals	Not good in itself; should not seek it; possible to draw nearer to God through it	Be prepared for death; justification by grace frees humans to focus on the present	

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Anglican	Early on: sin causes sickness; later, scientific medicine		Eventually came to support them	Early on: monarchs thought to have divine powers of healing; some attracted to Wesley's ideas	Minister to all types of illnesses; Ministration of the Sick; realism and Christian humanism emphasized	BCP	Medical missions in the 19th Century; healing an aspect of outreach	Do it patiently, like Christ	Early on: plagues and death during childbirth—try to die well, rather than fearing death; later, death as a normal event in the course of life	Individual reason and conscience
Wesleyan-Methodist	Early on: belief in existence of demons and witches	Evangelical era: disease as divine punishment for sin (but many disagreed)	Initially critical of motives of scientific healers; generally supported scientific medicine; medical activities can manifest sanctification	*Primitive Physick*; early plain & simple popular therapies; possibility of supernatural intervention; some interest in divine healing via prayer	Love of God affects body and mind; inward principle; emphasis on chaplains, but little on parish priests working w/ physicians	J. Wesley on theory & practice of med; Methodist visitors; H. Wilkins and heroic med; Tyndall and sci. studies of prayer; Nazarene & Holiness groups; H. Clinebell	Restore body to relieve and rescue the soul; strong missionary activity, especially 1790-1880; hospitals with deaconesses	Inevitable; could strengthen faith; counters human pride	Try to alleviate anguish and sickness when possible; deaths should reflect fullness of sanctification; later, dying with dignity and de-emphasis on heroic med	Must choose to accept salvation; Christian perfection; poor health habits cause disease; watch diet; pray!
Anabaptist	Usually assume a causal link between sin and sickness	Method of training and chastising	Some heterodoxy; generally supportive of physicians	Attitude of resignation more important than healing; generally reject miraculous healing	Hutterite barber-surgeons	Visible, concrete certainty of the church; care for church family first; deaconesses at one point	Established hospitals and nursing homes; some medical missions; active in mental health	Cope with it; suffering will be unknown in the next life	Emphasis on separation from the world at large; life's short; next life will be better; ambivalent at death	Personal responsibility for religious decisions; deeds necessary for salvation; pray for healing

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Reformed	Afflict-ions not directly caused by sin but a conse-quence of it; illness not necessarily a punish-ment for sin	God sometimes uses affliction to chastise	Use them; ask for help when needed—they're gifts from God; supported Baconian inductionism	Physical and spiritual health shaped by a person's hearing and receiving the Word; opposed to faith healers and "positive thinkers"	Get medical care but also incorporate some words of truth; empha-sized pastoral visits; should work with the doctor (or be one)	Work of deacons; Sylvester Graham, Anton Boisen, Karl Menninger, Seward Hiltner	Founded many hospitals; conducted a fair amount of medical missions work	Opportunity for humility; a way to help people to deal with sin and bear burdens; may be empowering	Always be prepared for death; problem of pre-destination; focus on ethical issues, especially with regard to artificial life support	Complete dependence upon God; Everything in moderation
Disciples of Christ	Violations of moral law results in pain	All nature governed by God's law	Rationalistic, natural-law orientation; science and Protestantism rising together	No theological objections to the miraculous; vitriolic critics of independent healing revivalists; opposed to any expectation of divine intervention in healing		Emphasis on strong local congreg-ations; elders oversaw moral and physical condition of members; deacons	Emphasis on outreach to the marginalized; foreign missions; institutional benevolence	Conservatives: suffering as providential and corrective; should try to alleviate it		Respect for moral law crucial for one's physical well-being; prohibition; healthful recreation
Unitarian-Universalist		Strains of deism; religious humanism also grew	Bridges between medical and pastoral professions; some interest in phrenology and homeopathy	Some emphasis on spiritualism; rejected super-naturalism; rely on external facts rather than the internal state of mind		Benjamin Rush, WE Channing; E. Jarvis and statistical taxonomies; C. Barton and Red Cross; Cabot at Harvard	Strong ethic of social service and outreach; established HMS, MGH, and McLean; moral treatment of insane; little on missions	Partially a reflection of human suffering and guilt	Transcen-dentalism; death severs ties to the world but does not obliterate person; death is unavoidable	Strong individual-ism; free will leading to salvation, (universal-ism); elements of *Common Sense* realism; exercise and fitness; reason!

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Baptist	Correlated, but causality generally not stated (?)	May reflect God's anger at sin toward repentance or for spiritual maturity	Use them in conjunction with religion; Baptist doctors often evangelized their patients	Pray; God uses physicians and other means; reject mind-cures; many believe that the age of miracles is over	Strong emphasis on pastoral care, with openness to clinical psychology	Some evidence of anointing; deacons and elders also do pastoral counseling with lots of advice; monitor social and personal behavior; Harry Fosdick, Wayne Oates	Tend to emphasize saving souls over curing bodies or preserving health; medical missions with emphasis on proselyti-zation; established hospitals with lots of Bibles	Ambivalent; a curse for sin and a gift of grace for spiritual stamina; reminder of the Fall	Heavy emphasis on personal belief and conversion via (adult) baptism	Priesthood of all believers; religious freedom; pray!; stay away from alcohol/ tobacco; personal behavior has health conse-quences
Evangelical and Fundamentalist	Sickness, like sin, caused by Satan and contrary to God's will; old view—mental illness due to sin, organic disorder, and demonic possession		Generally accept biomedicine; psychologists must be from their doctrinal flock; still favor vices over medicalization; not particularly concerned w/ most bioethical issues	Well-being centered on relationship w/ God; 19th C. focus on religious healing; various views on miracles; prayer may work apart from medicine	Essentially unmediated relation-ship between human and Divine, but professional counselors	Revivalism; Biblical literalism	Primary m.o. is evangel-ization; few hospitals due to decentral-ized governance	There's a place for it in the Christian life; every-one can expect to experience it; has potentially beneficial effects; seldom viewed as a sign of God's anger or dis-pleasure; a form of chastise-ment	Key emphasis on necessity of personal conversion for salvation; hell for the unsaved; dispensational-ism quite big; death a re-flection of the Fall	Body a temple for the Holy Spirit; emphasize asceticism of mind and will; various points of view on nutrition; prayer matters; no necessary connection between godliness and health

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Pentecostal	Early on: sin causes disease; demon possession a constant threat	God may withhold healing for unknown reasons	Early on: meds or MDs as deliberate rebellion against God; most eventually turned to MDs, except for mental health	Miracles still available; exorcism for demon possession; healing mediated through Christ's atoning and sanctifying work	Ministrations from the pastor or a call-in evangelist in times of need	Charismatic gifts of healing stem from the church; Maria Etter; Dwight Moody; Oral Roberts; prayer partners during illness	Orphanages and retirement homes; financial investments	Don't deny the pain or symptoms of illness	Failure to be healed as evidence of inadequate trust in God's word; truly converted should be protected from illness; death a transition to a higher and better stage of life (for the saved)	Strict, renunciative behavior; fasting and prayer
Adventist		God sometimes allows /sends suffering as blessing in disguise	Rarely condemn Western med, but hydropathy big for a time; MDs assist nature; rejected mind cure	Rejected dualism; fair place for prayer in healing; emphasis on holism		Ellen White as prophetess; JH Kellogg	Lots of foreign missions and medical institutes, w/ evangelism as the ultimate goal	Could be to perfect character or to guarantee salvation	Immortality conditional upon the acceptance of Christ	No mastur-bation!; dietary reform; no alcohol or tobacco
Afro-American	Often syncretic w/ voodoo et al.; illness conceived broadly to include social ills; jealousy; sickness from original sin		Conjurers early on; race issues undercut greater use of biomed; can't answer the question of why someone becomes ill	Restore order and wholeness; calm social strife; divination and cure	Laying on of hands	Communal health and illness con-ceptions; a form of political action/ symbolic expression of power?			Complicated relationship; ancestors buried but accessible	Fair interest in occult practices; possession, divination, and veneration of gods

	Sin and Illness Etiologies	Divine Role in Illness Causality	On Physicians and Science	Religion's Role in Healing	Priest's Role in Illness and Healing; Pastoral Theology	Role of the Church; Notable Figures	On Hospitals and Outreach	On Suffering	This World, Death, and the Next	Individual's Responsibi-lities
Jehovah's Witness	Disease a degenerative process that reflects the Fall		Generally fine except for blood transfusions (no blood consump-tion, though ok for hemo-philiacs) and psychiatry	Bodily perfection after Armageddon through combo of human and divine agents		Charles Russell; lots of prophecies	Generally shy away from official involvement in caring and curing; far more concern w/ saving souls	Can be redemptive and can refine one's character	Apocalypse; reject immortality of the soul	Family and moral values big; no alcohol or tobacco
Christian Science	Illness is an illusion; sickness, mental illness, and death do not exist	Evil and sin do not exist; they reflect false beliefs	Physical world doesn't exist; could consult surgeons for bone-setting and OB's for pain control	Greater understandin g of the goodness of spiritual reality leads to an awareness of illness as an illusion	Early on: practitioners to make a living from the practice of healing as evangelist-physicians	*Science and Health* as impersonal pastor; MB Eddy	General social outreach	Does not appease God and ideally does not exist; follows from sin and sickness; opens the possibility of spiritual under-standing	Humans as perfect ideas that proceed from God; death as a challenge to be met and not as an escape	Mind cure; roots in mentalism; patient expected to contribute to the process of healing; general hygiene and lifestyle habits
Mormon	Some illnesses through demonic possession	Death and disease sometimes seen as chastise-ment, presence of God's healing power, or a test	Early on: self-help or herbalism; gradually embraced biomedicine, except for mental health				Less direct payment for illnesses	Implicit in mortality and the Fall; prepared the righteous to become as God	Human potential godhood; exaltation of the dead through ordinances; eternal family relationships	Healthy lifestyle; no alcohol, tobacco, etc.; recreation

APPENDIX B: SOME KEY MEDICAL, SCIENTIFIC, AND RELIGIOUS EVENTS RELATED TO HOSPITAL CHAPLAINCY IN THE U.S.

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
1524	Cortes establishes the Hospital de Jesus in Mexico City, the first in North America			
1542				"New Laws" of Spain forbid Indian enslavement and demand humanitarian treatment of Indians
ca. 1563			Council of Trent officially prohibits priests from practicing medicine	
1573		Tycho Brahe tries to rationalize Copernican and Ptolemaic systems		
1609		Kepler introduces the first laws of planetary motion		
1610		Galileo undertakes telescopic observations of the moon, stars, *et al.*		
1620				Pilgrims land at the site later known as Plymouth
1624			Church of England established in Virginia	
1628		Harvey publishes findings on the circulation of blood		
1630s	First almshouses established, for aged, orphaned, insane, ill, and debilitated			
ca. 1640s-1700s				Angelical Conjunction in New England
1665		Hooke publishes extensive findings through use of the microscope		
1680s-90s			Jews begin to enter into colonies on a permanent basis	
1682				Quakers settle Pennsylvania
1687		Newton formalizes his laws of motion and laws of gravitation		

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
1689			Toleration Act permits limited religious freedom in colonies	
ca. 1690			90% of all colonial congregations are Congregationalist or Anglican	
1692				Salem Witch Trials
1706			Presbytery of Philadelphia organized	
1707		Linnaeus lays foundations for modern scientific schemes of taxonomy	Philadelphia Baptist Association established	
1716			Synod of Philadelphia organized	
1730-40			First Great Awakening	
1730				Amish begin settling in Pennsylvania
1741			Moravians/Brethren arrive in PA	
1748			Lutheran Ministerium of Pennsylvania established	
ca. 1750-1850	Hospitals primarily voluntary or public			
1752	Pennsylvania Hospital opens as the nation's first permanent (voluntary) general hospital designed to care for the sick			
1769			First Methodist preachers arrive in colonies	
1776-1783				Revolutionary War
Late 1700s	Decline of midwives			
ca. 1783			~20% of (free) adult population holds church membership	
1790-1830			Second Great Awakening	
1791				First Amendment ratified
1797		Lyell elaborates findings on the geological history and structure of the earth		
1816			AME Church founded in Philadelphia	
ca. 1820s	American medical students begin to travel to Europe, esp. France, for education. Rise of medical skepticism.			

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
1830s			Christians/Disciples of Christ formed	
ca. 1830s-1850s	Numerous attempts at licensure at the state level			
1830	Gunn's *Domestic Medicine*, a popular household favorite, is published		Joseph Smith publishes *Book of Mormon*	
1830s	Grahamism gains popularity as a health movement.			Growing popular interest in natural reason and democratic rationality
1831				First cholera epidemic strikes; many clergy and laity interpret it as divine punishment. Protestant Sisters of Mercy initiated to respond to the illness.
1838		Schleiden argues that all plants are made of cells		
1840	Beginnings of psychiatry as a profession		(Free) adult church membership 30-40% of US population	
1845			Baptists split over slavery; SBC formed	
1847			First Mercy hospital in U.S. opens in Pittsburgh	
1849				Second cholera epidemic; clergy attacks on science continue
ca. 1850-1890	New hospitals primarily religious, ethnic, and/or specialized (e.g., women, children, disease-specific)			
1850s	Gradual decline of heroic medicine and Rush's theories. Growing use of scientific diagnostic devices. Growth of religious and medical (pluralizing) sectarianism. First (failed) attempts to establish health insurance companies.			
1859		Darwin publishes *On the Origin of Species by Means of Natural Selection*		
1860s-1870s	Pasteur and Koch make key advances in bacteri-ology; germ theory of disease gains credence			

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
ca. 1860s	Homeopathy, based on Hahnemann's theories, gains in popularity			
1861-1865				Civil War
1865		Mendel develops theory of (genetic) inheritance		
1866				Third cholera epidemic; public health efforts limit interpretations of disease as magical or moral phenomena
1869		Mendeleev formulates the periodic table		
1870s-1890			Dwight Moody preaches evangelistic message to large audiences in US and Britain	
1872	178 hospitals exist in U.S.; ~75 are Catholic			
1877	Granite Cutters establish first national sick benefit plan			
1880s	Gradual rapprochement between allopaths and homeopaths			
1881				Mary Baker Eddy founds Massachusetts Metaphysical College, forerunner of Christian Science
1884			Zion's Watch Tower Society (Jehovah's Witnesses) organized	
ca. 1890-1920	New hospitals primarily for-profit and focused on surgery; elite voluntaries focus on acute care, municipal and county both acute and chronic			
ca. 1890s	Beginnings of chiropractic field; growth of surgery, particularly within hospitals			
1893	Hopkins Med School opens; science and research more firmly joined to clinical hospital practice			

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
ca. 1900	Most physicians' work in hospitals and/or offices; standardized tests for statistical norms for physiology and behavior gain popularity		~50% of US adults claim church membership	
1901				AMA, Presbyterian and Methodist churches support legislation for board of public health to serve as medical examiners
1904			N. American Shinto Church organized	
1905		Einstein introduces his special theory of relativity		
1906			First Hindu temple built in N. America, in San Francisco. Beginnings of Emmanuel Movement.	
ca. 1907			Beginnings of Social Gospel movement	
1906-1909			Pentecostal Azusa Street Revival movement	
ca. 1910s	Public health begins to stress education in personal hygiene and routine medical examination of the entire population. ~400 Catholic hospitals exist in U.S.			
1912		Wegener introduces the theory of continental drift		
1913		Bohr produces his model of the atom		
1917-1918				U.S. participates in World War I
1918				Xn. Science and insurance companies oppose (and help defeat) health insurance referendum
1920	AMA achieves 60% MD membership nationwide; beginnings of organized medicine. 4013 general hospitals in US (avg. 78 beds); 521 mental hospitals (avg. 567 beds)			
1924			Anton Boisen begins chaplaincy work at Worcester State Hospital, a mental facility	

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
1925			Boisen has three summer students at Worcester; beginning of CPE movement	Scopes trial in Tennessee
1926			Synagogue (Conservative) Council of America founded in NY	
1929		Hubble presents evidence for the concept of an expanding universe	The Council for the Clinical Training of Theological Students, Inc. established in Massachusetts	Blue Cross begins to offer hospital insurance in Texas; Depression forces voluntary hospitals to look to insurance plans—not direct payment—to remain solvent
ca. 1930	Non-physician medical specialists (x-ray techs, nurse anesthetists, *et al.*) increasingly formally subordinated to doctors' authority within hospitals. Increasingly clear division between professional and administrative lines of authority in hospitals.			Depression forces doctors and charities to ask welfare depts. to pay for treatment of people on relief.
ca. 1933	5/6 physicians have hospital access and charge patients directly for services		Rev. Russell Dicks appointed first full time Protestant chaplain at Mass. General Hospital	
1937	Beginnings of categorical approach to illness intervention			March of Dimes spurs broad increase in money for medical research
1939				25 states have passed enabling acts for hospital service plans that preserve hospital choice and prevent increases in moral hazards
1941-45				U.S. participates in World War II
ca. 1945				Collective bargaining and unions spur growth in employee-provided health insurance; aims to improve middle-class access to hospitals; capitation, group practice, and prevention given lower priority
ca. 1948-1950				Truman attempts, and fails, to secure national health insurance

Date	Medical Event	Scientific Event (includes some non-U.S. discoveries)	Religious Event	Broader Social Trends Related to Religion and Science/Medicine
1946				Hill-Burton Act provides construction funds for community hospitals; funds disproportionately to middle-income communities
1949			National Council of Churches founded; US adult church membership around 65%	NIMH established
1950		Hoyle coins the term "Big Bang"		
1953		Watson and Crick introduce the helical structure of DNA		
1954				*Brown v. Board of Education* decision
1960s			Death of God theology gains followers	
1962-5			Vatican II	
1963	Community-based mental health centers help to lessen reliance on inpatient mental hospitals			
1964		Penzias and Wilson offer experimental evidence for the Big Bang		
1965				Medicare and Medicaid programs established
1967			Four pastoral care organizations merge to form the ACPE	
1970s	Acceleration of therapeutic counter-culture and therapeutic dissent			Various government initiatives aim to reign in medical over-utilization and expenses
1972	AHA Patient's Bill of Rights includes informed consent and considerate / respectful care			

APPENDIX C: NOTES FROM HOLIFIELD: *A HISTORY OF PASTORAL CARE IN AMERICA*

	European Antecedents & Early Colonial Days (17th C.)	Later Colonial Era (18th Century)	Antebellum America (ca. 1800-1860)	Post-Civil War America to World War I (1865 – ca. 1918)	Interwar Years (1918 – ca. 1939)	Post-WW II (1945- ca. 1960)
Principal Concern(s)	Salvation	Revival and eternal salvation, gradually tied to morality	Evangelical gentility, conversion of souls, spirituality of women	Winning souls, hearts, friends, confidence, battles. Later: salvation as a receptivity to promptings of an immanent God that "enlarged the scope of an active life of service and love" (197)	Insight and moral reform toward growth; self-realization, character building, freedom	Self-realization within the context of modernity
Theological Focus	Sin (as act of transgression, original sin, breach of civic unity, or general lack of faith); soul moved through a series of levels/ steps toward holiness; find balance between understanding, will, and affection	Sin, moral behavior *Chauncy*: focus on intellectual assent to religious propositions *Dickinson*: focus on transient affections *Edwards*: sensible understanding, analogous to direct sensory perception; immanentist God who checked affections	Appeal to the will to cure souls; emphasis on ethical decision-making, fitness of the mind to receive divine revelation and to make assertions and validations about God; sickness viewed as a soft beauty/silver lining, a "violent warfare upon the impulses of our nature" (152); some moves toward self-love	Vitality of human nature. Uplift the soul rather than push for repentance. Concept of the natural increasingly coming under scrutiny. Reliability of experience. Liberals: communion with an immanent person. Conservatives: conversion, rationality, power of a transcendent spirit.	Theology as guide for the personality; movement away from adjustment to either ethical formation or freedom and autonomy. Freedom v. social constraints/norms	Sensitive responses to pain and hurt; self-realization as a response to social conventions and institutions. Bultmann: radical obedience to God Bonhoeffer and Barth: against a legalistic moralism. Tillich: trans-moral conscience and self-realization as rooted in the command to love.

	European Antecedents & Early Colonial Days (17th C.)	Later Colonial Era (18th Century)	Antebellum America (ca. 1800-1860)	Post-Civil War America to World War I (1865 – ca. 1918)	Interwar Years (1918 – ca. 1939)	Post-WW II (1945- ca. 1960)
Principal Exponents	RC, Lutheran, Anglican, Reformed	Old (higher & lower powers) / New Lights (surface and depth)	Various groups, incl. rational orthodox and Amer. Tract Society; Arminians and the will as the locus of sin (some rejected or modified original sin); sin as act rather than status; mental philosophers	Soft and hard (my terms) pastors; camps increasingly dictated by divisions in psychology and psychiatry. Emmanuel Mvmt. and the curative power of nature; relaxation as prelude to self-control, esp. over the subconscious	Cabot/Boston: counseling and formation. Emphasis on the presence of a "third" reality that draws pts. and chaplains beyond themselves (238). Boisen/NY: freedom from destructive social/personal expectations. Theological realists: re-injected sin into self-realization to focus more on the divine	Growth in seminary/higher education training in psychology and religion
Back-ground Theories	Reason and logic as aids to interpreting Revelation and natural theology; Locke & Medieval theologians	Locke on understanding and elementary sensations; Newton and the growth of rational scientific inquiry	Psychology the servant of faith; Baconian induction and the classification of persons and their maladies; priority of observation, unity of truth and natural theology toward revelation and its interpretation; Locke on human understanding	Science, technology, and popular culture ideas/metaphors leading to a "natural style" of pastoral care (164), Darwin and nature as power/energy/ force, physiological psychology and the mind in the context of the culture/society. Freud and the subconscious. Psychotherapy.	Mental hygiene movement and "adjustment"; clinical education to form moral judgments. Depth psychology. Neurologists (mostly Boston camp) v. psychoanalysts (mostly NY camp). Tillich and religion v. cultural values that subvert rationality.	Increasingly, reliance on and development of own theories and schools of thought. Fromm: realize one's powers and one's insecurities. Struggles between individualism and autonomy and alienation that modern capitalism generated. Real, public, and pseudo selves. Jung and surrender to a higher power.

	European Antecedents & Early Colonial Days (17^{th} C.)	Later Colonial Era (18^{th} Century)	Antebellum America (ca. 1800-1860)	Post-Civil War America to World War I (1865 – ca. 1918)	Interwar Years (1918 – ca. 1939)	Post-WW II (1945- ca. 1960)
Modes of Intervention	Confessions, analysis of motives and feelings through questioning, sacraments, preaching, classification of ailments of the spirit	Judgments grounded in discernment (diagnosis?) of the state of the soul. Old: more reserved and polite—gauge visible behavior and persuade. New: probe for hidden religious inclinations for signs of faithful-ness as a scholar might interpret a text	Offer advice, argue, exhort, take careful notes of each conversation, house calls, preach, some use of silence, some formal confessions among Episcopalians and Lutherans	Division between those resembling "indulgent parents" and "straight-talking cops" (178), skepticism among the latter about the usefulness of pastoral calls (esp. those based on affect), offer cheerfulness and wit in the sickroom with heavy emphasis on listening over sermons on Xn truth. Later: psychology of religion and deep probing.	Cabot model: listening to the unspoken word to discern the "growing edge" of the soul. Dicks: verbatim accounts combined with moral reflection. Help patients discover the direction asserted by the immanent divinity within and help them to assimilate and obey God's plan to grow. Start with patients where they are. Boisen: living human documents. Struggle for control over inner turbulent self leading to insight and liberation. End harsh moral judgments, negative views of sexuality, legalistic preaching, and authoritarianism (248)	Listening combined with training in psychology and counseling. Movement away from authoritarian church, repressive religious moralism, and dogmatism. Hiltner: distinguish moral clarification from moral coercion. Rogers: foster healthy self-acceptance and demonstrate genuine acceptance of the patient.

	European Antecedents & Early Colonial Days (17th C.)	Later Colonial Era (18th Century)	Antebellum America (ca. 1800-1860)	Post-Civil War America to World War I (1865 – ca. 1918)	Interwar Years (1918 – ca. 1939)	Post-WW II (1945- ca. 1960)
View of the Pastor/ Minister	Counselor responsible for the cure of souls, understand and interpret the upper level of hierarchy (the supernatural) for those on earth— specialists in the supernatural, caretakers of the conscience; high social standing	Emphasis on the diversity of pastoral gifts and pastoral constitutions	Balance of refinement and rationality, decisiveness and delicacy	Civil War: greater shift to bold virtues and muscular Christianity (forcefulness, vision, virile powers of persuasion), YMCA and expansion of church outreach (teaching, outreach organizations, etc.) Emmanuel: physicians' aides? (206)	Concerns about levels of education; sermons as a form of group counseling, Coe and increasing emphasis on religious education to transcend personal limitations	
Expectations of the Individual Receiving Care	Good works and confession (RC/A), become cartographers of the inner life/self-scrutiny, maintain order in the soul	Views of rebirth: New: conviction of sinfulness Old: gradual, if laborious, change that was gentler	Read devotionals and reflect on experiences to guide the will, fair emphasis on resignment and submission to God's will; sick have duties to families, attendants, physician, minister	Cabot: engage in physical activities to keep mind alert and positive (work cure) James: allow for spiritual/inner repose. H.C. King: shift attention from introspection to the exterior world.	Continual adjustment of the self to the changing social and natural order, even to the point of assimilation. Cabot: move away from self-deceit	
View of the Individual/Self	Calvin: ignore self, focus on Christ; Anglicans & Pietists: inward change in the faithful; self usually implied self-centeredness; soul created by God	Soul: before or after fall or after transformation by grace. Introduction of some positive ideas of self-love Edwards: moral responsibility in the face of Calvinist determinism	Slaves: some viewed them as mentally sound, though others saw them as incapable of much instruction; pastoral care among slaves primarily on a mutual basis	James: subliminal a source of energy beneath conscious-ness. Salvation in self-surrender a form of power. Cabot: neurology/ mental illnesses have a materialist component.	Socially constituted	

	European Antecedents & Early Colonial Days (17th C.)	Later Colonial Era (18th Century)	Antebellum America (ca. 1800-1860)	Post-Civil War America to World War I (1865 – ca. 1918)	Interwar Years (1918 – ca. 1939)	Post-WW II (1945- ca. 1960)
Social Context	Hierarchical society	Awakening, British market economy and the pursuit of individual happiness	Market and agricultural economy into urban and industrial order; increasing inequality; urban gentility w/ rational enlightenment and sentimentality	Civil War, urbanization, industrialization		Cultural preoccupation w/ psychology (incl. self-help books), postwar affluence, critique of mass culture, ethic of self-realization, health coverage of psychiatric conditions
Key Texts/ Figures	*Country Parson, Discourse of the Pastoral Care, Directions Given to Clergy*	Edwards, Dickinson, Chauncy, Moses Mather	Beecher, Spencer, Wesley, Thomas Upham (mind as intellectual and sentient powers), Asa Burton and tripartite psychology (146), John Witherspoon and self-governance/ self-culture in relation to a higher power	Phillips Brooks, Wm. James, Dewey, Cabot, Franz Mesmer, A.A. Brill, Freud, Emmanuel Movement (E. Worcester & S. McComb) in response to Christian Science	Harry Emerson Fosdick, Coe, Seward Hiltner, Cabot, Anton Boisen, Dicks (first full-time Protestant chaplain at MGH), Austin Guiles, Adler, Freud, Tillich, Niebuhrs	Erich Fromm, Karen Horney, Carl Rogers, Norman Vincent Peale, Seward Hiltner, Carroll Wise, Wayne Oates; move toward professional associations and institutionalization (273)

APPENDIX D: LEVEL I AND II ACPE OUTCOMES

(from ACPE Standards Manual, 2005)

At the conclusion of CPE Level I, students are able to:

Pastoral Formation

311.1 Articulate the central themes of their religious heritage and the theological understanding that informs their ministry.

311.2 Identify and discuss major life events, relationships and cultural contexts that influence personal identity as expressed in pastoral functioning.

311.3 Initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Pastoral Competence

311.4 Risk offering appropriate and timely critique.

311.5 Recognize relational dynamics within group contexts.

311.6 Demonstrate integration of conceptual understandings presented in the curriculum into pastoral practice.

311.7 Initiate helping relationships within and across diverse populations.

Pastoral Reflection

311.8 Use the clinical methods of learning to achieve their educational goals.

311.9 Formulate clear and specific goals for continuing pastoral formation with reference to personal strengths and weaknesses.

At the conclusion of CPE Level II, students are able to:

Pastoral Formation

312.1 Articulate an understanding of the pastoral role that is congruent with their personal values, basic assumptions and personhood.

Pastoral Competence

312.2 Provide pastoral ministry to diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, and justice issues without imposing their own perspectives.

312.3 Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources.

312.4 Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.

312.5 Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.

312.6 Demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.

Pastoral Reflection

312.7 Establish collaboration and dialogue with peers, authorities and other professionals.

312.8 Demonstrate self-supervision through realistic self-evaluation of pastoral functioning.

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(N.B. I had originally considered integrating the bibliography and acknowledgments sections of this thesis to denote my overwhelming gratitude to the individuals listed below for their contributions to my project but concluded that UMI would be rather displeased with my innovation and so decided to retain the traditional layout.)

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