An examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution

by

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Thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Ministry in the Divinity School of Duke University

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ABSTRACT

An examination of the contemporary challenges to the pastoral authority of Christian chaplains who ministers in secular medical institutions with implications for holistic care by

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ABSTRACT

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Duke Divinity School, 2015

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Assistant Research Professor of the History of Christianity; Associate Dean for Academic Programs

The purpose of this thesis is to examine the challenges that Christian chaplains experience to their authority in secular medical institutions and to explore possible recommendations that can help alleviate them. More specifically, by means of a questionnaire this examination intends to explore if these challenges are both or either personal or institutionally related. Therefore, this examination should be a resource that encourages the Christian chaplain to be an informed interlocutor pertaining to the issues of what his or her God-given authority means. Lastly, this thesis will demonstrate why it is essential for chaplains to know, understand, accept, and embrace the God-given authority bestowed upon them to minister effectively and competently in secular medical institutions.

Key Terms

For the purpose of this study, seven terms require annotation. First, the term “Christian chaplains” refers to individuals who have been baptized, profess Jesus Christ as their Lord and
Savior, who ascribe to the orthodoxy and orthopraxis of the Christian faith, and who minister in secular medical institutions. Second, the term “secular medical institution” denotes a public, non-religious institution that provides medical care for people. Thirdly, the term “living human document,” which was coined by Anton Boisen, refers to those to whom Christian chaplains minister. This group includes patients, their families and friends, and the chaplain’s colleagues. Fourth, the term “voices of suffering” refers to the patients who share their narratives while seeking pastoral care. Fifth, the term “bearing witness” refers to the belief that as Christians we are called to develop the skills to bear witness in both word and deed to the gospel of Jesus Christ. Sixth, the term “narratives” refers to the personal stories that patients share. The seventh term “holistic care” is a concept in medical practice that upholds and respects all aspects of a person’s needs: physical, emotional, and spiritual.

I employed three methods in this thesis. The first method was exploratory research to review and study literature to support my argument. The second was to use a method of analogy. In this method, the anecdotal evidence was aggregated in correlation with personal related experiences to help Christian chaplains to learn how to minister effectively in the challenging contexts of the secular medical institution. Moreover, this was done in order to examine how the Christian chaplain can learn to walk competently and effectively with authority between the worlds of religion and medicine. Third, I used a confidential questionnaire to gather additional information from seven Christian chaplains who have ministered or are currently ministering in this context to support the argument of this thesis, as well as to offer recommendations that can help alleviate some of the challenges they experience regarding their authority.

The basic conclusion drawn from the examination and methods employed is that Christian chaplains do experience various types of challenges to their authority than can impact
their ministry. However, the conclusion demonstrates that as a result to their commitment to the call of chaplaincy, chaplains recognize that irrespective of the challenges they experience to their authority they are called to compassionately and effectively serve the sick and suffering. Moreover, as a result of their commitment to the call of health care chaplaincy, the chaplains have provided their insight that indicates why some of these challenges exist. Lastly, as a result of the questionnaire the participants provide some practical recommendations that can be implemented into CPE programs, which could possibly help alleviate some of types of the challenges they encounter to their pastoral authority.
DEDICATION

I dedicate this thesis to The ONE who makes this and ALL things Possible

“The Alpha and the Omega, The Lord God, who is and who was and who is to come, the Almighty.”

“How Solo Deo Gloria” — To GOD Alone Be the Glory!
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compassion for the sick, which was a hallmark of His ministry. Be blessed; God is with you in the mission fields of your secular medical institutions! Remember, Jesus said, “…I was sick, and ye visited me …”¹

¹ Matthew 25:36 KJV
INTRODUCTION

An Examination of the Contemporary Challenges to the Pastoral Authority of a Christian Chaplain Who Ministers in a Secular Medical Institution

Those who have “answered” the call to ministry might on some occasion wonder why there are so many challenges for those who so earnestly seek to serve God’s people. As one who has answered her call to ministry (particularly to pastoral care) I have asked myself this question. More specifically, as a former Christian chaplain who worked in a secular medical institution, my colleagues and I have discussed (on many occasions) this very same question. We ask: Why do we experience challenges to our pastoral authority when we are trying to live-out our calling to compassionately serve the sick and suffering? Yet, beyond this question is a deeper yearning to discover some reasons that may provide some insight on “why” chaplains experience challenges to their authority and to discover why and to whom and what can these challenges be attributed. Moreover, an extension of this question should ask what can be done to help. Two additional important questions that will be explored that is central to the argument of this thesis is to examine what is meant by authority; and why does authority matter for chaplains (and all persons) who work in the context of a hospital setting. To explore these questions the purpose of the examination in this thesis is significant.

Although hospital ministry can be challenging, being a Christian chaplain who cares for others in this context is a rewarding ministry. It is rewarding because chaplains bear witness to what it metaphorically means to be the “hands and feet of Jesus” to those who are sick and suffering. However, in the midst of this rewarding ministry the aforementioned question about the challenges still remains a pertinent reality that must be explored. Many of the challenges that Christian chaplains encounter is related to the idea of authority. This is often due to the Christian
chaplain’s perspective of authority. By the nature of their baptism and belief in the Christian faith, Christian chaplains have a unique theological viewpoint of who grants them their authority, and how it should work within the culture of a secular medical institution. Hence, the meaning of pastoral authority is an important consideration for this examination.

The term “pastoral authority” is complex because we live in a post-Christendom society. Moreover, because of our current cultural climate of secularization, many Christians have been marginalized in their ability to express or act on the beliefs and practices of the Christian faith. For Christian chaplains ministering within the walls of secular medical institutions, the idea of identifying and exercising their prophetic pastoral authority and presence can be extremely challenging. In an article in *Christian Bioethics*, professor and physician H. Tristram Engelhardt, Jr. affirms that the Christian hospital chaplain “…takes on an identity independent of and hostile to traditional Christian concerns.” ¹ Moreover, Engelhardt believes that Christian hospital chaplains have an identity that is directly linked to their religious beliefs, which can cause tension for them in this context. Hence, this thesis will examine what may be some of the probable causes of why chaplaincy in secular medical institutions can become a hostile environment for Christian chaplains. Accordingly, those who are interested in the vitality of hospital ministry and the call and authority of the Christian chaplain working in such a secular context should be concerned. Engelhardt states that “[t]hose who do not acknowledge this threat to the authentic Christian identity [and authority] of chaplains likely hold that the emerging profession of chaplaincy can embrace numerous religious narratives and accounts of spirituality

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without imposing one of its own.”² However, the distinct identity of the Christian chaplain is founded upon the biblical narrative. Thus, a pastoral authority to minister to the sick (even in a secular or dominant culture that is different from his or her own) is viewed as given by Jesus.

Then Jesus called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to proclaim the kingdom of God and to heal. He said to them, “Take nothing for your journey, no staff, no bag, nor bread, nor money— not even an extra tunic.” They departed and went through the villages, bringing the good news and curing diseases everywhere. (Luke 9:1-2 & 6, NRSV).³

Today, Christians are called to be “the twelve.” As Christians who hold the Bible not only as an historical resource, but also as the authoritative Word of God, we are the post-apostolic emissaries called to proclaim the good news and to care for the sick. Therefore, as twenty-first century Christian disciples, chaplains are called to continue to care for the sick and suffering, which is a hallmark of Jesus’ ministry.

**The Significance of the Examination**

For these reasons, I want to study some of the twenty-first century challenges to pastoral authority that Christian clinical chaplains encounter while serving in secular medical institutions. Individuals are whole human beings, who are composed of their mind, body, and spirit. Therefore, it is essential to make a claim that the chaplain’s authority regarding spiritual matters should not be undervalued because it should be an essential component of the interdisciplinary care team in order to provide a model for holistic care. Moreover, there is a plethora of information that supports how an individual’s faith has a vital role and influence upon them.

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³ All scriptures cited are from the New Revised Standard Version (NRSV), unless otherwise noted.
during their time of illness. Elizabeth Burns Coleman and Kevin White address this in their book and explain that “Research is confirming what has been known since the foundation of medicine. Religious faith and/or the practice of a personal spirituality does impact on the emotional and physical wellbeing of individuals and families, and ‘during illness or other painful experiences, people do turn to their spiritual resources finding them helpful.’”\(^4\) Furthermore, in their research on hospital chaplains and spirituality, Larry VandeCreek and Laurel Burton conclude that because persons are not mechanical bodies who only need physical care, persons share that their faith is important to them during their experience with illness. \(^5\) Moreover, VandeCreek and Burton explain that “Persons find that their spirituality helps them maintain health, cope with illness, traumas, losses, and life transitions by integrating body, mind, and spirit.”\(^6\) In her book, Lucy Bregman, offers a vivid account of how David Watson’s (an English evangelist) faith had an influence on him while he was struggling with terminal illness “He believes that God can heal, and that it is wrong to be fatalistic about illness and suffering.”\(^7\) Often persons who experience illness turn to their faith as a coping mechanism. As a former hospital chaplain, hundreds of times, patients have shared this sentiment with me ‘my faith will see me through.’ Hence, chaplains recognize that persons need (and want) holistic approaches for their overall well-being. Therefore, I propose that the anecdotes in chapters one and two also demonstrates what influence faith has on patients and their families during their times of illness. Although, the

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5. For a full explanation of several studies cited in this article that explain the role and importance of faith during times of illness refer to Larry VandeCreek and Laurel Burton, eds, “Professional Chaplaincy: Its Role and Importance In Healthcare,” *The Journal of Pastoral Care* 55, no.1 (Spring 2001): 88-92

6. Ibid., 82.

role of how the patient’s faith impacts them is not the focus of this thesis it is important to consider. Thus, a holistic approach to medicine is important because it involves the whole care of the human being, which includes the spiritual care that chaplains can offer. Moreover, The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) in the United States says, “Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychological, and spiritual values.” Thus, this thesis will examine why chaplains should be considered a vital part of the patient’s care team. Therefore, it is important that chaplains learn how to exercise and employ their pastoral authority to integrate their prophetic voice, presence, knowledge, theological language, and wisdom. Furthermore, I want to examine some of the practical and theoretical issues of authority of which chaplains need to be aware of at all times. I will do so by examining literature from the field of CPE and by analyzing the results from a questionnaire provided to seven Christian chaplains. As we examine these issues, several questions will arise: what are the identity, role, responsibility, limitations of authority, power, and obstacles that can be challenging and problematic to the Christian chaplain’s authority, and how might they be overcome? We will see that a chaplain’s authority in these secular medical institutions tends to be affirmed primarily in situations of a terminal diagnosis or when death is imminent or a death has already occurred. I will argue, however, that death highlights the other aspects of a person’s being and health—that is, that a person is not merely a bodily entity but also spirit and soul. Hence, the thesis will explore (a) limitations and obstacles to the authority of chaplains, (b) the ways in which death opens up other aspects of a human being’s existence to which chaplains have something to say, (c) that because the mind,

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8 Larry VandeCreek and Laurel Burton, Professional Chaplaincy: Its Role and Importance In Healthcare, *The Journal of Pastoral Care* 55, no.1 (Spring 2001) 82. The Joint Commission on the Accreditation of Healthcare Organizations, is an independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States.
body, and spirit are all vital parts of a person, therefore the whole person needs a voice to advocate for their spiritual care, and (c) thus, the ways in which a more holistic approach to healthcare enable chaplains to be more fully part of the care team and provide more thorough care of the patient.

This thesis also makes the claim that authority is important for institutions. The idea of authority is not a new concept. The Bible speaks of authority as well. The book of Romans provides a scriptural reference to help (specifically Christians) understand and identify that God is their ultimate source of authority. Furthermore, this scripture speaks about why authority matters, and it teaches Christians that they are subjected to secular authority as well. It reads: “Let every person be subject to the governing authorities; for there is no authority except from God, and those authorities that exist have been instituted by God. Therefore whoever resists authority resist what God has appointed, and those who resist will incur judgment” (Romans 13:1-2). Therefore, since according to this scripture all authority has been instituted by God, (and there are consequences for those who resist authority) the authority of the chaplain in a secular medical institution is important to examine. In this context, authority exists as a hierarchical model, which provides a means to establish accountability, organization, structure, and policies—all of which help govern the daily mission and goals for those who work in secular medical institutions. Moreover, authority is important because it allows persons in this setting to know and understand what are the expectations, roles and responsibilities of each member of the care team. Furthermore, authority is important because it grants a person with the ability to create norms, maintain order, make decisions, implement policies and procedures, adjudicate personnel matters, and ensure that the rules and regulations of the institution are being followed. Thus, without authority an institution would be ineffective. In this sense authority is good, but it
remains important for chaplains to recognize the different types of authority that exist within the diversity of secular medical institutions.

In secular medical institutions that have their own unique ethos, landscape, goals, and missions, Christian chaplains have a distinct identity that is intrinsically associated with their theology. Although they must learn to navigate competently and effectively between the worlds of religion and medicine, their primary identity and ultimate authority come from their belief in God and their baptism into the family of Jesus Christ. Yet, identifying and employing their unique identity and pastoral authority in this context is a challenge. Accordingly then, how Christian chaplains employ their pastoral leadership authority and pastoral competence within the walls of medicine presents a unique set of issues for them as they care for others of diverse cultures and religions.

**Structure of Thesis**

I will examine the multifaceted purpose of this thesis in three chapters. Moreover, the purpose of this chapters is to examine what are some of the probable causes that indicate why Christian chaplains do experience challenges to their authority in secular medical institutions, and I will also examine: what is authority; why does authority matter in this setting; who grants chaplains their authority; what are some of the probable causes of these challenges such as are they institutionally or personally related (or both); how can the challenges to their authority impact the chaplain; and what are some constructive means to help chaplains deal with these challenges, including proposing suggestion on how to implement the helpful ideas into CPE programs.

More specifically, in chapter one I will present the evidence of the problem from literature review, as well as by defining Christian authority and secular authority to investigate
both the similarities and differences. Furthermore, I will present a brief overview of the historical significance, challenges, and contributions of clinical pastoral education (CPE) in relation to the Christian chaplain’s role and responsibility. Chapter two examines how Christian chaplains can learn to minister effectively between the worlds of religion and medicine irrespective of the challenges they experience to their authority. Moreover, the purpose of this chapter is to ascertain what insight can be gleaned to explore and examine how Christian chaplains can learn to use their authority to effectively minister. Chapter three reports and analyzes the data received from a confidential questionnaire regarding the current climate of the challenges that Christian chaplains encounter to their authority. It explores some suggestions that can be implemented into CPE programs to help strengthen Christian chaplains’ experiences of their pastoral authority. Lastly, I will present my overall conclusion, in which I will argue that the challenges that Christian chaplains encounter to their authority are both institutionally and personally related. Although these challenges impact the chaplain (both personally and professionally), evidence from the questionnaire supports that irrespective of these challenges chaplains remain committed to their vocational call to pastoral care. Furthermore, I will highlight the ways in which situations around death highlight the possibilities of the chaplain’s authority and role in the care team and argue for ways to expand an understanding of the chaplain’s important contributions in secular medical settings.

As a final point, I must disclose that throughout this thesis there are remnants of the author’s personal experiences (both individual and communal), which are shared from her journey as a Christian chaplain intern and resident, ministering in a major academic secular medical institution. The purpose for sharing them is to prompt some insightful conversations that
will become a valuable theological and practical resource for the practice of clinical pastoral care.
CHAPTER ONE

An Examination of the Problem of a Christian Chaplain’s Authority in the Secular Medical Institution

In this chapter I shall first examine the nature of a Christian chaplain’s authority and the challenges to the nature of this type of authority as experienced in a hospital setting. I will also examine the practical problems that hospital chaplains face when there is no clear agreement about what sort of authority they exercise. However, while I shall argue for the importance of being clear about Christian authority, I will nevertheless consider that—from a Christian perspective—that the lack of worldly authority as issued by those in power in the secular medical institution might be a good thing because it will help chaplains understand that their ultimate authority to minister in this setting comes from God. Specifically, through the examination of secondary literature on this topic, I will explore how situations concerning death or a terminal diagnosis provide indications of the importance of the chaplain’s role and authority that point beyond merely a context shaped by impending or actual death. I will argue that a more holistic approach to patient care in the secular medical institution is a key way to understand that care of a patient’s spiritual needs are not only needed in situations involving death. Moreover it is important to acknowledge that holistic care examines and treats more than the physical disease in a person, it looks at the effects of the emotional and spiritual needs as well.

The word authority is a derivative of the Latin word auctoritas, which means invention, advice, opinion, influence, or command. ¹ Unfortunately, some people tend to perceive the word

with trepidation. The reasons for such trepidation vary, but they can perhaps be linked closely to our post-modern society and its historical issues with the idea of authority. Missiologist Lesslie Newbigin provides a valid and reasonable explanation for the suspicion toward authority, which he terms the “movement of emancipation.”

Owing to the enlightenment era, we have become a generation of free thinkers: Sapere aude—daring to know. In today’s vernacular, many refer to this type of knowing as “trusting your gut,” which can promote a suspicion or even distrust of authority.

In his examination on authority, Roger Olson supports the idea that the suspicion of religious authority (especially Christian authority) diminished because religious representatives are not always being held accountable to truth. As a result of a lack of a “truth protector,” Olson explains that the lure of power [and authority] often trumps the idea of truth, which can directly perpetuate the idea of the diminishing of trust for various figures of authority. In this manner, modernity acts as a catalyst that causes people to question any person or institution of authority.

Additionally, the emergence of the era of New Thought, including the prominent social sciences (like psychology and sociology), has produced variables that have contributed greatly to the erosion of religious and spiritual authority over the centuries. Dr. Robert Thomsen, and Chaplain Barbara Henderson have a long standing interest in how medicine (including the social sciences) and religion affect one another, and their research offers valuable insight as to how scientific medicine has contributed to the rift or decline of the spiritual authority of the chaplain in the hospital context. They explain that the “recent tendency toward evidence-based scientific


medicine has accentuated the gap between therapeutic disciplines [such as spiritual care] and medicine.”

Additionally, Russell Dicks, Professor Emeritus of Pastoral Care, uses a helpful metaphoric analogy to explain how the scientific model of medicine attributed to the skepticism of the authority of any religious presence (like a chaplain) in the secular medical institution. Dicks explains, “With the coming of the so-called scientific period in medicine, a hundred years ago, the child gradually lost sight of its parent and the parent disowned its offspring.”

By this Dicks implies that as hospitals became more secular, there was also a paradigm shift. This shift toward accepting the authority of the scientific model of medicine ultimately places physicians (and other medical persons) as the ultimate figures (parents) of authority in secular medical institutions. This is unfortunate. It is unfortunate because this thesis argues that a shared-model of authority is the best means to provide holistic care. Hence, a shared model of authority is best for the patients because it recognizes and includes that both the medical and spiritual representatives are figures of authority working together to provide optimum patient care.

Additionally, Allan Cole explains how medicine and the social sciences have contributed to the skepticism and in some cases erosion of religious and spiritual authority over the years. In his research, Cole explains, “By the mid-twentieth century, especially in North America, pastoral care was guided largely (and some would argue, primarily) by perspectives tied to psychology, psychotherapy, and related other clinical disciplines.”

As a result of these new perspectives, the

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4. For a an in-depth analysis of how the tendency of trust in the medical and social sciences are viewed as sources of authority over religious figures in the hospital context see: Robert J. Thomsen and Barbara D. Henderson, “Healing the Rift between Pastoral Care, Psychological Counseling, and Medicine,” Chaplaincy Today 20, no.2 (Autumn/Winter 2004): 17, 19-20.


role and the authority of the hospital chaplain was greatly diminished. Moreover, I believe that this type of skepticism of religious authority in the hospital setting (where the authority of science and medicine is more valued) can be linked to what Thomsen and Henderson’s examination further reveals. What I identify as a skepticism (based on my experiences and some of the experiences that will be revealed from the responses of other chaplains in chapter three) toward the religious authority of chaplains in secular medical institutions, Thomsen and Henderson identify as the rift. In their examination they note that they believe this rift happened because although historically body, mind, and spirit were and have always been one, “with the development of scientific thinking, medicine split away to seek a rational understanding of the human body.”

Thus, the authority that the Christian chaplain has concerning attending to the spiritual needs of patients is often over-looked or met with skepticism because much of the authority of those in secular medical intuitions is attributed to the physicians (and other medical staff). Often, at the foundation of their missions and goals, the field of medicine bases its practices on an understanding of, belief in, and implementation of the social sciences to improve the lives of the patients in their care. Richard Quebedeaux summarizes this critical problem well in his landmark examination of the questions of authority and the decline of religious and Christian authority. “As the authority of geology, biology, and the ‘social sciences’ increased,” Quebedeaux writes, “so the authenticity of the traditional Christian interpretation of the world became, in the nineteenth and twentieth centuries, patently less tenable.”

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7. For an in-depth analysis of how the authority of the religious authority (chaplain) in the secular medical institution, is met with skepticism as the recent tendency to rely more solely on the authority of medicine (and subsequently physicians) became more prominent see: Robert J. Thomsen and Barbara D. Henderson, “Healing the Rift between Pastoral Care, Psychological Counseling, and Medicine,” Chaplaincy Today 20, no.2 (Autumn/Winter 2004): 17, 19-20.

his point by quoting Wilson’s explanation of the subject in *Religion in Secular Society*: “And it was the very application of the scientific method to the Bible itself in ‘higher criticisms’—with its canons of objectivity, neutrality, and empiricism—that contributed greatly to the widespread scrutinization of religious authority to follow.” Consequently, the Christian church (and by inference its clergy) can no longer affirm the position or role of being a dominant voice of authority in society—a state of affairs that has significant implications for the Christian chaplain in a secular medical institution who must minister with authority but who is frequently met with suspicion, which contributes to the challenges that the chaplain encounters daily.

Moreover, the Christian chaplain must be aware that his or her pastoral authority can both constrain and empower. Thus, Christian chaplains ministering are often faced with two vital questions (that come from both self and others): Who gives us our authority, and who are we, as opposed to anyone else, to say something that exercises and validates our authority? Yet, Christian chaplains should not be surprised or intimidated by such questions. The following experiences reveal some of the types of challenges that chaplains encounter to their authority.

Jerry Griffin—a board certified retired hospital chaplain with thirty years of service—reflects from a practical perspective on the significance of needing to comprehend his unique Christian authority. He states, “As I reflected across the span of my career, I realized early on that I did not fully grasp or represent the embodiment of the power and integrity of who I am and who/what gives me the authority to minister in clinical settings.” Accordingly, since the questions regarding Christian authority continue to plague the field of hospital chaplaincy, this examination of the problem of a Christian chaplain’s authority is relevant today. Furthermore, it

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9. Ibid., 104-105.

is relevant because the medical model must seriously take into account that the spiritual needs of the patient also play a vital role in their overall care. If the medical model does not consider the authority of the chaplain then what is at stake is a pertinent two-part question for consideration: How will the emotional and spiritual needs of the patients be met, and who will meet their needs? As Christians, our faith teaches us that persons are embodied souls (and people are souls). Moreover, for Christians, the soul is the part of the person that relates to God, or, for nonbelievers, at least acknowledges that humans are more than mere physical entities. Therefore, this thesis argues that the interdisciplinary care model that takes into account the care of the mind, body, and spirit should be recognized because it is vital to providing holistic care to patients to address all of their needs.

Furthermore, recent research conducted by three pediatric chaplains who minister in a secular medical institution reveals that a Christian chaplain encounters clear challenge to his or her authority because of the way in which the medical personnel (specifically physicians) view the identity and role of the chaplain as ancillary care. Chaplains Cage, Calle, and Dillinger asked pediatric physicians how they understand and work with chaplains. Their research disclosed that physicians see chaplains as part of the interdisciplinary care team who perform rituals and support patients and their families—especially around death. Interestingly, there is no mention in their research that physicians viewed the pediatric chaplain as a religious figure of authority to care for the spiritual needs of their patients. Secular medical institutions offer few opportunities that could initiate and strengthen the relationship between chaplains and physicians; thus, relational distance, lack of understanding, and an apparent unwillingness to accept the role and

authority of Christian chaplains persist as barriers to real accord between physicians and chaplains.

The hospital in which I ministered has a policy that states: “No one dies alone.” It basically means that at the end stages of life, someone from the medical team must call a chaplain to be present so that a patient does not die alone. Although this may be viewed as a way in which physicians or other members of the hospital administration recognize the chaplain as a figure of authority on the spiritual matters of death, it is a very limited sphere of authority. Primarily calling on the services of chaplains to be present in the case of an impending death limits the role and authority of the chaplain. Recognizing the chaplain as a person of authority that can only primarily be engaged with patients near their death limits the chaplains ministry because it can associate the chaplain’s role and responsibility as one who only deals with matters mostly pertaining to death and fails to recognize the important ministry the chaplain offers to the living. Furthermore, such a focus on the chaplain’s duties around death can create a sense of fear for some patients and their families because it could infer that a visit from the chaplain is only related to death. Although offering care and comfort at the end of life for patients and their families is unique to pastoral care, it is not the only role and responsibility that chaplains can offer through their ministry. Chaplains can also offer their presence and authority on other spiritual matters such as questions regarding spiritual rituals, prayer, counseling, connecting persons with local faith communities, and questions pertaining to theodicy (that is, questions around suffering).

Additionally, in a national survey conducted in 2004 by Flannelly and Fogg, researchers reported the views of administrators and physicians on the roles of chaplains, which “suggest
that chaplains work most regularly with nurses.”¹² This is an important assessment. It indicates that the ways in which hierarchical relationships are perceived in hospitals can directly impact how one views (or does not view) the chaplain as a figure of authority. Therefore, the physicians’ perception about chaplains and nurses is a challenge to the development of relationships of trust between physicians and chaplains that would welcome the difficult, yet possible idea of shared-authority in the patient’s care. Therefore, I propose that a model of a shared-authority ministry would be helpful to address the overall physical, emotional, and spiritual needs of the patient within which both physicians and chaplains work together. This idea of shared authority must embrace an understanding that the patient’s care team (which includes those who represent the medical, social, and spiritual needs of the patient) must truly all be regarded as contributing figures of authority that represent a means to offer their patients optimum holistic care. Conversely, each member of the patient’s care team must learn how to work together and to understand the roles each of them play for the common benefit of the patients. This can be achieved by offering more specific educational opportunities (such as conferences and scheduled workshops), which could serve as a means for physicians and chaplains to learn about the unique role of authority that each holds within the medical institution.

Dale Rosenberger, another prominent voice from the ministry of clinical chaplaincy, supports the idea that one of the problems related to the Christian chaplain’s authority is the result of the chaplain’s own struggle with his or her self-identity and understanding of his or her God-given authority. Rosenberger offers valuable critical analysis regarding the reluctance of Christians to identify, accept, and exercise their God-given authority. He addresses the similar

aforementioned questions of who gives us authority and who validates it, with his own question: “Wherein derives your authority?” Rosenberger suggests, “Until we answer this question among ourselves—Who are we to speak about matters of eternal destiny? [As those with God-given authority]—we will be consigned to the margins and relegated to ineffectuality. Christianity will be sadly reduced to another ‘lifestyle option’.”

In secular medical institutions there are people of various faith traditions. And there may also be individuals who are agnostic (in the traditional sense a person who neither believes or disbelieves in the existence of God) or atheists (those who do not believe in God). Therefore, I acknowledge that making the argument that Christian chaplains have a God-given authority may be difficult for those who are not Christians or who are atheist to recognize. Yet, this thesis also makes a claim that irrespective of one’s personal religious belief in God (or lack of belief in God) the chaplain can still be accepted as a figure of authority. Barger, Austil, Holbrook, and Newton support this claim in their research, which explains:

In staff relationships, the salience of “chaplain as counselor” [and a figure of authority] is never far below the surface. It is important that the chaplain be involved in consultation regarding patient progress and treatment, and in shared consultation regarding patient needs this includes the spiritual needs of the patient. The chaplain believes it to be important that he or she be accepted as a fellow staff member in mutual trust [and authority] and is available to the hospital staff. The machine-like care of some medical treatments, and lack of follow-up on patient’s following their dismissal from the hospital are viewed as important negative aspects of the health care context.

Furthermore, their study supports the claim that spiritual care is a very important and necessary component in the model of holistic care for patients. Hence, being a chaplain involves more than just caring for the patient around the matter or rituals of death. Indeed, Allan Cole also argues


that chaplains are figures of authority on other subject matters. Cole explains that pastoral care involves soul-care, which includes four ancient pastoral functions of clergy, such as the chaplain: “healing, sustaining, guiding, and reconciling.” Chaplains are figures of authority who guide their patients to engage in meaningful, non-judgmental conversations to help them grapple with what the meanings of healing, sustaining, and reconciliation mean for and to them (especially in the midst of their illness). In chapter three, I will set forth findings from a questionnaire given to seven Christian chaplains that will further support the claim that alongside the care of the human body and mind, there should be the an attentiveness and recognition of the care of the soul, which is part of the chaplain’s role, responsibility, and source of his or her authority as a valuable member of the patient’s care team.

A Christian Chaplain’s Account of Challenges to Her Authority

As a Christian chaplain ministering in a secular medical institution, I can relate all too well to Rosenberg’s question. My personal experiences have shown that both the external questions posed by others and my own internal questions regarding my authority are only exacerbated by the larger question about the (divine) source of authority. Consequently, I am not a stranger to the challenges and suspicions about the beliefs and theological practices of God-given and Christian authority. The following two case studies present anecdotal evidence of the problems pertaining to this issue.

During my internship, one evening on call, I received a page to go to the pediatric intensive care unit (PICU). I met a mother who appeared hysterical because of her infant’s sudden illness and near death experience. I learned that the mother had immediately requested

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15. For a more in-depth discussion on the chaplain’s pastoral functions of “soul-care” as it relates to healing, sustaining, guiding, and reconciling see: Allan Hugh Cole, Jr., “What Makes Care Pastoral?,” *Pastoral Psychology* 59, no. 6 (July 2010): 715-16.
the presence of a chaplain, due to her child’s precarious condition. I was escorted to a private room where there were several medical personnel surrounding the infant as they prepared her petite body for surgery. I stood in the room as a chaplain and, as such represented a religious figure of authority to offer intercessory prayer, for what seemed like ten minutes, although time seems to lapse very slowly in critical moments such as these. In the room, the mother immediately took my hand as we stood together watching the medical staff. The situation grew more critical and intense by the moment, and the attending physician (the person with the assumed “real” authority) was paged to the room. I witnessed what I deemed was an intrepid effort of medical brilliance. However, such brilliance made me question my authority to offer care for the mother. I was intimidated by the other figures of authority in the room who were doing something, and I chose to be silent. I realized at that point that I was a Christian chaplain who was attempting to practice an incarnational ministry in a secular medical institution where I perceived that the physical needs of the family were greater than the spiritual needs (my perception was, of course, a mistake). I wondered silently: who am I, why I am here, what and who gives me the authority to be here with these brilliant medical professionals (the real authorities)? What could I possibly even attempt to do to help in any manner?

The trajectory of this type of questioning relates directly to Rosenberger’s suggestion, that as Christians, we must confront and ask ourselves first if we believe that we have the God-given authority to speak on such matters. If we do not believe in our own God-given authority, then we can become consigned to the margins and rendered ineffective. For a few moments, I was literally just that—consigned to standing at the margins of the room, relegated to ineffectiveness as a Christian chaplain who doubted, however briefly, her God-given authority. I stood helpless, albeit momentarily, in a room with physicians practicing the craft of medicine
with authority and began to recognize that there were two kinds of authority coexisting—rightfully—in the room.

As the attending physician concluded his preparation, he instructed the team about how the infant was to be transported to the operating room. At that point, the mother interrupted him and said, “Before you take my baby anywhere, I want the chaplain to pray now!” The chief attending physician looked directly at me; but feeling overwhelmed by the invitations of the mother, and the chief’s relentless glare, I mistakenly relinquished my authority by saying, timidly, something like: “Would you like me to pray on the way to the operating room?” The mother replied instantly “Pray now,” and at that moment everyone in the room appeared to (metaphorically speaking) inhale, as they all stopped for a moment and stood still. As was my practice in such situations I said a silent prayer for courage and wisdom. Immediately, I felt a sense of empowerment and the presence of the power of the Holy Spirit. As I prayed, I experienced a sense of peace and seemingly accepted that I was also a legitimate figure of authority in the room (and it was the prayer that helped me realize that I too was a contributing presence of authority in the room). Everyone held hands and seemingly accepted my authority to provide spiritual care. My provision of spiritual care was achieved through the practice of an incarnate theology.\(^{16}\) It is the uniqueness of the incarnation of Jesus Christ that clearly indicates we are \textit{not} Jesus Christ.

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16. For this explanation and a more detailed explanation of the meanings of incarnation and incarnational theology, see Katharine Doob Sakenfeld, et al., \textit{The New Interpreter’s Dictionary of the Bible} (Nashville, TN: Abingdon Press, 2008), 30. “Incarnation literally means enfleshed. In Christian tradition the term takes its meaning from John 1:14: the Word became flesh.” Furthermore, “In its technical sense, then, \textit{incarnation} expresses belief that the divine took human form, or, to be more specific, that God’s word became the human being in the person of Jesus from Nazareth.” Thus, the term incarnate theology means that the Christian chaplain becomes the “visible” representative and presence of Jesus Christ to those they serve.
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Incarnational ministry is not a new concept, but it has been more recently studied within the last two decades. It is also not a term that should be associated with rhetoric—it is too important. J. Todd Billings explores the concept of incarnational ministry that supports the idea of why it is extremely essential to the ministry of caring for the sick and suffering. Billings affirms that “God’s love is not love from a distance, but love up close, love made manifest in a culturally particular, person-to-person way. The Incarnation is the ultimate revelation of this character in the love of God.” Moreover, Joe Pennel emphasizes that the ways in which incarnational ministry was vital to his pastoral ministry to the patients in the numerous hospital visits he made during his tenure as a pastor for over forty years. Pennell poignantly supports that Christian chaplains are called to live-out an incarnational ministry and explains, “The Christian doctrine of Incarnation is foundational to the ministry of presence. Just as God’s love for us was incarnate in Jesus Christ, so also we strive to emulate and embody the love of God as we reach out to be with others. By being the hands and feet of Christ, the Word becomes flesh as we are present to those who suffer.” Hence, the practice of incarnate theology expresses that the Christian chaplain becomes the embodied “visible” presence of Jesus through their compassionate ministry. And furthermore, because we are called to be holy as Jesus was holy, chaplains can demonstrate the virtue of their holiness by being present with and caring for the sick and suffering as Jesus did in his earthy ministry. Thus, when the chaplain practices a form of incarnational ministry they join in the narrative of those for whom they provide care and become a visible presence and symbol of the love of God. In this narrative I did this when I prayed for


the medical team, the infant, and her mother to be empowered and guided by the wisdom and love of God. Additionally, I gave my contact information to the family, assuring them that I was available to them as needed. The post-operative pastoral care and prayers that I provided to the family gave me further opportunity to embody Jesus for them. As a result of this experience, I learned that as a Christian chaplain I have a God-given authority to help the sick and suffering.

Such experiences as described in this anecdote helped me to realize that as a resident chaplain I would continue to encounter challenges to my pastoral authority and conflicts with power issues—both internally and externally. As a result, during my time as a chaplain intern, I sometimes developed ambivalent thoughts about my pastoral authority, presence, and role as a Christian chaplain ministering in a secular medical institution. However, at this point in my ministry, I had more experience and training; thus, I was aware that God provided the authority and power that I needed to minister. Therefore, in affirmation of this authority, I boldly requested an opportunity to make an initial spiritual assessment of the patients in a manner similar to my peers in the care network team. Moreover, another encounter best exemplifies my struggles with my pastoral authority in the secular medical institution. In the intensive care nursery (ICN), where I was a chaplain resident, the interdisciplinary care team meetings were held weekly. The purpose of the meetings was to present to the interdisciplinary care team (which included the chaplain) a brief overview of the newly admitted infants and pertinent information on the family’s status. After each case was presented, any member of the interdisciplinary care team could request an initial consult based on the information they had heard. However, in the ICN, the nurse made initial consult requests for spiritual care, and the chaplain could not. Yet, because I was confident in my authority, I voiced my concerns directly to the chief resident of ICN who led the interdisciplinary care team meetings.
I made a request to allow chaplains to make initial consultations (like the other members of the team) to assess the spiritual needs of the patient’s parents. In the ICN, it is principally important for the chaplain to make initial contact with the parents of the patients because it is the parents and extended family members who will be the primary recipients of the chaplain’s ministry. In addition, because of the restricted visiting hours in the ICN, the chaplain should have the opportunity to make an initial consult in order to meet the patient’s family. During that consult, the chaplain would be able to inform them about the ministry available to them from the department of pastoral services. Although intentional wandering is one of the roles of the chaplain, the ministry of wandering in the ICN can be very awkward since the patients are infants, and the often stressed parents may not be aware of the chaplain’s services. Thus, this makes it also unlikely that the parents would be the ones to make an initial request to see a chaplain.

Ultimately, my request was denied. However, in all fairness to the chief resident, she shared with me that she would continue to encourage the nurses in her unit to attend the training sessions offered by the Department of Pastoral Care, to teach the nurses how to do a spiritual assessment\(^{19}\) once a patient is admitted to the hospital. However, I would argue that due to the demanding and sometimes critical responsibilities (such as patient charting and medication distribution) required of the nurses to attend to the overall physical care of their patients, that it is more reasonable for chaplains to make a spiritual assessment of the patient’s needs. Perhaps this

\(^{19}\) A spiritual assessment is a resource used by some secular medical institutions to help learn, and understand if and what are the spiritual needs of the patient. Hence, it is important to note that a spiritual assessment (as done according to my experiences) does not overtly state to the patients “I am going to do a spiritual assessment now.” Rather, the assessment serves as a resource to introduce the chaplaincy services available at the hospital upon the patient’s request. In addition, the assessment is a resource that allows the chaplain to inquire from the patient if they (or their families) would like to take advantage of any of the various services offered by the Department of pastoral care. Lastly, the assessment also serves as a resource tool to help the chaplain learn about the spiritual identity, beliefs, and practices of the patients and their families.
decision to allow the nurses to make an initial spiritual assessment is largely because the
authority, identity, and ministry of the chaplain are not fully understood by their medical
colleagues. The misunderstanding of the identity and role of the Christian chaplain by other
figures of authority is another major contributing factor that further complicates the problem of
the Christian chaplain’s authority. This misunderstanding is largely due to the fact that in such an
institution, authority (and power) is often granted only to physicians and other medical personnel
by the hospital administration. In the context of a secular medical institution, it is commonly
accepted that the physician is the dominant figure of authority. This can be due in part to the fact
that in medical school, students learn that when they graduate and become physicians they will
be viewed by others as the persons with authority. In their study of the chaplain-physician
relationship, Professors VandeCreek and Burton argue that there is a difference in the way
chaplains and physicians view not just their roles as authority figures, but their roles and
expectations with the patients and administrations as well. Accordingly, they suggest that
chaplains “do well to remember that while they may feel somewhat neglected and
underappreciated by society or their hospital peers, most physicians experience the opposite. As
a result of the physician’s roles and expectations, they are often expected to work miracles and
threatened with legal action if they fail in a task to which they have given their best efforts.”

Although meeting the spiritual needs of their patient is extremely important in the work of
Christian chaplains, they are not expected (by hospital administration) to work miracles, and
generally they do not have to worry about malpractice suits. Hence, although the Christian
chaplain is a role of authority, the expectations and roles of their authority have different
expected outcomes as described above. Moreover, in Medicine as Ministry, Margaret

20. Larry VandeCreek and Laurel Arthur Burton, eds., The Chaplain-Physician Relationship
Mohrmann, M.D., offers her reflections on the perceived value of the physician’s power and authority. Mohrmann suggests that western culture often expresses a form of idolatry toward physicians, our health/body, and technology because of an insidious fear of death. Consequently, the physician who has been given sole “control” over the patient’s body, his or her health, and the use of medical technology is expected to be the figure of authority and power who can create the “cure du jour” for his or her patients. These are some specific examples of the unequal distribution of authority that exists in the chaplain-physician relationship and the misunderstanding by the physician of the Christian chaplain’s specialized training.

The purpose for recounting these two personal narratives is that they serve as anecdotal demonstrations of the problems encountered by chaplains and their reluctance (whether subconsciously or consciously) to identify and “own” their God-given authority, especially when ministering in a sometimes unsympathetic or antagonistic setting. The second personal anecdote also shows how problems can be connected to the hierarchal structure of institutional authority. One reason for such hierarchal structures is to establish who has the primary authority when caring for patients. Due to the mission of many hospitals—to care for the sick and to do no harm—the physician is the primary figure of authority. But if physicians are heeded as preeminent medical authorities, what sort authority is represented by the Christian hospital chaplain and Christian figures more broadly?

**Examining the Meaning of Christian Authority**

It is because of the distinction between sacred and secular authority that Christian chaplains who minister in secular medical institutions must not allow their distinctive God-given

authority to be eclipsed by the authority of the secular institution. If Christian chaplains do not recognize their God-given authority to minister, then their valuable contributions could become overlooked. This would be a loss for the patients and staff who value the spiritual authority and presence of the Christian chaplain.

Accordingly, it is important to define Christian authority in such a way that chaplains will not become intimidated or reluctant to minister within the means of their God-given authority. However, due to the complex and diverse understanding of authority, formulating such a definition is arguably problematic. This is primarily because the exercising of authority is contextual and not necessarily universal. Hence, authority is established by a governing agency to particular individuals and institutions in accordance with the hierarchical structure (“the powers that be”) to meet the intended purpose of the organization. Rev. Dr. David Stagaman recognizes the difficulty of defining authority. He explains that authority is often viewed “as synonymous with individual persons.”

If authority is defined as synonymous with an individual, the hierarchal structure of the institution will dictate who (and at what levels) can be an authoritative figure. The practice of this type of philosophy of secular institutional authority can definitely present challenges for the Christian chaplain because of its restricted views, which emphasize who can be an authority figure within particular contexts. This is another valid reason why it is important for Christian chaplains to recognize the uniqueness of their God-given authority. It is an authority that the hospital cannot give or take away from them regardless of the hierarchal structures of authority that exists. As my experiences as a hospital chaplain attests, this type of limited definition and understanding of authority can become highly visible in the experiences of Christian chaplains.

Accordingly, the Christian chaplain must be cognizant of the fact that both the verbal and non-verbal language used by both staff and patients signals the authority of medical professionals (most specifically the physicians). This seems sensible because the mission and goals of secular medical institutions are structured largely on the principles of caring primarily for the physical well-being of the patient. It is true that some secular medical institutions developed a holistic approach to health care by adopting an interdisciplinary paradigm that includes mind, body, and spirit, which is designed to be inclusive of the authority of the physicians, chaplains, and others caring for the whole person. This holistic approach to care for the person’s mind, body, and spirit, was mandated in 1998, by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This model of holistic care will be expanded when I examine the history of hospitals and clinical pastoral care in the later part of this chapter. Still, the physicians and hospital administrators receive the ultimate entitlement of authority. Moreover, presenting the challenges of defining authority will help the Christian chaplain value the absolute need for knowing and understanding the ethos and nuances that exist in the secular medical institutions where they practice pastoral care.

Furthermore, I propose that Pastor Jackson Carroll’s typology of pastoral authority is helpful for this context because he reminds us that authority is two-dimensional: it examines the bases of authority, and the degree of institutionalized authority. Carroll suggests that the “bases of authority” considers the minister [chaplain] as the person of authority who can engage in the work of the ministry. He describes institutional authority as deriving from the institution that grants the authority to the minister. Carroll’s typology is based on the Christian chaplain’s God-

given authority, which enables him or her to participate in the ministry to the sick. And second, the secular medical institution also grants Christian chaplains a degree of authority to carry-out the works of their ministry in accordance within the guidelines of the institution. Furthermore, Carroll’s typology can serve as a paradigm that can help Christian chaplains understand the bases of their authority in relationship to how they can use it to serve those in need within the secular medical institution. Also, Carroll’s typology on authority can aid Christian chaplains in understanding the dual dynamics of their God-given and institutional authority.

However, Christian authority is distinct. Genuine Christian authority can be defined as an authority that does not seek to dominate; rather, it radiates out of a center of truth and love, combined with compassion, confidence, and a conviction that recognizes that such authority originates with, and is accountable and obedient to God. Therefore, what distinguishes Christian authority from secular authority is that it comes from God and evidences a compassionate commitment to serve all of those in need.

Fr. Henri Nouwen in *The Wounded Healer* affirms this philosophy of Christian authority and notes that compassion must become both the core and the nature of Christian authority as exemplified by Jesus.24 Drew Dyck makes a salient comment regarding what it means to minister with the authority and compassion of Jesus when he says, “[W]e can’t claim the same authority as Jesus, but as followers shouldn’t our words possess a modicum of his authority? Shouldn’t our leadership?”25 What Dyck means is that although Christians cannot claim the unique authority that belongs to Jesus Christ as the Son of God, our words (and actions) should communicate that

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we understand that we have a God-given authority and have been given the right to exercise it in our ministry.

Accordingly we can define Christian authority further as a compassionate authority that is incarnational, which demonstrates the credible presence of the Triune God at work in the world. Finally, it is beneficial to add that the Christian chaplain’s authority is a sovereign authority shared by God with Jesus, who shares it with believers of the faith. Stagaman understands this concept of shared authority: “Christian authority is understood in the context of the story of God’s unbounded love and mercy which calls every man and woman into the divine mystery of God’s adopted sons and daughters.” 26 Examining these diverse meanings of Christian authority from Rev. Stagaman, Jackson Carroll, and Fr. Nouwen helps to clarify what is meant by the term “Christian authority.”

Thus, it is important for Christian chaplains to recognize that their spiritual authority should not function in a competitive manner with other figures of authority, but instead should be the prism through which they understand and implement, both theologically and practically, their own authority. In understanding this, chaplains can experience much less difficulty with recognizing and submitting to the claims of their God-given authority.

Additionally, I propose that the idea of utilizing our authority should come with a sense of assurance that both empowers and constrains. It empowers us because as Christian chaplains we understand that our authority has a distinctive nature (that is different from the secular views of authority) because it is divinely given to us by God. However, this unique God-given authority also constrains Christian chaplains because they are aware that their actions will be held accountable by the supreme source of all Christian authority—God the Father. Granting that the

idea of having a God-given Christian authority may be accepted as a common truism by Christians, it remains significant for Christian chaplains to acknowledge their authority because it will empower them. The authority bequeathed by God is also significant because it is often identified as charismatic authority. According to sociologist Max Weber, charismatic authority "is that authority which is derived from the 'gift of grace' or when the leader claims that his authority is derived from a 'higher power' (e.g. God) or 'inspiration' that is superior to both the validity of traditional and rational-legal authority." 27

Moreover, since God is the Christians' supreme authority, it is to our advantage that we are equally empowered by and constrained by our authority because it should help us to remember that we are accountable to God concerning how we implement and practice a biblical idea of authority. Furthermore, I advocate its importance because Christian chaplains should understand that their God-given authority will both empower and constrain them in their hospital ministry to be competent, effective, and compassionate participating members of the interdisciplinary care team.

It cannot be overstated that Christian chaplains must know that they do have a God-given authority and are significant and unique members of interdisciplinary teams of care. When Christian chaplains accept that they have a unique, God-given authority, regardless of the existing problems they encounter in their ministry, they are better able to meet the spiritual needs of the patients and their families. However, to further understand the complexity of the problem of the Christian chaplain’s authority, I will now turn to examine the history of clinical pastoral education (henceforth referred to as CPE) to demonstrate that from its inception there have been

challenges to this ministry. In addition to the above, the fact that chaplains have been beset by these challenges may offer hope to them in navigating their problems.

**A Brief History of CPE**

The history of CPE is extensive and ever-evolving. CPE was originally defined as “A program of professional training through the long-term supervised encounter of ministers and theological students with men and women in crises in hospitals, prisons, and social agencies.”

Although hospital chaplaincy and CPE have a history, it is important to note that research done by Lawrence Holst, (a prominent director of pastoral care with over thirty years of service) observed that “Before the middle of the twentieth century almost no literature on hospital chaplaincy existed.”

Because of this, only a relatively brief summary on the early challenges of a hospital chaplaincy is included here. However, a summary of the history of CPE is important to this thesis because it shows that the challenges related to a hospital chaplain’s ministry (and authority) in the secular medical institution are not entirely new. Hence, I agree with Stephen D. W. King that it is important for the twenty-first-century chaplain to know the history of CPE and the problems that were encountered at its outset. Furthermore, according to King, “The clinical pastoral education (CPE) movement has been a story of explorations and struggles toward new or different vistas as its participants sought an identity with which they could flourish and through which institutionally they could guarantee consistent and quality education.”

Hence, I will now turn to briefly examine the history of the early hospital and the role of the hospital

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chaplain to explore some of the particular struggles with authority that the ministry of pastoral care (and the hospital chaplain) faced from its inception until now.

**The Early Roles of Hospitals**

During the middle ages hospitals served different functions than today’s modern medical institutions. Hospitals were seen as almshouses to help serve the poor and sick.\(^{31}\) “The word hospital comes from the Latin *hospes*, signifying a stranger, or foreigner, hence a guest.”\(^{32}\) Therefore, it would seem that a chaplain would rightly embody a place of authority in a hospital, since a major component of his or her ministry is dedicated to being with and ministering to “strangers.” At the inception of hospital chaplaincy many chaplains often came from a background and training that was affiliated with their churches’ ministry that served the sick. It is here where chaplains were traditionally identified as those who “care for the soul” (a common term used in pastoral care to describe the authority and work of the chaplain). Hence, as a result of their background and training, it would be conceivable to recognize and distinguish chaplains as individuals that should have some authority to care for the spiritual needs of the sick and suffering in a hospital. Furthermore, the hospital chaplain ministers to such “strangers” (their patients) by helping to serve the spiritual, emotional, and psychological needs of the sick and suffering. However, in the early stages of hospitals (around the 1930’s) physicians and other medical professionals were understood to be the predominant figures of authority because they were specifically trained in the areas of biology and psychology. Although as previously stated, the hospital chaplain’s affiliation with the ministry to the sick in their perspective churches


should conceivably recognize them as individuals who have some authority to care for the sick and suffering, this idea was not originally accepted in the secular hospital. This is primarily due to the fact that the hospital chaplain would not be seen as a figure of authority because during this time period, he or she lacked specific medical training in these areas. As a result of the coming of the scientific period in medicine (over a hundred years ago) more emphasis was placed on the importance of medical technology, medical breakthroughs and the biological and social sciences such as biology and psychology. Thus, during the early stages of the of hospital chaplaincy many chaplains lacked specific medical training. Consequently, as a result of the chaplain’s specific lack of training in the biological or social sciences, the hospital chaplain’s authority was marginalized.33

Furthermore, a pioneer in the field of CPE Lawrence Holst and one of his hospital colleagues Harold Kurtz claim that one of the early issues in CPE was to make sure ministers were trained as clergymen and not psychiatrists, as to not lose their spiritual identity.34 Additionally, the authors note, “Often it was not heard when it was said that training was being given in the understanding of the human condition so that clergy could function better as clergy.”35 Therefore, in the early stages of CPE, the result of the lack of the hospital chaplain’s training and understanding of the human condition essentially became a disadvantage for how others might perceive them as figures of authority. Consequently, what could plausibly be


35. Ibid.
brought into question (by their medical colleagues) is the idea that a chaplain would have some authority in the hospital. Furthermore, according to Holst and Kurtz “Though he [the hospital chaplain] is a member of the hospital staff, he is not ordinarily seen as part of the medical management.” Hence, in the early stages of CPE, the broad diversity of hospital chaplains’ identity and role and their lack of specific medical training is an issue that contributed to the chaplain not being viewed as a contributing member of the team or a figure of authority. Yet, as Holst later concludes in 1985, because hospital chaplains walk between the worlds of theology and medicine they essentially should recognize they are a figure of authority. The process has been long and tedious toward a full acceptance of the hospital chaplain’s authority for caring for the sick and suffering. Furthermore, the research cited in this thesis indicates that there are still many challenges regarding accepting and validating the authority of the hospital chaplain. However, current, and the emerging paradigm shift of the model of interdisciplinary care, (where the hospital chaplain is supposed to have some authority in meeting the spiritual needs of patients) indicates that an early challenge for hospital chaplains was defining their role and function.

Consequently, the inability to clearly define the diverse roles of hospital chaplains makes it more challenging for them to be considered as a figure of authority by their medical colleagues. Holst and Kurtz describe some of the complexities of defining the chaplain’s role, noting that hospital chaplains do a great deal of individual counseling but are not counselors;


37. Holst, as a prominent figure of authority in the field of Pastoral Care and CPE for over thirty years, offers a detailed account of what it means to say that the hospital chaplain walks between the worlds of theology and psychology (medicine), thus making him or a figure of authority in both contexts. For further discussion, see Lawrence E. Holst, ed., *Hospital Ministry: The Role of The Chaplain Today* (Eugene, OR: Wipf & Stock Publishers, 1985), 18-22.
they relate to the social milieu of the patient, but they are not social workers; they are asked to intervene in conflict (personal and situational), but they are not personnel directors; and finally they act as pastors when they pray and conduct worship and religious services for patients, families, and staff, yet they are not the parish or individual pastor.\(^\text{38}\) On the other hand, many of the hospital chaplains’ colleagues (such as the physicians and nurses) have job descriptions that affirm them as identifiable figures of authority within the medical institution and clearly delineate in quantifiable ways their functions—functions often significantly different from the nurturing and support provided by chaplains. Additionally, in the early 1950’s, Chaplain Russell Dicks observed something interesting that contributed to the challenges of the hospital chaplain’s authority. Dicks notes that in the early stages of CPE, because of the lack of clarity vis-à-vis the role of the hospital chaplain, although hospital administrators and physicians were interested in the issue of providing pastoral care, they wondered “who in their right mind would employ a clergyman [or view him as a figure of authority] and give him the run of the hospital.”\(^\text{39}\) The perceptions from some of their medical peers contributed, as well, to some of the reluctance of viewing the hospital chaplain as a figure of authority. Chaplain Dicks explains this first-hand from his experience in the ministry of pastoral care: “In the past when treatment of the soul was considered as apart from medical care of the patient, and was believed to have nothing to do with his health, the hospital and the physician were not greatly concerned with the spiritual condition of the patient.”\(^\text{40}\) Consequently, because the role of chaplains was unclear, their ministry was not

\(^{38}\) For a detailed account of the complexity of the hospital chaplain’s role and issues regarding how to define their authority, see Lawrence E. Holst and Harold P. Kurtz, eds., *Toward A Creative Chaplaincy* (Springfield, IL: Charles C. Thomas Publishers, 1973), 3-5.


considered to benefit the well-being of the patient, and what they did could not always be quantified. Consequently, a reluctance to accept hospital chaplains as figures of authority naturally resulted.

Furthermore, prior to the turn of the twentieth century, the very idea of an “interdisciplinary care team” did not exist. This term became known later because a paradigm shift occurred that sought to treat the needs of the patient using a more holistic manner:

The development of a holistic approach (mind, body, and spirit) to care giving . . . and regulations mandated in 1998 by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to provide spiritual and religious care to hospital patients [consequently] opened the way for specialization of care that chaplains can provide. The professional chaplain emerged as the primary and most qualified provider of spiritual and religious care for the sick and dying.

Prior to this mandate by the JCAHO, the hospital chaplain was beset by many questions, concerns, and some skepticism. Hence, some of the pioneers who served as chaplains had to overcome the challenges they encountered if they wanted to be perceived as contributing team members and figures of authority in the hospital.

The Contributions of CPE Pioneers

We turn now particularly to Anton Boisen, one of the most notable examples of a pioneer in CPE. Doing so demonstrates that this significant pioneer encountered both personal and professional challenges at the onset of his ministry as a hospital chaplain; yet his contributions to

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41. The term interdisciplinary care team is a term I learned as a Christian chaplain intern and resident at Duke University Medical Center in Durham, NC. In general, it refers to a model of care that is inclusive of all of the disciplines of medicine, the social sciences, and religion. This model, which is also found in many academic hospitals in the United States, recognizes the patient as a “whole being” that includes the mind, body, and spirit. Thus, this model includes the contributions of chaplains to help assess and treat the patient to provide a comprehensive plan of care.

the field remain invaluable. As a result of Boisen’s mental health issues and his eccentric personality, he was sometimes cast as a voice from the margins by his peers in ministry as well as those in the world of the hospital. However, Anton Boisen is most notably considered the founding father of CPE, and the coiner of the phrase the “living human document.” Boisen’s ministry as a hospital chaplain was at times met with skepticism due to his vocational calling to be a spiritual presence for the mentally ill, in a secular medical institution. Moreover, due to his mental illness, Boisen suffered from a certain kind of voicelessness and isolation, which on occasion hindered his ability to be perceived as a voice of authority as a hospital chaplain. In his autobiography, written five years before his death, he wrote about his perception and struggles with his mental illness. He shared that because of his status as a mental patient “I am by that very fact discredited.” Yet, with the feeling of being discredited, along with all that Boisen had to overcome in his personal life, it took his efforts to help hospital personnel begin to change their perception of hospital chaplains from being considered “just” a spiritual presence who listens to people, to a person of authority and to one who has skills and training that can contribute to the well-being of the patients. But, before he could successful accomplish this, “Boisen had to first convince hospital administration that students would be making a valuable contribution.”

Boisen’s own contribution is salient because it demonstrates that such challenges did not prevent his or other various contributions (in the early stages of CPE) to greatly influence the growth and

43. The “living human document” is a term used to state “…that individual human experience, especially of people in crisis, should be ‘read’ by theological students and pastors alongside the classical texts of theology and biblical study in order to test theological assumptions and develop a complete, holistic theological understanding.” See Glenn H. Asquith, Jr., ed., The Concise Dictionary Of Pastoral Care And Counseling (Nashville, TN: Abingdon Press, 2010), 16.


acceptance of the hospital chaplain as an emerging figure of authority. Lastly, this recapitulation of the early stages of CPE describes how some of the challenges that beset the ministry contributed to how the issue of the hospital chaplain’s authority came into question. Therefore, it is important that Christian chaplains understand that such challenges to their authority have a long history, but that they offer, and have always offered, an essential spiritual presence.

Although the identity, role, and authority of the hospital chaplain in the early stages of CPE had its share of challenges, there were many positive significant contributions that arose from this time period as well. One is the shepherd motif. This motif recognizes that the Christian chaplain is like a shepherd who tends to his or her flock of patients in the hospital. Seward Hiltner, a pioneer in pastoral care, seemingly understood the relationship of this motif and the Christian chaplains’ ministry in the hospital.46

From the 1930s through the 1950s, CPE benefitted from the significant contributions of Seward Hiltner, an American Presbyterian minister. In his book, Dykstra shares the thoughts of Hiltner’s work from an historical moment in his career that is linked to his groundbreaking work in *The Christian Shepherd*, one of his four widely used books, all of which remain relevant for CPE students today. Dykstra explains in his book that Hiltner’s work in *The Christian Shepherd* substantiates a common assumption that there is a link between pastoral care and the shepherding acts of Jesus as seen in the Gospel of Luke.47 Hiltner draws on Luke 15 to emphasize the metaphor that portrays Jesus as the solicitous shepherd who left the ninety-nine (healthy) sheep

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47. Ibid.
to seek out the one sheep that was lost and possibly hurt. Hence, Hiltner understood the role of the pastor and hospital chaplain as one who shepherds.48

Hiltner’s perspective remains relevant to the ministry of CPE today. It conveys a message to Christian chaplains that they have been given a pastoral authority that has biblical origins, and is patterned after the ministry of Jesus—the Great Shepherd—whom they should emulate. Essentially, when chaplains take on the nature of the shepherd, which includes having genuine compassion for the needs of their patients and the communication of the hope of healing and a message of concern for the sick and suffering, they bear witness to the love of Jesus.

Shepherding is an important ministry; however, Christian chaplains must be aware that such acts of shepherding can sometimes create challenges when ministering in a secular medical institution. For example, I was invited by one of the pediatric fellows to attend an interdisciplinary care meeting that from the outset was a very emotional situation. A pediatric social worker, the patient’s nurse, the fellow, and I were all present to hear the physician’s current diagnosis, prognosis, and recommended treatment of care for the patient. However, some of the other professionals there misinterpreted my attempt to model the shepherd motif by showing compassion and care to meet the spiritual need of the patient’s mother, and they challenged my authority. Prior to this interdisciplinary meeting, I only recall meeting once privately with this young single mother. However, I do remember that this emotional young woman shared with me very briefly that she had “left the church” and didn’t attend service anymore, and thus wondered if this could be the reason her baby was ill. As I listened, I discerned that the mother was feeling guilty and was grappling with the idea that perhaps her

baby’s illness was a consequence of her “leaving the church.” This was a vital aspect of her narrative.

During the meeting, the mother seemed ill on hearing the news that her infant daughter’s chances for survival were slim. She sobbed openly in the room and kept asking me to pray as she called on the name of Jesus for help. Initially, I allowed her time and space to grieve. However, I also made eye contact with the social worker several times to show that I was aware of her valuable presence. Learning to communicate non-verbally is also a very important skill for the chaplain to master, especially in medical institutions where at times the clamor of sounds can be overly stimulating and overwhelming. As the mother continued to sob and the social worker remained in her chair, I heard the ineffable voice of the Holy Spirit tell me to go to the mother and minister to her. It was at that moment that I was able to focus on the ultimate need of the mother, which I concluded was a need for human touch and compassion. This type of ministering is one way that demonstrates what it means to be a shepherd—one who offers compassion and care. Chaplains are skilled active listeners and must learn how to use the “hermeneutical stethoscope,”49 which is a resource that can help them to understand the spoken and unspoken religious language in a patient’s narrative. The mother’s spoken religious language was boisterously communicated and heard by me in her repeated cries to Jesus for help. I remained present and focused, and thus sought to help this mother in her time of need and her request for prayer. I approached the mother, who was sitting in a chair, and knelt down next to her. I prayed as I held the sobbing, almost inconsolable mother in my arms. Eventually her strength deserted her, which resulted in both of us landing on the floor.

Afterwards, I learned that the social worker informed my unit supervisor that she felt "displaced" by my presence. In this instance, both my pastoral authority and presence were a challenge to the pediatric social worker. Perhaps the social worker’s perception of my special bond with the mother, and her feeling of being displaced caused her to think I was overstepping my boundaries and my authority. However, had the social worker made me aware of her emotions at that time, I could have validated her feelings by listening to how she perceived my ministry and shared an appropriate and caring response. Later, I was also informed by my pastoral services unit supervisor that the social worker requested a meeting with my supervisor and me. As a result of the meeting I learned that the social worker perceived that I had overstepped my authority. Thus, the social worker felt displaced and that her services were not needed as it seemed I was acting as the dominant figure of authority. I was disappointed to learn that the social worker perceived my shepherd-like acts of compassion as my attempt to be the one in charge of the situation concerning the mother’s emotions—yet this is a teachable lesson.

Sometimes the authority of chaplains can be misinterpreted or misjudged, even when they are earnestly attempting to show the characteristics of the compassionate shepherd. I have witnessed how pain, suffering, and illness completely disrupt the everyday narratives of people’s lives. Consequently, when people encounter the disruption and distraction of illness, the idea of thinking rationally about such basic human needs as eating and sleeping is totally distorted and sometimes mislaid temporarily. Therefore, it was not that the mother did not need or want the services that the social worker was able to provide. However, as a pastoral figure of authority, I was able to assess that the mother’s ultimate concern at that time was not about herself, but about the inconceivable possibility that her baby daughter could die. Consequently, what I discerned
that the mother needed at that moment was compassion to help ease her hurt and fear. I provided this comfort through the courageous and compassionate act of shepherding.

In this context of encountering the living human document, I perceived that the mother’s pre-illness narrative (to see her child grow up) was disrupted. Because of the mother’s professed Christianity, which was revealed in the meeting by her calls to Jesus for help, she expressed that what she needed at that time was to experience the compassion and love of Jesus, which I tried to bring as the chaplain through my supportive presence. Hence, although the shepherd motif is worthy of emulating, especially in the ministry of CPE, it is important for Christian chaplains to recognize that such acts of compassion can create challenges to their authority.

Additional contributions from those in the ministry of pastoral care further describe the relationship between the shepherd motif and the Christian chaplain. For example, Robert Dykstra states, “But only in Christianity is the effort to shepherd and to heal, when needed, regarded as itself the one indispensable way of communicating the gospel on those occasions.” Here, Dykstra makes a valid point; the act of shepherding is essentially communicating the gospel to those in need. Furthermore, Dykstra summarizes this point best in his inclusion of an excerpt from Seward Hiltner’s *The Christian Shepherd*: “The ultimate goal of shepherding, like that of communicating and organizing, is to relate the gospel to the need and condition of [humanity].”

Shepherding is clearly important in the New Testament gospels that record the life and ministry of Jesus, the Great Shepherd. It is Jesus himself, in one of his seven great “I Am” declarations, found in John 10:11, who says, “I am the good shepherd. The good shepherd lays down his life for the sheep.” Moreover, Hebrews 13:20 informs us that the Lord Jesus is “the

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51. Ibid., 50.
great shepherd of the sheep,” and 1 Peter 5:1-2 communicates that we are to be shepherds of the flock that God gives us to care for. Therefore, Christian chaplains are called to do his will and emulate him as “undershepherds,” a common term used in pastoral care and CPE. Likewise, in Luke 15:4-7, Jesus utilizes language that links the acts of compassion and caring to the shepherd motif when he teaches “The Parable of the Lost Sheep.”

Although since the advent of CPE there have been challenges to the role and authority of chaplains, there have nevertheless been many significant contributions made by pioneers in this field. Therefore, the contemporary Christian chaplain who experiences challenges or opposition should understand that the history of their calling demonstrates that such problems should not prevent them from offering an effective, competent, compassionate and loving ministry to those in need.

Lastly, the history of CPE reveals that perhaps Christian chaplains will always to some extent experience challenges to their authority because they will always have difficulty fitting into the power structure of a secular medical institution. Many view the inability of the Christian chaplain to completely “fit into” the secular medical institution as a good thing. It is good because Christian chaplains should recognize they have been called to a vocation that embraces a sacred perspective that is not motivated or governed by human-made power structures. Moreover, although evidence demonstrates that there are challenges to a Christian chaplain’s authority in the secular medical institution and that these challenges are important to recognize and address, the chaplain’s God-given authority is of a supreme calling. Therefore, the Christian chaplain should recognize that it is inevitable that there will be tensions between the meaning

52. The term “undershepherd” is often used or cited in CPE and the Christian church to make a reference to a metaphoric analogy that compares a religious person of authority, such as a chaplain, as one who is called to shepherd/help or attend to the flock of his or her people (the sheep) by caring for them. It is also associated with the scripture found in 1 Peter 5: 1-4.
and purpose of their sacred and secular authority. This tension exists because the Christian chaplain is “sent” to bear witness to God’s love in the world, although they are not from the world (cf John 15:19). However, what Chaplain Dicks observed from his experiences in hospital ministry over sixty years ago remains a certainty, and is important for contemporary chaplains to recognize as well if they are called to hospital chaplaincy. Dicks explained, “If a chaplain is to have a place in the hospital, even to be permitted inside its doors, he must be of such a character and judgment that he can be trusted with complicated human and spiritual problems. This will mean having the confidence of the staff, for many of these problems must be worked upon by more than one person.”

Indeed, the Christian hospital chaplain can become such a profound type of character for the sick and suffering. One way that chaplains can achieve and demonstrate these profound types of characteristics (so they can effectively minister with authority to the sick and suffering) is to learn “how” to walk between the worlds of religion and medicine. Therefore, in chapter two, I shall explore what it means for the Christian chaplain to walk (with authority) between the worlds of religion and medicine.

CHAPTER TWO

Ministering in the Middle with Authority: an Examination of the Paradox and Problems between the Worlds of Religion and Medicine

Medical institutions are complex, marked by paradoxes, and probably among the most emotionally highly charged institutions in existence. However, it is important to point out that medical institutions do not create paradoxes; life does. Therefore, chaplains learn in CPE that the medical institution is one place that creates an atmosphere that almost forces people to confront and engage the paradoxes of life. This is due largely to the spatial confinement and the sometimes distressing and terminal prognoses of the patients. Hospital chaplains can help patients face the reality (of presumably) such distressing times as suffering and illness through their specific education and training as spiritual care professionals (ministers) in a hospital CPE program. Therefore, as a result of their training chaplains do have the competence and some authority to help patients see beyond the limitations of their current contexts. Chaplains who participate in CPE programs do receive some basic training in the field of sociology and psychology. Also, in some instances chaplains are afforded the opportunity to attend some medical rounds to gain a basic understanding of some of the medical language and issues that primarily pertain to the patients on the units they are assigned. This is one reason that the chaplain remains a vital link between the two worlds of religion and medicine. Accordingly, it is constructive to reiterate sufficiently how crucial it is for chaplains to learn how to navigate the topography of the secular medical institution from the middle position—a position described by Lawrence E. Holst, a chaplain and professor of pastoral care:
The hospital chaplain walks between two worlds: religion and medicine. To put it in more political language, between two monolithic structures: the church and the hospital. Each world, or structure, has its own domains and demands, its assumptions and mission. Each needs the support of, but independence from, the other. Often these worlds are complementary; sometimes they are in conflict.¹

Through his teachings, Holst insists that chaplains must learn how to walk, function, and live in the very distinct and different worlds of religion and medicine in order to function as a figure of authority and as a crucial member of the interdisciplinary care team. Essentially, a chaplain must understand that ministering in the middle requires him or her to be an observant participant in and of each world to understand how those worlds function interdependently.² Furthermore, Holst’s idea of ministering between these worlds explains that chaplains must be aware that the worlds of religion and medicine each have a distinct purpose and mission to fulfill; therefore, each world will inevitably demand that different paths be taken to fulfill its purpose. Hence, the separate yet integrated images of these two very powerful domains (almost innately) create an atmosphere of tension for all of the participants.

Holst suggests that the tensions the hospital chaplain experiences can be identified in four categories: first, “the context of the hospital; second, the chaplain’s specialized training; third, the strong influence of psychology in the chaplain’s ministry; and fourth, medicine’s and religion’s conflicting perspectives.”³ To expound upon Holst’s perspective is to understand that the context of the secular hospital can at times create tensions for Christian chaplains such as


² According to the Oxford English Dictionary, interdependent means “…two or more people or things… dependent on each other.” Interdependence differs from dependence in that in a dependent relationship someone is dependent and someone else is not. http://www.oxforddictionaries.com/us/definition/american_english/interdependent

feelings of ambivalence, being disrespected, not valued, not competent, and not an important member or necessary member of the patient’s care team. Although secular hospitals rely heavily on the contributions of the social sciences like psychology and these sciences can influence the chaplains’ ministry, most CPE programs offer minimal training in the social sciences, which contributes to difficulties in the Christian chaplain’s effectiveness to walk between both worlds. Furthermore, hospital chaplain’s specialized training (in general) helps them to deal more specifically with the spiritual and religious aspects of their patients. This often means that conflict can arise between these two worlds. Conceivably, then, such tensions can create challenges to the Christian chaplain’s pastoral authority. However, chaplains can master the challenging position of walking between the two very different worlds of religion and medicine by learning, understanding, and accepting that their pastoral identity and authority provides them with an invitation and the call to minister in this context. Chapter one affirms that Christian chaplains, by the nature of their baptism into the faith and by their acceptance of their unique vocational calling, have a God-given authority to minister in this context. But, the worlds of religion and medicine will never be completely without challenges and some conflict. Today, Holst’s contributions remain an invaluable resource for Christian chaplains who minister in secular medical institutions.

In the world of medicine, the physicians and other members of the medical staff have a primary allegiance to the medical institution, and the performance of their duties relates directly to the purpose and mission of that institution. Therefore, one of the duties of CPE training programs is to teach student chaplains how to become integrated colleagues with their medical peers. Three specific ways that chaplains can become integrated members of the inter-disciplinary care team is, first, to attend the care team meetings on their units that are open to
them. This will allow chaplains to build relationships with the physicians and other members of the patient’s care team. Second, chaplains should attend conferences and workshops offered to them by the hospital. Third, chaplains should read and contribute articles to the journals in their field, in order to stay abreast of the current research in CPE. These three suggestions can help chaplains to become more acclimated to the world of medicine, while also serving as a means for their own personal growth and development in pastoral care. It is important to reiterate that this requires balance; and furthermore, chaplains must be aware that engaging in these types of activities can also be challenging. It is challenging because it requires chaplains to become more intentional about learning about various means that can help them learn how to minister more effectively between these two worlds.

While it is important to note the distinct differences between the Christian chaplain and the secular medical institution, it is equally important to note (as Holst presumes) how both need the support of the other in order to provide exemplary patient care.4 From the middle position, the Christian chaplain has a commitment to the worlds of religion and medicine; therefore, he or she must be an authority in both who has knowledge about both. This means that it is mandatory for the chaplain to learn and master the skill of what James Travis, professor emeritus of pastoral care, refers to as the “art of the dance.”5

Travis makes a purposeful choice in using the term dance. A skilled chaplain must learn the art of becoming accustomed to and comfortable with being able to move insightfully between these sometimes cooperating and sometimes conflicting worlds of religion and medicine.


5. James Travis, Class Notes from an Introduction to Pastoral Care, Duke Divinity School, Spring Semester, 2009.
Consequently, Christian chaplains ministering in a secular medical institution must be flexible as well as confident that their God-given authority and the skills they acquire in CPE will teach them how to appropriately “dance” with the partner of medicine in order to address, compassionately, effectively, and professionally, the spiritual (and at times the secular needs) of all people for whom they offer care. Attaining this kind of confidence (like most confidences) will take time. Therefore, chaplains should proceed with patience as they learn how to be comfortable and flexible between these two distinct worlds. However, mastering the ability to dance in the conventional context of the worlds of religion and medicine does not imply that a skilled chaplain who adapts to this type of environment will be able to minister without encountering both challenges and misinterpretations of their authority.

Amidst any such challenges or misinterpretations of his or her authority, the chaplain is responsible for being the one who makes clear and defends his or her practice of ministry, especially if it is viewed by those in the secular medical institution as problematic. Furthermore, it has been shown by examining the pastoral vignettes included in this thesis that building bonds of trust is a necessary prerequisite to help chaplains to learn how to prevail over the contemporary challenges and opposition they encounter to their pastoral authority.

A concept that is familiar to Christian chaplains that can be applicable to their ministry is that of hope. Hope is a central theological concept that the chaplain has to offer to both of these worlds. And hope is a significant aspect of the Christian chaplain’s theological training. As a Christian chaplain, my experiences indicate that embracing the idea of hope (trusting, expecting or believing in the possibilities of something) is essential in a hospital context. By this I mean that irrespective of different beliefs and faiths that persons have in this context, chaplains and the patients and their families are not the only persons who have hope. Physicians, nurses, social
workers, and all of those who care for the sick and suffering in the hospital have some modicum of hope, due to their commitment (and in some cases oath) to help those who are suffering. Therefore, the concept of hope is important because it can serve as a way in which chaplains can offer their voice in a setting that can be inundated by an aura of hopelessness.⁶

The theology of hope is not a new concept. The apostle Paul speaks about the idea of hope in the eighth chapter of his letter to the Romans. However, one might ask how St. Paul’s first-century theology of hope can relate to the claim that the twenty-first century Christian chaplain is also a voice of hope in pastoral care. In his study of understanding hope in relation to pastoral care, Robert Carrigan contends that the word hope is crucial to biblical faith and pastoral care.⁷ Moreover, Carrigan argues hope is an essential virtue in pastoral care because persons are “hoping beings.”⁸ Hope is important in pastoral care, explains Carrigan, because “For the Christian, the question is not whether a person has or does not have hope, or even of hope seen as a reflection of a personal mood; hope is a primal mode of existence for the person of faith.”⁹ In this way, I agree that the concept of hope (specifically in the Christian faith) functions as an original or inherent means for our expectations in life; and thus, hope is an important virtue for chaplains to recognize when providing pastoral care to the sick and suffering. Furthermore, the virtue of hope is a means in which Christian chaplains can help patients understand the possibilities of what can be (the not yet)—like creating a new narrative or new reality in light of

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⁶ I will support the claim that hope is an important concept for chaplains to be aware by providing an anecdotal account later in this chapter to demonstrate how hope can look from the perspectives of the chaplain, physician, and a patient’s family.


⁸ Ibid., 41.

⁹ Ibid.
the sickness and sufferings they experience. Conversely, Alan Cole’s research in What Makes Care Pastoral? indirectly refers to the virtue of hope. Cole states “that caring ministers, by virtue of their distinctive vocation, have something to offer persons in the way of care and nurture that professional caregivers (e.g., psychologists, social workers, psychiatrists, and psychotherapists) do not have to offer, at least not by virtue of their professional orientations or commitments.”

Hence, by the distinctive nature of their vocation, Christian chaplains can prophetically speak with authority about the important virtue of hope as a means to offer compassionate pastoral care. Not only do Christian chaplains have an authority bestowed upon them by God, but often, as spiritual leaders in secular medical institutions, they will be granted formal and informal authority that comes from the relationship and trust of the patients, families, and staff for whom they care. This type of formal and informal authority will vary and can be present as invitations to pray and conduct special religious services, as well as personal invitations from physicians to attend family care meetings and medical rounds for the patients. Yet, it is important to note, that as a voice of hope, the chaplain must be equally aware of reality. By reality, I mean that chaplains must not allow their faith perspective (or definition of hope) to obstruct the medical facts and opinions of the physicians.

Greg Jones, for example, claims that the “Christian virtue of hope is not optimism, but an accurate reading of reality.” By this, Jones proposed that hope should accurately take into account all of the facts of a situation; hence, hope becomes a more accurate reading of reality and not just an optimistic idea. Christian chaplains have a specific theological task of imparting

10 Alan Hugh Cole, Jr., “What Makes Care Pastoral?,” Pastoral Psychology 59, no. 6 (July 2010): 713.

hope—hope in this life, as well as hope in our eternal life with Jesus Christ. However in this context, the chaplain’s ability (or freedom) to impart hope should be considered in conjunction with the information that the medical facts provide. Furthermore, Craig Dykstra suggests that hope involves risk because it takes into account not just the current context of someone, but the possibilities of a new future.\textsuperscript{12} Therefore, because of a belief in the Christian concept of hope, chaplains run the risk of being misunderstood or, even worse, creating a false sense of hope for their patients.

Chaplains ministering in the middle between the worlds of religion and medicine should not be surprised that people will expect them to participate in their yearnings, which frequently hopes for a miracle (or at least offer a foretaste of something that resembles one). This is often due to a patient’s feeling of vulnerability. I have witnessed the unpredictable nature of illness that can make patients very vulnerable. Because of a patient’s illness they become vulnerable as they are (metaphorically and literally speaking) exposed physically, mentally, and spiritually. Therefore, the chaplain who ministers in the sometimes precarious position between these two worlds must be able to recognize the vulnerabilities of those to whom he or she ministers. David Hormenoo, CPE Pastoral Supervisor at Duke Medical Center in Durham, N.C., notes that being in the precarious position of ministering in the middle can be either a “gold mine or a land mine.”\textsuperscript{13} Hence, the Christian chaplain must recognize the power and work of the gift of the Holy Spirit. Although it could be suggested that understanding the promptings of the Holy Spirit may

\textsuperscript{12} Robert C. Dykstra, Images of Pastoral Care: Classical Readings (St. Louis, MO: Chalice Press, 2005), 191-92.

\textsuperscript{13} The idea of the chaplain being in the precarious position of ministering in the middle between the worlds of religion and medicine was presented as a metaphorical analogy by Rev. Dr. David Hormenoo, during a CPE didactic session to my residency group in the Spring of 2011. The purpose of his metaphor was to teach chaplains that ministering in the middle between the worlds of religion and medicine can times be very rewarding (a gold mine), and at other times it can be very challenging (a land mine).
be a difficult concept to “prove,” Christian chaplains who participate daily in prayer, read the Bible, and create space in their schedules for a time of daily devotion (all realistic practices) will grow in their ability to understand how the Holy Spirit operates in their ministry.

In particular, one riveting and highly emotional experience that I chose to present to my group during a class session occurred when I was a pediatric chaplain intern assigned primarily to the pediatric intensive care unit (PICU) at Duke University Medical Center (DUMC) and had to negotiate the space between medical and Christian concerns. I was invited by one of the physicians, with whom I had built a relationship of trust, to attend a meeting regarding the prognosis of a teenage boy whose recurring brain tumor was now inoperable. The physician, the teenager’s mother and stepfather, and I were present for the meeting in the large family conference room where an aura of melancholy seemed to permeate the atmosphere. Earlier, the physician expressed to me that the reason he solicited my help was that he felt that the stepfather was creating a false sense of hope for his wife and himself. However, I knew this was not the case because of my meeting with the parents prior to this inter-disciplinary conference.

I discovered from my previous meetings with the parents that the stepfather was from Jamaica, with deep roots in the Pentecostal faith tradition. In addition, the father expressed to me repeatedly that he believed without a shadow of a doubt that his faith had taught him that “with God all things are possible.” Therefore, he believed that we “were all going to see a miracle.” (I, too, hoped and prayed that we would all see the miracle he hoped for and needed so badly.) Additionally, I had a cordial professional relationship with the physician who invited me to the care team meeting, and I had been able to discuss religion and medicine with him on two previous occasions. Because of our relationship, I felt confident in his authority as a physician, and equally confident in my authority as a Christian chaplain. Therefore, I shared with him that
as a Christian chaplain, I did not subscribe to the idea of false hope in this case,\textsuperscript{14} but rather that the Christian faith teaches that hope is always a possibility; therefore, a genuine understanding of the virtue of Christian hope cannot be false. False hope is more aptly described as optimism.

In the meeting, the mother remained mostly quiet. I observed her profound sense of fear and sadness by the tears that rolled down her stoic-looking face. After a rather lengthy discussion during which the physician described the complicated location of the tumor that made it inoperable, as well as its rapid growth, he respectfully asked the parents if they would like to hear his recommendation, to which they agreed. In the world of chaplaincy, we call this type of conversation “med-talk” –a term that physicians use comfortably as part of their daily vernacular.\textsuperscript{15} This is an important lesson of which chaplains should always be aware as well. The physician knew that, eventually, his recommendation for hospice regarding the future care for the patient had to be heard and understood by all. Yet, although the physician was the dominant figure of authority (from the medical perspective) the intonation of his voice suggested that he struggled with sharing the patient’s dire prognosis with the family.

The physician gave his report, which included a recommendation for hospice care, and which, the stepfather adamantly refused to hear. It is highly unlikely that I will ever forget what occurred next. The stepfather said “no worries,” and repeated, while pacing around the room, “I am going to put in a call to the man upstairs.” For a brief moment, the physician looked puzzled, and then looked at me. Before I could interject, the physician said to me, “If he needs to use the

\textsuperscript{14} An explanation of a false sense of hope implies that the concepts of optimism and wishing or wishful thinking will provide a desirable outcome. However, these ideas are more secular and differ from the dynamics of Christian hope. Christian hope is substantiated in a confident expectancy and assurance on the will God.

\textsuperscript{15} Med-talk is a term I learned during my CPE internship and residency. It refers to the specific language that physicians and other members of the medical team use in their medical evaluation. It can be highly specific to their field, and thus sometimes requires “translation” into more common simplified terms to help others understand the meaning of this unique terminology.
phone, I would be happy to offer him some privacy, and we could leave, and he could use the phone in the room.” Initially, I pondered how I would speak up to this physician—this person of authority whom I admired and respected. Yet, I was aware that I was now in the precarious middle position. I stood between the worlds of religion and medicine and realized that what was needed was an interpreter; one who understood the context of both worlds because he or she had practiced that delicate walk and dance between each. I was that person. Therefore, this was an opportunity for me to be an interpreter of some of the unique idioms and theological language used in the Christian faith. As a result, I interpreted to the physician what the stepfather meant by saying that he was going to “put in a call to the man upstairs.” Once again, this demonstrates that chaplains must be aware of their authority.

In the meeting, the physician's unique vernacular about the patient’s brain tumor demonstrated that he was an authority in the world of medicine. Hence, chaplains must become acclimated to each to learn and become an efficient communicator and translator of the distinct vernacular that belongs to both worlds. One way that the chaplain can become acclimated to the unique vernacular is to attend the interdisciplinary care team meetings regularly, where he or she is able to ask questions and learn about some of the basic medical aspects of certain illnesses.

As a result of my basic understanding of the medical aspects of this situation, I translated what the physician said. I followed-up by asking the parents if they understood the physician’s prognosis and recommendation for their son. I honestly do not recall the mother’s response because it was probably obscured by the father’s consistent articulation of his “genuine hope” to wait, because we were all going to see a miracle. I asked the parents if they understood the physician’s assessment of their son’s prognosis in order to interpret the emotional state of the parents (the care-seekers in this narrative) and to see if they understood the physician’s position.
and recommendation clearly. After the meeting, I met briefly with the physician and assured him that the parents were aware of their son’s dire prognosis and his professional recommendation for hospice care. Therefore, the parents expressed a fierce hope that they would maintain, regardless of the news and reality of their son’s prognosis, and that they did not need to “bargain with hope.” What this narrative demonstrates is that the parents of this teenager clearly articulated (to me) that they maintained that they understood, but were not going to give up on the hope of a miracle and healing of their son.

Chaplains must recognize that even highly trained physicians, who are the dominant and powerful figures of authority in secular medical institutions, can struggle with the art of articulating unfortunate news appropriately. In such contexts, chaplains can minister from the middle by utilizing their compassion, training, and skills, especially their unique theological language, in order to be a chaplain not only for the patients and their family but for their colleagues as well. Hence, chaplains can serve as ministers for physicians, who may be struggling with a sensitive situation such as end-of-life care. As a result of their medical school training, physicians and others in secular medical institutions often view death as a personal defeat or failure. VandeCreek and Burton explore the physician’s perception of the idea of death as being a failure: “The physician is faced almost daily with the possibility of a patient’s death and his [or her] usually irrational sense of failure when it happens.”16 Moreover, they say, “Although experienced physicians may have learned to objectify this, all occasionally wonder whether the decisions they have made were best for the patient.”17 Hence, because physicians (unlike chaplains) deal daily with this type of rationalization, it is conceivable that physicians


17 Ibid.
(and other medical personnel) who primarily treat the physical aspect of the patient may regard
death as a failure or some kind of limitation of their authority and ability. In her book, Dr.
Mohrmann discusses how the perception of death can be understood as a failure. She suggests
that the western world’s fierce fear of death (which broadly includes the medical field) is related
to an idolatrous attitude towards medicine and technology, and a consistent pursuit of perfect
health. Furthermore, Mohrmann offers that the medical world’s preoccupation with pristine
health “represents a fear of death and often a denial of death’s inevitability, both of which
indicate a failure of hope.” After all, hospitals are places where people are supposed to come to
feel better and to be healed by physicians. Although I agree with Dr. Mohrmann regarding the
inevitability of having to talk about death with patients, families, and in some instances other
members of the medical team, it is not as “easy” to practice in chaplaincy. My experience as a
pediatric chaplain is that there seems to be an innate human penchant for the desire of parents to
want good health for their children. Therefore, in this context death is not an easy subject to
countenance. People want their children to live (rightfully so). This is where the chaplain is in a
unique position to speak with authority about death as it relates to the world of medicine (the
physical death) and the world of religion (the spiritual death). Hence, in instances like the
aforementioned narrative, chaplains have a unique perspective on life and death (and eternal life
for those who believe) and can use their wisdom and authority to compassionately minister to all
individuals in both worlds.

Hence, chaplains must be careful when ministering in the middle never to allow the
world of medicine to take away their patients’ hope, which patients often say is the only thing
they have left, especially when medicine or the chaplain cannot offer anything with which to

18 Margaret E. Mohrmann, Medicine as Ministry: Reflections on Suffering, Ethics, and Hope
(Cleveland, Ohio: The Pilgrim Press, 1995), 17.
replace their hope. Christian chaplains should not use their authority to impose their belief on anyone who expresses a different faith, opinion, or belief. Along these lines, the chaplain can learn an important lesson from the aforementioned pastoral experience. Chaplains who misuse their authority to persuade those they minister to, would be a misusing the gift of authority granted to them.

Furthermore, the Christian chaplain must keep in mind the issue of anticipatory hope (the idea or an anticipation that things will change for the better), especially when ministering to those of the Christian faith. When chaplains minister between these two worlds, often people will gravitate to this idea, especially when the science of medicine appears to try and extinguish it. Christian chaplains will find utilizing the Bible as the authoritative word of God to be very helpful for their understanding of the basic attitude of hope. There are attributes of anticipatory hope present, as Paul declares in Romans 8:24-25: “For in hope were saved. Now hope that is seen is not hope. For who hopes for what is seen? But if we hope for what we do not see, we wait for it with patience.”

In this anecdote we see the father was aware of the reality of the situation, but apparently chose to hope for what was not yet seen. Hence, Christian chaplains must know that the Bible teaches that they have the authority to be an agent of genuine hope, especially between the sometimes-opposing worlds of religion and medicine. Chaplains should understand that with each patient, they are ministering to a living human document that is experiencing the intrusion of illness and suffering. If you take hope away from people whose lives have been altered by illness, then you are denying them the ability to believe things can possibly change for the better. Therefore, Christian chaplains (as noted in the aforementioned anecdote) can speak with
authority of the concept of hope and how it can be a stabilizing idea that provides comfort and care to those in need.

Additionally, ministering in the middle is challenging for chaplains because, in part, the challenges they experience are often related to the power dynamics that occur in the ethos of secular medical institutions. Moreover, the implicit or explicit unique relationship that exists between the chaplain and the physician is also subject to the experiences of the power dynamics that exist between these two figures of authority. Therefore, because authority and power is often present and functioning in secular medical institutions, it is necessary to examine briefly the differences between power and authority.

The Differences between Power and Authority

One additional challenge for chaplains who are called to walk with authority between the worlds of religion and medicine is to understand the conceptual differences between power and authority. This is important because it can help chaplains understand the complex dynamics of how authority and power appear and function in secular medical intuitions, which in turn should help chaplains minister more effectively between these two worlds.

Authority in this context is defined best as a means to enable individuals and institutions in the secular medical institution to practice their expertise. Moreover, authority is multidimensional: it is found in the person, the bases of authority, and the degree of institutionalized authority. Power is the ability (whether it be personal, communal or institutional) to make things happen and to get things done that results in a change of action.\(^\text{19}\) Moreover, power permeates

the ethos of secular medical institutions and is a naturally occurring phenomenon that is always at work, which is demonstrated by the hierarchal structures (such as chaplains not always being invited to care team meetings, rounds, or even being able to make initial spiritual assessments as discussed in chapter one) that are present. The concept of power has undergone extensive review, and therefore, it is important to review some relevant postmodernist theories of power.

One such understanding of power can be found in Nancy Ramsay’s *Pastoral Care and Counseling*, in which she explains that power is “the ability to assert knowledge and authority as forms of social control. Power can be psychological, physical, relational, institutional, and cultural. Power is claimed and used by those who have been given, by the culture, the right to both name and shape reality.”

Although chaplains may not be perceived as powerful agents of change in secular medical institutions, they must remember their God-given authority, as well as their commission by their endorsing denominations, which provides them with a sense of power to help name *and* shape a possible new reality (or narrative), particularly by ministering to their patients and families.

An additional concept of power comes from the work of Stanley Barrett, who suggests that one cannot discuss the idea of power without considering the work of Michel Foucault, whose “reputation is that of a theorist of power,” and one that influenced his thoughts as well. Power is fluid; it moves from one person to another, sometimes implicitly and at other times, explicitly. For example, fluidity of power moved between the physician, the chaplain, and the parents in the account provided above. Barrett then explains:

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22 Ibid., 35-37.
Power suppresses an activity, and then it encourages it. Power is the cause of something that happens, but also its effect. Power opposes knowledge while simultaneously nourishing it. Power is ever on the move, generating conditions and disrupting them, settling momentarily on individuals and then flitting through institutions, leaving both individual and institution ravished or enriched in the process. Power is positive and negative, intentional and unintentional.\(^\text{23}\)

From my experiences as a Christian chaplain, Barrett’s explanation of Foucault’s idea of the paradoxical nature of power was very visible. At the same time that the secular medical institution endorses the work of the chaplain, it suppresses it. For example, the power structures within secular medical institutions have sometimes challenged or suppressed the knowledge and theological insight of Christian chaplains, as noted in chapter one when chaplains were denied the opportunity to make an initial request upon admission to assess the *spiritual needs* of patients. While at other times, in a positive manner, as Barrett notes, the power structures of the medical institution support the chaplain’s authority by providing funding and opportunities for internship and residency CPE programs. Funding of CPE programs is another example of how those who are in the position of power can (and often do) determine the number of chaplains to hire. As Barrett states power is always on the move; and as a result of the fluidity of power, it is capable of both generating and disrupting conditions for Christian chaplains. For instance, at the same time those who are in the position of power in secular medical institutions (the “power-makers”) support the valuable programs of CPE, these same persons in power send a conflicting message when money for these programs is reduced in times of financial difficulty. My department experienced this during my residency. The Director of Pastoral Care was asked either to eliminate the “on-call” chaplain positions or to decrease (by one) the number of chaplains accepted into the residency program, due to a lack of funding. Although at the same time as these

reductions were made mandatory, the hospital was embarking on building a multi-million dollar cancer center and recruiting staff from around the United States (albeit no chaplains). David Belgum's findings substantiate this claim about the radical reduction in support to chaplaincy and CPE programs in mental institutions and university-owned hospitals and notes that it will continue over time. If CPE programs are the first to be cut from hospital budgets, then it is conceivable that a reduction in such training programs will directly impact the chaplain. Accordingly, I concur with Barrett that the fluidity of power in this context sometimes appears to demonstrate (or send) conflicting messages.

Although such conflicting messages may present challenges for chaplains, it is important that they understand the effects of the fluidity that exists in the dynamics of power. Power is both intentional and subjective; it is personal, and therefore subject to the biased viewpoints of the person with the power. This is an important concept for Christian chaplains to understand so that they do not succumb to the ontological hierarchy of the power distribution in secular medical institutions that may position them at the bottom of the power pyramid. In relation to their position or ranking in secular medical institutions, chaplains must be cognizant of, and comfortable with the fact that in this context, they are often not viewed as the person with the power (which is a biased, subjective opinion of power). Thus, ministry in the middle between

24. David Rudolph Belgum, “Uniqueness, opportunities and problems of chaplains in university-owned hospitals” American Hospital Protestant Association; American Protestant Hospital Association College of Chaplains 47, no. 2 (January: 1983): 64-65. In this article Belgum reports that funding to CPE programs has experienced significant reductions in financial support in the 1980’s, which he predicted will continue over the next decades. Belgum proposes this because based on his research; university-owned hospital’s ancillary programs are often the first to be designated for cutbacks in spending.

these two worlds requires Christian chaplains to be cognizant that they have been given both the sacred and secular authority to be an essential presence in both.

One can surmise from this examination that learning to walk and dance between these two worlds is a challenging position to be in. The chaplain who engages in this type of ministry is an extraordinary person. Moreover, to integrate (not assimilate) a ministry that aims to help all of those in need requires chaplains to prepare to meet the needs of the human spirit. This preparation will require chaplains to be a minister to those in the world of religion as well as a minister to those in the secular world of medicine. As a student and teacher, a chaplain must be compassionate, courageous, flexible, insightful, and full of wisdom and knowledge to minister effectively in both the worlds of religion and medicine.

In the final chapter, I turn my focus to examine what the current climate of hospital ministry reveals about the challenges that Christian chaplains experience to their authority. Such will be examined through an analysis of seven Christian chaplains’ responses to a questionnaire about their experiences around challenges to their authority. The questionnaire gave these chaplains the opportunity to share what they believe are some of the factors that contribute to these challenges and asked them for recommendations concerning how one might alleviate some of these challenges and make a positive difference in the ministry of pastoral care. The findings will not only confirm the many challenges to Christian chaplains’ authority in secular medical institutions, but they will also confirm that pastoral authority is more recognized in situations surrounding a terminal diagnosis or death and shed light on constructive ways forward toward a practice of holistic care that includes chaplains as full members of the care team.
CHAPTER THREE

An Analysis of Authority Issues Encountered by Christian Chaplains in Secular Medical Institutions: A Qualitative Approach

In matters of truth and justice, there is no difference between large and small problems, for issues concerning the treatment of people are all the same. -- Albert Einstein

Purpose Statement

Albert Einstein’s thoughts reveal that when challenges, large or small, affect how people are treated, then truth and justice should be pursued. I agree. The purpose of this chapter is to learn about some possible truths regarding the current climate of hospital chaplaincy for Christian chaplains. Therefore, in search of some possible “truths,” a confidential questionnaire was created to accomplish this goal. This questionnaire has a three-fold purpose. The first purpose is to obtain information directly from seven Christian chaplains, all of whom, have extensive experience as chaplains and would be knowledgeable, about the current climate of hospital chaplaincy. The information they provide serves as a valuable source in ascertaining the themes that emerge, which can be used for theological reflection and learning. The second purpose is to address several specific questions concerning challenges to chaplains’ authority, such as the following: If Christian chaplains experience challenges to their authority in secular medical institutions, then what are some of the probable causes that create these challenges? How do these challenges affect the identity and ministry of the chaplain? What will be some potential consequences for chaplains and medical institutions if these problem persist? What does the data say about the current relationship between Christian chaplains, their medical
colleagues, and secular medical institutions? What are some constructive suggestions that can be used to help alleviate these types of challenges?

As a result of analyzing the data, I will show how the outcome serves as evidence-based research that supports my claim that Christian chaplains experience challenges to their authority. The consequences of these challenges matter for providing holistic care. Therefore, I will use the information from my analysis to explore some of the emerging themes that can serve as a resource in order to offer some possible answers for the aforementioned questions. Additionally, the hope is that all of the information discovered from the analysis of this data will function as a pedagogical resource to help other members of the interdisciplinary care team understand and respect the role, responsibility, and authority of chaplains.

**Executive Summary of the Data**

The data from the questionnaire confirms that there are various reasons that Christian chaplains experience challenges to their authority. These challenges can be categorized as both internal and external. The external challenges come from hospital administration (policy), physicians, nurses, and social workers (and in one reported instance from the patient). The internal challenges are more directly related to the way in which a pastoral experience affects how the chaplain views his or her identity as a figure of authority in this setting. Additionally, the data demonstrates that chaplains encounter explicit challenges that border on the dismissive to implicit challenges to their authority, which appear to be unintentional. In response to explicit challenges that some chaplains’ experienced, one can conclude that more specific education is needed to help chaplains and physicians learn how to build a mutually respectful working relationship. Based on the implicit responses, it can be inferred that sometimes physicians and other members of the interdisciplinary care team may be unaware of how their actions can affect
the chaplains. This is an important finding because it indicates that not all of the challenges that the chaplains experience to their authority is intentional or personally related. Therefore, chaplains should recognize that the highly-charged context of many hospitals, and the nature of the work that requires physicians and other medical personnel to think rapidly, could possibly be some contributing factors that unintentionally hinder members of the medical team from being able to recognize, communicate, and understand that chaplains are spiritual figures of authority who have a vital role in providing holistic care for the patients. In this manner, chaplains could use this information to learn that the challenges to their authority that they experience are not always directed at them personally. Rather, such challenges as these can be regarded as a type of reality of what chaplains may be encounter in hospital settings.

Moreover, there were several responses that suggested that a representative from the Department of Pastoral Care should be an integral member of the team who helps establish the policies that affect patient care, which includes the institution’s concept of the medical model. The need for additional education was a common response from the majority of the participants. The data supports two distinct ideas that can be accomplished through education. First, there is a greater need for more specific training to assist the medical staff and chaplains to work together. Second, there is a greater need for education that affirms the religious and spiritual identity of chaplains. Lastly, it should at least be noted that the data clearly indicates that despite the challenges that Christian chaplains experience to their authority, they remain committed to and passionate about serving the needs of the sick and suffering.

**Methodology: (Data Collection)**

This questionnaire is qualitative; therefore, it is important to mention that due to the limitation set upon this thesis, although the sample group is quantitatively small, the qualitative
aspects of the data are reliable. Guidelines were set to construct descriptive and open-ended questions for the seven participants from which an inference could be made about the wider population. To ensure the reliability of the data, the participants were asked to respond to the same five questions: one question regarding their demographics (race, gender, age, etc.,) and four open-ended questions. The method employed to collect this data was achieved by creating an on-line version with Dropbox.¹

The questionnaire was developed by me and carried out from January 1, 2015 through February 7, 2015, and involved several meticulously laid out steps. Electronic mail including a personal cover letter that introduced the researcher, as well as the purpose of the questionnaire were sent to the following: the Directors and Assistant Directors of Pastoral/Spiritual Care at Duke University Medical Center (DUMC), University of Chapel Hill (UNC), Wake Medical Hospitals (Raleigh), and the Veterans Administration (VA) Hospital, in Durham, to post and to announce in their department meetings. As a result of this letter, nine chaplains responded to me by email within the time frame stipulated in the letter. I responded to each of the potential participants and sent a cover letter by email to introduce myself and the purpose of my thesis. From the nine initial respondents, eight chaplains actually committed to completing the survey, but I finally received only seven completed questionnaires due to the technical challenges encountered by one participant. All of the chaplains consented to participate via email and were sent a link with the instructions on how to complete the questionnaire using Dropbox. Next, each chaplain was asked to email their completed questionnaire to me within two weeks from the original date it was received. Lastly, as I received each response, each chaplain was assigned a number from 1-7. These steps helped to maintain the confidentiality that was mutually agreed

¹ Dropbox is a virtual on-line resource that allows files to be shared between two or more people.
upon by the researcher and the participants. All of the respondents received their CPE training and worked at or are currently working at Duke University Medical Center (DUMC); Wake Medical Hospitals (Wake Med); Wake Forest University; Hartford Hospital, Hartford Connecticut; Mary Washington Hospital, a private Hospice facility in North Carolina; and one person who is in private practice in North Carolina.

**Cumulative Demographic Information**

In total there were seven Chaplains, two males, and five females. They have 28.5 years of cumulative experience in hospital chaplaincy (this does not include their years of volunteer service as a chaplain through their church’s ministry for the sick). Two of the chaplains have less than five years of experience each; three have two to five years of experience; and the final two chaplains each have five or more years of experience. Five of the seven chaplains are ordained and one is in the final process of ordination in the UMC (The other chaplain is not seeking ordination at this time.) The chaplains are affiliated with five denominations: American Baptist, Baptist, United Holiness Church, Presbyterian (PCUSA), and Protestant (Non-denomination). The chaplains range in age from twenty-seven to fifty-nine years old. They self-identified by race/nationality as Caucasian, Native-American, Hispanic, Peruvian, African-American and “mixed.” In regards to their education, all of the chaplains hold a Master of Divinity degree or above, and one has a license to practice clinical counseling in the state of North Carolina.

**Limitations of the Questionnaire**

This thesis, like others, has limitations. One important limitation is the number of chaplains (seven) who responded to the questionnaire. The number selected is particularly due to the size limitation of the thesis itself. However, as previously noted the seven chaplains represent
a demographically diverse group. Therefore, I conclude that the data ascertained from this examination can be beneficial when read and considered as a pedagogical resource by Christian chaplains and all persons who care about the ministry of pastoral care.

**Structure of Analysis**

The responses from the questionnaire have been divided into three sections. The first section examines the participants’ responses to questions two and three to determine how pastoral identity, confidence, years of experience in ministry, gender, and age may or may not be variables that affect the chaplain’s authority, pastoral identity, ministry to the sick, and the relationship with their medical colleagues. Through my analysis of the data of section one, I will examine some of the correlations between the years of experience in ministry, as well as age and gender, to the chaplain’s strength of pastoral identity and perceptions of challenges to pastoral authority.

The second section examines the participants’ responses to question four to determine if there is a correlation among the chaplains, their medical colleagues, and the secular medical institution that makes possible the conditions for these types of challenges to occur. Furthermore, I will analyze the question as to whether the perceived ambiguity of the role and the responsibility of chaplains may or may not directly or indirectly affect the acceptance of them as a figure of authority within the institution and with their medical colleagues. The third section examines the participants’ responses to question five to offer these chaplains’ recommendations for constructive resources that could be implemented into CPE programs to help alleviate some of the challenges that Christian chaplains encounter to their authority. One of the purposes of this resource is to provide the chaplain’s medical colleagues with an opportunity to learn about, acknowledge, and respect the authority of the chaplain as an integral member of the patient’s
interdisciplinary care team. Lastly, a full verbatim account of the participants’ responses may be found in the appendix of this thesis.

**Data Analysis**

The analysis has been divided into three sections to focus upon some emerging themes from the data. A first goal of the data is to answer the question of whether challenges to authority is a problem that chaplains do in fact encounter. A second task is to analyze the data in order to discover what might be needed to move hospital chaplaincy toward an authentic medical model of holistic care, which acknowledges that both chaplains and the medical staff are distinct figures of authority in their respective fields. The larger goal is to affirm the recognition that these two figures of authority share a goal that should enable them to be able to collaborate responsibly and respectfully in order to offer optimum holistic care for the whole being of their patients that includes their mind, body, and spirit.

**Section 1: Analysis of Survey Questions 2 and 3**

Questions 2 and 3 read as following:

2. *Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.*

3. *In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)*

The intent of these survey questions is to identify and analyze some of the probable causes that contribute to why chaplains experience challenges to their authority and what happens to the chaplain and their ministry as a result of these experiences.
The data uncovers a number of the probable causes that contribute to the challenges that these chaplains experienced. In response to question two, Participants 1, 4, 5, and 7 reported experiencing challenges to their authority that resulted from their encounters with physicians and nurses. In contrast, Participants 2 and 3 reported challenges to their authority that derived from their own internal questions about their authority. First, it is confirmed that chaplains experience various types of challenges to their authority. A common source of the challenges comes from the physicians and other members of the medical team. Moreover, as noted by Participants 1 and 7, when a chaplain’s authority is questioned or disregarded, it often reflects feelings of being disrespected. These types of challenges can be categorized as “external” because they are a direct result of someone else’s actions. Hence, the data demonstrates that the external challenges that chaplain’s experiences to their authority are distinct. The survey also confirms that chaplains not only encounter external challenges to their authority directly from physicians and nurses, but their pastoral identity and authority are also challenged by the patients and hospital administration.\footnote{This type of challenge can pose a greater problem for chaplains because the hospital administration sets and governs the policies and procedures for the Department of Pastoral Care, and the chaplains that they hire. Recognizing that the survey confirms the experience of a chaplain’s authority challenged by hospital administration (and its’ policy) leads me to argue for the need for educational training at all levels within the hospital’s hierarchy model.}

Moreover, challenges from the hospital administration points to a larger cultural paradigm shift—something which Participant 7 indicates. Namely, it points to the paradigm shift that has occurred within the last five decades, in which there is more suspicion about religious

\footnote{2. See in the Appendix the response from Participant 3.}
leaders. Such a growing suspicion leads to the decline of chaplains as being viewed as spiritual figures of authority. This confirms the finding of missiologist Lesslie Newbigin when he pointed to the growing phenomenon of the suspicion of religious/spiritual authority. Newbigin essentially argues that the “movement of emancipation” and the emergence of the era of New Thought, including the prominence of social sciences, have greatly contributed to the erosion and suspicion of authority over time.³

The survey data also reveals that some of the challenges are related to an experience that directly affected the chaplain’s own perception of his or her authority.⁴ This type of challenge can be categorized as “internal” because it derives from the chaplain’s own sense of authority. Therefore, it is worth asking chaplains to reflect upon what Chaplain Griffin asked after thirty years of service: Do Christian chaplains fully grasp or represent the embodiment of the power of who they are and who/what give them the authority to minister in clinical settings?⁵ Noteworthy is the fact that both male and female chaplains experienced challenges to their authority. Such findings infer that gender does not play a direct role in whether or not these types of challenges will be experienced.⁶ Furthermore, Participant 4 noted that the curt behavior of some medical personnel can be a result of a lack of awareness of the sacredness that the chaplain’s presence

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⁴ See in the Appendix the comments of Participants 2 and 5, whose experiences appear to have contrasting effects on their pastoral authority.

⁵ Refer to: Jerry Griffin, “The Integrity of Authority and Identity, “Chaplaincy Today: Journal of the Association of Professional Chaplains 26.2 (Autumn/Winter 2010): 36 (cited in chapter one, on page three). His reflections are important to consider here because they teach chaplains that they should recognize the significance of whom and what gives them their authority to minister in the secular medical institution.

⁶ I was somewhat surprised to learn this because it could be assumed (based on my knowledge of societal norms and the perceived acceptance of a male being the role model for a chaplain) that males might not experience as many challenges to their authority as their female colleagues.
and ministry means to the patients. This incident teaches that it is possible that not all challenges that the chaplains experience should necessarily be viewed as being intentional, or a result of an uncooperative attitude of the acceptance of the chaplain’s authority.

A final observation is that the research of pediatric chaplains Cage, Calle, and Dillinger and the responses from Participants 1, 2, and 7 support the claim that sometimes medical staff can view the care that a chaplain has to offer to the patients as a type of ancillary service (or “as needed” and “replaceable entities” as reported by Participants 2 and 7, respectively). A recent article titled “Neosecularization and Craft Versus Professional Religious Authority in a Nonreligious Organization” highlights the responses from a Director of Chaplain Services and a former nurse. This article cited a “case study of a state university hospital that attempted to create a more ‘holistic’ corporate culture.” In regards to the perception of how chaplains are viewed in state hospitals, the Director of Chaplain Services states, “If it came down to us and the guys who change the light bulbs, you know administration would let us go.” Conversely, the former nurse was quoted as saying, “The other chaplains may not want to admit this, but nurses can do many of the same things they do.” The sentiments expressed in these quotes should be taken seriously by all persons who care about the future of hospital chaplaincy.


9. Ibid.

Furthermore, it is evident that a lot of the work (if not the majority of it) done in hospitals is evaluated by quantitative standards such as the number of patients seen, the number of patients successfully discharged, efficiency of criteria such as waiting times, and the number of grants/funding received. Often, the value or worth of those who meet or exceed the standards set by this type of quantitative evaluation are recognized. Larry VandeCreek’s research examines some recent studies that demonstrate the emphasis placed on quantitative work done in hospitals:

Hospital chaplains lack the professional security that many other health care disciplines enjoy. Their job descriptions are relatively vague when compared to their more technologically-based colleagues. The procedures that effective pastoral care requires in particular instance often are less specific, and generate less easily measurable results than many medical and surgical procedures.¹¹

On the other hand, the spiritual ministry that chaplains offer is not quantifiable in the same way since it consists in acts of spiritual care like being present, offering prayer, and performing religious and non-religious rituals such as the blessings of hands for their colleagues. This type of work is more difficult to recognize or assess on a quantitative scale. Hence, as reported in the majority of the responses, the value of the chaplain’s contribution is sometimes not seen or understood as a vital aspect needed for the well-being of the patient. Yet, a study on how patients understand and appreciate the chaplain as a person of spiritual authority and value supports the significance for patients to have a holistic care team available to them. The research conducted by Eliis, McManus, and Newton states, “Most patients reported positive attitudes towards hospital chaplains; they felt chaplains were an important part to the team of caregivers, who were particularly trained to listen, whose job principally concerned patients’ religious needs,

and who were not merely counselors.”

Therefore, there is a greater need for education and training between the medical staff and hospital chaplains to help them learn about the roles and responsibilities of the hospital chaplain. And education will be a means toward implementing a working model of holistic care.

One additional probable cause that could be attributed to why chaplains experience challenges to their authority could be related to race. Although Participant 7 did not directly indicate that race was an actual cause of the challenge experienced, there is a clear correlation. The relationship made between the challenge the chaplain experienced and race are inferred in the staff and the patient’s “surprise” to see a Hispanic chaplain.

We now turn to an examination of Question 3. This question was proposed to learn “what” the effect these challenges have on the chaplain and their ministry. Thus, another salient reason for purposing this question was to examine how these challenges to chaplains’ authority impact their identity and perspective of their own pastoral authority.

The responses to this question tend to fluctuate due to the number of years of experience, the gender of the chaplain, level of confidence of the chaplain, age, and the pastoral identity of the chaplain (and in one case the different medical setting of Participant 4). The chaplains with the greatest years of experience did not appear to let the challenges that they experienced adversely affect their confidence. Particularity, Participants 1, 4, and 5 demonstrate a positive understanding of their authority, and Participants 1 and 4 did not have a problem with directly addressing the physician and nurse who were the perceived “cause” of the problem. Such findings suggest that if chaplains have a positive view of their authority, then they will most...


13. For the verbatim account of Participant 7. see the Appendix.
likely understand that they are also a figure of authority that is called to meet the important 
spiritual needs of the patients. In addition, then, one can infer that the number of years of 
experience is an important factor to chaplain’s understandings of their authority.

Another interesting observation is that Participants 2 and 3 reported that their 
experiences affected them negatively because it challenged their vocational call, authority, and 
pastoral identity as being an “effective” chaplain. This of course impacted how they ministered 
in these contexts. Participant 2 “pulled away” from ministering to a family after the death of their 
son because of feelings of inadequacy. Therefore, it is important to reiterate here why it is 
essential for Christian chaplains to identify, acknowledge, affirm, and accept that they have been 
bestowed (by the nature of their vocational call) with an authority by God to minister in secular 
medical institutions, irrespective of the experiences they find that may challenge their authority.
Thus, this sheds light upon why Rosenberger’s question-- “Wherein derives your authority?” -- is imperative for chaplains to consider. As Rosenberger suggests, “Until we answer this question 
among ourselves—Who are we to speak about matters of eternal destiny? [As those with God-
given authority]—we will be consigned to the margins and relegated to ineffectuality.” One can 
see from the chaplains’ responses that their commitment to pastoral care plays a significant role 
for the patients, their families, and the staff in providing holistic care.

Although Participant 3 was also negatively impacted by the experience, the supervisors, 
and subsequently the hospital administration’s decision to implement a change concerning how 
chaplains can pray (based on their faith tradition) presented further challenges. Also, the data

14. Dale Rosenberger, Who Are You to Say: Establishing Pastoral Authority in Matters of Faith 
(Grand Rapids, MI: Brazos Press, 2005), 14.

15. Ibid.
shows that Participants 1, 4, 5, and 7, were positively impacted by their experiences. In particular, Participants 1 and 5 reported that their experiences with physicians had a positive effect on their ministries. These participants viewed their experiences as positive because when they used their training to deescalate situations, they helped the physicians and nurses to recognize that chaplains, too, have authority. Thus, chaplains are equally important members of medical teams, and they are responsible for providing holistic care for the patients. Additionally, Participants 4 and 7 reported that their experiences had positive impact on their ministries. Participant 4 noted that the experience did not adversely impact the care offered to the patients, and the challenge helped bolster this chaplain’s confidence. Likewise, Participant 7 was inspired by the challenge, which caused the chaplain to become more conscious, through reading, about the unique relationship between faith and medicine. One common reason that can be identified in their responses is that their challenging experiences (interestingly) gave them a sense of confidence in their pastoral authority. Likewise, Participant 5 has a healthy attitude of authority. Hence, because Participant 5 believes that the chaplain is a figure of authority, this will help others to accept his or her authority as well. Moreover, based on their responses their positive view of their authority can be attributed to the chaplain’s gender (two were males), willingness, vocational professionalism, and compassion for those they care for, which allowed them to deescalate the situation.

One important common theme found in all of the responses demonstrates that although all of the chaplains experienced some type of challenge to their authority that directly or indirectly involved their medical colleagues and the decisions of hospital administration, all of the chaplains were committed to providing compassionate pastoral care to their patients and families in their time of need. It is apparent from the participants’ responses that a lack of
awareness, lack of sensitivity, impolite attitudes, (whether intentionally or unintentionally demonstrated), lack of understanding who the chaplain is, that come from both external and internal sources are some of the probable causes to challenges to authority that these chaplains experienced. Furthermore, the responses generated from Question 3 establishes that there is a notable impact (sometimes positive and sometimes negative) on the chaplain and his or her ministry when they experience these types of challenges to their authority. Next, we will examine the responses from question four to determine if the chaplains believe the challenges are more institutionally or personally related (or both).

**Section 2: Analysis of Survey Question 4**

Question 4 on the survey reads as follows:

4. *What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?*

Here we will examine some of the contributing factors that challenge the chaplain’s authority in order to determine if the participants identify these types of challenges as more institutionally or personally related. Based on the responses of participants there are a number of factors that contribute to the challenges to their authority that they experience. The most obvious was the challenges that they received from the physicians, nurses, and in one instance the social workers. However, it is important to acknowledge that Participant 2 (according to his or her experiences in the field of mental illness) attributes this level of disrespect to the chaplain’s authority to the larger view that “[s]ocial workers believe they have a deeper knowledge of the ‘ins’ and ‘outs’ of human needs in response to social needs and behaviors.” Furthermore, Participant 2 adds, “Nurses believe they have a deeper understanding of the overall needs of the patients due to their training
in regards to the human body. Yet, Participant 2 reported that chaplains understand the spiritual needs of the patients, and therefore, the spiritual aspect of the human soul can only be discerned by those who have been called to be spiritual present with the brokenhearted, and lost. To institutions such as medical hospitals chaplains are deemed to be replaceable entities. Additionally, according to Participants 2 understanding and faith belief, “the spiritual aspects of the human being weigh far greater than the physical aspect which is temporal.”

Furthermore, responses provided by Participants 1, 2, 3, 4, and 7 indicate that there is a clear misunderstanding about the importance of the role chaplains play in the holistic model of patient care. Similarly, Participant 3 identifies this lack of awareness of the role and function of the chaplain as a spiritual figure of authority to a “devaluation of religious worship and belief to the merely instrumental.”

This is important to note because the other members of the interdisciplinary care team must recognize and acknowledge that chaplains are spiritual figures of authority whose presence offers a vital contribution towards holistic care. Based on a study done by Ellis, McManus, and Newton, their evidence supports that the chaplain’s contribution of spiritual care as being a significant component of a holistic care model. For instance, Ellis, McManus, and Newton write,

> Hospitals provide not only medical care but also pastoral care within the broadest meanings of that term. Hospital chaplains provide an important and sometimes neglected aspect of such care. The quality of care provided by hospitals cannot be assessed only in terms of strictly medical outcomes; as complex social institutions they provide care in many ways, one which is through consideration of the spiritual as well as the temporal needs of their patients.

Moreover, VandeCreek cites a 2008 study that reveals that a majority of the patients who participated in this study responded overwhelmingly that they appreciated the spiritual presence

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16. For a verbatim account of Participant 2’s response to this question, reference the Appendix section of this thesis.

17. For a verbatim account of Participant 3’s response to this question, reference the Appendix section of this thesis.

and comfort that chaplains offer through pastoral care. Throughout my experiences as a chaplain, my colleagues and I have discussed on numerous occasions how many of our patients (and their families) have expressed their appreciation for our presence and compassion as we provided spiritual and pastoral care. Furthermore, during both my internship and residency, both patients and their families expressed these positive sentiments in their letters of appreciation that they sent directly to the Department of Pastoral Care. Research and personal experiences such as these support the idea that chaplains should be recognized as a vital part of the interdisciplinary care team who help to provide an exemplary model of holistic care.

Another contributing factor that the data overwhelming supports is that physicians are identified as the ultimate persons of authority as it relates to patient care. This idea of sole authority can make it difficult for physicians to consider the concept of shared authority—especially when it concerns understanding the authority of another who cares for the patient in a non-physical manner. This can specifically be seen in the responses from participants 1, 4, 5 and 7. This highlights the need to advocate for acknowledging, affirming, and accepting that spiritual care is an essential component of holistic care. And chaplains are figures of authority who can offer this unique kind of spiritual care. Furthermore, what could be lost if these types of challenges prevail is that patients and staff could miss out on the opportunity to experience a true working model of holistic care that considers their whole being: mind, body, and spirit.

On possible outlier to viewing these challenges as coming primarily from medical practitioners can be seen in the experience of Participant 5. This participant is not surprised by the challenges, and therefore does not appear to identify a sole contributing factor as a probable...

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cause for these types of challenges. Rather, Participant 5 says, “Challenges are to be expected when religion or spirituality, i.e. Christian or any other faith, is intermingled with secular institutions. Possibly these challenges will always exist and may never be overcome.”20 “The mere combination of opposites is a contributing factor.”21 In fact, this affirms a general suspicion that exists between the worlds of religion and medicine. For example, Holst says the worlds of religion and medicine are two distinct domains. However, the chaplain has to learn the culture, and understand how each of these worlds operates dependently with and independently of each other in order to function effectively in both worlds.22 Hence, in the ‘inbetwix’ place the chaplain is a figure of authority that offers valid contributions, such as presence, listening skills, counseling, support, rituals, and prayer to both the world of religion and medicine.

A final contributing factor that reoccurs may be seen in the experiences of Participants 1 and 4. These participants specifically identify the current medical model (based on the experiences at their hospitals) as a contributing factor to the challenges they experience to their authority. In particular, Participant 1 explains, “I believe that the medical model is designed to diagnose and treat a narrow aspect of the person’s needs: the psychological need to exist in the face of system dysfunction. Other aspects of patient needs such as emotional, spiritual and relational are not well recognized in the medical model.”23 Furthermore, Participant 4’s response affirms that there is a problem with the current medical model that contributes to the challenges that chaplain’s

20. For a verbatim account of Participant 5’s response to this question, reference the Appendix section of this thesis.

21. Ibid.


23. For a verbatim account of Participant 1’s response to this question, reference the Appendix section of this thesis.
experience. Participant 4 explains, “The medical model for patient care focuses on the physical aspect of pt care. It does not leave much (if any) for the spiritual aspect of pt care. I believe this challenge is related to the medical institution and is not ‘personal.’ If spiritual healing or improvement could be measured analytically, and a proven link could be made between spiritual well being and spiritual healing/health, then I believe the medical institution would make more room for spiritual care in its model. Because spirituality’s benefit is subjective to a great degree, I believe it remains an afterthought to most medical models.”

These perceptions also explain why the participants’ believe that the challenges they experience to their authority are both institutionally and personally related. For those who report that the challenges they experience are more related to the institution, they indicate that there are problems with the current medical model of patient care. Furthermore, these participants propose education as a means to help change the medical model so that it supports spiritual care. Also, Participant 4 supports the important need for change for the current medical model and specifically suggests that the current medical model “needs to make room for spiritual care.”

Further analysis from the data indicates that three of the participants (1, 3, and 5) understand that this problem is both institutionally and personally related. Participant 1 sheds light upon how the challenges are perceived to be personally related by examining how power and the fear of death have a role in personal accountability and the idea of authority. Participant 1 explains that because death is seen as a failure on the part of medicine (particularly by physicians), it can also be linked to the fear of medical liability issues. Hence, according to

24. For a verbatim account of Participant 4’s response to this question, reference the Appendix section of this thesis.

25. For a verbatim account of Participant 4’s response to this question, reference the Appendix section of this thesis.
Participant 1, the physician (and other members of the patients medical team) feel the need as figures of authority to “focus on preserving life at all costs.”

As we have already seen in chapter two, this idea that physicians are consistently faced with the fear of death and liability issues is supported by the research of Dr. Mohrmann.

Alternatively, the reason that participants 1, 3, and 5, also believe that they are personally related is primarily due to a lack of awareness or education of their peers. Unfortunately, if hospitals do not provide the medical staff with some opportunities to attend educational classes, (regarding the role and authority of chaplains) then the medical model’s integration of holistic care will be inadequate. Furthermore, scholars’ research supports the finding that chaplains are sometimes frustrated by both the institutionally and personally related challenges that they experience because they are not perceived as skilled, highly-qualified figures of authority by the institution and their medical colleagues. For example, the work of Barger et. al. states,

Chaplains expect to be involved in continuing education of some sort, keeping up to date in their competencies. This professional orientation helps to explain certain recurrent frustrations reported by chaplains. They are impatient with ‘institutionalism’ and in the area of role relationships, as a member of the health care team, they find confusions by others regarding the competency areas of the chaplain and the narrow conception others have of the chaplain’s role puzzling and a source of a need for interpreting (the) role of others.

Hence, education appears to be a reoccurring theme that can help alleviate the challenges (and frustrations) that chaplains experience to their authority. Therefore, the need for more

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26. For a verbatim account of Participant 1’s response to this question, reference the Appendix section of this thesis.

27. To reference this information see chapter two, page 9, and: Margaret E. Mohrmann, Medicine as Ministry: Reflections on Suffering, Ethics, and Hope (Cleveland, Ohio: The Pilgrim Press, 1995), 17.

specifically focused educational opportunities to address this issue is examined in the next section.

**Section 3: Analysis of Survey Question 5**

Question 5 of the survey reads as the following:

5. *What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.*

“Change is the end result of all true learning.”⁴⁹ I agree with the late Professor Buscaglia perception on true learning—change (positive) is the end or the desired result. Therefore, the intent of this section is to report and analyze the constructive recommendations that the participants of the survey proposed that can be implemented into CPE and hospital training problems. All of the participants with the exception of Participant 4 stated that more specific training such as educational training offered by chaplains that focus on the importance of spiritual care could be implemented into CPE programs to enhance a better understanding, appreciation, and acceptance of the role and responsibility of the hospital chaplain. The participants make clear their belief that education and training can foster a more cohesive opportunity for effective communication between all personnel who are called to serve the physical, emotional, and spiritual needs of the patients and their families to reflect a true model of holistic care.

Although the participants’ responses provide valuable insight based on their individual experiences, there are many similar recommendations. First, several of the participants: (1, 2, and 7), noted that the allowance of the chaplain’s participation in the medical and social rounds of

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their patients would be immensely helpful. This would enable the chaplains to not only learn more about the spiritual needs of their patients and families, but it would also be a means where the chaplains could become more visible and personally known by their colleagues. When chaplains attend medical and social rounds, it provides for a fuller and deeper knowledge and understanding of patient and family information and needs. However, rounding also provides some opportunities for chaplain-physician (and other medical colleagues) relationship to be developed. In my own experience, as a result of our presence during medical rounds, my co-chaplain and I extended an invitation to lunch for one of the Pediatric Oncologist on our unit, and he accepted. This opportunity developed our relationship with the physician and fostered the mutual respect we learned to have for each other as vital figures of authority that constitute the holistic care team. Indeed, Participant 2’s response supports this experience when Participant 2 states that “rounding with the medical team (doctors and nurses on a daily basis)…would give some credence to our presence and acceptance by the team, patient, and their family members.”

Another recurring theme is the request for the documentation of the spiritual and emotional needs in the medical records by the physicians, nurses, and social workers. Participant 1 believes that this would help the chaplains and serve as an acknowledgement “that the patient is a person whose spiritual, relational, and emotional well-being are equally important vital signs.” Participant 4 recommends that the medical model itself has to change. Participant 4 now serves as a Hospice Chaplain and explains how the medical model of hospice care is a collaborative effort of the spiritual, psychological, and physical care team to provide exemplary

30. For a verbatim account of Participant 2’s response to this question, reference the Appendix section of this thesis.

31. For a verbatim account of Participant 1’s response to this question, reference the Appendix section of this thesis.
holistic care for their patients. What Participant 4 experiences in hospice care is evidence that the medical model in secular hospitals can successfully use educational opportunities (such as those recommended by all of the participants) to move toward a more real and practiced model of holistic care. An additional recommendation from Participant 6 focuses on the Department of Pastroal Services to be held responsible to create educational opportunities on the care units that the chaplains can facilitate. Such educational opportunities will provide the chaplain’s colleagues with an opportunity to better understand the role of the chaplain. Likewise, such educational opportunities would also create a constructive environment where the medical staff can learn why it is essential to understand how important the spiritual care of the patient is in holistic care.

In addition, Participant 3 recommends that there be training for chaplains to help them better understand and value their spiritual authority and faith tradition. Hence, this type of learning opportunity will be beneficial for chaplains because it can help teach them that their pastoral identity does not need to be compromised in their attempts to offer care to people of different (or no faith tradition). Moreover, Participant 7’s educational recommendation focuses specifically on the need for CPE programs to be more intentional about integrating more biblical studies (Theology and Sacred Texts) and some psychology for a wider understanding and valuing of the whole person—mind, body, and spirit.

One last observation comes from Participant 5. This participant’s response supports the claim that it is essential that Christian chaplain’s recognize themselves as important members of the interdisciplinary care team. It supports the view of Chaplains as equally important members of the care team who work toward a medical model that understands that they are valid figures of authority who make spiritual contributions toward offering holistic care specifically by

32. For a verbatim account of Participant 5’s response to this question, reference the Appendix section of this thesis.
supporting the patient’s request for spiritual care. Furthermore, Participant 5 also highlights the need for Christian chaplains to recognize and accept that their ultimate authority comes from God and to embrace their call to the unique ministry of pastoral care. I propose that when Christian chaplains know and accept who they are and whose they are—Sons and Daughters of the Most High God—then they should not let the opinions of others define them or shape their ministry. Christian authority comes God, and it radiates out of a center of truth, love, and an obedience to God.\(^{33}\) Hence, Participant 5 explains, when Christian chaplains recognize their own God-given authority, then many of the challenges they experience to their authority will not have a lasting negative impact for them as a professional and minister called by God to the unique ministry of pastoral care. Therefore, it is my hope that the recommendations proposed in this chapter, be carefully considered by hospitals, chaplains, medical staff, and all members of the patient interdisciplinary care team to move toward an improved model of holistic care.

**Conclusion**

**Purpose Statement**

The primary purpose for examining the challenges that Christian chaplains encounter to their authority in secular medical institutions is to investigate some of the probable causes. Moreover, a secondary purpose of this examination is to look at what will be the consequences for chaplains, the medical institution, and most importantly the quality of holistic patient care that will or will not be offered if this problem continues. Lastly the purpose of this examination is to advocate for and to establish some constructive suggestions that can be implemented into CPE programs. The suggestions are to serve as educational opportunities that will help the

\(^{33}\) For a full definition and explanation of “Christian authority,” and why it is important for chaplains to acknowledge, understand, affirm, and except that their authority comes from God, refer to chapter one pages 11-15.
medical care team move toward reflections and conversations that can help them learn how to accept the chaplain as a vital figure of authority whose contributions of spiritual care is essential to a model of holistic care. In doing so, this will enable chaplains to walk competently and effectively between the worlds of religion and medicine (the sacred and the secular) while understanding that they are a valuable contributing presence in the institution.

**Concluding Statements**

The recounting of an anecdote from one of the Christian chaplains who responded to the questionnaire helps to demonstrate the current climate of the challenges that a Christian chaplain experiences in secular medical institutions. The anecdote reads,

As a chaplain resident, the wife of a patient in intensive care invited me into the room for prayer. Moments later, the ICU attending entered and curtly dismissed me from the room. Later, I confronted the attending respectfully and assertively to suggest that a collegial approach would have been more appropriate. He was clearly offended by my coaching him and attempted to 'put me in my place.' By resisting his invitation to react angrily, the situation was deescalated and he was able to hear my standpoint. In essence, I stated that as the patient lay dying and his wife grieving, spiritual and emotional interventions with the family were at least as important as the medical interventions which were diminishing in effectiveness.” In this instance, the chaplain made a valiant attempt to help the physician acknowledge and respect the patient’s wife (and presumably the patient too), not only valued and needed the physical care being offered by the medical team, but they were also in need of and requested and invitation to the chaplain to provide spiritual care as well. Hence, the chaplain’s interventions represent a move toward a more holistic view of caring for the whole patient—mind, body, and soul.

Throughout the history of CPE, it is clear that hospital chaplains continue to encounter challenges to their authority. Furthermore, one can see how challenging (albeit rewarding) the ministry of CPE can be. Therefore, in light of the examination of the survey results, several contributing factors that challenge the authority of Christian chaplains can be observed: a lack of educational opportunities for chaplains, physicians and other hospital personnel to learn how to recognize and respect one another’s perspective on authority; institutional policies that do not
take into the account the identity, role and authority of chaplains; lack of opportunity to develop deeper personal relationships between the chaplains and medical staff; and introspective thinking by the chaplain on understanding his or her own authority.

More specifically, how Christian chaplains perceive and understand their own pastoral identity and authority impacts how others perceive their authority, and in some cases it impacts the care they offer. This conclusion is supported by other studies and secondary sources on this topic, as discussed in chapter three. Therefore, it is imperative to reiterate that Christian chaplains must participate in the practice of introspective reflection to help them understand the nature of their authority, and that their ultimate authority comes from God.

Although the data in this examination identifies that a lack of specific training and educational opportunities for chaplains and physicians is some of the probable causes that contribute to this problem, this examination also sets forth (in chapter three) some constructive suggestions. In addition, I have argued that a more intentional effort must be made to offer chaplains the opportunity to become more visible figures of authority in the medical model of interdisciplinary care. Furthermore, one specific contributing factor identified as a probable cause (which exacerbates the problem for chaplains) is that sometimes institutional policies do not take into the account the identity, role and authority of chaplains and, thus, fail to provide opportunities to develop more insightful interpersonal relationships between the chaplains and medical staff. As noted throughout this examination, and specifically by the data analyzed in chapter three, the challenges that Christian chaplains experience to their authority is both institutionally and personally related. As suggested by the majority of the participants in this study, alleviation of this problem will require education, training, and a collaborative effort from

34. Once again, the results from the data outlined in chapter three offer some practical suggestions on how this task can be accomplished.
the chaplains and their medical colleagues to understand and respect each other’s role as a vital part of the interdisciplinary care team.

Thus, I conclude that even though the challenges exist and are problematic at times, Christian chaplains must recognize that they have been called to a unique vocation. It is a vocation that has a high calling that requires Christian chaplains to bear witness to Jesus’ compassionate ministry for the sick to care for all of those in need. Moreover, this unique vocation calls for Christian chaplains to bear witness to Jesus’ compassionate ministry to the sick and suffering, care for the spiritual needs of people, and to observe, listen to, and be with the voices of suffering inside the corridors of secular medical institutions, irrespective of the objections to their authority that they may encounter. Ernest Bruder, a Director of Pastoral Care, shares the same sentiments about the unique calling of the hospital chaplain: “What we need above all else is someone sensitive to the hidden, often complex deeper needs of troubled people [the sick and suffering], and theologically trained to understand them.”

Therefore, more intentional efforts need to be explored to create specific educational opportunities for physicians and nurses to learn about the unique vocation and abilities of chaplains who are theologically trained to meet these spiritual needs to which Bruder alludes. Then education and training will become a means to improving the medical model so that it truly represents a holistic model of care to best serve the physical, emotional, and spiritual needs of the sick and suffering.

Throughout this examination, we have seen that there is a distinct difference between the worlds of religion—in this context, Christianity—and medicine. Consequently, it is likely—if not inevitable—that there will be challenges between the worlds of religion and medicine and, thus, to Christian chaplains. Moreover, it is wise for Christian chaplains to know and understand

that those who minister under the divine authority of God will encounter opposition and challenges to their authority because Divine authority has a different perspective from the world’s authority, or, in this context, the authority of secular medical institutions.

The present study offers some practical resources for Christian chaplains, asking the question, “How can Christian chaplains who minister in secular medical institutions defend their authority in an environment that consists of people and authorities that will challenge and sometimes oppose their authority?” On the basis of this examination, I recommend that Christian chaplains consider six important ideas:

Chaplains should be cognizant and accepting of their God-given authority. It means chaplains must understand the meaning, recognize the differences, and acknowledge the similarities between Christian and secular authority, and learn how they function as chaplains in both the worlds of religion and in the practice of medicine inside secular medical institutions.

Chaplain must understand why it is important to study and learn the invaluable history of pastoral care and CPE. Studying the history of their vocation will help chaplains understand their relationship to hospital ministry and the role and responsibilities of the hospital chaplain. Furthermore, the twenty-first century Christian chaplain can learn from the history of CPE (and many of its pioneers) about how to competently and effectively minister in the secular medical institution irrespective of the challenges he or she may encounter to their authority.

Chaplains need to understand what it means to minister in the middle, between the worlds of religion and medicine in order to be able to walk compassionately and competently with authority between both worlds. This means that chaplains must first understand, accept and affirm that their authority is important, which includes both the sacred and secular authority they have been given. Moreover, this is important because essentially the chaplain is a vital member
of the interdisciplinary care team whose primary responsibility to is respect and care for the spiritual needs of the patients (and any other persons who request their ministry). Doing this will help the chaplain learn that the ministry that they have to offer is not an ancillary service, but it is an essential part of the holistic model of medical institutions that was designed to take into consideration the value and dignity of treating the mind, body, and spirit.

*Chaplains should know and understand the dynamics of power that permeate the culture of secular medical institutions and the chaplain-physician relationship.* They need to understand that challenges are inevitable in this relationship, but can be managed or possibly overcome. Medical institutions are one place where authority and power demonstrates that they have limits. Regardless of how valuable is the superior medical training that physicians and nurses receive or how rapidly we experience the advancement of science and technology, hospitals are places where many people still die. Thus, chaplains’ awareness of their own (and their colleagues’) limitations of secular authority and power in this setting will help chaplains better understand the unique culture and the dynamics of power that can create challenging experiences especially when self-limitations and the limitations of others are acknowledged.

*Chaplains should take an introspective look at their call to ministry and consider secular medical institutions as a kind of mission field awaiting their service and ministry.* In doing so, Christian chaplains will discover that today, through their ministry to the sick, God is, and always will remain, at work in and with them. Hence, no challenges, opposition, or hostile environment can hinder God’s mission to which Christian chaplains, called to the ministry of pastoral care in secular medical institutions, should continue to pursue.
Chaplains need to pray, read, and study the Bible daily, keeping prayer and the Bible as personal companions. Integrating these practices into their ministry will help Christian chaplains manage and potentially overcome any challenges to their authority.

I have woven these six points together to construct a theological and practical paradigm for a resource for Christian chaplains ministering in secular medical institutions. Moreover, the six points are intended to help Christian chaplains understand that their unique vocation affords them the privilege not only to have encounters with the living human document, but also to consider that every opportunity to minister with compassion, and to listen to the voices of suffering is a personal encounter with the Divine. Physicians and other medical personnel are sometimes given a fixed amount of time that they can spend with their patients. This can be attributed to some factors such as: the number of patients that must be seen, federal funding, insurance stipulations, other professional responsibilities, and lack of awareness or training regarding the spiritual needs of patients that preclude the medical staff from spending quality time with the patients. Specifically, the lack of spiritual training or awareness of how to tend to the spiritual needs of the patient is a real concern. Fortunately, this is where the chaplain’s authority on spiritual matters is an essential component of the model of holistic care. Moreover, as this thesis has argued, the chaplain’s spiritual authority encompasses more than being with persons at the end-of-life, or assisting families during their time of bereavement (albeit these tasks are very important in the chaplain’s ministry). The chaplain offers spiritual care “to assure that faith continues to have a prominent place among the healing resources available to all persons.” Hence, the chaplain offers a supportive presence that is able to be with persons as well as attend to their spiritual needs. The diversity of the spiritual needs that chaplains can assist

36. See, for example, the work of Wendy Cage, Katherine Calle, and Jennifer Dillinger, “What Do Chaplains Contribute to Large Academic Hospitals? The Perspectives of Pediatric Physicians and Chaplains,” The Journal of Religion & Health 50 (March 2011): 300.

with includes: spiritual assessments, grief and loss counseling, and crisis intervention. Chaplains also provide the important services of attending to questions related to theodicy and illness, serving as a facilitator to patient’s pastor or congregation, assisting with securing some social needs for the patient’s families, and assisting with completing and explaining power of attorney and Do Not Resuscitate (DNR) documents (in some hospitals). Moreover, chaplains provide specifically spiritual support through prayer, religious rituals (baptism, christening, marriages), and non-religious rituals such as a blessing of the hands ceremony for the staff. These and many others services is why the chaplain should be acknowledged and accepted as a legitimate figure of authority, whose many contributions play a vital role that should not be limited only to bereavement counseling, but recognized for the breadth of support the chaplain provides as a valuable member whose contributions are essential to reflect the model of holistic care.

Through my experiences, I have discovered that intentionally being willing to enter into the vortex of illness with patients and their families to tend to the carousel of emotions that often accompanies illness and suffering is an arduous task; and it requires specific theological training and a calling to this ministry. Christian chaplains have been given both the spiritual and secular authority to help them carry out the ministry of pastoral care, which enables them to listen compassionately to and be present with those for whom they care. Hence, Christian chaplains must accept that they do have authority, and should use it wisely to care for the sick and the suffering. N.T. Wright summarizes this point with this poignant statement: “Jesus went about feeding the hungry, curing the sick, and rescuing lost sheep; his Body is supposed to be doing the same.”

Although Christian chaplains experience challenges and objections to their authority in the mission fields of secular medical institutions that are real and relevant, this present work provides a practical paradigm that can help them to fulfill their calling to this unique ministry.

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Today, Christian chaplains have a mandate to hear the call of their discipleship, and remain faithful and dedicated to continue to provide effective compassionate ministry to the sick, particularly in challenging environments such as secular medical institutions. Lastly, the important question to revisit is “What is at stake, or what are some of the consequences that may occur for chaplains, medical institutions, and the patients if the challenges to their authority continue?” Namely, one is that there will continue to be a misconception that fails to recognize and acknowledge that chaplains offer a needed and valuable contribution towards a genuine model of holistic care. Moreover, if this type of misconception persist then the spiritual care that chaplains have to offer will be diminished to a type of ancillary service. VandeCreek explains, “Hospital chaplains lack the professional security that many other health care disciplines enjoy. Their job descriptions are relatively vague when compared to their more technologically-based colleagues.”³⁹ This perception is one that continues to be an obstacle to acknowledging the authority of the chaplain as an integral member of the interdisciplinary care team. However, this study has provided several suggestions (that focused around creating educational opportunities for chaplains and their medical colleagues) that can serve as tangible means for change that will constructively promote a climate where the chaplains are acknowledged and understood as vital contributors in patient care. Every patient regardless of their religious beliefs is composed of a mind, body, and soul—all of which require distinct care. Thus, it is worth reiterating what the JCAHO mandates, “Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychological, and spiritual values.”⁴⁰ Finally, it


⁴⁰. Larry VandeCreek and Laurel Burton, Professional Chaplaincy: Its Role and Importance In Healthcare, The Journal of Pastoral Care 55, no.1 (Spring 2001): 82. The Joint Commission on the Accreditation of Healthcare Organizations, is an independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States.
bears reiterating as a source of encouragement that irrespective of the challenges that chaplains experience in the secular medical institution, being called to serve the sick and suffering is a rewarding privilege. Chaplains should not forget this.
APPENDIX A:

LETTER TO REV. LIL GALPHIN

Lori Anne Brown
103 Star Flower Court
Apex, NC 27539
January 6, 2015

Rev. Lil Galphin
Wake Med Hospitals
300 New Bern Avenue
Raleigh, NC 27510

Dear Rev. Galphin:

I am a candidate for the doctorate of ministry degree at Duke Divinity School in Durham, North Carolina. I am writing to you because I understand that you are the associate director of pastoral services at Wake Med Hospitals.

One of the requirements for the completion of my degree is to write a thesis. My thesis topic is “an examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution.” The research that I have examined supports my argument that Christian chaplains do experience challenges to their authority in secular medical institutions. Therefore, I am soliciting the help of a total of five Christian chaplains who have recently or are currently working in secular medical institutions to gather further information to support my argument.

To accomplish this, I have created a confidential questionnaire that requires the chaplains to answer five questions. The purpose of this questionnaire is to discover information concerning the nature of the challenges that Christian chaplains are currently experiencing in the secular medical institution. Moreover, I am soliciting the help of Christian chaplains to share with me any possible recommendations that they believe could be implemented into the CPE program to help alleviate some of these challenges.

I would greatly appreciate your sharing this with the chaplains in your department. If any of your chaplains choose to participate in this survey, please inform them that I would need to know by no later than Monday, January 12, 2015. Once I have acquired the suitable number of chaplains needed for this questionnaire, I will send to you and to the participants an email that will include the actual questionnaire as well as any other pertinent information.

Thank you for your time and consideration. Please inform the chaplains who are willing to participate that they can contact me directly at (804) 543-9857, or by email at: lori.a.brown @ duke.edu.

Respectfully,

Lori Anne Brown
APPENDIX B:

LETTER TO REV. KATHERINE HIGGINS

Lori Anne Brown
103 Star Flower Court
Apex, NC 27539
December 20, 2014

Rev. Katherine Higgins
UNC Hospitals
101 Manning Drive
Chapel Hill, NC 27514

Dear Rev. Higgins:

I am a candidate for the doctorate of ministry degree at Duke Divinity School in Durham, North Carolina. I am writing to you because I understand that you are the associate director of pastoral services at UNC Hospitals.

One of the requirements for the completion of my degree is to write a thesis. My thesis topic is “an examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution.” The research that I have examined supports my argument that Christian chaplains do experience challenges to their authority in secular medical institutions. Therefore, I am soliciting the help of a total of five Christian chaplains who have recently or are currently working in secular medical institutions to gather further information to support my argument.

To accomplish this, I have created a confidential questionnaire that requires the chaplains to answer five questions. The purpose of this questionnaire is to discover information concerning the nature of the challenges that Christian chaplains are currently experiencing in the secular medical institution. Moreover, I am soliciting the help of Christian chaplains to share with me any possible recommendations that they believe could be implemented into the CPE program to help alleviate some of these challenges.

I would greatly appreciate your sharing this with the chaplains in your department. If any of your chaplains choose to participate in this survey, please inform them that I would need to know by no later than Monday, December 29, 2014. Once I have acquired the suitable number of chaplains needed for this questionnaire, I will send to you and to the participants an email that will include the actual questionnaire as well as any other pertinent information.

Thank you for your time and consideration. Please inform the chaplains who are willing to participate that they can contact me directly at (804) 543-9857, or by email at: lori.a.brown@duke.edu.

Respectfully,

Lori Anne Brown
APPENDIX C:

LETTER TO REV. DR. JIM RAWLINGS

Lori Anne Brown
103 Star Flower Court
Apex, NC 27539
December 19, 2014

Rev. Dr. Jim Rawlings
Director, Department of Pastoral Care
Duke University Medical Center
2301 Erwin Road
Durham, NC 27710

Dear Rev. Dr. Rawlings:

I am a candidate for the doctorate of ministry degree at Duke Divinity School in Durham, North Carolina. I am writing to you because I understand that you are the director of pastoral services at Duke University Medical Center.

One of the requirements for the completion of my degree is to write a thesis. My thesis topic is “an examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution.” The research that I have examined supports my argument that Christian chaplains do experience challenges to their authority in secular medical institutions. Therefore, I am soliciting the help of a total of five Christian chaplains who have recently or are currently working in secular medical institutions to gather further information to support my argument.

To accomplish this, I have created a confidential questionnaire that requires the chaplains to answer five questions. The purpose of this questionnaire is to discover information concerning the nature of the challenges that Christian chaplains are currently experiencing in the secular medical institution. Moreover, I am soliciting the help of Christian chaplains to share with me any possible recommendations that they believe could be implemented into the CPE program to help alleviate some of these challenges.

I would greatly appreciate your sharing this with the chaplains in your department. If any of your chaplains choose to participate in this survey, please inform them that I would need to know by no later than Monday, December 29, 2014. Once I have acquired the suitable number of chaplains needed for this questionnaire, I will send to you and to the participants an email that will include the actual questionnaire as well as any other pertinent information.
Thank you for your time and consideration. Please inform the chaplains who are willing to participate that they can contact me directly at (804) 543-9857, or by email at: lori.a.brown @ duke.edu.

Respectfully,

Lori Anne Brown

APPENDIX D:

LETTER TO REV. MARION THULBERRY

Lori Anne Brown
103 Star Flower Court
Apex, NC 27539
January 20, 2015

Rev. Marion Thullbery
VA Hospital
508 Fulton St.
Durham, NC 27705

Dear Rev. Thullbery:

I am a candidate for the doctorate of ministry degree at Duke Divinity School in Durham, North Carolina. I am writing to you because I understand that you are director of pastoral services at the Veterans Administration Hospital, in Durham, NC.

One of the requirements for the completion of my degree is to write a thesis. My thesis topic is “an examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution.” The research that I have examined supports my argument that Christian chaplains do experience challenges to their authority in secular medical institutions. Therefore, I am soliciting the help of a total of five Christian chaplains who have recently or are currently working in secular medical institutions to gather further information to support my argument.

To accomplish this, I have created a confidential questionnaire that requires the chaplains to answer five questions. The purpose of this questionnaire is to discover information concerning the nature of the challenges that Christian chaplains are currently experiencing in the secular medical institution. Moreover, I am soliciting the help of Christian chaplains to share with me any possible recommendations that they believe could be implemented into the CPE program to help alleviate some of these challenges.

I would greatly appreciate your sharing this with the chaplains in your department. If any of your chaplains choose to participate in this survey, please inform them that I would need to
know by no later than Friday, January 23, 2015. Once I have acquired the suitable number of chaplains needed for this questionnaire, I will send to the participants an email that will include the actual questionnaire as well as any other pertinent information.

Thank you for your time and consideration. Please inform the chaplains who are willing to participate that they can contact me directly at (804) 543-9857, or by email at: lori.a.brown@duke.edu.

Respectfully,

Rev. Lori Anne Brown
APPENDIX E:

LETTER TO CHAPLAINS REQUESTING PARTICIPATION

December 15, 2014

Dear Chaplains:

My name is Lori Anne Brown; and I am a candidate for the doctorate of Ministry degree at Duke Divinity School in Durham, North Carolina. The topic of the thesis that I have chosen is: “An examination of the contemporary challenges to the pastoral authority of a Christian chaplain who ministers in a secular medical institution.” The research that I have examined supports my argument that Christian chaplains do experience challenges to their authority in the secular medical institution.

Therefore, as part of my thesis, I am conducting additional research regarding the current climate relating to the challenges of a Christian chaplain’s authority in the secular medical institution. In line with this, I have created a confidential questionnaire and survey in which I am seeking your participation. The purpose of this questionnaire and survey is to discover information concerning the nature of the challenges that Christian chaplains are currently experiencing in the secular medical institution. Moreover, I am soliciting the help of Christian chaplains to explore any possible recommendations that they suggest which could be implemented into the CPE program to help alleviate some of these types of challenges.

Therefore, I greatly appreciate your willingness to be part of this research. I am confident that your responses will offer practical suggestions to help alleviate some of the challenges that Christian chaplains experience in the secular medical institution to help make our ministry more helpful for everyone. Again, thank you in advance for your time and consideration. I look forward to your responses.

Respectfully,

Rev. Lori Anne Brown
APPENDIX F:

THESIS QUESTIONNAIRE

Thesis Questionnaire & Survey

INSTRUCTIONS: When you have completed this questionnaire, please save your document with the following format: Chaplain<first initial><last name><MMDDYY>. Please answer no to any additional questions about saving the document. Return the completed form to me at lori.a.brown@duke.edu.

Please answer the following:

1. Demographic information:
   - What is your gender? Female Male
   - What is your race/nationality?
   - What is your age?
   - What is your religious/denominational affiliation?
   - Are you ordained?
   - Where did you receive your CPE training?
   - How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical
institutions. Describe how your recommendation could be practically implemented in a CPE program.
APPENDIX G:

PARTICIPANT 1

Participant #1: (7 Years’ Experience)

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

   As a chaplain resident, the wife of a patient in intensive care invited me into the room for prayer. Moments later, the ICU attending entered and curtly dismissed me from the room. Later, I confronted the attending respectfully and assertively to suggest that a collegial approach would have been more appropriate. He was clearly offended by my coaching him and attempted to 'put me in my place.' By resisting his invitation to react angrily, the situation was deescalated and he was able to hear my standpoint. In essence, I stated that as the patient lay dying and his wife
grieving, spiritual and emotional interventions with the family were at least as important as the medical interventions which were diminishing in effectiveness.

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)

By declining to react angrily, I was able to establish the chaplain's role upon equal footing as the others in the medical team. Spiritual and emotional aspects of patient and family care were elevated to equivalency with physical care. I feel certain that such a change in the different aspects of care had little lasting effect upon this doctor or the ICU culture. Professionally, this event solidified my understanding of the importance of diverse approaches to patient and family care and the great responsibility I held to minister to patients, family and staff in very challenging times.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

I believe the medical model is designed to diagnose and treat a narrow aspect of person's needs: the physiological need to exist in the face of system dysfunction. Other aspects of patient needs such as emotional, spiritual and relational are not well-recognized in the medical model. I believe this is both institutional and personal. On the personal level, doctors face their own existential crises of helplessness in the wrestling match of life and death. Acknowledging this vulnerability requires a spiritual and emotional awareness that is very problematic in a driven, focused, competitive environment. The drive to live is very powerful and the awareness of our powerlessness in the face of death can be terrible for many. Institutionally, the medical system
feels the need to focus on preserving life at all costs to protect itself from liability. Also, rational decision-making is diminished when the emotions of loss in the face of death arise. Our human propensity to fight for every breath for ourselves and others is miraculously strong.

5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

Documenting in the medical records the spiritual and emotional needs of a family would be helpful. A more humble, less physically assaulting approach to medical interventions would be helpful. An acknowledgment that the patient is a person whose spiritual, relational and emotional well-being are equally important vital signs. An increased presence of the number of chaplains (full-time, paid staff) in medical rounds and decision making events would be most helpful. Also, assertiveness training for diminutive pastoral care providers to advocate for patient and family needs that extend beyond physical needs.
APPENDIX H:

PARTICIPANT 2

Participant #2

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

   When one of my patients died after an intensive 5 mos involvement with he and his family. I was in vested in every way, believing in my entire being through prayer that God was letting me know the patient would beat his fight with lymphoma. The patient died at 19 years of age.

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)
It affected me negatively for a little while. I was devastated over the death of this patient, and the more his parents reached out for me, I pulled away fearing I had let them down as a minister, one who stood with them and encouraged their hearts to have faith that God was heard their prayers. For a week or so, I went through a mirage of feelings: deceived by God, unsure of my calling as a minister, or work as a chaplain. I became challenged when I had to speak the words of prayer. I was afraid God had shut his ears to the sound of my voice for I feared I had somehow sinned against him, and he was now refuting the call I believed was on my life.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

What challenged my authority the most was how the social workers and nurses were challenging the spiritual aspect of our place with patients. On more than one occasion did I have to fight to see patients or speak about patients spiritual needs being relevant in their overall journey to health and wellness. I believe these challenges to be more institutional related rather than personal. My own personal background working in mental health allows me the opportunity to say this without remorse. Social Workers believe they have a deeper knowledge to the “ins” and “outs” of human needs in response to social needs and behaviors. Nurses believe they have a deeper methodology due to their training in regards to the human body. The spiritual aspect of the human soul can only be discerned by those who have been called to be spiritual present with the brokenhearted, and lost. To institutions such as medical hospitals chaplains are deemed to be replaceable entities. The spiritual aspects of the human being weigh far greater than the physical aspect which is temporal.

5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.
I recommend that the CPE training of chaplains should be more in-depth learning with the medical and social teams. This would entail, more involvement such rounding with the medical team (doctors and nurses on a daily basis). This would give some credence to our presence and acceptance by the overall team, patient and their family members. The same can be done meeting with social workers and their teams allowing the chaplains to be more involved reporting on their assessments with the patients and families dynamics both socially and behavioral.
APPENDIX I:

PARTICIPANT 3

Participant 3 (3 Years’ Experience)

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

An experience that challenged my authority as a Christian chaplain in a secular medical institution happened when my supervisor informed me that a patient felt uncomfortable with the way I ended my prayer "in Jesus name." The patient was not of the Christian faith and she did not feel my prayer was inclusive. She was offended and made a formal complaint to the hospital staff. Therefore, my supervisor informed me as well as other chaplains that the hospital decided that it was in our best interest not to mention Jesus' name in our prayers.
3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)

   This negatively affect the way I minister to those I care for daily by making me to question my call to Chaplaincy. I come from a Christian tradition where praying in Jesus' name means praying with His authority and asking God the Father to act upon my prayer because I am coming in the name of His son, Jesus. Praying in Jesus' name means the same thing as praying according to His will and purpose concerning His creation. Therefore, I considered my prayer ineffective because it is the glory of God to recognize the name of Jesus in prayer and answer according to the faith we use.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

   One contributing factor within the secular medical institution that challenges my authority as a Christian chaplain is the devaluation of religious worship and belief to the merely instrumental and experiential. Chaplaincy is more generalized and less identified with any particular tradition. Chaplains are trained to de-emphasize their individual religious identities in order to let patients take the lead in terms of any religious specificity. I believe these challenges are both personal and institutionally related because the overall goal of a chaplain is to provide spiritual healing, purpose and meaning to the patients entrusted in their care.

5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

   I recommend Christian chaplains create dialogue with their employers about what it really means to be a Christian chaplain in a secular medical institution. Chaplains should find a way to be inclusive but it should not cost them their Christian integrity. They should do everything to support their patients while remaining true to their faith tradition. This could help
to alleviate the challenges Christian chaplains experience relating to their authority in secular medical institutions. My recommendation could be practically implemented in a CPE program by providing training for chaplains on how to remain true to their faith tradition while being inclusive of the ones they care for on a daily basis.
APPENDIX J:

PARTICIPANT 4

Participant 4 (7 Year of Experience)

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

   What is your gender? Female Male

   What is your race/nationality?

   What is your age?

   What is your religious/denominational affiliation?

   Are you ordained?

   Where did you receive your CPE training?

   How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

   This is a hard question for me to answer. Certainly, there are many such minor infractions I have experienced along the way to working as a full-time hospice chaplain, but it is hard to remember any specifics. I go into hospitals rarely to see hospice patients - most are at home and the hospice nurse and social workers greatly value the involvement of a chaplain with pts/families. When I have been visiting a hospice pt recently in the hospital, and gotten to a pivotal point in the visit and poised to pray, a nurse/CNA has come in to take pt's vitals and break the energy of the visit. I spoke with authority and politely asked if she could give us a few more
minutes which she did. She had no idea what was happening in the room and appeared to be more than willing to wait outside or do something else for a few minutes until the visit was over.

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients' families as well as your colleagues, if applicable.)

   This "challenge" has not effected the ways I minister to those I care for on a daily basis. It is more of an example of how I minister to those I care for on a daily basis. My experience as a hospice chaplain has given me much more confidence in my authority as a spiritual care counselor for people who are dying and the urgency surrounding their limited number of days on earth. I am much more comfortable standing up to medical staff/authorities because of my hospice work which gives me the opportunity to work very closely with nurses and, sometimes, doctors.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

   The medical model for patient care focuses on the physical aspect of pt care. It does not leave much (if any) room for the spiritual aspect of pt care. I believe this challenge is related to the medical institution and is not "personal". If spiritual healing or improvement could be measured analytically, and a proven link could be made between spiritual well being and physical healing/health, then I believe the medical institution would make more room for spiritual care in its medical model. Because spirituality's benefit is subjective to a great degree, I believe it remains an afterthought to most medical models.
5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

I do not believe there are any changes to CPE programs that would make a difference in chaplain authority in the medical institution/model. The medical model itself has to change for a difference to be recognized. In my work as a hospice chaplain, the hospice model of patient care very much embraces spiritual care and gives the chaplain authority within the hospice team consisting of Social Worker, Nurse and Chaplain. The team works by the members communicating about all aspects of care. For example, when the SW or Chaplain see physical patient problems in the home setting, we call the nurse. If the nurse or chaplain see financial needs or need to transport pt somewhere else, we call the SW. If the SW or Nurse see spiritual issues in the pt/family, they would call me, the chaplain. All 3 team members work together for the good of the pt/family. This kind of model does not exist (to this degree) in any hospital setting I have worked in as a chaplain. Until the institution has reason to change its model, I do not believe a chaplain's authority will be able to change in a hospital setting (no matter what a CPE program does).
APPENDIX K:

PARTICIPANT 5

Participant 5 (4 Years’ Experience)

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

I was speaking with a patient at bedside. A physician entered room and rudely interrupted our conversation. I am unsure whether the physician would have done the same thing had I been someone other than the chaplain. I cannot say for certain, but I have witnessed dismissive behaviors from some healthcare providers. I believe this particular physician, judging from his expressions and mannerisms, devalued my work as a chaplain. Interestingly, this
occurred mostly during my internship at Duke University Medical Center where chaplains wear white coats similar to physicians. I did not experience this disrespect during my residency in Connecticut, or possibly I was more experienced in claiming my authority as a chaplain. Yet, maybe each medical institution is different and something we need to think about when considering challenges. Where are we situated?

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)

The incident described above positively affected me because I instantly recognized that being a chaplain in a “secular institution” is not an easy task, and I must be confident and view myself as an integral part of patient care, and that I play a vital role within the institution. As long as I viewed myself in this manner, others will too.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

Challenges are to be expected when religion or spirituality, i.e. Christian or any other faith, is intermingled with secular institutions. Possibly these challenges will always exist and may never be overcome. The mere combination of opposites is a contributing factor. I would say challenges are both personal and institutional. Challenges are personal because chaplains must recognize such challenges exist and be able to continue to offer pastoral and spiritual care to those in need in the face of opposition, and claim their authority as a Christian chaplain. Discussions surrounding pastoral authority are important part of CPE programs. Institutions must also recognize that Chaplains play an important role in patient care, and good patient care is holistic. However, in my experience discussed above, it may be near impossible for institutions to implement policy and demand respect.
5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

Since I believe challenges will always exist, and it is inevitable, Christian chaplains must be prepared in two crucial areas. First, the chaplain must be constantly aware these challenges exist. Second, the chaplain should be able to assert themselves as an important player in the medical institution. Therefore, most alleviation must come from within the chaplain. Authority comes from within, what God has planted and called. My recommendation has been implemented into CPE programs, but each chaplain will respond and react differently. Some are able to continue in chaplaincy work while others are lead elsewhere. Not every minister can be a chaplain – we each have our own “call” from God.
APPENDIX L:

PARTICIPANT 6

Participant # 6 (13 months of experience: internship & residency only):

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

   In the places where I served, the chaplaincy program overall seemed to be well-integrated into the medical team, and so the staff called upon us when needed and valued the chaplain’s ministry. Still, there were times when it seemed that persons didn’t fully understand a chaplain’s role and function in the hospital setting.

3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)
This meant that I had to be intentional about embodying and articulating my role in a ministry situation.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

   I am not sure how to answer this question. [This may be due to the limited amount of time spent as a hospital chaplain.]

5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

   It seems that more education about the role and the function of a chaplain in the institution could help create greater understanding. Perhaps having CPE students participate in providing orientations/educational events on their units could help others better understand the role of the chaplain.
APPENDIX M:

PARTICIPANT 7

Participant #7 (3 years of experience):

Questions 1-5:

1. Demographic information: This information is reported in the Demographic Section in Chapter 3. To maintain the confidentiality terms that were agreed upon by both the researcher and each participant the demographic data is reported as a cumulative summary.

What is your gender? Female Male

What is your race/nationality?

What is your age?

What is your religious/denominational affiliation?

Are you ordained?

Where did you receive your CPE training?

How many years of experience do you have in this field? (Please include any clinical internships or residencies.)

Please respond to items 2-5 in one to three paragraphs per item:

2. Describe the nature of an experience that has challenged your authority as a Christian chaplain in a secular medical institution.

   My experience has been that Patients, Physicians and Nurses, - generally speaking - respect more the knowledge of medicine in a scientific sense. The role of a Chaplain as I experienced was more as “if requested”. I was perceived as “We will call you if patients request a chaplain”. And on beyond that, they were expecting a Caucasian Male Chaplain. And when they saw a Hispanic Chaplain with an accent they thought that I was not trained enough or prepared enough to the task of patient care. There seem to be the perception that religious Chaplains are less trained for the task of patient care.
3. In what positive or negative ways did this challenge affect the ways you minister to those you care for on a daily basis? (Please include the patients’ families as well as your colleagues, if applicable.)

The experience of not being respected in the same manner like a surgeon actually inspired me to train more. I remember spending many hours at the library reading books related to faith and medicine. It really challenged me to prove our hospital colleagues that as a Chaplain I can speak their language and I can provide quality care from the spiritual perspective. I remember one time that the family was really struggling with hard questions about the husband with terminal cancer. I visited the family many hours that I the end even though the husband died, they appreciated the care and love I provided for them. Part of my learning experience was that people really respond positively even in their grieving when the Hospital staff share a sense of compassion. Treat the patient as human and not as statistic.

4. What do you identify as some of the contributing factors within the secular medical institution that challenge your authority as a Christian chaplain? Do you believe these challenges are more personal or institutionally related?

I believe is culture related. Somehow, the general public perceives religious staff, Christian Chaplains, as we were closed minded fundamentalists. Our general culture seems to perceive Chaplains that we are fatalist people that repeat clichés such as “God is in control” “Everything happens for a reason” “He or She is in a better place”. I don’t think is personal, it is more the culture shift. We are living times when people are more suspicious about religious leaders. I read an article a few days ago that said that in the 50’s 70% of people respected the clergy as an authority figure. Today is the opposite. Only 30% of people hold Clergy in a place of honor. That is the culture we are living and we have to accept this reality and continue being faithful, authentic and compassionate caregivers in spite of.
5. What is one recommendation that you believe could help alleviate some of the challenges Christian chaplains experience relating to their authority in secular medical institutions. Describe how your recommendation could be practically implemented in a CPE program.

Continue integrating Biblical Studies, Theology, Psychology and Caregiving. For example, I would have loved to deepen the integration of Biblical Text such as Job with Pastoral Care. In my year as a Chaplain Resident I was invited to reflect on those connections, but it seemed to that my CPE supervisors were more interested in the Psychological aspect of training. Which I am very appreciative of, but going reflecting back on it, I wish I would have explored more of those connections. I encourage the CPE programs to continue exploring the art of putting it together, Biblical Text, Sacred Texts, Theology, Psychology and patient Care.


VandeCreek, Larry, “Defining and Advocating for Spiritual Care in the Hospital,” 64, no.2 (2010).
BIOGRAPHY

Lori Anne Brown was born and raised in New York City. She gave her life to Christ over thirty years ago. She was educated in the parochial school system in New York City, where she graduated from St. Agnes Academic High School. She attended Morgan State University in Baltimore, Maryland, where she earned a Bachelor of Science in biology with a minor in chemistry. Lori also attended Virginia Commonwealth University for graduate studies in forensic science. After serving years as the youth minister at Holy Rosary Catholic Church in Richmond, Virginia, Lori Anne heard “her call to ministry.”

Lori attended the Samuel DeWitt Proctor School of Theology at Virginia Union University, where she earned the master of divinity degree, with an emphasis in Christian education in May 2004. In May 2009, she earned the master of theology degree from Duke University in Durham, NC, with an emphasis in pastoral care. After a pilgrimage to Haiti and Uganda, Africa, in 2009, Lori was compelled to return to one of her heart’s desires, which was to minister to whom may be called “the least of thee…, the sick, the afflicted, and the oppressed children of God.” She graduated from a clinical pastoral education internship and residency program as a pediatric and women’s critical care chaplain in 2009 and 2011, respectively, from Duke University Medical Center in Durham, North Carolina.

Prior to and during her call to ministry, Lori Anne worked as a DNA forensic chemist for the Virginia Division of Forensic Science in Richmond, Virginia for seven years. After that, she began working as a full-time science educator, in what she describes as the mission fields of public education. She worked for Beaumont Juvenile Correctional Center, and two public school systems in Virginia, as well as the Wake County Public School System, in North Carolina.
Lori Anne was nurtured in ministry by her pastors, Rev. Dr. Linwood Carroll, Sr. and Rev. Dr. LaMont Wimbish, Sr., at her home church, Amazing Grace World Fellowship Church, in Richmond, Virginia. She was licensed to preach the Gospel on November 29, 2009, and ordained on September 30, 2012, both at Amazing Grace World Fellowship Church.

Additionally, Lori Anne is an avid writer and desires to write Christian children’s books in a series called *Nana’s Nest*. Currently, she is a contract writer for Augsburg Fortress Press and predominantly writes for their Vacation Bible School Series and Daily Devotional—*The Word In Season*. Some of her most recent publications include VBS Science Seawater and Rain Forest Adventure: Swing Vine Science. She wrote her very first book, *Harvest*, a few years ago, and hopes to have it published soon.

Currently, Lori Anne works as a full-time substitute teacher for Wake County Schools and is a faithful itinerant preacher of the Gospel of Jesus Christ. She desires to preach and teach the glorious Gospel of Jesus Christ, both nationally and internationally. She intends to do her very best to live by her mantra for her life and ministry: “*Solo Deo Gloria*” To GOD Alone Be the Glory!