

MAINTAINING A BIBLICAL PERSPECTIVE ON THE ROLE OF CHAPLAINS
IN THE EFFECTIVE CARE AND HEALING OF HOSPITAL PATIENTS

by

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ABSTRACT

Given the current dynamic nature of health care in America, it is important that Pastoral Care efforts maintain sound biblical foundational principles such that they were based upon.

Although the main goal of chaplaincy training in hospitals is to strengthen and address spiritual healing and confidence in faith in a multi-cultural missionary setting, it is precisely because of this characteristic that that goal is now being challenged in terms of orthodoxy.

This paper will demonstrate how such a biblical ministry is able to function in a dynamic and diverse contemporary environment, based on scriptures pertaining to the most powerful examples of Jesus' ministry to the lost and Paul's missionary enterprises. It will demonstrate the authority, immutability and pervasiveness of God's word and commands through time and their applicability at some of the best opportunities for crucial spiritual interjection in a person's life. It is critical that the Christian root of this ministry not be lost to post-modern syncretism, or assimilated under the auspices of another discipline or legal and administrative functions. Contemporary illustrations and methodologies of the ministry in a clinical setting based on 5 years of Chaplain work at Tampa General Hospital, a Level 1 Trauma Facility, from 2008-2013, will supplement the biblical basis for such a needed emphasis. Certain trends in clinical pastoral education that feed the chaplain pool will be noted, along with their benefits and challenges, in order to emphasize God's character, redemptive purpose and

promise through our role as supporters and promoters of the Christian faith in this particular line of ministry.

DEDICATION

I would like to dedicate this work to my supervisors, William Baugh and Wayne Maberry, and the CPE Program and Tampa General Hospital for the inspirational guidance behind this thesis topic. The grace extended through them over the years I spent training at their facility were a true testament to God's loving presence as a light in this world wrought full of the consequences of sin

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CHAPTER 1

INTRODUCTION

I served on staff as a chaplain at Tampa General Hospital's Pastoral Care department.

"Pastoral Care" sounds fairly traditional and Christian, invoking the image of the Shepherd and his sheep, and thus possibly sectarian in a pluralistic metropolitan setting. It was a bit of a surprise, however, when it was recently discussed at a department meeting whether to change the name to something more inclusive, such as the "Spiritual Care" department. This suggestion needed some serious evaluation. For instance, our department is a mix of professionally certified chaplains, educators and students. The certified chaplains are granted certification by the Association of Professional Chaplains. Because we also offer Clinical Pastoral Education (CPE) within the department, we are considered an educational entity, accredited by the Association of Clinical Pastoral Education (ACPE). ACPE, in turn, is accredited by the Department of Education. ACPE standards certify the educators (CPE Supervisors) who supervise or are candidates for supervision at a recognized facility. This can have broad connotations due to the many individuals and organizations involved in the network as a whole, each with their own set of requirements and goals. Add to this mix the differences in theological backgrounds of every person involved all functioning within the boundaries of a close setting. More often than not chaplains tend to try to find some continuity with the professional field outside the hospital as well. This is helpful in cases

where the two overlap. We may have military Chaplains serving through our department or in tandem with our department at times, and we often have hospice Chaplains on staff.

According the Army, more than 120 denominations are represented in their religious support staff.¹ At any one given time, our department can have between 15 to 30 chaplains, residents and interns. Each of these belongs to and is endorsed by his or her own faith group. The work is triaged and if we are not able to fill the pastoral role needed for the patient or family, we do everything to find external sources to assist.

Hospital ministry requires flexibility in terms of the very different type of people involved compared to the relative homogeneity of a church congregation. The broad exposure to various faith groups makes a commitment to soundness of orthodoxy imperative to the ministry and our faith. Unlike a church or parish setting where doctrine and fundamentals are consistently reinforced and rarely challenged, every hospital visit presents a unique world view and view of God, usually not in conformity to our own views. Over time, this can have the effect of watering down or overlooking some critical aspects of our faith, like the role of works, grace or Christ's redemption. Our ministry's effectiveness is dependent on the power of God to use us in supporting others in times of trial, however. This is not simply holding someone's hand, but actually grounding ourselves and our beliefs in those powerful elements that make up the Gospel's message, and imparting that message through our prayers, words and actions, according to the patient's needs. Whether those needs are medical, psychological, domestic, social, cultural, or spiritual, they can all be addressed in and through faith.

¹ Department of the Army. "Religious Support," *FM 1-05*, 2012: iv.

It is difficult to quantify such a need for orthodoxy to those who need proof and numbers, such as the hospital's administration or board members, or those who might seek more syncretism in an approach to spirituality due to their own definition of faith, or lack thereof. Like with the military, First Amendment rights play a role in that the hospital's pastoral care department must present itself as "nondenominational." While this will be explored to a limited extent, the scope of this paper, remains primarily to promote and validate the integrity of the chaplain's own faith rather than exploring ways how it might be challenged or compromised. Scripture will demonstrate through precept and example that even in such a pluralistic environment, we can and are called to be open to working with other faiths, professions and people in a missionary capacity to meet the spiritual demands of syncretic societies.

This paper is intended primarily to help seminarians, as faithful followers of Christ entering ministry or CPE, who often find themselves confronted with unexpected challenges either to their definition of God or Christian ministry while surrounded by such a variety of influences, teachings and beliefs in high-stress emergent situations. It is also intended to illustrate to those who have not explored the Christian foundation for the work of chaplaincy exactly how much of a Christian calling and enterprise it is.

The hospital is often the first and possibly the only time they will feel so exposed to the elements of the world and find themselves outside the safe confines of church structures or administration. All the while, they are in conditions that demand allegiance with others who are of different religious backgrounds and prioritize different functions. The rigors and

effects of the training are in my opinion, significant enough to warrant this effort and to offer encouragement and unquestionably Biblical grounds for the particularly trying, but certainly necessary and beneficial functions of a hospital chaplain. Seminary education needs to be seen not simply as preliminary to chaplain formation, but integrally foundational to every aspect of it. With Scripture as our standard, it serves to guide and filters any additional concerns or warrants brought on by the facility, department or professional umbrella under which we are to operate.

The Roles And Limitations Of Hospital Chaplaincy

Hospital chaplain roles vary from facility to facility. Those that offer Clinical Pastoral Education programs tend to have more demands and offer more variety to their work because of the size and location of these facilities. A copy of the ACPE standards, which are to be met as the intern chaplain advances through the program to resident and staff positions, are included in the Appendix to this work. The standards for the first two units emphasize the personal development of one's own identity, including awareness and use of self in the patient-chaplain interaction. The last two units are focused more on professional standards in ministry and the integration of the chaplain into the workplace in a specific area of hospital chaplaincy, for example in the NICU, pediatrics, oncology or transplant departments.

Those eligible for participation in the program must be in good standing with a faith or religious group. Through the interview process, supervisors evaluate and discern which individual strengths and weaknesses may make the student an asset to or even sometimes a

necessary challenge and growth opportunity for the group. They also evaluate how the supervisors might be able to work with the student. The peer group can have from a minimum of three to a maximum of seven participants under one supervisor. It is not explicitly stated, but prospective students do not have to come from a necessarily Christian background. Jehovah's Witnesses and Mormons have access to patients through their own network and generally tend to stay separate from our department. At any time, we can attempt to locate a spiritual leader for specific spiritual traditions for those patients who are not desirous of a hospital chaplain for spiritual care.

Many seminaries and denominations require a unit of CPE as part of their Master of Divinity programs and for ordination. Therefore, we see students come for reasons other than career chaplaincy. Catholics are often found among our interns, and on occasion, I have seen a few Unitarians, Buddhists and Rabbis join us as well. The department does not discriminate over sexual orientation and supports inclusivity. Integrative Medicine, which provides noninvasive mind-body sensory therapies such as healing touch, music, meditation and imagery based on ancient Hindu or Buddhist practices has its own department that works in tandem with Pastoral Care on occasion to alleviate symptoms in patients who are in pain or experiencing a lot of stress. Might it serve the patients to combine these two departments, or would it create confusion? Would the integration require the chaplains to serve in an even greater capacity, putting additional pressures on a department that is already stretched? Could it possibly become the grounds for conflicts in doctrine or ideology either for the chaplain, staff or the patient?

All of our supervisors are ordained Protestant Christians, and function as such in the community. The result is a diversified group of people, mostly Christian, whose members expose each other to the varied perspectives and emphases of their faith. This in turn helps us understand and minister to the patients better. In group or individual supervision we are given the opportunity to analyze our personal doctrines and see where they might converge or diverge with others. We are encouraged to explore these differences openly to allow for greater input and evaluation or to address what may need a dose of challenge or clarification.

The cases in this paper and my experience are based on events that occurred at Tampa General Hospital, a Level 1 Trauma Facility, that serves 5 counties and accommodates frequent helicopter arrivals every day. It is a 1000-bed facility, containing seven ICU's, a rehab center, a psych unit, and 5000 employees. Chaplain services are available 24 hours a day, 7 days a week. The Chaplains offer interdenominational services twice a week and on holidays, run a psych unit patient group session twice a week, and respond to staff crises as well as regular patient orders requested by staff, patient, church or family. The order of priority in our duties is as follows: 1. Trauma, 2. Code Blue, 3. Death, 4. Advanced Directive, 5. Regular orders. The work is intense, more often than not requiring the Chaplain to work with multiple disciplines, including medical staff, social work, law enforcement, as well as with the patient's immediate and extended family.

Shifts are usually 8 hours long, and depending on the type of call and the relationship with the family or patient a call can be as short as 15 minutes to up to two or three hours.

Training is necessarily challenging and intentionally mined, much like a medical residency,

to push you to your limits, physically, mentally and spiritually, often broadening your definition of God and providing an awareness for the eternal in new and unimaginable ways. Chaplain interns shadow mentor Chaplains for about two weeks. Then, regardless of experience, the Chaplain Intern can find himself or herself dealing with any of the following issues: divorce, fetal demise, substance abuse, suicide, domestic abuse, child abuse, psychological disorders, baptism, amputation, transplant, homelessness, viewing, terminal diagnosis, homicide and family dynamics among many others. Many of these situations will be explored throughout this work. Because of the traumatic nature of such crises, peer group and individual sessions prove to be an invaluable source of support among Chaplains, as well as offering improved effectiveness of help to patients. The scenarios often affect us in some personal way which is explored in depth. We quickly become intimate with each other's lives in ways that few can experience.

When it comes to emergent situations theology often is dispelled to make room for basic care, as the situation is unfolding in the immediate for the patients and their families. The deep discussions about salvation or redemption only make up a small portion of our interactions, even though God's hand is more than evident in the situation by the often extreme nature of the present life-changing events. People often respond in shock or extreme grief in such stressful situations and family structure reveals itself quickly (who is capable of taking the lead in making critical decisions), cultural backgrounds dictate resources or need for support (faith and family), crisis management comes into play

(including crowd control and visitation), as does grief counseling (which may touch on deeper issues of faith if there is room for it under the circumstances).

In terms of presence, the Chaplain is traditionally recognized as one who bears the Word and prays with and individual or family. The Chaplain exhibits calmness, representing the stable and loving presence of God in the midst of chaos, and offers companionship so they know that they are not alone in their suffering. Functioning in these ways means having open arms and open hearts to see them through, like Christ did and continues to do through the Spirit and other believers. This sustaining omnipresence of Christ is revealed in Colossians 1:17: “He is before all things, and in him all things hold together.”²

In the hospital the general tendency is to hope for God’s blessing in a bad situation. There are frequent requests for prayer for a miraculous recovery or restoration. The seriousness of those situations, however, call more for reverence and submission than hope. It is for this reason that prayer often appeals to God’s mercy, strength and grace. God’s blessing still comes, but perhaps in a different form than expected. The Psalms are a real balm to those who are facing their greatest fears.

God is our refuge and strength,
A very present help in trouble.
Therefore we will not fear,
Even though the earth be removed,
And though the mountains be carried into the midst of the sea;
Though its waters roar and be troubled,
Though the mountains shake with its swelling. (Psalm 46:1-3, NKJV)³

² Wayne Grudem, *Systematic Theology*. (Grand Rapids, Michigan: Zondervan, 1994), 175.

³ *NKJV Holy Bible*, (Grand Rapids, Michigan: Zondervan, 2002).

And in Isaiah:

Fear not, for I am with you;
Be not dismayed, for I am your God.
I will strengthen you,
Yes, I will help you,
I will uphold you with My righteous right hand. (Isaiah 41:10, NKJV)

One of our assignments in the program is to explain which biblical characters we identify with in our work and why. I identified with Jesus whose mercy, grace and pursuit of the lost stands out, and with Simon the Cyrene who helped Jesus carry the cross, as we help others to shoulder their crosses in their times of burden.

No one can argue our responsibility to the patients. It is our job as well as our calling to be a spiritual presence in times of hope or despair, to bring comfort and companionship.

In John 3:16:

“For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life.”

The great love and sacrifice that God demonstrated towards us for the sake of being reconciled to us is one that as believers we carry in our hearts. It is reflected in our devotion and obedience to God and in our service to others. There is no question that as ministers, we are recipients of this unconditional love and renewed hope. Knowing that the Spirit works within us in order to impart that love to others who are open to it is something we trust and have confidence in, in spite of our human limitations.

Romans 8:28: “And we know that all things work together for good to them that love God, to them who are the called according to his purpose,” compels, encourages and gives

us confidence in the final result as we continue to participate and refine our attempts to go further with the patient, given the opportunity and privilege.

On top of the various calls, there is an administrative component to the work that requires computer training, continuing education, and regular charting of each act of ministry throughout the course of the day. All visits are documented and posted.

There is never a lull, and most times, for most Chaplains, self-care is a great challenge. Once through the program many Chaplains move on to part-time work or a less emergent or demanding environment. The experience in a single unit of training or residency exposes developing ministers to the equivalent years of pastoral ministry to people's needs in a congregation. To expect to function at such a high level of stress in this type of Chaplaincy would be like a doctor trying to practice every type of medicine. It is a monumental expectation, yet we are called to be present and effective in whatever capacity we can, leaning on our faith and trusting God to bring some light and comfort to the situation.

Whether it be by catching the eye of a doctor who on occasion needs our intercession in trying to save a life, holding the bloody hand of someone who is scared and alone in the midst of a chaotic trauma bay, hearing confessions that will never be heard by another living soul, or being with the donor's family at the time of death, and then meeting the recipient, we see things through God's eyes, submitting ourselves to whatever the Lord has willed for the day. We feel and experience the great effect of sin in the world concentrated in this microcosm. Therefore, our faith in God's ability to use us and strengthen us, His hope and love in all things and for others, must overcome our human limitations.

God's provision is not only for eternal life, but also for assurance through present trials. This helps the patient in the midst of a negative diagnosis and the family in dealing with the news. Paul exhorts the Romans of this fact with these words full of his own conviction:

"For I am persuaded that neither death nor life, nor angels nor principalities nor powers, nor things present nor things to come, nor height nor depth, nor any other created thing, shall be able to separate us from the love of God which is in Christ Jesus our Lord." (Romans 8:38-39)

CHAPTER 2
FOUNDATIONS OF BIBLICAL CHAPLAINCY

Case Study 1 - Ministry to All Men

A morbidly obese, middle-aged man is admitted to rehab after a motor vehicle accident. For over 6 weeks his wife is a constant presence by his side. Staff has requested Pastoral Care to visit the patient. The patient seems to have lived a fairly secluded life due to his condition. He presents himself as untrusting and unwelcoming of any pastoral interaction. Several initial attempts to create a pastoral relationship do not lead to any meaningful progress. Although he remains open to follow up visits, he is angry and distant. Another visit ensues where he aggressively questions my role, my faith and beliefs. At the next meeting he surprises me by opening up about his feelings. He feels that God is using the accident to help him make some changes in his life. He proceeds to confess what he recognizes as the great sin in his life. This includes the sale of drug paraphernalia and pornography to the public. He is concerned about attempting to go to a church with his history and physical limitations due to his obesity. He overcame the shame that held him back and what caused the initial defensive response to my presence.

Personal faith tradition in chaplaincy is important to patients who are sensitive about being vulnerable with a complete stranger. One of the initial disclosures between the chaplain and patient is about each other's faith tradition, mostly to establish respectable boundaries, with clarification about practices and views if necessary. The ritual side of ministry and prayer often help in overcoming many of these differences and I found myself leaning on this, at first independently and eventually with the patient in times where our conversations seemed unproductive. As we dig deeper, we can see how experience in various churches gives each person their source of strengths and even weaknesses. We can explore this without judgment.

Therefore, having been justified by faith, we have peace with God through our Lord Jesus Christ, through whom also we have access by faith into this grace in which we stand, and rejoice in hope of the glory of God. And not only that, but we also glory in tribulations, knowing that tribulation produces perseverance; and perseverance, character; and character, hope. Now hope does not disappoint, because the love of God has been poured out in our hearts by the Holy Spirit who was given to us." (Romans 5:1-5, NKJV)

The message of the Gospel is simple; God's love redeems us, both body and soul. He does this through Christ incarnate, through the sacrifice of His blood instead of ours that could never atone, through His righteousness, and the resurrection of His body. Our response in believing and trusting in His forgiveness is the cornerstone of our faith. The Book of Romans gives a clear indication of three facts about what is commonly known in most Protestant denominations as "The Roman Road to Salvation." The first is in Romans 3:23:

“All have sinned and fall short of the glory of God.” The second is in Romans 6:23: “The penalty for sin is death.” The last is found in Romans 5:8: “Jesus Christ dies to pay the penalty for our sins.” As Grudem indicates, however, “understanding those facts and even agreeing that they are true is not enough for a person to be saved. There must also be an invitation for a personal response on the part of the individual who will repent of his or her sins and trust personally in Christ.”¹

This obese man’s idea of and claim to salvation was seriously challenged by his prior experience and behavior which consequently manifested itself negatively through his poor self image, self care, and anger. We can draw on the various positive influences of a person's faith that might present themselves, to encourage and affirm the truths behind them which can help inspire a person to more growth, while addressing some points that may prove less helpful, confusing or challenging. For this man, he understood the reality of his sin, and the consequent penalty, and was in the midst of reconciling with God through Christ’s forgiveness and the promise eternal life, wanting to respond to the present offer where there seemed to be no hope of this before.

In this way, we may be genuinely and meaningfully present to a diversity of people without undermining or compromising the Gospel. This can also be helpful when evangelism is not the primary reason for being with a person, when they have already professed their faith in Christ and need reassuring

¹ Wayne Grudem, *Systematic Theology*, (Grand Rapids, Michigan: Zondervan, 1994), 694.

in hard times, or if they are wary of religious talk of salvation but are in need of emotional support or comfort. If that support is rooted in God's word and truth, it will be fruitful.

“Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who comforts us in all our tribulation, that we may be able to comfort those who are in any trouble, with the comfort with which we ourselves are comforted by God.” (2Cor 1:3-4)

This man felt immobilized by his accident and his weight. These two setbacks personified the greatest burden on him and his life which was the sin that separated him from his God and a community of faith. The Chaplain made room for God to enter his life, for him to be vulnerable in his undeniable need for God. To be able to voice his confession and affirm God in His redemptive and loving capacity allowed for the possibility of his moving beyond the bondage of his past sins. Our hope and perseverance, humility and patience, derived from Christ's hope and perseverance, humility and patience, plays a critical role with every patient. Who else would inspire us to undertake the seemingly impossible, requiring resources and vision beyond our own limited scope, to be the open arms of God at such an opportune and critical time in a person's life?

These opportunities are plentiful, in and out of the hospital, and the experiences so rich and relevant to the world around us. Yet there is still the sense that many people are not reached or ministered to in their times of need. The world in all its materialism marginalizes faith and does not give it the room it deserves as an essential part of our being. Spirit-led pastoral support affirms

God's calling to this ministry, and the results are evident at every turn. In ministry it is important to be grounded in God's truth and to be truly present and working in people's lives right where they are, as they need us to be, as led by the Spirit.

This is a clear example of a man who may have difficulty understanding himself to be an image-bearer of God. He was challenging to approach. He knew he had not been a good steward of his body, or of the bodies of others as seen in his taking advantage of their weaknesses. He profited and gained from work that was contrary to God's commands and His plans for good. At first, the patient seemed almost to the point of being completely shut down. Yet, with concerned and consistent involvement, he was able to respond in faith at this critical time in his life. He openly admitted to his spiritual brokenness and a genuine desire to pursue God.

During our last visit, he and his wife had worked out how they could remove all the "bad" items from their inventory and replace them with things that would honor God more. They had contacted several pastors in their area, not all were receptive, but they had begun a dialogue with one of them about attending that church.

The results of faithful pastoral ministry and presence are not always as evident as in this case because most patients do not have the length of stay he had. No matter how small or short-lived the visits, however, ministering becomes part of an accumulated and effective influence on the lives of those in need.

Created Man

Genesis 1:27 reads, "So God created man in his own image; in the image of God He created him; male and female He created them." We are told we bear His image in this verse, not once, but twice. Mankind was originally created 'like' God, the original Hebrew *tselem* is used also in reference to replicas or statues representing likenesses.² Although we differ in our limited human bodies and sensory awareness, we are still able to reflect God's image various ways. Specifically, because of our relationship with God as Father and Creator; we are morally accountable to him unlike any other creature; we are spiritual beings able to relate to God and live beyond the limits of present existence; we are able to reason and use language like no other creature; we are aware of the future and able to create (children included) in an intentional way; and we are relationally Trinitarian in that men and women, in community, marriage and individually carry "equality of importance but difference in roles"; finally, we are given the ability and right to rule over creation and continue to become more like God.³

All these similarities encourage us to develop our own creative ministerial activity with a person or family, and to recognize that even the seemingly most fallen, distant or different of men must be treated with the dignity and respect he deserves as an image-bearer. We do this best as a community, always with the desire to assist in fulfilling God's plan for a

² Wayne Grudem, *Systematic Theology*, (Grand Rapids, Michigan: Zondervan, 1994), 442.

³ *Ibid.*, 445-447.

person. In most cases we never know how critical our presence or intervention can be, and it is for this reason that we must make the most of every encounter. Although God saw all of His creation as "good" and provided for everything it needed, men and women are God's crowning achievement in creation, on whom He bestows many privileges above and beyond any other part of His creation. Our perspective towards others and towards ourselves, as Christians, in obedience to our loving creator God, must honor that fact. Paul acknowledges the actuality of this likeness and identifies with it to a greater extent through his salvation experience in Colossians 3:9-10: "Do not lie to one another, since you have put off the old man with his deeds, and have put on the new man who is renewed in the knowledge according to the image of Him who created him." Whether it be a inward motivation to treat others with an attitude of respect or a outward act of treating each individual with the dignity they deserve, Romans 8:29 also speaks of being "conformed to the image of His Son, that he might be the firstborn of many brethren." Our understanding of humans as image bearers of God has eternal implications for God's entire family and plan of redemption. It is our task as ministers to use our positions and experiences so that we may work for the glory of God's kingdom, to increase its visibility in a world where, left to its own devices, sin devalues life and destroys meaningful relationships.

Because of the fall, there is an even greater separation from God than intended. When we recognize the sin that lies at the root of that separation, we can differentiate it from what is still present in the individual as an image bearer of God. In serving others as a chaplain, we can probe their concerns, reassure them of God's continued presence and teach

them, where we are able, how that presence can help them navigating their particular circumstances, while affording them the dignity they are entitled to in spite of any present cultural differences, sins or handicaps.

Case Study 2 - A Present God

Pastoral Care was requested to respond to a fetal demise for a blessing. The baby died unexpectedly at 38 weeks. The nurse indicated that the mother was having a hard time even looking at the baby. The mother is unmarried with two older children, 9 and 16. Her partner, the baby's father, has been supportive but inconsistently present due to his grief. In the room are her best friend and her mother. I found myself grateful that the baby was fully developed and that the mother could remember him that way. The patient is clearly exhausted, the mother seems anxious and the best friend is tearful and will not look at me. It is common as God's representative in a situation to receive reactions of anger, seeking, and gratitude. I realize none are directed at me personally, but I never know what to expect in such a religiously diverse context, or what the patients may expect from me. In this case, the mother, even in her weakness, takes the lead and asks for the baby to be blessed. I offer to bring the baby from the bassinet to her, God's representative holding her child possibly bringing her some comfort. She takes the baby very gently into her lap. I ask her faith and she replies simply, Christian. I offer prayer for her, the child and the family, speaking his name and blessing him with the sign of the cross on his forehead

with holy water. The mother then starts speaking to the baby, describing her love for him and her regret that she cannot bring him home. She expresses that she is looking forward to seeing him again. As she talks everyone is tearful. I then go to gather my books and certificates. The patient's mother and the patient begin an exchange in Spanish, and I realize that they have been estranged and that they are in the midst of reconciling. The mother reassures her that she is there for her and the daughter is her grateful. I take my leave, comforted by the fact that they have their faith as a resource for support.

The patient sought God, choosing to ask for God's presence in this tragic event which was far beyond her control. Through her faith she was able to initiate and effectuate the work of healing from such a terrible loss. Not only did that faith bless her and her child, but the event served to bring reconciliation and forgiveness to an earlier rift between mother and daughter, blessing the mother, and even the friend by their witness. A present God does not mean we do not suffer, it means that God is there in the midst of our suffering and can bring something greater, unexpected and beyond our own limitations to the circumstances. I found myself blessed by this witness reminding me of the expansiveness of God's grace.

“Rejoice with those who rejoice, and weep with those who weep.” (Romans 12:15)

God as Caregiver

God demonstrated superlative care in creating the universe and all that is in it. He gave men and women an entire planet to enjoy and rule over. Mankind, in his sinful transgressions against God, continues to produce negative consequences for himself. God has been merciful and faithful to restore His relationship with man, through conciliatory covenants, each out of love and eliciting a faithful response in mankind. Each of these covenants had its own sign and each addressed a specific outcome that would work towards accomplishing His will and His redemptive plan for man.

The following is a summary of the five main covenants as described in Robertson Palmer's insightfully systematic approach to them in his book *The Christ of the Covenants*.⁴

The Adamic covenant included blessed communion with God in creation which was lost as part of the curse caused by man's disobedience in the Garden of Eden.⁵ After this there ensued a period of great sin and evil in the world, spurring God to destroy the world and all men except Noah, the only godly man alive. As He restored the world, God made a promise not to destroy the world in similar fashion ever again.⁶

Abraham's covenant was based upon Abraham's faithfulness and for his lineage to continue to be a Godly one, for it to be fruitful and multiply. In the process God

⁴ O. Palmer Robertson, *The Christ of the Covenants*, (New Jersey: P & R Publishing, 1980).

⁵ *Ibid.*, 93.

⁶ *Ibid.*, 109.

demonstrated favor towards Abraham by giving him a child in his old age and spared him the sacrifice of his child.⁷

The Mosaic covenant between God and the Israelites took place after their liberation out of Egyptian slavery. It included a series of laws to be used as a temporary guide for sinful man to be able to be in right relationship with God and receive the blessings of such a relationship. Through this, God demonstrated a consistent desire for a right relationship with His people, and God's providence was clearly seen in rescuing them from the Egyptians in miraculous fashion.⁸

The Davidic covenant points to Christ and establishes the lineage from which He is to come, as the promised redeemer of God's people. God protects and blesses this line in preparation for Christ's arrival.⁹

The final covenant through Christ is a cumulative effort which incorporates all the previous covenants by providing for the inclusion of all people to enter into God's family. It is initiated through the sacrifice of Jesus Christ, God's son, the only possible mediator between God and man for the sins of the world. The sacrifice of Jesus demonstrated and proved God's great love for mankind: "He who did not spare His own Son, but delivered Him up for us all, how shall He not with Him also freely give us all things?" Romans 8:32.¹⁰

⁷ Ibid., 127.

⁸ Ibid., 167.

⁹ Ibid., 229.

¹⁰ Ibid., 271.

With great steadfastness God extended care towards mankind ever since creation. While allowing for sinful consequences, God does not turn from man. Rather, God faithfully makes a way for men and women to be reconciled to Him at every turn, to give them a hope for the future and strength for the present. God never forsakes.

These greater covenants were all established through particular individuals, but God also ministered directly to people throughout history, though on a somewhat less grand scale. Through the prophets God provided warning and guidance to His people so that they might avoid sin and punishment.

On an even more individual level, we see His caring and provision for Jonah's protection when his fear causes him to resist his call to go to Nineveh. We see God's grace in including Ruth, a poor foreigner, into the line of Christ. There is His work of restitution in response to Job's faithfulness through harsh circumstances and his miraculous preservation of Daniel from the fiery furnace.

God is just as caring by bringing accountability and protection of the faithful by the punishment of extreme sin or pagan threats. We see this in the flood, the destruction of Jericho in Joshua 6, Sodom and Gomorrah in Genesis 19 and the Amalekites in Exodus 17.

His Word as it was passed on through His people in stories, poetry and psalms are a balm in times of need and are a reminder of His goodness. The faithful can find comfort and blessed fellowship with God through it.

As we can see, it is part of God's character and desire to care for, preserve, protect and love what he has created, if not in this life, then in the next. The story of the mother and

baby shows how as humans we can be at a complete loss of how to understand or manage events. How God can allow such suffering is hard to fathom. It is often the reaction to be angry with God, to feel guilt, shame or judgment. A greater perspective of God's work over the course of history can help us see how we are not judged according to our sins. In the Reformed tradition, our faith in Christ's perfect obedience and atoning work assures us of our salvation in spite of the gravity of our sins. "As there is no sin so small, but it deserves damnation; so there is no sin so great, that it can bring damnation upon those who truly repent."¹¹

The mother, in spite of her clear and intense aversion to what had happened, somehow found the strength and determination to act in faith, to open herself and her defeat up to God on a level that went beyond her grief, anger and lack of understanding. This allowed her to receive God's blessing for herself, her family and her child. It was the most she could have done in the midst of her loss. In humble submission to a God she truly wanted to know and understand as loving, she invited Him to work in whatever capacity He could for good in the midst of the worst of tragedies. Part of that goodness manifested itself within a very short period of time with God receiving the child into eternal life, by the reconciliation between the patient and her mother, and with the beginning of healing.

Case Study 3 - A Distorted God

A young woman with cerebral palsy is admitted for attempted suicide. This is my first encounter with her. She asks me to close the door when I enter. She struggles to

¹¹ *Westminster Confession of Faith*, (Scotland: Free Presbyterian Publications, 2003), 15:4.

Speak, her words come at long intervals, and at first I think she is handicapped in a different way than she appears. I see her as a child initially. She is knitting a scarf and I ask her about it. She quickly takes the lead with more serious conversation and I can see that rather than being mentally challenged, she is very intelligent, relational and thoughtful.

She tells me about her illness, that it was brought on by the administration of a medication she was allergic to at a very young age. She tells me about the pain in her leg and how unbearable it is - a constant 10 on a scale of 1-10. Their insurance has run out, she is unemployable with her condition, and her mother has an injured arm and she feels guilty when she has to help lift her. Every sentence is just a little more heartbreaking. Her suicide attempts are triggered by low self-esteem about the way she looks and who she is. She tells me that she feels like God is mad at her. Her pastor told her that she should not complain, that she cannot suffer because Jesus suffered everything for us already. She feels like a bad person inside for feeling the way she does.

In spite of her limitations, she says she has lived and seen a lot. I think to myself that she most probably has, but again she surprises me with the complexity of it all. She continues to talk, and speaks about a man who was caring for her when she was ten years old and molested her. He was punished, thankfully. Wanting to bring some kind of light into her life, I affirm her feelings, her pain, and try to touch again on her

thoughts about what her Pastor said and what she has understood about Jesus' suffering and our suffering as humans, as Christians.

She seems to be relishing in the company of someone who listens with concern and without judgment, something she has little of on a daily basis. She shares more about herself, revealing that she plays guitar, she speaks seven languages, and has travelled the world. It all seems so improbable and with the many, many stories I hear from people I often have to check myself to see if they are speaking metaphorically or even out of some delusion. I tell her I love languages too. She explains she knows Spanish because she is from Ecuador, Italian because she lived there and has family there and others from her travels. It just didn't seem possible, so I start with my own Italian and a big smile comes across her face. It is beautiful and I am grateful. She refuses to turn back to English and her Italian is excellent. She speaks of the cities she has been to, she is captivating and has adapted to learning languages in an amazing way, probably aided by her handicap. She recites some of her personal poetry in Italian, using big words. I ask her if she knows French, and yes, she responds in French with deliberate enthusiasm and more conversation. She asks about my children and we weave in and out of theological ideas.

There seems to be two such distinct people in this one girl. Her gifts and talents are many, and it is not surprising that she feels unfulfilled when she has so much to offer and no position to do it. I urge her toward the hope of finding a way to use her

talents, possibly through online support groups where there are others going through similar struggles, even in different countries.

As abnormal as she feels, she is completely normal in her feelings. Her church leader and members may not be the most present or helpful to her, but in our prayer together I try to emphasize God's love and purpose for her, stressing that God does not want to hurt her, that she is not alone in her suffering, and list Christ as an example of how to bear our burdens. We ask for forgiveness of our sins to ease the burden of guilt, so that she may be able see beyond the confines of her physical ailments.

As I look back on our visit I realize again how a distorted view of God can hinder one's faith. If one piece of our theology is misaligned and taken to heart, it can skew our entire world view and ability to claim God's grace in our lives. It is imperative to attempt to understand, identify and address these incongruities in ourselves and in others in order to promote and effectuate God's true healing power. Similarly, people's unfamiliarity with who God is or a limited or cautious view of Him or of the people who represent Him may interfere with healing. As chaplains, we are in a unique position to help people gain a clarity that is truer to themselves, with respect to how some views conditioned by the world or a limited or controlled environment can stand in the way of fulfillment for a person's life. We can join them for this part of their journey in life and faith, where they may be able to entertain or

consider God in new and unexpected ways, ways that would serve them well in dealing with the hardships at hand.

“You have heard that it was said, ‘You shall love your neighbor and hate your enemy.’ But I say to you, love your enemies, bless those who curse you, do good to those who hate you, and pray for those who spitefully use you and persecute you, that you may be sons of your Father in heaven;” (Matt 5:43-45a)

Christ’s as Caregiver

Seeing Christ as God incarnate gives us a deeper understanding of the likeness that God intended for us. Jesus valued each person equally. Scripture describes His work as directed to sinners, those who suffered at the hands of sinners, those oppressed by evil, and those suffering the consequences of the fall in illness. It was through His mediation and ministry with them that He gave meaning to His work and revealed Himself and God's redemptive plan, inspiring us to follow him and grow in our likeness to Him, whether it be by imparting or receiving that grace.

Jesus’ healing ministry demonstrates that as God’s Redeemer, He is sent directly and with bold humility to address the brokenness in the world. He is Prophet, Priest and King¹² above all others. Prophet as God’s own revelation of Himself as the Word incarnate (John 1:1), Priest as He approaches God for us both in His earthly ministry and presently as He intercedes for us in heaven (1Tim 2:5), and King in His authority over the church and the

¹² *Westminster Shorter Catechism*: Question 23. Accessed March 1, 2014. <http://opc.org/sc.html>.

universe (Eph 1:20-22).¹³ He exercises these mediatorial offices all to humble perfection while on earth and in His exalted state at the Father's right hand in heaven.

From His teachings in the temple, to addressing individuals and disciples, Jesus declares God's love for us, and alerts us to ways our behavior can be an affront or a blessing to God and others. There is an expectation of discipleship, for His care and concern, sacrifice and function to be carried on and spread throughout the world. God originally intended us as humans to rule the earth as kings, to commune directly with Him and to know His will intimately. All of these correspond to Jesus' offices of King, Priest and Prophet. We see repeated the original intent for humans as image-bearers of God to conform to God's family; a royal priesthood (1Peter 2:9); to present ourselves as living sacrifices for Him (Romans 12:1); and to know Him and rule with Him after His return (Rev 3:21), since we are also mandated to function in those capacities, as Christ did.¹⁴

Matthew 25:40 tells us so in His exhortation to "Go therefore and make disciples of all the nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all things that I have commanded you; and lo, I am with you always, even to the end of the age." Amen.

The strength and confidence with which Jesus asserts this command comes from a place far removed from our own worldly surroundings. It carries the authority of God in heaven, they are His words, it is His will, it cannot help but be fulfilled, and events throughout history make this authority all the more evident.

¹³ Wayne Grudem, *Systematic Theology*, (Michigan: Zondervan, 1994), 624-629.

¹⁴ *Ibid.*, 629-630.

While we recognize the power of Christ's ministry, it is important to note that it was inaugurated by His Baptism, with the Spirit of the Lord descending upon Him (Luke 3:21-22) and with Him throughout it. He speaks the passage below at the beginning of His ministry to His own people in Nazareth who reject him. Luke 4:18 is particularly inspiring to those who seek to follow in His ministry, particularly as a chaplain where the response is not always predictable or welcoming.

“The Spirit of the Lord is upon Me,
Because He has anointed Me
To preach the gospel to the poor;
He has sent Me to heal the brokenhearted,
To proclaim liberty to the captives
And recovery of sight to the blind,
To set at liberty those who are oppressed;”

We know to walk in the Spirit in spite of the lack of belief around us by the power of the Spirit that works in and through us for God's will. It is important not to lose sight of that, to know that regardless of the response, God's Word and work will bear fruit. When we respond to and depend on the Spirit's presence, there is an “atmosphere of power, love, joy, truth, holiness, righteousness, and peace.” It grants us access to God (Eph 2:18), it allows us to pray in His power (Eph 6:18), and love beyond our own capabilities (Col 1:8).¹⁵

The other side of Jesus' healing ministry involved miracles. He revealed Himself for the loving God He was with various people needing His help. They actually believed He could help him (the blind man, the demon-possessed, the leper, Lazarus, the cripple, the nobleman's son, and Jairus' daughter). Jesus' leans on no other authority than His own, and His relationship with God the Father and the Holy Spirit. His preaching and teaching comes

¹⁵ Ibid., 648-649.

from His very own selfhood, without imperfection or compromise, with complete soundness of speech and intent. He is inspired by events and governed by God's unchanging character as revealed in the Old Testament. He is supernatural in character and action, unlike other faith traditions' leaders.

Yet His humanity gives us reason for which to base all our own actions and understandings. It is from His Word, relevant to His contemporary circumstances, and pervasively relevant throughout time, that we are able to claim the hope of restoration through Him, by His agency, as we engage with patients and their families.

“Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who comforts us in all our tribulation, that we may be able to comfort those who are in any trouble, with the comfort with which we ourselves are comforted by God.” (2 Cor 1:3-4)

When we consider a person's ability to handle stress, change and crisis in life, after some experience in the midst of those, there is a noted discrepancy in how the events are managed and processed depending on the individual's or family's depth of faith and reliance on Christ. Those distant from God tend to cling to the appearance of control and are more reactive, while those close to God, though still suffering in their circumstances, demonstrate more vulnerability, acceptance and a greater capacity to adapt to what has transpired. They are usually better supported by community as well. Thus we get a sense of how Christ's healing works preemptively in people's lives, if it is properly nurtured. A distorted view of God, perhaps of His anger or vengeance, can become an added burden to the circumstances as we saw in the previous illustration of the young girl with cerebral palsy. In our roles as chaplains we can help awaken the lost or broken to God's presence, and be a

part of a community of support for those already leaning on their faith. In this way we help them explore and refine God's nature in situations where limited and possibly misinterpreted spiritual guidance has been given.

Christian Church and Community as Caregivers Throughout History

Beginning with the very first disciples of Christ who chose to pursue His teachings and ministry and support one another in challenging times of persecution, we see the concept of brotherly love as the foundation of Christian ministry and work. Christ's attitude towards His disciples and His guidance on how they should behave towards mankind represents the Trinitarian relationship in its finest form, even though the limited way in which it is practiced by humans it becomes flawed and challenged by sin and needs continual encouragement and reminding of the Source of that love.

At Pentecost the power of the Spirit brought a large body of believers together in a single community representing the early church with the blessings of God on it. As the church developed over time the teachings of Christ continued to unite Christians who flourished in communities, where they practiced and developed Christian ethics and responsibilities based on Christ's ministry. This response included tending to the poor and afflicted, lifting people up based on the image of God inherent in them and moving them away from being marginalized by a society or the church because of their conditions.

Writers such as Cyprian, Dyonisius, and Eusebius documented ways that times of major illness such as smallpox or the plague actually assisted the Christian cause precisely

because it was the Christians who responded to people in crisis by providing important physical help. Eschatologically it gave people a hope for the future, exposing the inability of existing Greco-Roman or pagan structures and religions to help people cope with such crises. Those who found themselves at a loss of community or family because of the great number of fatalities also found welcome, meaning and strength in Christian community.¹⁶

Many people in areas stricken by disease react in a fearful and self-insulating manner. It was clear that Christians were different in their response and commitment to brotherly love. They were taught how to enter into difficult situations and do what they could in terms of assistance, be it feeding, healing, cleaning, fellowshiping, sacrament, or worship in spite of the direness of the circumstances. This often found them working side by side among physicians and nurses, in their facilities or homes for the sick and sometimes even in lieu of the more traditional healers who lacked a cure. The earliest hospitals were extensions of the ministry of the church and driven by a desire to help one's fellow man.

A striking earlier example of this that is well-documented by Cyprian and Eusebius among others includes the "Plague of Galen". In 165, at the time of Marcus Aurelius' reign, one of his Gladiators led an army to the East and contracted the disease that spread throughout the Empire. Since disease was virtually unknowable and untreatable at the time, there was little help from pagan or authoritarian leadership, and there was little consolation in trying to understand why such horrible events should take place or how to manage them. The faith community's response to such concerns, both practically and spiritually, proved better equipped in its ability to respond in ways that would lessen mortality and provide

¹⁶ Rodney Stark, *The Rise of Christianity*, (New York: Harper One, 1996), 74-75, 77.

meaning and comfort to those afflicted. In fact, this devastation provided the opportunity for Christianity to shine in the midst of hardship where other religions could not.

Cyprian wrote that such times also contributed for the Christians a way to “gladly seek martyrdom while . . . learning not to fear death . . .; they give to mind the glory of fortitude; by contempt of death they prepare for the crown. . . .”¹⁷

A later example of this is the smallpox outbreak in Iceland in 1707 that, like the Plague of Galen was estimated to have killed a quarter to a third of the population. The non-Christian response fostered isolation and fear, where Christians demonstrated the opposite in face of the challenge.¹⁸

Their ministrations served to improve the conditions for the people and as a result of the effects of their efforts in solidarity mortality rates declined, rendering plague and small pox less rampant in those communities where they intervened. Stark quotes McNeill on the nature of the care that was needed and provided at great personal risk.

“When all normal services break down, quite elementary nursing will greatly reduce mortality. Simple provision of food and water, for instance, will allow persons who are temporarily too weak to cope for themselves to recover instead of perishing miserably.”¹⁹

Christianity gained validation with these acts of love which directly correlate to the person and teachings of Jesus. Because of the impact of their sustaining presence, Christians are estimated to have improved the survival rate to 80% compared to that of 50% for their

¹⁷ Ibid., 81.

¹⁸ Ibid., 76-77.

¹⁹ Ibid., 88.

pagan counterparts.²⁰ Their witness to non-believers subsequently allowed for the further spread and support of the faith. Situations like this presented themselves as early as the 1st Century AD and persisted to varying degrees globally ever since.

The “Christian Church” in its original form, as it was when Christ established it under His own direction, is definitive in its scope of worship and beliefs and is full of grace. It is a humble and serving institution. While the church has changed over time due to various influences, and syncretism seems to have veiled the reasons and need for seemingly intangible work, those who minister to the poor and sick are true to Christ’s heart and the one true faith He represents. Those called to chaplaincy cannot help but manifest those intentions, similar to how the Apostles went out after being commissioned to continue to care and provide for people as Christ did. Times of crisis and epidemics only serve to illustrate how other religions and pagan institutions are evidently lacking when it comes to combating great attacks on a population. Christians stood out in stark contrast to those who fled, hid or were otherwise unable to make be a positive influence on the situation.

Chaplaincy

The origins of the word ‘chaplain’ comes from the French *chapelain* and the Latin *capella*, both words for the “cloak” worn by Martin, Bishop of Tours. He was a great humanitarian monk and was said to have torn his cloak in half to share with a beggar on a cold night while he was still a soldier. Although he lived in the 4th century, the word did not come into common use until the 11th century after the shrine which housed it was replaced

²⁰ Ibid., 93.

by a larger structure that came to be known as the *chapelle* (French), *capella* (Latin), or our English “chapel” which was guarded by a “chaplain”. This role included the safeguarding of all things sacred and acts of compassion towards others in keeping with Martin’s ministry.²¹

This role was further developed over time in times of combat, homes for the sick, and other more self-contained situations, and has always been fulfilled by Christians for the most part over the centuries. There is no limitation as to who a chaplain can serve, other than one who is in need. This exhortation or calling is not as prevalent in religions other than Christianity. Christ’s teachings command and inspire compassionate action, not just passivity. They are the foundation for the degree of fervor, sacrifice and dedication that is seen among Christians and the reason for its widespread impact on the world. God, Jesus and the scriptures have inspired us to act in this capacity throughout history, regardless of human intervention or authority, and often in times and places where both are absent.

²¹ Naomi Paget and Janet McCormack. *The Work of the Chaplain*, (Pennsylvania: Judson Press. 2006), 2-3.

CHAPTER 3
THEOLOGY OF PASTORAL CARE

Case Study 4 - Seeds of Faith

A young father travelled down from Ohio to be with his two year-old daughter who was bludgeoned by her mother's boyfriend. The daughter was unlikely to survive, with a large shunt in her head, a long road to rehabilitation and the likelihood of extensive brain damage. The father moves into the room, spends his nights there, on his own, by her side. He makes sure she is cared for and fed as she becomes able. He is a common figure in the hallways, going for his cigarette breaks. He is friendly enough, and not given to emotion. After a few simple check-ins, I decide to ask him a little more about his feelings about the events, and about his faith. There is anger, but more than anger there is also simple acceptance about what he has to do for his daughter. His concern for her prognosis or her future does not seem to be a priority, he is simply in the present. He trusts that the authorities will take care of the mother and her boyfriend.

When I ask him about his faith, he explains that he is wiccan, that he feels the presence of his aunt and uncle with him, and that he is "sensitive" to another plane of existence. This indeed seems to be the case with the way he is dealing with the crisis.

He also says he is attending a Spanish Christian church once a week with his aunt. He cannot understand the message or the Gospel being read, but he “feels” something that makes him need to be there. That is the extent of his faith at the time. He exhibits self-control, responsibility, and a sense of something greater, though not defined.

God is not absent, even if in this case it would appear that the individual does not acknowledge or know God in the biblical sense. He has a distorted view of spirituality, although he recognizes that on a practical level, it is important to him in his circumstances. Like many young people, he has superficial beliefs far removed from the absolute truths of Scripture. Still, he was coping in his situation and the daughter was certainly benefitting from his presence. She continued to recover in miraculous fashion and eventually was discharged, walking and talking playfully, although with a helmet on her head, like any other little girl. This young man seemed to be poised for a greater understanding and calling from God. I supported him on his journey and appreciated the gifts of raw faith and strength of character that would surely continue to serve him and his daughter well. He reminded me of a young Paul, Saul of Tarsus.

Paul: Human agency in healing

Paul, a human example of ministering to a lost world, looks to Jesus and the Gospel as his exclusive source of teaching and preaching as well as for inspiration on his own personal

journey. Through him we are able to see that God can use human servants He has called and equipped to bring men and women to saving faith.

Far from being irrelevant to our contemporary world, Paul's approach to spreading the Gospel to a broken world and identifying with its needs was inspired by his own dramatic personal conversion. His letters to the various churches and people near and far speaks to the universality of the issues that challenge every community and human being regardless of ethnicity, social stature or background. God's Word can be heard by all men. In the churches of Galatia, Thessalonica, Corinth, Rome, Ephesus, Colossus and Philippi, that included free men and slaves, to young and old.

Paul addresses the brokenness found among men who distanced themselves from God in the forms legalism, idolatry, ignorance, gnosticism, persecution, false teaching, pride and sinful behavior.

Much in keeping with Paul's methodology, Frame puts forwards a similar helpful approach which includes; meeting people on their intellectual level; arousing their interest; interacting with some area of their life where there is a struggle; introducing something new and beneficial; and loving the person in Christ without compromise.¹

Let us examine Paul's speech in Acts 17:16-30 where his intervention is particularly supportive and indicative of God's healing power (v. 16-18). As chaplains we would do well in looking at this very example for Paul's boldness in facing such a large and diverse crowd

¹ John Frame. *Apologetics to the Glory of God*, (New Jersey: Presbyterian and Reformed Publishing Company, 1994), 69.

(v. 19-21), for his courage in challenging false beliefs (v. 22-23), and ultimately for his empathy in reaching out to a lost community with the Gospel to God's glory (v.24-30):

Now while Paul waited for them at Athens, his spirit was provoked within him when he saw that the city was given over to idols. Therefore he reasoned in the synagogue with the Jews and with the Gentile worshipers, and in the marketplace daily with those who happened to be there. Then certain Epicurean and Stoic philosophers encountered him. And some said, "What does this babbler want to say?"

Others said, "He seems to be a proclaimer of foreign gods," because he preached to them Jesus and the resurrection.

And they took him and brought him to the Areopagus, saying, "May we know what this new doctrine is of which you speak? For you are bringing some strange things to our ears. Therefore we want to know what these things mean." For all the Athenians and the foreigners who were there spent their time in nothing else but either to tell or to hear some new thing.

Then Paul stood in the midst of the Areopagus and said, "Men of Athens, I perceive that in all things you are very religious; for as I was passing through and considering the objects of your worship, I even found an altar with this inscription:

TO THE UNKNOWN GOD.

Therefore, the One whom you worship without knowing, Him I proclaim to you: "God, who made the world and everything in it, since He is Lord of heaven and earth, does not dwell in temples made with hands. Nor is He worshiped with men's hands, as though He needed anything, since He gives to all life, breath, and all things. And He has made from one blood every nation of men to dwell on all the face of the earth, and has determined their pre-appointed times and the boundaries of their dwellings, so that they should seek the Lord, in the hope that they might grope for Him and find Him, though He is not far from each one of us; for in Him we live and move and have our being, as also some of your own poets have said, 'For we are also His offspring.' Therefore, since we are the offspring of God, we ought not to think that the Divine Nature is like gold or silver or stone, something shaped by art and man's devising. Truly, these times of ignorance God overlooked, but now commands all men everywhere to repent"

Paul's speech to the intellectually-oriented philosophers in Athens is a tactful approach to dealing with leadership on their level, of eliciting serious and thoughtful consideration for the message he was presenting in a way that they could identify with it. His

examination of their culture gave him insight into what they understood, and what they did not. He carries the entire Gospel to them in a few passages in a conciliatory manner.

Paul's consistent incorporation of blessings for grace, peace and protection in the body of his letters demonstrates his absolute trust in God to bless and grow all those that God has chosen. In Ephesus: "So now, brethren, I commend you to God and to the word of His grace, which is able to build you up and give you an inheritance among all those who are sanctified" (Acts 20:32). In Hebrews 13:20-21: "Now may the God of peace who brought up our Lord Jesus from the dead, that great Shepherd of the sheep, through the blood of the everlasting covenant, make you complete in every good work to do His will, working in you what is well pleasing in His sight, through Jesus Christ, to whom be glory forever and ever. Amen."

These words are powerful and call upon God in His entire redemptive capacity. Paul claims the sacrificial blood, the Holy covenant, the perfection of Christ, and His very presence and action.

There is genuine humility in Paul's work. As great as his impact and influence was and still is, it is clear to him that it is not his own. He is a vessel, used by God. He effectively emphasizes the relationship with God and Christ as sustenance for faith and salvation to individuals so that they can address their own issues and do not become reliant on him. Though he still maintains a supportive role in times of need that can sometimes hinder spiritual progress. This is a great example for us to follow in our own ministries where many people, particularly new believers, are used to and easily reach for a human

presence that is more concrete to turn to in times of need. He is an inspiring orator and writer who works with the Spirit in evoking the response of faith in those that God has called, though he identifies more with the real human weaknesses of those who he is addressing:

And I, brethren, when I came to you, did not come with excellence of speech or of wisdom declaring to you the testimony of God. For I determined not to know anything among you except Jesus Christ and Him crucified. I was with you in weakness, in fear, and in much trembling. And my speech and my preaching were not with persuasive words of human wisdom, but in demonstration of the Spirit and of power, that your faith should not be in the wisdom of men but in the power of God. (1Cor 2:1-5)

God uses Paul to encourage them in their walk. He understands that nothing can come between the believer and God.

“Yet in all these things we are more than conquerors through Him who loved us. For I am persuaded that neither death nor life, nor angels nor principalities nor powers, nor things present nor things to come, nor height nor depth, nor any other created thing, shall be able to separate us from the love of God which is in Christ Jesus our Lord.” (Romans 8:37-39)

Emphasis on life, even in the face of death, illness, or limitation is a certain sign of spiritual health and healing. In 1 Corinthians 1:9 Paul writes, "God is faithful, by whom you were called into the fellowship of His Son, Jesus Christ our Lord." Jesus is life, the purest form of life, and our communion with Him calls us into that life, regardless of our circumstances.

The more we suffer in our humanity, the more reason we have to seek His truth and fellowship there. Further, as members of his body (1Cor 6:15-17), we are not alone in our struggles with pain and death. We should seek the many resources Christ provides in terms of mutual support through fellow believers, His Word, His presence in our hearts, and His

forgiving grace. Christ continues to grant us strength and courage, and His creative nature by using difficult circumstances in order to effect a positive outcome and meaning in life.

Case Study 5 - Irresistible Grace

A patient is admitted who is familiar to the Pastoral Care department for being a Bible scholar with a flair for the dramatic. His last visit, however, took an unprecedented turn when he decided to urinate in a cup in front of one of the younger female Chaplains.

The diagnosis on the file was of depression and when another order came in as a request for a Bible, I went, unaware of what had transpired during the previous visit. I didn't think much would develop with him on a theological level, since he was older, claimed to have an M. Div., and spoke several ancient languages. I was curious to meet him and thought he would simply need someone to talk with and pray with, but nothing is predictable in the chaplain's world, as some of the Chaplains had already experienced.

The room is sterile, with no personal effects in sight. I am taking standard precautions (mask, gown and gloves) which is not uncommon. The patient has his leg up and bandaged, he is disheveled and bent over to the side, grimacing in pain. I ask him if he needs the nurse. He says no, he has a tooth infection on top of everything else, it is killing him. Job, I think. What great work is God doing in this

man's life? He appears easy in his conversation in spite of the tooth, and leaves little room for interaction. He seems accustomed to his surroundings, even in his discomfort. I pull up a chair and he looks at the Bible in my hand. He tells me he knows the other Chaplains, he mentions the young girl. I ask him how come he knows us so well. He explains his seven other operations. I can see there is anger as he questions God's intent for him, but his anger is indirect. The nurse enters and he begins to preach Christ to her which prevents her from taking the swab she came in for. The nurse nods, waiting for him to finish, but it is clear he wants to continue. I interrupt him and ask him to let her take the swab so she can get back to caring for her other patients.

He then returns to his thought about "being turned over for the sake of the greater plan", going back and forth between long bouts of preaching and his personal experience. I am curious about this "greater plan", but feel it will reveal itself in due course. In the last five years he has lost his mother, father and son. He becomes tearful. His mother was a religious Baptist, and thanks to her influence he had a tremendous gift for quoting the Bible. He is isolated by his illness. He clings to his faith, but repeats feeling a sense of "emptiness." He feels like a victim for the sins of the world and that he has lost his salvation. These are serious admissions coming from a man of faith. He is angry at the psychological diagnoses and medication they have him on when he sees his sickness as a spiritual one. He feels great guilt. There is no breaking down the barrier that might allow him to reflect on that guilt. There is

only his denial of his ability to receive God's love and grace, or even to acknowledge it for himself because of how he has fallen short. He is intent on the role of Michael the Archangel in defeat of Satan in the world during what he sees as present end times. He feels he is failing in that role that he identifies with. He has shifted his role in the "greater plan" from being a great warrior to one in which he is to be martyred for the sake of God's conquest over evil. He does not seem to appreciate this role, but accepts it and claims it.

His zealous yet misguided faith background has a grip on him, which he is aware of with a mixed sense of pride and resignation in which he seems mired. A belief that the Lord should be enough to get him through anything, that he should never lack in joy or express doubt. Instead he is to cling to a role that he can't always maintain, without being able to share about his weaknesses for fear of betraying our faith.

Was this a distortions of 2 Cor 12:9? "And He said to me, 'My grace is sufficient for you, for My strength is made perfect in weakness.' Therefore most gladly I will rather boast in my infirmities, that the power of Christ may rest upon me." But there was no grace and no power in him, only him trying to play the part by demonstrating it through the incessant disconnected preaching of the Word.

The patient's faith seemed like bondage to Christ, a denial of our humanity or the journey of faithful recovery in response to our salvation. He could not allow for human weakness, the legitimate effects of sin or grief to work their way through, or the grace that sustains us and gives us hope through and beyond them.

His preaching seemed like the only way he could find to make it up to God for all the guilt, anger and negativity he was feeling.

We are called to live in Christ, to feel the fullness of the grace which is an integral and inseparable part of His redemptive plan. He ignores my trying to touch on anything personal, such as the grief he was feeling for the loss of his family, or the emptiness clearly contributed to by that loss. He tells me about his salvation experience. “It felt like liquid gold was coursing through my veins.” Now he does not even feel God’s presence.

He returns to preaching and signs of end times including war and catastrophic weather. I try to interrupt him, he ignores me. I try again, louder, “My concern is that you are not allowing yourself to accept God’s grace.” “I feel like I don’t deserve it, like I am not doing what I am supposed to be doing.” He does not feel accepted, he feels judged. “What would make you deserve God’s love? He loves you right now, right where you are, you know that in your head at least, you studied it.” He seems dismissive about this. I asked him if he ever thought it might be easier not to live than to live the way he has been or with what he has been feeling. I try to give him permission to admit such feelings in the presence of another believer.

He takes offense at my words, calls them “Satan’s words”. “Christ never wants us to feel that way, he would never accept that kind of thinking.” He looks at me with distrust and starts to preach again. I interrupt him. “Those are human thoughts, and God loves us even if we have them.” “I don’t believe that.”

It is time for me to leave, an hour has gone by. I tell him I would like to speak with him again and offered prayer, acknowledging his suffering, his grief, asking for God's grace to help him overcome his hardships, for His presence to be felt, for a reconciliation for whatever may be separating him from feeling God's presence, for confidence and assurance of His love, for healing. At the end he tells me, "Now you see Pastor, I don't feel like I deserved that prayer at all." He indicates that he would like to talk about when he met his wife next time, which we did a few days later. I was grateful to notice an absence of preaching and that he had softened since our first meeting.

Grace

For the purposes of this paper we will distinguish between two main forms of grace; the special or saving, redemptive grace of God and common grace as defined by what we normally experience in this world.

One of the particular strength of the Pastoral Care department at TGH is the abundant sense of grace there as it is extended through the department in its leaders and reciprocally amongst peers. The very nature of the work, its emergent, crisis-driven nature, I believe is what demands it. It would be far too easy for people to lose their heads or not persevere were it not for a gracious allowance for growth in dealing with specific and difficult scenarios, each one unique and unpredictable in its own way. This encourages and increases one's faith and ability to positively impact a patient. This is indeed a special form of grace, intended for

special circumstances which push us to our limits. We offer sacrifices of self to God in accepting a patient's anger towards Him. We tolerate and forgive weakness and error in terms of emotional interpersonal reactions with staff and peers. There is a degree of leniency with respect to exceptions to institutional policy, particularly in consideration of the often unexpected or unfamiliar roles imposed on us by our vocation. By reserving or redirecting any personal construct we may have, to make room for and facilitating what is at work on a greater level, we allow God's special grace to work through us for the benefit of others.

The degree to which an individual experiences the guilt of sin and appreciates the full value of God's grace involves a pivotal doctrinal distinction between many Christian denominations. Catholic, Reformed and Arminian distinctions all recognize that there is hope in God's grace. We must be careful, however, to note that opening the door even slightly to the contribution of our own works towards our salvation inversely impacts the effectiveness of Christ's redeeming work and infers a confidence in ourselves that can easily lead to a continued bondage to sin and the guilt that results from that sin. We know that God can forgive us, but we are never able to forgive ourselves because we can never really know how or if we measure up. This is not to discount God's saving grace or our own works that would witness to our faith. It does impact an individual's perspective on their circumstances, and the degree to which self-blame can interfere with their progress in healing, both spiritual in developing an assurance of their salvation, and by association physical, in gleaning the strength and peace that comes from that assurance. God's entire supernatural ability to work in the situation through our personal abilities and desires is handicapped by what a more

works-minded theology might effectuate. The amount of sin in an individual's life can be overwhelming and uncontrollable. For many in times of serious hardship or dealing with death, thinking about God's judgment can obscure potential for grace. The fact that some believe salvation can actually be lost makes the burden that much more unbearable, but scripture assures us of the perseverance and God's guarding of those who are truly called to Christ.²

Often chaplains enter a room as bearers of that needed special grace, whether the patient realizes it or not. We provide a point of contact between God and His image bearer. With a focus on God, it is likely that some connection will be made as that image is reflected, though dimly at first, in and through each other.

People question how a benevolent God could allow for suffering to the degree that it exists in the world or in their lives. We can trace the reasons for this suffering back to the fall, but attempting to understand its presence and effect on the world remains a sacred mystery (2 Cor 2:6-16). Therefore we cannot know what might atone for it, aside from putting all our trust in Christ as our mediator and redeemer. We also know and claim God's presence with the suffering believer (Romans 8:28) and can believe that He is able to "bring sanctification and growth in faith" through struggles and afflictions, healing us in unexpected ways.³

² Wayne Grudem. *Systematic Theology*, (Grand Rapids, Michigan: Zondervan, 2000), 791.

³ *Ibid.*, 1069.

Case Study 6 - Mea culpa

I was called to our Trauma ICU to speak with a man who had come in the night before, unconscious after being involved in a homicidal motor vehicle accident while driving under the influence. He had regained consciousness and was not aware of the fact that he had killed a man, a father of three. He was a displaced Spanish-speaking migrant worker, and as in most of these cases, the men make temporary connections with other workers and are distanced from family. This man was on his own and unknown to him facing a charge of homicide.

I enter the room, it is early morning. The patient is in his mid-thirties. His head and his leg are bandaged. He looks sleepy and confused about his surroundings. I approach the bed and ask him if he speaks English. He says no. I can smell residual alcohol on him. I explain to him in Spanish that I am the “Pastora” and that I would like to speak with him with the use of the Blue Phone that assists in translating the conversation. He agrees.

The operator introduces herself in a very efficient manner. She does not enter the conversation and has a strict protocol to follow regarding the formality of her role. The operators minimize their presence by keeping their function as unobtrusive as possible without any pauses, fluctuations in tone, hesitations or interruptions.

I ask him how he is feeling, he is ok he says, and looks at his leg with concern. The least of his worries, I think. I ask him if he is a Christian, he says yes. I ask him if he knows where he is. He says in a hospital, but seems to need confirmation. “Yes,

in Tampa,” I say. “Tampa,” he takes that as new information. I ask him if he remembers anything from the previous night. He says he was out with a couple of his friends, he remembers a car accident. I ask him if he remembers who he was with. He is vague about it, not really, some friends he names by their first names. He is not very talkative, but considering the situation, this seems appropriate.

I take a breath and explain to him that he hit a man with his car last night, and killed him. There is a pause on the line from the operator as she relays this information. He nods and looks away. I give him a moment to respond, he does not. I explain the police will be coming to speak with him. He nods. I let him know the man he killed had a young family. There is the slightest sign of complex emotion that crosses his face; grief, anger, sadness. He is starting to process. I give him time. We are all silent. He keeps his face turned away from me.

“Do you understand what I have explained to you?” He nods. More quiet.

“You don’t remember anything at all?”

“No,” he shakes his head.

“What are your thoughts about everything I just told you?”

He shrugs, and says, “I am very sorry for what I have done. I don’t know what to do about it.” Words are hard for him.

“Do you understand how serious this is?” He nods.

I explain that a lot of what will happen with medical care and the legal process both of which will be addressed by the nurses, doctors and the police. He will be

provided an attorney. I offer to help him contact his friends or family, if the police allow, and to come and see him again while he is in the hospital if he feels like he needs to talk about anything.

He looks at me now and nods.

“Is there anything else I can do for you right now?” He shakes his head. It was not surprising that he did not request prayer.

“Would it be ok if we prayed together?”

He agrees, but there is a sense of reluctance in which he seems almost fearful to approach God in this time. I offer prayer for the victim’s family, for the soul of the victim, for whatever opportunities for repentance that might present themselves for the patient and that he make the most of them. He nods through it all. I pray for his ability to seek God’s forgiveness and turn from the behavior that led to the tragedy. The operator remains very efficient and professional up to the end of our prayer.

Confession and Sin

More often than not, people in the hospital view chaplains as persons who can listen to their stories and share them with them for a while, sometimes even wanting them to enter into their experience. Many are isolated or simply incapable of speaking with anyone else about certain issues important to them.

It is a privilege to be the person and sacred representative of God who can be trusted in such a manner. Whatever impact these disclosures may have on their situation is unlikely

to be seen from our end, but for the patient, giving voice to their inner struggles is often an act of courage and demonstrates responsibility towards whatever moral belief system they subscribe to.

Confession is a sign of faithful responsibility so meaningful that it is considered a Sacrament in the Catholic church, where Penance as a consequence of sin falls under church authority. This is not the case in the Protestant church, where seeking Christ directly and with less formality requires no intermediary and allows for complete and immediate accessibility.

As chaplains we are not there to wield the Bible and the Commandments in judgment of what has transpired. The patient for the most part already feels their guilt or dis-ease. We simply provide them an opportunity to present their concern, where it otherwise may have gone or will continue to go unaddressed for an undetermined period of time.

Further, the admission of wrongdoing and reconciliation is an important component of our walk with Christ and entering into communion with Him. 1 Corinthians 11: 27-32 describes Paul's exhortation to examine oneself in order to be right with God before partaking in the sacrament of the Last Supper:

“Therefore whoever eats this bread or drinks this cup of the Lord in an unworthy manner will be guilty of the body and blood of the Lord. But let a man examine himself, and so let him eat of the bread and drink of the cup. For he who eats and drinks in an unworthy manner eats and drinks judgment to himself, not discerning the Lord's body. For this reason many are weak and sick among you, and many sleep. For if we would judge ourselves, we would not be judged. But when we are judged, we are chastened by the Lord, that we may not be condemned with the world.”

This last verse is a key component in the patient-chaplain interaction. In spite of the patient's concern for judgment and a frequent need to clarify the degree to which their confession impacts their relationship with God, our role is best limited to evoking their own responses to their sins in relation to God. In fact, judgment would be counterproductive to a pastoral ministry or relationship where we would seek to understand and promote reflection on their own lives and behaviors in order to strengthen faith and promote healing. Jesus himself would occasionally demonstrate righteous anger in the face of sin (Matt 23), but for the most part:

“Jesus . . . let most people convict themselves, as he also did with the rich young ruler. This was part of his pastoral care of people. Jesus knew that life itself is the therapist that never asks whether or not a person can bear its treatment.”⁴

Often unaware of theological implications, however, the patient finds a need to confess or speak of things that are weighing on them because of sin or dysfunctional roles and relationships which get repeated throughout a family's history. Such issues become more exaggerated and evident in times of crisis. It is likely to continue throughout future generations and this can be yet another point of exploration for the chaplain and the patient. We can help examine family history and these patterns through a new lens, and with that increased awareness the patient can attempt to impact the system of which they are a part in a positive way.

The same goes in recognizing God's role and providence in a family's history. Without the telling and passing on of stories and important events, which was a very

⁴ Wayne Oates, *The Bible in Pastoral Care*, (Grand Rapids, Michigan: Baker Book House, 1973), 30.

common practice in families in times when people remained in the same community and were less influenced by media, we can lose sight of our identity and God's work over the generations. Alternately, we are left to society's increasingly fragmented and distanced interactions to define who we are and who our children will become. Chaplains can act as agents in trying to maintain and promote a sense of connection with the past and with God's greater plan.

Let us consider sin to be that which separates us from God, from perfecting our knowledge of Him and that which interferes with His will for man. Patients who feel guilty often believe that they are being punished for the sin in their lives, possibly through a judgment of illness. The degree of sin can be from the slightest infraction, for instance simply feeling sorry for oneself, like the woman with cerebral palsy, to homicide, like the migrant worker, from a moment's weakness or a lifetime of bad choices. Sin is very real and a chaplain is not privy to the specifics of God's plan or provision. What we can impart is a greater understanding or clarification of God's nature and some direction on how to draw nearer to Him to better appreciate the blessings He bestows on men, particularly those sinners who believe and repent, regardless of past sins. These blessings grow as we enter into a deeper relationship with Him. A greater understanding of who God is allows for better personal choices and consequences that are in keeping with His design.

Most sin is driven by pride, greed and idolatry (including addiction) resulting in lies, anger and distanced relationships. Biblical principles for ministering to these sins have been incorporated in several therapy models, including AA's 12 steps, family therapy, and

individual counseling. Even though these therapies are touted as modern or scientifically researched, the same sins have been around since humans were created and God has provided direction through His Word and His Son since then as well. We recall His first and greatest command: “Thou shall have no other God’s before me.” (Exodus 20:3)

The fact that the patients are willing to speak and need to speak is the first step in healing by asking for assistance in a struggle. Admitting and renouncing the behavior that is contributing to their ailments, physical or spiritual is a part of it though it is often a stumbling block with many who have been living a certain way for so long. It is difficult for them to overcome the inertia or even see what it is that has a grip on them. It also takes humility and courage, not finding excuses why things need to remain the same or even get worse.

When it comes to healing and approaching those who are pursuing a challenging restitution, chaplains may have the ability to assist with as mediators between parties. They do this by allowing time and neutral space for the disclosure of feelings, apologizing, and understanding how to make amends, as well as accepting the consequences for and resolving to turn from the behavior that contributed to the circumstances. The more specific and sincere people are in these dealings the more meaning the exchange will carry.

“If we say that we have no sin, we deceive ourselves, and the truth is not in us. If we confess our sins, He is faithful and just to forgive us our sins and to cleanse us from all unrighteousness.” (1John: 8-9)

Particular criminal wrongdoings or those involved in assault of some kind require a more direct approach in addressing the serious nature of their actions. In spite of a person’s

belief system, it is clear within our societal boundaries that murder is wrong and punishable. Often there is no one to give this person room for anything but judgment, particularly in the immediacy of the occurrence.

As in the previous illustration, Chaplains may be called in to speak with patients who have committed such an infraction. They are usually aware that they have done something very wrong, and the Chaplain will give them that initial opportunity to confess it and think about their responsibility for it, without harsh chastisement, even though it may seem unforgivable and damning and may take some effort to push our own feelings aside to make room for God's work, we must attempt to intercede in this capacity on their behalf.

The Bible gives us direction in this respect in James 5:13-16:

Is anyone among you suffering? Let him pray. Is anyone cheerful? Let him sing psalms. Is anyone among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord. And the prayer of faith will save the sick, and the Lord will raise him up. And if he has committed sins, he will be forgiven. Confess your trespasses to one another, and pray for one another, that you may be healed. The effective, fervent prayer of a righteous man avails much.

Our walking through this with a patient can be helpful to how they react to authorities, to punishment, and towards the victim. Though some things may be obvious, we are not to take it for granted what is clear to them in their circumstances. Often they are at a complete loss, and hoping in God is their only source of mercy.

“He who covers his sins will not prosper,
But whoever confesses and forsakes them will have mercy.”
(Proverbs 28:13)

The chaplain enters at a time that can change the course of a person's life forever. Our guidance and interaction can set the tone for the patient's attitude and subsequent choices as he deals with his crime or circumstances and whether he can establish any kind of hope for his future.

“The thief does not come except to steal, and to kill, and to destroy. I have come that they may have life, and that they may have it more abundantly.” (John 10:10)

Case Study 7 - God's Word

The patient's room is softly lit, with a votive on the window sill, curtains drawn and a fluffy comforter from home on the bed. He has been here for a while, and he has just received a terminal diagnosis. He is very thin and sleeps most of the time. He wants and needs company. This first visit is a request out of concern from the nurse and doctor. He tells me he has no relationship with God and does not want prayer. I sense a very subtle anger and try to engage him about his care. He appreciates my concern and softens, opening up about his life. His strict father forbade his mother to go to church, even though she had a strong faith. His father is still alive, but they are not close. He owned several nightclubs during his lifetime and is homosexual, distanced from God aside from the early influence of his mother.

Upon my next visit I see another Chaplain has stopped by and prayed with him. He articulates a cautious desire to reconnect with his Christian roots at this

time in his life. He does not know how to go about it. Given the fact that he may never leave the hospital, I return to him with a Bible, a devotional booklet and suggest he read through Romans or John and see if there is anything in there he would like to talk about during our next visit. As I leave I ask him if, pending approval from the nurse, he would appreciate a field trip in an escorted wheelchair to our next interdenominational Chapel services and he lights up. A nurse's assistant brings him down and we sit together. Later that same day, he is informed that his 99 year-old father fell down some stairs and passed away. He calls down to the office to let me know. He finds some irony in the fact that his father would die before him.

During our next visit I express to him that the longevity in his family gives me hope that he will be able to leave the hospital again. My words come, unbeknownst to me, after a discussion of a proposed operation the doctors want to perform in order to help him extend his prognosis and return home. The cumulative effect of his long-term HIV illness and care, and the grief from the loss of his father is weighing on him and he does not want to go through any more major procedures. He simply wants to go home and die. I appreciate his fear, but share my concern for his care at home and his leaving without a proper discharge.

He tells me he is haunted by bad dreams and confused by some of his readings in the Bible. We look at Matthew 11:15. He identifies with Jesus' frustration in wanting to communicate to others and receive understanding. It is a blessing that

this is what has caught his attention. It demonstrates his genuine desire for Christ, and parallel's his own interactions and frustrations with the people around him who don't seem to be able to understand or respond to what he is saying. In spite of his anger and fear, he is connecting with the Word and Christ's humanity in a very real way. When I mention this observation to him, he seems delighted.

He overcomes his fear and decides to undergo and survives the procedure which allows him to be discharged. My last visit happens to fall within an hour of his departure from the hospital. He has a friend who is a Christian who he will try to reach out to for continued support. We ended with a mutual appreciation for our talks together.

"All Scripture is given by inspiration of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness, that the man of God may be complete, thoroughly equipped for every good work." (2 Timothy: 3:16-17)

What began with a man in a spiritual void with no hope for the future resulted in him embarking on a spiritual journey full of God's meaningful presence through His effective Word.

Word and Sacrament

How many chaplains have been caught unaware by such a simple order as the Bible request?

It makes one respect the power of the Word in a whole new light. We are bearers of the Word in the physical, personal and spiritual sense.

The words of John 1:1, 4-5 stand out strongly in chaplain ministry:

“In the beginning was the Word, and the Word was with God, and the Word was God. He was in the beginning with God In Him was life, and the life was the light of men. And the light shines in the darkness, and the darkness did not comprehend it.”

In these verses we return to creation, with Christ, the Word, being united with God.

The Word or *Logos* in Greek is one that had spiritual appeal to Jews and Greeks, although with different emphases. For our purposes it is enough to note that the Word of God was understood by the faithful to include the scriptures and the means by which creation was brought into being (“God spoke . . .”), effectively making Christ in His presence there an agent of creation rather than simply a creature Himself.⁵

And the Word became flesh and dwelt among us, and we beheld His glory, the glory as of the only begotten of the Father, full of grace and truth. (John 1:14)

Through His incarnation, Christ breaks through the dualist barrier that separates man from God, our plane of physical existence from the seemingly unattainable spiritual one. He offers further revelation of God’s greatness to man.⁶ By reconciling the material world in the

⁵ George Ladd, *A Theology of the New Testament*, (Grand Rapids, Michigan: Eerdmans, 2001), 276-277.

⁶ *Ibid.*, 278.

flesh with His spiritual nature He contradicts the worldly views that would separate the two as opposing and uncomplimentary.

By our being in Christ, by our faith, the Word lives in us and as Christians we become by extension an incarnation of the Word as well. As such, God's Word in our hearts, in our heads and in our hands is a tremendously powerful tool and resource. Often times patients seek the Word for comfort in suffering through a reading of the Psalms, and it is a witness to its power to see that effect manifest itself through lowered heart rate, more relaxed breathing, and lessened anxiety.

Patient's also feel the pastoral visit legitimized when inclusive of Scripture. They feel less overwhelmed and isolated in their experience when seen in parallel with a biblical counterpart, much like the man in the illustration above, seriously struggling with several family and health issues, who found communion with Christ in a similar struggle.

Along with the Word, Sacrament is another frequent request. Chaplains can offer communion, anointing and baptism. Catholic and Protestant churches vary in their definitions of what is considered Sacrament. More often than not, patients in crisis are welcoming of a holy presence, be it a priest, a pastor, or even a layman in cases where no clergy can be found in time and doctrinal difference become less of a priority.

It is certain that those in chaplain ministry are workers for the faith, but it does not preclude the fact that many of those do not rely on their work as a means to salvation. The same is to be said of Sacrament when considered a work in itself. The Sacrament is a

function or outward sign of our faith, a further witness to our salvation rather than the cause of it.

What does it profit, my brethren, if someone says he has faith but does not have works? Can faith save him? If a brother or sister is naked and destitute of daily food, and one of you says to them, "Depart in peace, be warmed and filled," but you do not give them the things which are needed for the body, what does it profit? Thus also faith by itself, if it does not have works, is dead. (James 2:14-17)

Such a perspective, in my opinion, opens the door to forgiveness and minimizes obstacles that might interfere with spiritual growth. As the chaplain grows in his or her faith, knowledge of God and abilities to minister, he or she is able to impart hope for the same with confidence to others.

"Do not fear, little flock, for it is your Father's good pleasure to give you the kingdom." (Luke 12:32)

The classic debate on whether or not salvation is dependent upon our good works is something that we can see working in the lives of people and how they view their sin, their salvation, and their ability to overcome certain obstacles in life.

It is harder to cultivate assurance of salvation when we are uncertain of the extent to which it depends on our performance, like the desperate Bible scholar mentioned previously. It takes our focus away from the joy, liberty and ironically the practice of a faith in which we can place our complete trust in Jesus and rest in God. For patients, particularly, who are debilitated and unable to function as well as some might, their hope already compromised, this would be a serious reason for further spiritual concern, as in the case of the suicidal young woman with cerebral palsy.

Sacrament of its own accord is a simple outward recognition of the place of God in our lives, it is not a means to salvation. We commune with Him in order to embrace His presence and bless our lives through that presence. For patients who are unaware of what is appropriate and who seek some sort of intervention at a time of birth, illness or death, chaplains can offer several options or attempt to provide what the family is seeking. This frequently opens the door to further discussion about family history, and commitment to faith and church. It is certain that no matter how their practice is defined, they are welcoming of the rite and the Godly blessing that it represents.

CHAPTER 4
CONTEMPORARY PASTORAL TRAINING

Case Study 8 - Defining God

The patient is sitting up in bed with his back to me. He stands and shuffles over to greet me as he organizes his clothes. The order was for an Advanced Directive that includes the completion of a surrogacy form and/or a living will that delineates a person's choice for the extent of extreme measures to be taken in sustaining life as a result of certain events or degree of illness. Appropriately, many people have these completed outside the hospital under less pressing circumstances. It usually involves decisions that can require challenging conversations with supportive friends or family.

The patient has a large bandage on the side of his head. He has made use of the entire space around his bed. He arranges a few more things, and then heads back to the bed. He has a southern accent and is congenial.

When I bring up the purpose for the visit, he welcomes it and explains that it was prompted by a friend whom he would like to make his surrogate. Without a formal surrogacy, next of kin would be the legal recourse, so I ask if

he has any living adult children or a wife. He says his children are not around and this friend has been supporting him since his stroke for the last few years. “Do you see this smile on my face? No, I am not married.” Because of the priority for the Advanced Directive, and the administrative nature of the visit, I think about returning to visit with this patient to give him an opportunity to speak about his relationship with his children and the reasons that might prompt such a comment. In spite of these declarations, he seems quite content and rational, so I proceed with the completion of the form.

As we get past the details of names and addresses and onto the nature of life support, he starts talking about the recent procedure that gave him the feeling back on the entire left side of his body after nine years of paralysis. He is itching all over and loves the feeling. I notice for the first time that his left arm is atrophied. He says that at night he wakes up terrified because he thinks there is someone else in the bed with him. He was not able to feel his other leg before the operation. He is amused by it all. We finish up with the forms at which point I offer to pray with him. He declines and says, “Thanks, but I know without a doubt that there is a God out there. I did my time and now I am released.” “What do you mean?” He explains that nine years ago he drove off the roof of another hospital’s parking garage in his car. He saw the last nine years’ paralysis as punishment for something terrible he had done

and now he feels released. He says he just knows there is “something out there at work,” waving his hands in the air, “. . . and it’s alright.”

Clinical Pastoral Education

The modern hospital CPE training program is diversified, both in content and in context. Students come together for a rotation of didactic presentations, one on one supervisory sessions and group sessions on a daily basis over the course of several months.

The department provides opportunities to explore several topics including meeting with leaders from different religious practices, viewing operations, Myers-Briggs personality test, fetal demise effects and therapies, certification procedures, individual evaluations, consultations committees, response to major catastrophe, meeting with doctors from various specialties including integrative medicine and palliative care, spiritual evaluation techniques, computer training, hygiene education, bereavement, retreats for self-care, movie reviews, genogram and family systems analysis, sacred stories, and history of CPE.

Additionally, students are given current articles pertaining to the field. Supervisors will recommend reading that may be of benefit to the students’ work and progress. These come from a wide variety of sources, most of which are psychologically-oriented because intern chaplains are normally required to be enrolled in seminary and a mature relationship with God is assumed. From the supplementary materials, they can learn about interactive techniques for various personality types that have not been explored before. Some of the

major figures and their contributions include: Karl Menninger, Irvin Yalom, Wayne Oates, Murray Bowen, Carl Jung, Carl Roger, William Glasser and Edwin Friedman.

As these opportunities and resources combine with faith and experience, there can be a shift in theological perspective for many students. A secular venue poses new challenges to ministry, especially when working alongside professionals who are scientifically-minded for the most part and patients who subscribe to a vague or undefined spirituality.

Oates comments on the maintaining integrity of faith in a diversified secular setting. “The pastor’s alternative is not restricted to a choice among Catholic authoritarianism [or other], or the theologically laissez-faire and indifferent counsel which draws insight from sources that have no necessary relation to the Christian faith. The alternative is that a pastor deepen, rather than neglect his understanding of religious experience itself as it is related to the existential realities which the spiritual pilgrimages of all people have in common.”¹

Ministering to the lost and the schismatics

The illustration above is a good representation of many middle-aged individuals who find themselves facing a new situation in life. There is usually little definition of God except for possibly some distant notion from their youth of a benevolent or judgmental force at work in the universe. It is a perspective that comes from living in a society that promotes self-image over traditional values, that leads us down a path of spirituality that does not see the greater truths of God that govern the universe, but rather the small conveniences that would suit ourselves or those trying to profit in the immediate.

¹ Wayne Oates. *The Bible in Pastoral Care*, (Grand Rapids, Michigan: Baker Book House, 1973), 90-91.

While faith in this kind of undefined or self-defined ‘god’ may be an easy alternative to unfamiliar and institutional Christian doctrine, we often find that the relationship that lacks between God and man because of such insular introspection or ignorance also lacks what is needed to support us in times of real trial and hardship. The Chaplain can act as a vessel of God’s reassurance, strength, courage and hope where fear and suffering overwhelm a human’s limited capacity to cope based on his or her resources alone.

”Concerning this thing I pleaded with the Lord three times that it might depart from me. And He said to me, “My grace is sufficient for you, for My strength is made perfect in weakness.” Therefore most gladly I will rather boast in my infirmities, that the power of Christ may rest upon me. Therefore I take pleasure in infirmities, in reproaches, in needs, in persecutions, in distresses, for Christ’s sake. For when I am weak, then I am strong.” (2Cor 12:8-10)

A healthy view of God is comprehensive, it governs our entire lives, not just one area. While the man whose paralysis was healed had faith enough to see the blessing and the the consequences of the sin in his life, he did not have enough definition to his faith to apply it to some other areas.

While we need to be careful with how we treat unbelievers or schismatics, we can encourage them where they are and continue to promote and represent the faith, gradually introducing new concepts and answering tough questions as they arise in the patient. This can be difficult in a hospital setting because of time constraints and relational limitations.

Case Study 9 - When to let go

A distraught nurse called Pastoral Care in to evaluate the need for an ethics consult for a patient who was struggling with stage four breast cancer. The patient had

previously been an oncology nurse and was familiar with her form of the disease in an intimate way, as well as the suffering that came along with an inevitable death.

Her husband had been sick previously with a different form of cancer, where survival was uncertain, yet his wife did what she could to nurse him back to health and he recovered. Now he was watching his wife die and felt for certain he must do all that he could to save her. Several times the nurse had witnessed the patient asking her husband in her weakened state not to request any aggressive or life-prolonging treatment. She was in a lot of pain and often too medicated to engage the doctors about her care in a direct manner. The nurse who had spent the most time with her knew her wishes, and she finally was able to help her scribble and sign a note pleading with the doctors to change her current plan of care to a palliative one. The husband refused, in spite of the patient's wishes, stating that she was too incapacitated to make a decision like that. An ethics meeting ensued and the patient remained on the more aggressive treatment and died a few weeks later after increasing and continued suffering, the nurse refusing to be part of her care any longer.

End of Life Care

Chaplains are often involved in Palliative Care meetings and asked to be present at times when end of life decisions are being made with family. There are varying degrees to which people want to entertain life-extending measures. Traumatic events can bring an abrupt end to life. It is difficult for people to let go of loved ones so suddenly and life may be extended

by all measures available until family members can be present. In such cases Chaplains try to be consistently present, facilitating support, prayer, and orientation to unfamiliar surroundings and people. We act as liaisons with medical personnel and advocate with impartiality for the patient or families' desires while remaining sensitive to the realities and limitations of the case. Patients and families can get confused or distracted by the diagnoses and options available to them. Many patients come to terms with their own wishes before the family members are able to accept them, and this at times can add to the challenges.

Physicians will do everything they can if there is any chance of recovery. The options vary beyond that, depending on if there is any brain activity or not. Physicians can rely on Chaplains to have sensitive conversations with families about how much effort they want to put into extending their loved one's life. Moving from wanting to save them at all costs, to allowing for a more natural and comfortable passing is a difficult step. Once a family witnesses the extreme nature of continued resuscitation efforts on a human and often elderly and fragile body, they realize that it inflicts more suffering than not, and they mercifully suspend such measures. There are those, however, who demand up to the very end to have everything done. It is difficult to support such measures, and fortunately those times are infrequent. Where there is continued controversy over appropriate measures as seen in the example above, ethics committees are solicited to determine the best course of treatment.

Ethics

Hospital or medical ethics are formalized through an interdisciplinary committee which meets on a case to case basis. Situations are evaluated based on the best interest of the patient while taking into consideration the religious beliefs or cultural values of the patient or family, methodology of practice, prior experience, legal repercussions, and the possibility of challenges to the family system. At TGH the department head is present in these cases since they often require wisdom, sensitivity and the maintenance of relationships in spite of conflicting views. Ethics is an area where the hospital can be held legally accountable and shows us once again that even in the secular world an appeal to basic moral standards needs to be given voice. Where these standards come from ultimately is rooted in the theological concepts already explored in this paper. They are life-supporting, hope-filled efforts often relying on overcoming obstacles in a cooperative fashion.

We have already seen examples in this paper where patients' views are challenged through secular or distorted religious influences and how reactions to illness vary in response to those influences. As Vandrunen so aptly puts it, "Christians' commitment to Scripture [defines] their views of human nature, suffering, death and resurrection in ways that will always be determinative for their moral thinking."²

Approaching ethical dilemmas that involve beginning or end of life decisions from the presupposition that all men are created in the image of God allows us to establish some common ground with the doctors, patients and families regardless of faith tradition or lack

² David Vandrunen, *Bioethics and the Christian Life: A Guide to Making Difficult Decisions*, (Illinois: Crossway, 2009), 35.

thereof. We can be confident that all people know something about the inherent value of life and protecting it where possible, granting that it may be more challenging to do so in some cases than others. Upholding those values and standards in light of difficult decisions need never be compromised, even if the choice is for a less aggressive form of treatment.

Ultimately, our Christian hope lies in the resurrection of the body in Christ, and not in the extension of the life of the mortal body.

Where there is time to cultivate coping skills and a relationship with God, the Christian virtues of faith, hope, love, courage, acceptance and wisdom can go a long way in facing the termination of life and the challenges that it brings.³ The realm of ethics gives us a venue in which to pursue Godliness in the midst of suffering and reaffirm life, rather than watch it be toted as a dispensable convenience by some. Doctors or departments who have been spoken of as “death squads” are challenged in their humanitarian efforts to simply grant a peaceful termination to a life that has no chance of recovery. We must be careful to recognize when we are interfering with God's timing and attempting to make a stand for other more personally motivated causes, versus providing the patient with the best possible and realistic plans of care for their circumstances.

The distinction between ordinary and extraordinary measures is not always clearly defined. Frame's book *Medical Ethics* delineates the three main components involved in addressing and evaluating difficult decisions, particularly those that pertain to life and death.

These are the normative, the existential and the situational.⁴

³ Ibid., 94.

⁴ John Frame, *Medical Ethics*, (New Jersey: Presbyterian and Reformed Publishing Company, 1988), 4.

For Christians the normative is Scripture. Are we dealing with a person who affirms Biblical truths and can apply them to their circumstances? Ultimately, are they regenerate?⁵ If so, then an appeal to Scripture can assist in making the decision. Otherwise, we must fall back to the position that we are all, regenerate and unregenerate created in the image of God and by appeal to the value of life, we can promote healing, yet also allow for death when all other efforts would not prove beneficial.⁶

The existential is the conscience.⁷ In the present secular world this is similar to individual rights. The word "autonomy" is one that needs evaluation. It is used in the medical world where the intent is for every individual to have a say in his or her treatment. However, there are times where this is not practically helpful, and the word can even impart a sense of rebelliousness⁸ against a system. Where grief incites anger or a desire to blame, this may not be a concept to value over say "community".

The reality is that a person ordinarily looks for support in times of need, and "autonomy" exacerbates thoughts of isolation in facing death or impairment. Relationships are a valuable resource and should be included in part of the plan of care.⁹ The use of "autonomy" is, I believe, a sign of syncretism with its emphasis on the self, and our own abilities to evaluate and make the best decisions without as much emphasis on other resources that may be available or beneficial to us. For the God-centered Christian,

⁵ Ibid., 4.

⁶ Ibid., 63.

⁷ Ibid., 26.

⁸ Ibid., 35-38.

⁹ Ibid., 39.

"autonomy" is not a concept that brings comfort or guidance to the individual. Whether the decisions be autonomous according to one person's will or another, be it a doctor or family member or patient, so long as it is an individual's perspective, acting apart from a normative authority or supporting community it will be lacking in its effectiveness of outcome.

The final factor to be considered in ethical decisions is the situational which varies because of the trauma, the people, the treatments involved and the laws that govern them.

Often times criteria will dictate a recommended course of action. At this time, neurological exams are definitive in determining to what extent recovery is possible, and which systems will be compromised as a result. It is biblically permissible to withhold life support when it is the only thing keeping a body alive and there is a lack of resources, or the amount of suffering is such that merciful withdrawal of aggressive measures is deemed appropriate.¹⁰ Also, it is morally questionable to continue aggressive life sustaining measures just because resources are available if it involves continued suffering without the possibility of recovery. Each case is unique and requires sensitive yet realistic evaluation by the family and physicians based on the patient's best interest.

Justifying Program Support

I have observed a consistent effort put out by our department to help promote and validate our contribution in the hospital to the Administration. It is almost unimaginable to have a hospital without Pastoral Care support, yet according to visiting students, transferring staff and patients, ours is unique in its scope and function compared to many others. There looms

¹⁰ Ibid., 66-67.

the uncertainty of the consequences of unpredictable annual budget cuts, and much like the atmosphere in which we find ourselves in evolving emergent circumstances, the reality is that things could shift greatly in very little time, affecting our presence and available resources for ministry.

This is due to a great extent to competing warrants for limited resources.¹¹ Boone defines a warrant as a statement that connect a reason to a claim.¹² In the hospital there are many critical humanitarian and spiritual needs, a variety of disciplines demand state of the art equipment, along with government-regulated compliance, not to mention investors looking for efficiency and yes, profit. We can see how there would be several competing warrants.

Each warrant has two parts to it, the general circumstance and the general consequence that justifies it.¹³ They all share the same general circumstance of serving a population's medical needs, the consequences or outcomes differ but can compliment one another when properly balanced. Each discipline has a very legitimate reasons for their allocated funds, but can we actually prioritize one over the other when the reality is that they all need each other in order to fulfill their function for the best and most sustainable end result?

Money is derived from government and business investors with the expectation of compliance and a margin of return. Safety and medical advancements rely on this. Medical staff need to maintain a level of care that is adequate, if not excellent, with limited staffing

¹¹ Frederick Smith, *Persuading a Budget-Balancing Administrator to Invest in Non-Revenue-Producing, Full-Time Clinical Chaplains*. www.healthcarechaplains.org. Accessed 3/3/14.

¹² Wayne Booth, Gregory Colomb, and Joseph Williams. *The Craft of Research, 3rd Ed.* (Chicago, Illinois: University of Chicago Press, 2008.), 152.

¹³ *Ibid.*, 155.

resources. All these areas are quantifiable and can be analyzed in order to provide reason for continued or discontinued support.

Pastoral care is difficult to quantify. However there have been studies that demonstrate a positive correlation between health outcomes and spirituality.¹⁴¹⁵¹⁶ It can be monitored to some extent through surveys and staff input, but our function is currently accounted for in terms of numbers of visits and through the administrative roles we play in processing trauma patients and advanced directives. In spite of this, it is reassuring to see that Pastoral Care continues to be included in the hospital's budget to provide not just a chapel for people to pray in, but the actual active ministry of up to 30 people. This fact alone is indicative that secular contexts, where life-changing events are continuously evolving, greatly benefit from the inclusion of the sacred and holy presence of God. In a way it is a humble acknowledgement that the circumstances in which we often find ourselves are out of our control and a greater resource is required to complement the medical care that is being provided. In many cases it can be a rare opportunity to reach people who otherwise may never be moved to consider spiritual care as part of their medical or even life experience.

¹⁴ Gowri Anandarajah and Ellen Hight. "Spirituality and Medical Practice: Using HOPE Questions as a Practical Tool for Spiritual Assessment," *American Family Physician*. Vol. 63, No. 1, (Jan 2001): 81.

¹⁵ Katherine Piderman, et al. "Predicting Patients' Expectations of Hospital Chaplains: A Multisite Survey," *Mayo Clinic Proceedings*. Vol. 85 No. 11, (Nov. 2010): 1002.

¹⁶ Christina Puchalski, et al. "Improving the Quality of Spiritual care as a Dimension of Palliative Care: The Report of the Consensus Conference," *Journal of Palliative Medicine*, Vol. 12, No. 10, (1999): p.902.

Technology and a New Generation of Leaders: An Exhortation

In the five years that I worked at TGH, there was a comprehensive computer programming system change which required extensive technological training of existing and incoming Chaplains. This training continues to be updated as the program is adapted and updated in an evolving medical environment. Seeking accountability and higher performance standards has made 'outcomes' or goals with patients more definable through the use of specific templates for each discipline. The completion of these in addition to regular charting means less time with patients and more challenge in managing time.

We can appreciate the value of technology in patient care. Often the information stored is accessed in the future to help us locate patient family or understand the patient's history better, both medically and personally. It helps guide us in approaches to patients that have been helpful in the past or overlooked in terms of support, without which we would have little knowledge of.

The goal to a paperless ministry is difficult to achieve, however. We still carry paper trauma sheets and advanced directive forms, we provide information to the patients through printed materials, including devotionals, bereavement materials and of course, the Bible.

Clinical Pastoral Education was formally established in the 1920's at Worcester State Hospital, Massachusetts by Anton Boisen, who was brought up in the Reformed tradition and believed, based on his own experience, that healing the soul was often more effective than medicinal interventions in many cases. His program and its educational value was supported

by many protestant churches and spread quickly.¹⁷ Original Standards for spiritual care were delineated in 1940 prescribing the following¹⁸:

1. The Chaplain Shall Be Responsible to the Administration of the Hospital
2. The Chaplain Shall Cooperate with the Other Personnel of the Hospital
3. The Chaplain Shall Have a Rational Plan for Selecting his Patients
4. Records of the Chaplain to be Maintained
5. Interdenominational Worship in the Public Hospital
6. Chaplain Training
7. Chaplain Appointment
8. Compensation

We can see how the updated Standards (Appendix A) are similar, but more descriptive, reflecting a progress in the development and details effective Pastoral ministry.

It is only recently that we are starting to see the retirement of several of the founders and early developers of the program. Because it was deeply rooted in Christian tradition, those leaders were heavily grounded and motivated by Scripture.

As new, younger leaders gain an increased role in the future of CPE, from a greater variety of denominations than what was available or recognized at the time of the formation of the CPE program, and with the added inclusivity of the technological advanced that encroach on limited resources of time, we must be mindful not to forgo a Biblically-grounded

¹⁷ *ACPE History*, accessed March 1, 2014, www.acpe.edu.

¹⁸ Russell Dicks, "Standards for the Work of the Chaplain in the General Hospital," *Hospitals*, (Nov. 1940).

perspective on the faith nor be distracted by the numerous opportunities and demands that continue to direct our energies elsewhere.

CHAPTER 5

CONCLUSION

We must remain true to the original intent of chaplaincy as keepers of the sacred, defining it when and where possible as helpers to mankind in a fallen world.

One of the greatest wonders of hospital Chaplaincy work is its lack of predictability. Every day is replete with uncontrollable events. A patient that is hopeful and conversing with you one day, could pass away by the next morning's shift. What you read in the notes may lead you to believe that the visit will be a short one, yet you end up staying for two hours. You may find yourself with a Muslim family welcoming your prayer. A call may be put in as an administrative need for an advanced directive, when the person's true need is suicidal thoughts, or they are facing an abortion. I have left patients rooms several times shaking my head at the amazing uniqueness of the situations, never lacking of God's presence, at times peaceful, or serious, or humorous, but always sacred.

The doctors and nurses are warriors in such a place. They are tried and tired. They fight disease and minister to human responses several times a day. They combat death and we walk with them, behind them or before them to ease the burden in any way we can. Seeking the person of Christ and His atoning work on behalf of others through faithful obedience and deference to His Word is what graces us with His vision, and allows us to

recognize the privilege and the incomparable meaning found in such a calling as that of Pastoral Care.

I would like to conclude with the following exhortation from Paul the Apostle to the people of Colossus, where he recognizes the inherent vulnerability of Christian integrity surrounded by secular influences. It speaks to us as ministers “complete” in Christ in these present times just as much as it did two thousand years ago and continues to provide guidance for the future.

“For I want you to know what a great conflict I have for you and those in Laodicea, and for as many as have not seen my face in the flesh, that their hearts may be encouraged, being knit together in love, and attaining to all riches of the full assurance of understanding, to the knowledge of the mystery of God, both of the Father and of Christ, in whom are hidden all the treasures of wisdom and knowledge.

Now this I say lest anyone should deceive you with persuasive words. For though I am absent in the flesh, yet I am with you in spirit, rejoicing to see your good order and the steadfastness of your faith in Christ.

As you therefore have received Christ Jesus the Lord, so walk in Him, rooted and built up in Him and established in the faith, as you have been taught, abounding in it with thanksgiving.

Beware lest anyone cheat you through philosophy and empty deceit, according to the tradition of men, according to the basic principles of the world, and not according to Christ. For in Him dwells all the fullness of the Godhead bodily; and you are complete in Him, who is the head of all principality and power. (Col 2:1-9)

APPENDIX¹

ACPE OUTCOMES

309-319 Objectives And Outcomes Of ACPE Accredited Programs

CPE provides theological and professional education using the clinical method of learning in diverse contexts of ministry. ACPE accredits two types of clinical pastoral education programs: CPE (Level I/Level II) and Supervisory CPE. ACPE accredited programs provide a progressive learning experience through a two level curriculum. Level I curriculum outcomes must be satisfactorily addressed prior to admission to Level II. Completion of CPE (Level I/Level II) curriculum outcomes is prerequisite for admission to Supervisory CPE.

309-310 Objectives of CPE (Level I/Level II) CPE (Level I/Level II) enables pastoral formation, pastoral competence, and pastoral reflection. Some CPE centers offer pastoral specialization(s) as part of their Level II curriculum.

CPE (Level I/Level II) objectives define the scope of the CPE (Level I/Level II) program curricula. Outcomes define the competencies to be developed by students as a result of participating in each of the programs.

Standard 309 The center designs its CPE (Level I/Level II) curriculum to facilitate the students' achievement of the following objectives:

¹ *ACPE Standards*, accessed December 5, 2013, www.acpe.edu.

Pastoral Formation

- 309.1 to develop students' awareness of themselves as ministers and of the ways their ministry affects persons.
- 309.2 to develop students' awareness of how their attitudes, values, assumptions, strengths, and weaknesses affect their pastoral care.
- 309.3 to develop students' ability to engage and apply the support, confrontation and clarification of the peer group for the integration of personal attributes and pastoral functioning.

Pastoral Competence

- 309.4 to develop students' awareness and understanding of how persons, social conditions, systems, and structures affect their lives and the lives of others and how to address effectively these issues through their ministry.
- 309.5 to develop students' skills in providing intensive and extensive pastoral care and counseling to persons.
- 309.6 to develop students' ability to make effective use of their religious/spiritual heritage, theological understanding, and knowledge of the behavioral sciences in their pastoral care of persons and groups.
- 309.7 to teach students the pastoral role in professional relationships and how to work effectively as a pastoral member of a multidisciplinary team.

- 309.8 to develop students' capacity to use one's pastoral and prophetic perspectives in preaching, teaching, leadership, management, pastoral care, and pastoral counseling.

Pastoral Reflection

- 309.9 to develop students' understanding and ability to apply the clinical method of learning.
- 309.10 to develop students' abilities to use both individual and group supervision for personal and professional growth, including the capacity to evaluate one's ministry.

Standard 310 Where a pastoral care specialty is offered, the CPE center designs its CPE Level II curriculum to facilitate the students' achievement of the following additional objectives:

- 310.1 to afford students opportunities to become familiar with and apply relevant theories and methodologies to their ministry specialty.
- 310.2 to provide students opportunities to formulate and apply their philosophy and methodology for the ministry specialty.
- 310.3 to provide students opportunities to demonstrate pastoral competence in the practice of the specialty.

311-312 Outcomes Of CPE (Level I/Level II) Programs

Standard 311 Outcomes of CPE Level I

The curriculum for CPE Level I addresses the fundamentals of pastoral formation, pastoral competence and pastoral reflection through one or more program units. Satisfactory achievement of Level I outcomes must be documented in the supervisor's evaluation(s).

At the conclusion of CPE Level I students are able to:

Pastoral Formation

- 311.1 articulate the central themes of their religious heritage and the theological understanding that informs their ministry.
- 311.2 identify and discuss major life events, relationships and cultural contexts that influence personal identity as expressed in pastoral functioning.
- 311.3 initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Pastoral Competence

- 311.4 risk offering appropriate and timely critique.
- 311.5 recognize relational dynamics within group contexts.
- 311.6 demonstrate integration of conceptual understandings presented in the curriculum into pastoral practice.
- 311.7 initiate helping relationships within and across diverse populations.

Pastoral Reflection

- _____ 311.8 use the clinical methods of learning to achieve their educational goals.
- 311.9 formulate clear and specific goals for continuing pastoral formation with reference to personal strengths and weaknesses.

Standard 312 Outcomes of CPE Level II

The curriculum for CPE Level II addresses the development and integration of pastoral formation, pastoral competence and pastoral reflection to a level of competence that permits students to attain professional certification and/or admission to Supervisory CPE. Level II curriculum involves at least two or more program units of CPE.

The supervisor determines whether the student has completed Level II outcomes based on the student's competence. The supervisor must document completion of Level II outcomes in the student's final evaluation.

At the conclusion of CPE Level II students are able to:

Pastoral Formation

- 312.1 articulate an understanding of the pastoral role that is congruent with their personal and cultural values, basic assumptions and personhood.

Pastoral Competence

- 312.2 provide pastoral ministry to diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, and justice issues without imposing their own perspectives.
- 312.3 demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources.
- 312.4 assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.
- 312.5 manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.
- 312.6 demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.

Pastoral Reflection

- 312.7 establish collaboration and dialogue with peers, authorities and other professionals.

- 312.8 demonstrate awareness of the Spiritual Care Collaborative Common Standards for Professional Chaplaincy (Appendix 2). Note: The ACPE Standards and Code of Ethics supersede these standards.

- 312.9. demonstrate self-supervision through realistic self-evaluation of pastoral functioning.

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