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### **“There Is No More Sacred Place:” Healing and Faith in Chaplaincy and Religious Hospitals**

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“There Is No More Sacred Place.” Healing and Faith in Chaplaincy and Religious  
Hospitals

by

Annalise Mangone

Honors Thesis

Submitted to:

Department of Sociology and Anthropology

University of Richmond

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## Introduction

Before he was a hospital administrator, Dave was the head of a bereavement center, which offered services comforting and aiding those grieving the loss of their loved ones. His staff consisted of chaplains and they provided both individual and group care opportunities. As I interviewed him, even over the Zoom screen we were using to speak to each other, I could see that his work in the bereavement center was important to him. Dave was proud of what he had accomplished there, sitting just a little straighter in his seat as I asked him about his time there. Despite his role as an administrator for the center, Dave sought out opportunities to interact with patients through the various support groups they hosted for grieving family and friends of the departed. When I asked him if there were any patients or groups that stood out to him his answer came clearly and without hesitation. He recounted to me the story of a support group that he had run for men grieving the recent loss of their spouses. This group was supposed to run for eight weeks, but “the men just clicked with each other.” In this support group, and through the Christian faith that they all shared, the men had found some of the sense of community and comfort that had been lost with their spouses’ passing. In Dave’s words, “they found their grief unifying.” Despite their different backgrounds in life and religious practice (all the men were from different Christian denominations) the men continued to meet after the eight weeks of the session ended, and continue to meet today.

Without this support group for bereaved widowers, these men would have had no reason to encounter each other. Nor would they have been easily provided the tools to communicate their grief and through it find a unifying thread that would go on to forge a friendship extending beyond their grief and period of mourning. For Dave, this “Catholic tradition” of unity is an especially important part of the function of a religious hospital and of spiritual care more

generally. At the end of our interview, he spoke wistfully of the children's pageants and coffee meetings that his catholic hospital would hold before the COVID-19 pandemic prevented people from gathering in person or sharing food. Community and shared struggle, it seemed, defined Dave's understanding and interpretation of Christian care.

I find this topic of spiritually guided healthcare and spiritual care services to be not only important to an understanding of the American system of medicine, but also personally fascinating. I grew up immersed in both the world of hospitals and medical care and the world of religion and faith. My father is a surgeon, and so I could often hear the sharp sounds of his medical dictations as I watched television as a child. After school my sister and I were sometimes stashed in a nurse's station while my dad "just dropped by to check on one patient" that quickly turned into two or three and we often ended those nights doing homework quietly in the hospital while snacking on the granola bars or old pastries left over in the staff lounge area. Yet just as the hospital was familiar to me so was the church. My parents would drag me, often protesting, to our United Methodist church in downtown Asheville every Sunday. And as a Catholic school student I was regularly exposed to prayer and worship with daily religion classes and Wednesday mass. Rarely, however, did these two seemingly disparate parts of my life, the world of medicine and the world of faith, seem to interact. So as I grew up I was surprised to uncover just how much of American healthcare was immersed in what I refer to as "socio-spiritual" traditions. By using the term socio-spiritual, I aim to call to mind the complex ways in which spirituality influences interactions between people, and in the medical context influences interactions between patients and their larger network of care. Chaplains act in a socio-spiritual role by navigating these social networks with the language of spirituality, enhancing communication and guiding patients as they experience the turmoil and pain that is a shared

experience amongst those in hospitals. This seeming omnipresence of spirituality that I have come to see in American medicine has led to the research question that has guided this thesis. As I set out to investigate the connections of faith and medicine, I was guided by a deep curiosity as to how religious hospitals and spiritual care providers contextualize and understand their role in a biomedical system.

As I progressed through my interviews with chaplains, administrators, and nurses alike, clear themes began to emerge in how they viewed the role of faith and spirituality in healthcare. Like Dave's experience with the grieving men's support group, spiritual care provided, in their opinion, a way to understand and move through the pain and loss of the hospital environment. In fact, many of my research participants stated that they did not feel complete care existed without paying attention to the spiritual needs of their patients. For spiritual care providers and spiritual care systems, truly effective medical treatment cannot exist without seeking to look after not only the physical needs of those who are ill, but also the emotional, existential, and spiritual needs of all those in the hospital, including not only patients but also their families and care providers. Through this lens of holistic, whole-person care, spiritual care providers move themselves beyond the status of religious figures or groups, and present themselves as conduits and nodes of connection and expression for the feelings of bereavement, grief, and helplessness. This healing builds up within patients, families, and even medical professionals who must come to grips with the physical and emotional pain that is sometimes ever-present in their surroundings. In this role as a conduit for emotional expression within religious hospital systems, chaplains contextualize themselves not as religious figures, and especially not as proselytizers. Instead, they characterize themselves as fellow medical professionals filling a gap in medicine

that has been too often overlooked in the past, but is necessary to achieve effective treatment and healing.

In Section 1, I will discuss the background and context of this research. I will begin by establishing the methodology of this research and discuss my research partners and their involvement with my work. Additionally, I will review the literature that has influenced my understanding of spiritual care and argue that the field of anthropology must further examine Christianity in relation to Western healthcare systems. Finally, I will establish the history of chaplaincy and religious hospital systems in the United States and their influence on current systems of healthcare.

In Section 2, I will argue that chaplains and religious healthcare systems understand their role in hospitals to be a method of integrating spiritual care, which they view as necessary and vital to the healing process, with systems of health that are traditionally focused almost exclusively on bodily symptoms. I will also discuss the pathways through which chaplains enter spiritual service in hospitals in order to examine the call to chaplaincy and how experiences of grief and loss, whether personal or witnessed craft chaplains as “agents of support” for loved ones and patients. I will also investigate the ways in which chaplaincy and spiritual care negotiates a place within biomedicine by examining the Spiritual Distress Assessment Tool, a hospital resource used by some chaplains to provide a more empirical method of evaluating and addressing spiritual concerns.

In Section 3, I will examine the effect that the COVID-19 pandemic has had on the nature of chaplaincy and systems of spiritual care with a focus on the nature of patient-practitioner interactions in an age wherein touch and proximity have been largely forbidden. Finally, I will conclude with a re-examination of how chaplains and religious healthcare systems perceive their



role as filling a gap in the biomedical system of care that typically excludes spiritual need, even as they negotiate place in the medical world through the use of empirical methods to integrate spiritual care with clinical treatment. I will also contextualize this argument, showing that spirituality in healthcare is an area in need of focus beyond only Richmond, Virginia, and offers rich data that must be explored with anthropological frameworks.

## Section 1: Background

### *Methodology*

This research study was carried out under the shadow of the COVID-19 pandemic, as it occurred during Fall and Winter of 2020 and ongoing through the Spring of 2021. Unfortunately this has led to barriers in my ability to explore my research as thoroughly as I would hope to as an ethnographer and anthropologist. One of the most prevalent barriers came in the form of determining to whom I would reach out and interview during my research. I had originally planned to interview medical professionals like nurses with some administrators and chaplains as supplementary sources of information. But with the continuous spikes of COVID across the country and in the Richmond area nurses had precious little free time and I was loath to take any of it from them or push too hard for an interview. As a result, my 9 research participants are almost entirely hospital administrators and chaplains, with only one nurse as well as one chaplain who is also a pediatrician representing my interactions with practicing biomedical professionals. Additionally, when I first envisioned this research project, I had hoped that I would eventually be able to enter the hospital environment and have face-to-face, in-person meetings with those that I planned to interview. As I inched closer and closer to beginning this project, though, it became clear that this goal was untenable. Instead, my interviews were carried out in the safety of the virtual world. Either the speakers or my cell phone or the boxes of Zoom would have to connect us instead. This was especially challenging in the phone interviews where I could not watch and observe facial expressions or body language. Yet these online interviews could also provide opportunities that I did not expect. With the comfort of their homes around them and their faces hidden from my view, research participants seemed more inclined to share personal stories and emotional moments of their lives, which immensely enriched my research.

I had a few questions that were common amongst all of my research partners, whose names have been changed throughout this paper to preserve their confidentiality and privacy. I almost always began by asking my participants about how and why they chose their field. I also commonly asked them to define their role to me in their own words. This question was especially helpful, and much of the data I pull from throughout this paper relates to responses from this conversational thread. Additionally, I questioned nurses and chaplains, who have direct patient interaction, about whether they had experiences that stood out to them as examples of spirituality playing a role in the flow of treatment, or instances that they considered to be special in their memories. For ethicists and administrators, I asked about both the potential challenges and benefits that they perceived in working for religious healthcare systems. While these questions were foundational to my research, they are by no means comprehensive. Every interview was slightly different, and was influenced by the research partner's own life experiences, perceptions of their place of work, and understanding of their own faith and beliefs.

### *Literature Review*

When researching Christian spirituality and healing, I found a concerning lack of anthropological data. Anthropologists eagerly turn their gaze to the East and to the South, writing profusely about indigenous healing rituals and ancient Chinese medicines, but are far more reluctant to turn their gaze inwards and examine the role that religion and Christian spirituality has played in forming our own systems of health and healing. A search of Anthrosource, the database containing journals, articles, and book reviews of most major Anthropology publications, demonstrates this stark difference in theoretical attention. Searching "Eastern

medicine” or “Indigenous medicine” returns thousands of hits; a search of “chaplain,” “chaplaincy,” or “Christian healing” returns less than one hundred.

This lack of research into Christian spirituality and healing within American medicine, despite the plentiful resources on non-Christian systems, reflects a continuing legacy of orientalism within the anthropological community that we must continue to resist and counter. Non-Christian forms of religion have been longstanding subjects of research by the academic community. Our interest in these religious forms of healing is not inherently bad, and spiritual healing has increasingly offered alternatives and options that have expanded the medical community in a meaningful way. However, our unwillingness to turn the same academic attention on American Christianity and its influence over our own systems of health reaffirms rather than challenges Orientalist notions of Western biomedicine as the unchallenged Self and other forms of medicine as the Other (Said 1978). With this research, I hope to begin the process of critically examining the interconnected systems of medicine and spirituality that have guided my understanding of my own body and health, as well as larger Western patterns of healthcare.

This topic is critically in need of examination in order to more fully understand biomedicine, American healthcare, and Christian spirituality. However, this is not a topic that has gone totally unresearched. Cheryl Mattingly, for example, has worked extensively on issues relating to hope and meaning for patients experiencing chronic illness and their loved ones. In *The Paradox of Hope*, Mattingly investigates how “hope emerges as a paradoxical temporal practice and a strenuous moral project” when “biomedicine offers no cure” (Mattingly 2010, 3). When investigating both the self-perception of chaplains’ positions within the hospital and the relationship between spiritual care and the American healthcare system, I also found myself turning to the theories of psychiatrist and medical anthropologist, Arthur Kleinman. Although

Kleinman does not seek to specifically address the issues of chaplaincy and religious care, he demonstrates in *The Illness Narratives* the ways in which the biomedical system, which does not include chaplaincy and spiritual care, creates distress in patients and causes misunderstandings that are barriers to medical care and treatment (Kleinman 1988). Understanding the narratives and perspectives of patients, including spiritual influences, is therefore crucial to effective treatment; in fact, “it is clinically useful to learn how to interpret the patient’s and family’s perspective on illness” (xiii). But despite these authors, among others, who have touched upon issues relating to spirituality and faith in healthcare, there remains an unsatisfactorily small amount of research that aims to directly examine and address the topic of chaplaincy and spiritual care services in American healthcare systems, one that this article hopes to begin to address.

## Section 2: Spirituality in Healthcare

### *History of Religious Healthcare and Spiritual Care in Hospitals*

Like Christianity itself, Christian ethics are engrained into American healthcare systems. These private healthcare systems “play a significant role in delivering healthcare to medically underserved, diverse, and poverty stricken neighborhoods” and have inarguably become one of the foundational pieces of health services in the United States (Wall 2011,1). As I drive through any city or town in the United States, I can easily spot a “St. Mary’s Hospital” or a “St. Joseph’s Medical Center” or, famously, “St. Jude’s,” all of which publicly declare their religious origin and affiliation. Though affiliated with religious organizations, these hospitals do not operate unsupported or unaided by the government. They receive billions of dollars of public funding from the government every year, while retaining their status as private health systems. That alone communicates to savvy observers how important private religious healthcare is to the functioning of the public health system. As a result, public policy both shapes, and is shaped by, the religious values of Christian, and most commonly Catholic, healthcare. For many, Catholic hospitals are more accessible than public institutions; in some rural areas religious healthcare is the only option near them (Wall 2011). It is not hyperbole to state that the United States healthcare system would not exist without the history of Catholic care.

Catholic healthcare began as outreach by religious orders. Nuns were especially well known for offering medical services that eventually grew into fully-fledged hospitals. Although these hospitals are no longer solely staffed by the members of various religious orders, their influence is clear. Most prominently, Catholic healthcare systems are guided by central tenets and values called the Catholic Care Directives. These Catholic Care Directives serve as a guide

for both hospital policy and the individual actions of hospital employees as to how providers can ethically provide care that falls in line with the religious mission of the governing body of the Church. These directives remind care-providers that “Jesus’ healing mission went further than caring only for physical affliction. He touched people at the deepest level of their experience; he sought their physical, mental, **and** spiritual healing” (My emphasis (Catholic Bishops 2018, 6). To emphasize this, the religiously oriented caregivers must also remember to act in “faithful imitation of Jesus Christ” (6). This sentiment forms the basis of Catholic Care systems’ focus on holistic treatment that includes mental and spiritual care alongside biomedical treatment plans. According to the Catholic Care Directives, “the care offered is not limited to the treatment of a disease...but embraces the physical, psychological, social, and spiritual dimensions of healthcare” (10). Therefore, as a prerequisite to operating as a Catholic healthcare system, administrators and care providers are instructed to take a “whole-body” approach to care that belies the atomistic biomedical approach that concerns itself solely with the physical body.

Chaplains still do, however, operate distinctly from other areas of the hospital, given that they act as the human manifestation of spiritual care in both religious and secular health contexts. This is especially true in public systems. Despite this, religious systems and increasingly secular systems as well are acknowledging the need amongst patients, loved ones and even providers themselves for spiritual care as an element of any medical systems and medical treatment. Chaplains see themselves as offering this socio-spiritual element. Like religious systems, the profession of chaplaincy is engrained in healthcare. Medical chaplains have been employed in secular institutions since the early 20th century (Wall 2011). Nowadays, there are entire educational training programs solely dedicated to the vocation of chaplaincy, and chaplains are oftentimes ordained ministers as well. These chaplains are not volunteers; they are paid members

of the hospital staff just like any of the doctors, nurses, or administrators. They are also not only available to offer services to people of their own faith. Going into this study, I held the mistaken assumption that chaplains primarily served people who were religious in the same way they were religious. In examining this bias, I can only think that it originates in my childhood under the auspices of Catholic education in which even the school nurse and guidance counselors were Catholic, and explicitly so. When I think of religion, my mind jumps to the rigid rules of communion and membership that govern activities within traditional church environments. The chaplains I spoke to were quick to correct me and inform me that they were available for all people, including those who are not even religious at all. In an almost unified and certainly resounding voice, chaplains emphasized that their role was spiritual more than it was religious, and that their goal was to “walk with” patients and speak their language, so to speak, rather than impose the vocabulary of religion. In this, they expressed that their goals in chaplaincy, while often motivated by a religious background, were not governed by any one organizing tradition. Instead, their actions were and continue to be guided by the needs, expectations, and desires of the patient. Only in this way, they seemed to agree, could chaplaincy and spiritual care operate within the holistic model that religiosity in healthcare seeks to offer.

It is well understood that a patient’s mindset and perspective can influence their physical state of being. Studies of the placebo effect show that simply taking an inert pill that one believes to, at least potentially, be effective can influence the progression of illness (Moerman and Jonas 2006, 342). However, meaning responses, or “the physiologic or psychological effects of meaning in the origins or treatment of illness” also influence how patients respond to treatment and their illness (342). While meaning response as Moerman and Jonas define it refers solely to the effects that are seen in medicine, the chaplains’ and religious hospitals’ perspectives expand



upon this interpretation to include the effect of socio-spiritual perspectives on outlook and treatment that are formed through patients' relationships with the divine or with members of the hospital community.

### *Religious Care is "Filling the Gap:" Spirituality and Holistic Care*

Traditionally, biomedicine has held little concern for the spiritual, and often even mental, needs of patients when designing treatment plans. Deborah Gordon, a critic of this style of scientific practice, focuses particularly on the atomistic approach of Western biomedicine, arguing that the biomedical assumptions of empirical fact that are uninfluenced by cultural or social factors are just assumptions, albeit extremely tenacious ones (Gordon 1998). The spiritual care providers I spoke with also fundamentally disagree with the biomedical Cartesian approach that separates mind, spirit, and body from each other. These administrators, nurses, and spiritual care providers perceive a "gap" of care as caused by this Cartesian model. This Cartesian model represents the belief that the spirit and the body are independent and separable aspects of personhood. Therefore, that which affects the body does not affect the mind, and that which affects the mind is similarly irrelevant to the body. Since the early days of biomedical systems of care, healthcare has traditionally relied on this mind-body dualism in decisions about treating and caring for patients (Scheper-Hughes & Lock, 1987). They argue that whereas many secular, solely biomedically focused, health systems do not adequately account or prepare for the spiritual needs of the patients, loved ones, or employees who walk through their doors, which they see as a vital part of the process of healing and health more generally.

Nate is an ethicist for a Catholic hospital in the city of Richmond, Virginia who met with me over Zoom in the Fall of 2020 to discuss his role in the hospital and the ways in which a

religious hospital expresses religiosity in its service. We discussed the perceived “gap” in care that exists where spiritual care is not sufficiently present. Nate repeatedly emphasized the importance of the spiritual. “Spiritual well-being,” Nate told me, “can have profound effects on our mental and physical health.” The need for spiritual fulfillment cannot be treated by machines or injections, and it does not go away if left alone. Treating spiritual needs requires a human element. When there is not adequate provision for spiritual care in the hospital, the responsibility is placed on local religious leaders to care for the sick patients and their families as well as their home congregations. Nate was impassioned about this point throughout our interview. He sat up further in his chair when speaking about the burden that can be placed on local religious leaders, leaning forward a little bit and gesturing a little more widely than he had before. It was clear to me that he was not just concerned with the spiritual health of the individual. He asserted that the spiritual health of a community is at stake when hospitals fail to adequately fulfill the spiritual needs of their patients. When I asked Nate about his opinions on the difference between public or secular hospitals and religious systems like the one he works in, he was thoughtful, but his answer returned to the same theme. The essential difference between secular and religious institutions is the latter’s openness to fulfilling spiritual needs, which these religious institutions regard as fundamental to “whole-body” care.

Nate seems proud of not only the work that he does, but also the place in which he does it. Nate became a hospital ethicist because although he genuinely loves the theory and debate of ethics, and wrote his graduate dissertation on Aristotle, he wanted to avoid academia so that he could be more involved with the practice of ethics and not just the epistemology of it. He has worked in this hospital system since 2013, and in his own words feels “free” to be religious at this hospital. Nate is not alone in the fact that he likes working in religious systems because of

the freedom it grants him to be religious around patients. Britany, a nurse that I spoke with who works within the same religious healthcare system, also expressed her feeling of freedom to be religious and interact with patients in a religious manner. While in other hospitals she would not be allowed to do things like open a window for a family after their loved one passes to allow the spirit to escape and move on, here she is free to honor wishes like those as well as take actions like praying with patients. Smiling a little, she fondly remembered an older man who she had prayed with who seemed comforted and happier after having been able to share in the community of prayer. She believes that actions like praying with patients not only offers spiritual comfort but also builds trust between herself as a medical provider and the patient during a time of stress and pain. She suggested that this helps to mitigate a struggle of trust in both the medical system and even the medical providers themselves.

While Nate may have less experience with these spontaneous moments of connection with patients, as an ethicist his job is to help people find consensus when there is disagreement over treatment plans or other medical issues. When I asked him about the type of issues that he had encountered at the hospital, I have to admit that in the back of my mind I was thinking of urgent life-or-death issues like we see in hospital dramas on television. It is in fact more routine than that. “Ninety-eight percent of the issues that I see are basically the same,” Nate said with the slight grin and relaxed posture of someone who has been asked this question many times before. The sorts of issues that caused disagreements that need his intervention often have spiritual overtones. One of the most prevalent areas of concern is end-of-life decision-making, or the decisions that patients must make about medical proxies, resuscitation, and other concerns related to who will make decisions for them if they are unable to and how those decisions will be made. For Nate, understanding the spirituality of those involved is essential to solving

disagreement and finding consensus. He gave an example of one woman struggling to make decisions about end-of-life. The woman had had a near-death experience earlier in her life in which she reported seeing a tunnel and deceased family members. Many doctors and medical professionals throughout her life had dismissed this experience and her use of it and making end-of-life decisions as delusional or irrational. But, Nate says, his religious hospital system chose to instead treat the woman's experiences as serious; thus they were able to speak to her on her own terms and progress in making these difficult decisions because they took the time to understand her viewpoint and as a result built trust.

These bonds of trust are one of the essential services that chaplains articulate as contributing to their hospital environments. In order to make a well-informed diagnosis and find the most effective treatment plan, medical practitioners require total openness and honesty from their patients about their symptoms and feelings. However, these patients often lack the trust necessary for this level of honesty, for they are hesitant to reveal intimate details about their spiritual life to their doctor who they likely don't know very well. For some, this distrust may stem from the long history of mistreatment and unethical actions in the field of medicine. This legacy has left a lasting scar in the way that medical treatment is accepted across the United States, and especially in communities of color which have suffered the most from the unethical treatment of medical professionals (Gamble 2006; Kendi 2020). For other patients, their hesitancy may be borne out of concern that their doctors do not share their values or priorities when deciding on the best course of action and treatment. Anne Fadiman explores this perspective of distrust in *The Spirit Catches You and You Fall Down*. Doctors treating Lia Lee, a young Hmong girl with epilepsy, repeatedly took actions that her Hmong parents found offensive and actually harmful, such as cutting off bracelets that Lia had received from religious

authorities in the Hmong community to anchor her spirit to her body during her seizures. Her parents felt that cutting these bracelets off placed Lia in spiritual danger (Fadiman 1997, 36). In Lia's case, her parents began to mistrust her doctors because they held conflicting beliefs about health and proper medical treatment that were left unaddressed and unresolved. These are the contexts in which a chaplain is needed, says Caroline, a chaplain from a local Richmond area hospital. To her, one of the great benefits of chaplaincy is that patients are willing to talk to her about their struggles, especially about decisions and concerns that they feel reticent to share with doctors. Therefore, the chaplains can uncover problems patients are having with treatment of doctors, or address questions patients have about complicated decisions such as End of Life care, before the issues reach a critical level that will negatively impact the patient and their health.

Equipped with the trust of patients, chaplains report that they work in conjunction with other people in the hospital to ensure that issues are addressed properly. Chaplains can file reports about the concerns that are visible to the patients' doctors and nurses, or they can speak directly to those medical professionals. Either way, chaplains see themselves as serving as a critical intermediary for patients, "translating," so to speak, the concerns of the patients from the language of the patients into the language of the medical world. This terminology of language was a frequent part of my interviews with chaplains. The idea of speaking to patients in their own language is an essential foundation for chaplains, and is the stepping-stone upon which the understanding and trust of patients is built. Jessie told me of how chaplaincy gives her the opportunity to "help patients tell their own stories in a more meaningful and holistic way." Caroline illustrated the power of embracing the story and language of patients' values and beliefs with the example of an especially memorable case. There was a man in the hospital, she told me, who needed to have his leg amputated, but was unwilling to do so. When asked why, he stated

that he was concerned that God did not want him to have his leg amputated and instead wanted him to remain whole. No amount of reiterating the medical need or the prognosis without amputation could convince him. Chaplains and religious leaders in the community were called in to help. These spiritual leaders spoke to the patient through his own language and framework, advising him that God would not want him to remain in pain, get an infected leg, or die because of the complications. These reassurances led the man to eventually accept the need for amputation and undergo the surgery. Sometimes the medical facts are not enough. As Caroline reiterated to me at the end of her story, religious values and beliefs are oftentimes an important part of someone's decision making process, and this is not an area that doctors are trained to handle. Spiritual care providers she implied, act as points of connection between the medical framework and the patients' framework, filling a gap that could otherwise become a chasm separating understanding and a barrier to treatment and health.

### *Becoming Chaplains: Finding Fulfillment and Defining Work in Spiritual Care*

A common thread throughout the stories of the chaplains that I spoke with was that chaplaincy was not their original intention or career path in their lives. For some of them, they knew that religious service was their vocation, but not that chaplaincy in the hospital environment was where they would feel called. Paul and Richard both intended to be fully ordained priests serving as leaders of churches within their communities. However, both of them did a training residency as a chaplain in hospitals. Richard spoke to me about his feeling of fulfillment within the hospital environment. He felt that he was doing good for his patients while in his position there, and felt called to remain as a hospital chaplain. Caroline's path to chaplaincy was much more complex. She was called to religious service because of a devastating

loss within her own life. Over the phone, I could not see Caroline's face, but the pain in her voice spoke to the hardship of loss and the toll that it took on her. However, the hospital chaplains were a gift, she said. They sat at her side as she waited for news and prayed for her loved one. As a result of her experiences with the hospital chaplaincy, she felt called to serve as a chaplain in turn. Jessie's experience was unique as well. While Jessie was a chaplain before being employed at the hospital, it was in a position of prison ministry. She still feels called to prison ministry and "to be quite honest," she told me, moving to a hospital was because of the better pay and benefits that employment as a hospital chaplain was able to provide. However, she sees prison ministry as similar to hospital ministry. She said that people in prison and people in the hospital are both undergoing crucibles in their lives. And in their efforts to fill the "gap" of holistic care through the provision of spiritual resources, hospital chaplains seek to aid patients, staff, and families during critical moments of pain, grief, and loss in their lives.

Another point raised by Jessie and others is that chaplains are often called to serve the most ill people with the least optimistic prognoses, and this interaction with grief and death informs a patient's understanding of their own positions and purposes. Jessie sees herself as "an agent of support," and finds that conversing with chaplains helps patients begin to talk about death and dying. She works in the cancer ward, where death is an overwhelming presence, and yet even there she finds that without chaplains, patients are reluctant to speak about their own mortality. Thinking about your own death is difficult, and painful, especially when you know that it is close. As an agent of support, part of Jessie's job is to help people prepare to die, even though it is hard and painful to discuss. However, when they are willing to talk about their mortality with a chaplain like Jessie, she finds that they are more willing to consider options like hospice, palliative care, and ending painful active treatment that is just not working anymore.

Ultimately, these choices, says Jessie, can offer the patient comfort in their last moments, but they require patients to acknowledge that they are beyond the reach of medical treatment and this is hard to accept without someone supporting them. Jessie has found that places like the cancer ward also have a profound effect on the mental and spiritual health of the doctors and nurses who work there, and her actions as a chaplain and an agent of support extend to them as well. Despite the pain that Jessie sees every day, she is fulfilled in her work. “I feel like I am on the cutting edge with people between life and death and there is no more sacred place in the world than that,” Jessie told me, passion lighting up her words even though I could not see that same passion in her eyes over the phone. Similarly, Caroline told me that “in emergency moments, having a chaplain there [by your side] is profound.” The sanctity of the work fulfills these chaplains.

Paul believes that there are three major points in defining chaplaincy. The first is to help people find meaning in the process. This emphasis on meaning was also evident in Dave’s men’s bereavement group, in which he helped the men find common ground in their Christianity and their grief while also finding meaning and community again even after devastating loss. The second point that Paul brought up was connecting to that which is sacred. Jessie’s narratives emphasized this point; Jessie also finds connection to the sacred in every aspect of her work. Jessie said that simply “walking alongside” people on their journey of illness or death was sacred to her, reiterating Paul’s point. Paul’s third point is that chaplains are there to “be present and hold pain and hold burdens with people.” He calls this the ministry of presence. Sometimes, chaplaincy is as simple as letting people talk. Even those with loving families by their sides may not fully unburden themselves, hoping to spare their loved ones the pain of knowing how much pain they are experiencing, or the troubles that are plaguing them. However, a chaplain listens. They are present to hear concerns and pain; it’s their job to do so. Simply by being present and



listening chaplains can offer profound amounts of relief to patients who have been suffering and worrying in silence.

### *Establishing Spiritual Care in the Medical World*

As providers of holistic care filling a gap within the medical world, Chaplains and religious medical practitioners seek integration with medicine and want to be recognized as a necessary part of whole-body medical care. Although they understand themselves as vital parts of the system of healing and health, “one...outcome of the modern transformation of the medical care system is that it does just about everything to drive the practitioner’s attention away from the experience of illness” (Kleinman 1988, xiv). Essentially, many healthcare systems discourage doctors from turning to chaplains or listening to the spiritual needs of their patients. Therefore, chaplains and religious hospital systems perceive part of their role to be reintroducing recognition of the importance of spiritual care in biomedical practice. For some, this recognition comes through working in a religious hospital that embraces their belief system. Brittany gravitated towards becoming a nurse at a religious hospital because of the freedom it offered her to utilize her religion in her medical care.

For those working in public or secular institutions, integration into the medical system cannot be achieved in the same way. Spiritual care at Caroline’s hospital embraces and utilizes instead, the data-driven and scientific process of biomedicine within the process of chaplaincy. At Caroline’s hospital, chaplains are advised to evaluate the spiritual needs of patients through the use of the “Spiritual Distress Assessment Tool” or SDAT. The SDAT was established through empirical scientific means and published in a research journal before being introduced into hospitals, although it is based on previously existing models of assessment for spiritual

needs (Monod et. al 2010, 1). As chaplains speak with patients, they use the four categories of the assessment tool to “score” the spiritual needs of patients. The first category is “Meaning,” and in this section chaplains seek out knowledge about whether a patient is trying to create meaning in their illness, injury, or time in the hospital. They might say that they “don’t have the strength to live any longer” or that they are struggling to cope (5). The second category is “Transcendence” and asks questions such as “Does the patient feel the need to pray” and “Does the patient seek connection with God?” Patients experiencing distress in the category of transcendence may worry that God has abandoned them, for example (5). In the third category, chaplains look for signs from patients about their “Values Acknowledgement,” which addresses their experience in the hospital and any concerns they have with the care they have received. They might express frustration with the brisk attitude of their nurses and doctors, saying things like “I’m just a number here” (5). Finally, chaplains also evaluate the category of “Psycho-identity,” which encompasses questions about loneliness and support from outside the hospital environment. This distress most often manifests in feelings of loneliness or loss of self-identity. Patients receive scores in these categories, and those who score highly are evaluated as being in “Spiritual Distress” and in need of further spiritual intervention.

The SDAT relies heavily on the data-driven methods of biomedicine to determine the spiritual needs of patients. Survey data and scoring matrices are hallmarks of the scientific method that undergirds medical advancement. This by no means indicates that the chaplains of public hospital systems have turned away from holistic care that fills the gaps of biomedicine; rather it displays an integration with the style and methods that are respected and therefore accepted by the medical community. It is, however, an empirical turn in the approach of chaplaincy. The SDAT was introduced through the peer-review system of academic journalism

that is the standard for the scientific community. By utilizing the methods of empirical knowledge to integrate the field of spiritual care within medicine, the SDAT represents the Foucault's argument about the continuing power scientific discourse holds in the hospital environment to legitimize or reject forms of care, including spiritual care (Foucault 1963).

Chaplains in the public healthcare sector also do not have the same levels of support from the administrative body of hospital systems that benefit chaplains in private religious systems. Paul discussed this difference between spiritual care in the religious and secular healthcare sectors in his interview when he told me how “[non-religious systems] don’t place the importance on spiritual care and so they minimally manage chaplain staffing [and resources].” By crafting a style of spiritual services that works within the biomedical methodology of health, spiritual care groups, such as Caroline’s, create credibility in an environment in which their field may be considered secondary to the treatment of the physical body. In the eyes of some chaplains, however, this can pose risk to the holistic purpose of spiritual care. To Richard, a chaplain within a religious hospital system, the inherent difference between spiritual care in religious hospitals and secular hospitals is that in secular hospitals spiritual care is seen as “just another department, like radiology or oncology.” Therefore, he states, it becomes just another segmented part of the hospital that may not be able to effectively “fill the gap” of biomedicine.

Even in religious hospitals, however, spiritual care is governed and administered within the sphere of the biomedical approach. Spiritual care in Catholic hospitals is advised by the Catholic Care Directives, and spiritual care providers work with medical professionals when addressing many concerns. Peyton is an ethicist at a Catholic hospital in Richmond who began her hospital career as a neonatologist, treating newborn babies at risk of death. As she worked in the NICU (neonatal intensive care unit) she noticed how often ethical questions arose in relation

to issues about the beginning of life and how to treat suffering children. These questions drove her to enter the field of ethics where she now serves. In questions of ethical action at the hospital, Peyton looks at both the biomedical needs and the advice of documents such as the Catholic Care Directives when evaluating cases. In turn, these ethics decisions influence how care is given and received at the hospital. So even in religious healthcare settings, spiritual care is regulated, at least partially, by the methodology of biomedicine.

## **Section 3: Final Thoughts**

### *Responding to COVID-19: Chaplaincy in a Global Pandemic*

Especially for those in the hospital, both as employees and as patients, the COVID-19 pandemic has been a period of extreme isolation, terrifying sickness, and overwhelming loss. Loved ones have been barred from entering hospital spaces to visit loved ones, nurses and doctors have had to live away from their own families to protect their safety, and some patients lost the ability to interact with others almost completely due to the need to intubate or sedate them. Incredible amounts of stress and anxiety contribute to the feelings of isolation and hopelessness that patients and medical professionals are experiencing. Nevertheless, in this moment of isolation, spiritual care providers have also had to grapple with how to continue to be resources during the exponential growth in the need for spiritual care and interaction from within the hospital.

Like any other space, chaplains have relied heavily on virtual technology to address the needs of their patients. Through video messaging services like Zoom, Skype, or Facetime,

chaplains have been able to speak with those in need in the hospital, as well as set up opportunities for loved ones to see and speak to their critically ill patients. Additionally, in Paul and Richard's hospital, some chaplains have been allowed to physically enter the rooms of patients with severe spiritual needs so that they can offer more complete care. The most challenging aspect of the pandemic, however, has been the lack of community and communal activity. Children's plays had to be cancelled, and weekly meetings akin to Dave's bereavement group either have moved online, or also have been cancelled.

However, this pandemic has also highlighted the gaps within biomedicine that chaplaincy and spiritual care seeks to address. Treating COVID-19 is not simply a matter of treating the symptoms. There is an underlying fear and anxiety even in the asymptomatic and the healthy about the consequences and meaning of a global pandemic. These existential questions cannot be resolved within biomedicine and yet they are essential to an understanding of the virus. Like any other area of American society, COVID-19 will have profound effects on the future of hospital chaplaincy that cannot be fully understood until the pandemic has receded. Spiritual care is also not only for extraordinary cases. Chaplains assist in writing End of Life Directives, as well as comforting patients in palliative care or families watching their loved ones being treated.

### *Conclusion*

Spirituality is essential to understanding both the history of American healthcare and patients' responses to their illnesses and treatment plans. Spiritual care, chaplains and religious hospital administrators argue, must be recognized, accepted, and integrated with current approaches in systems of biomedical health in order to accomplish effective and holistic healing. In public hospitals, some chaplains and chaplaincy programs aim for this integration by

embracing the empirical tools such as the SDAT. In religious hospitals, spiritual care has been built into the administrative fabric of the institution. Spiritual care providers serve an essential function in not only walking alongside patients and listening to their struggles but also in translating between medical practitioners and patients. Essentially, chaplains argue, spiritual care fills the gap left by body-focused systems of medicine that ignore the socio-spiritual needs of patients. Religious hospital administrations seek to address this gap in current healthcare systems through the use of policy like the Catholic Care Directives, which drive the hospital to include spiritual and holistic care in the foundation of their work. Others integrate spiritual care into hospital systems by working within the system, publishing studies and using empirical methods to establish chaplaincy as an essential part of medicine. However, chaplaincy and spiritual care remain for these providers resources for the bereaved and isolated as well as a source of fulfillment in their own lives.

The belief in the importance of religion and spirituality in medicine is not an isolated phenomenon to the chaplains and administrators in Richmond. Initiatives of recognition are ongoing in many cities and hospital systems throughout the United States, where chaplains feel that their work is underrepresented. Religious hospitals represent a growing method for accessing medicine and treatment for the American populace, with one out of every six hospital patients being treated in a Catholic facility annually (Hafner 2018). The chaplains who walk alongside patients, loved ones, and medical providers witness some of the most profound moments of grief, as well as fear and hope, in people's lives. In the cancer ward, Jessie witnesses people as they prepare for death, and often acts as an aide in understanding and preparing for mortality. Yet the body of anthropological work focusing on grief often overlooks the preparatory work of chaplains and those who are ill and dying. Even Renato Rosaldo in his

discussion of the need to “emphasize the rage in grief” and recognize and study emotion focuses on the aftereffects of grief (Rosaldo 1989, 10). Chaplains see themselves as walking alongside those who are fearful for their lives or grieving a loss that has yet to happen. Chaplains believe this requires them to focus on the emotional and spiritual toll of illness in order to address the deepest concerns of patients. While the scientific discourse of medicine at times seems to overlook these emotional and spiritual needs, chaplains make such needs central to their efforts, crafting a holistic approach that, in conjunction with the biomedical system, addresses body, mind, and spirit in hospital care. In essence, then, chaplains in religious hospitals see their work as essential to patients’ and their families’ well-being.

## Works Cited

- Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her american doctors, and the collision of two cultures*. Farrar, Straus, & Giroux: New York.
- Foucault, M. (1973). *The birth of the clinic: An archeology of medical perception*. (A.M. Sheridan, Trans.) Routledge (original work published 1963).
- Gamble, V. (2006). Under the shadow of Tuskegee: African Americans and healthcare. In E.D. Whitaker (Ed.) *Health and healing in comparative perspective* (pp. 418-426). Pearson Education Inc.
- Gordon, D. (1998). Tenacious assumptions in western biomedicine. In M. Lock & D. Gordon (Eds.) *Biomedicine Examined*. (pp. 19-56). Kluwer Academic Publishers.
- Hafner, K. (2018, August 10). As Catholic hospitals expand, so do limits on some procedures. *New York Times*. <https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html>
- Kendi, I.X. (2020, April 6). What the racial data show. *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2020/04/coronavirus-exposing-our-racial-divides/609526/>
- Kleinman, A. (1988). *The illness narratives: suffering, healing, and the human condition*. Basic Books: New York.
- Mattingly, C. (2010). *The paradox of hope: Journeys through a clinical borderland*. University of California Press.
- Moerman, D.E., & Jonas, W.B. (2006). Deconstructing the placebo effect and finding the meaning response. In E.D. Whitaker (Ed.), *Health and healing in comparative perspective*. (pp. 340-347). Pearson Education Inc.



- Monod, S.M., Rochat, E., Büla, C.J., Jobin, G., Martin, E., & Spencer, B. (2010). The spiritual distress assessment tool: An instrument to assess spiritual distress in hospitalised elderly persons. *BMC Geriatrics*, *10*(88), 1-9. <http://www.biomedcentral.com/1471-2318/10/88>.
- N.a. (2018). *Ethical and religious directives for Catholic health care services: sixth edition*. United States Conference of Catholic Bishops.
- Rosaldo, R. (1989). Introduction: Grief and a headhunter's rage, In *Culture & truth: The remaking of social analysis*. Beacon Press Books: Boston.
- Said, E. (1978). *Orientalism*. Pantheon Books.
- Scheper-Hughes, N. & Lock, M.M. (1987) The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, *1*(1). pp. 6-41.
- Wall, Barbra (2011). *American Catholic Hospitals*. Rutgers University Press.