THE CHALLENGE FOR CHRISTIAN CHAPLAINS: TO PROVIDE SPIRITUAL CARE TO ALL

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ABSTRACT

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By
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The purpose of this doctoral study was to answer the following question: How do Christian chaplains serving in diverse interfaith/intercultural healthcare settings provide spiritual care to patients, families, and staff and nurture their own spirituality? Christian chaplains provide spiritual care to persons of all faith traditions and cultural backgrounds.

Robert G. Anderson, a long-time pastoral educator and CPE supervisor, answers the pivotal question: What is spirituality? He also provides five steps for spiritual/cultural chaplain competency.

The reader is provided a brief history of Georgia’s first city, Savannah, and its two oldest hospitals: Candler Hospital, founded in 1804, and St. Joseph’s Hospital, founded in 1875. The author looked at the mission and theological stance of Candler Hospital’s department of pastoral care, which is where the biblical and theological foundation for the study was laid.

The literature review was approached from six distinct perspectives: (1). Sociological/political; (2). Pastoral care and counseling; (3). Anthropological; (4). Historical; (5). Theological; (6). Biblical.

As a means of gathering valuable data for this doctoral study, the researcher traveled throughout the state of Georgia, from the thriving metropolis of Atlanta to the
small rural military towns of Hinesville and Fort Stewart, Georgia. A total of twenty (20) Christian chaplains were interviewed, representing fifteen (15) different healthcare institutions. Although all chaplains identified themselves as Christians, they represented a wide variety of Christian traditions.

Generally, Christian chaplains serving in interfaith/intercultural healthcare contexts consider themselves blessed and highly privileged to do ministry in these settings.

As a result of having completed this doctoral project, the researcher has the following recommendations: First, he encourages Christian chaplains of all faith traditions to continue to develop their skills in spiritual/cultural competency. Secondly, he urges Christian chaplains of all faith traditions to both revisit and strengthen their ties with their respective faith traditions. Third, Christian chaplains must be permitted and encouraged to network with other Christian chaplains at the local, state, regional, national, and international levels to support, affirm, and facilitate the work of chaplaincy wherever it is being done. Finally, denominations must stand firm in insisting that its female clergy be granted full clergy rights and privileges.
DEDICATION

This dissertation is dedicated to my loving wife, Mrs. Zelene Rooks Burns, who provided much needed motivation, nurture, and support during my pursuit of doctoral studies. I also dedicate this dissertation to my mother, Mrs. Catherine King Burns, and father, the late Deacon C.B. Burns, Jr., and our three daughters: Mrs. Dominique Smith, Mrs. Courtney Alderman, and Ms. Shannon L. Burns.

C.B.B.
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To the twenty-(20) Christian chaplains who invited me into their respective healthcare institutions and cheerfully participated in this doctoral research project.

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To the members of the dissertation committee who guided this study: Dr. David Rensberger, Dr. Leon Spencer, and Dr. Ndugu T’Ofori-Atta.
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CHAPTER I
INTRODUCTION

This doctoral study looked at religious and cultural diversity in America. As America becomes more religiously and culturally diverse, all major institutions of society are compelled to address the issue of diversity in a variety of ways. Having experienced an influx of Latino/Latina farm workers over the last several years, even small hospitals in rural South Georgia are having to take extra precautions to ensure that Latino/Latina patients for whom English is a second language are able to communicate with doctors, nurses, and other healthcare professionals to the extent that these patients can participate in their own healthcare.

This doctoral study also looked at spirituality in healthcare contexts. What is spirituality? Who defines spirituality in healthcare contexts? But more specifically, this doctoral study looked at Christian chaplains who are “brokers of the spirits” in interfaith/intercultural healthcare settings. Who are these Christian chaplains? How do they function as “brokers of the spirits” in interfaith/intercultural settings? Using a twenty-two item structured interview guide, this doctoral study examines the responses of twenty (20) Christian chaplains serving in fifteen (15) different healthcare institutions throughout the state of Georgia, from the metropolis of Atlanta to rural Hinesville, Georgia.

The study consists of the following chapters:
• Chapter II of this study outlines the ministry issue.

• Chapter III explains the ministry setting.

• Chapter IV provides the biblical and theological foundation for the study.

• Chapter V provides the literature review from several different perspectives—sociological, theological, anthropological, historical, and pastoral care and counseling.

• Chapter VI provides the purpose, description and method of the act of ministry.

• Chapter VII provides the evaluation of the study, implications for future ministry, and the conclusion.
CHAPTER II

THE MINISTRY ISSUE

Christian chaplains throughout America are routinely called upon to provide spiritual care to a patient population, which is increasingly diverse in language, culture, and religion.

America is more of a melting pot (or a garden salad) today than at any other time in its history. According to the 2000 census, the foreign born population nearly doubled in the 1990’s and now comprises almost 11 percent of the total population in America.\(^1\) African-Americans, Asian-Americans, and Hispanic-Americans now constitute almost 30 percent of the country’s population, or 85 million people.\(^2\) According to Diana L. Eck, in her recent book, *A New Religious America*, one of the best-kept secrets in America is the fact that America is the most religiously diverse country on the face of the earth:

Envisioning the new America in the twenty-first century requires an imaginative leap. It means seeing the religious landscape of America, from sea to shining sea, in all its beautiful complexity. Between the white New England Churches and the Crystal Cathedral of southern California, we see the sacred mountains and the homelands of the Native peoples, the Peace Pagoda amid maples in Massachusetts, the Mosque in the cornfields outside Toledo, the Hindu temples pitched atop the hills of Pittsburgh and Chicago, the old and new Buddhist temples of Minneapolis.\(^3\)

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\(^2\) Ibid.

According to Diana Eck, the Muslim population in America is conservatively estimated to be about six million and growing. America’s more than 1,400 mosques give a visible testimony to the presence of Islam in America. 

There is great consensus that the Hindu population in America is a little over one million. There is no consensus on the number of Buddhists in America, but estimates range from a low of 1.4 million to a high of 2.8 million. Tom Smith is inclined to accept the lower figure of about 1.4 million Buddhists in America.

This Doctor of Ministry project looked at the growing religious and cultural diversity in America and asks the following question: How do Christian chaplains serving in interfaith/intercultural health care settings provide spiritual care to patients, families, and staff and nurture their own spirituality? During the very early stages of this doctoral project, after having decided to study Christian chaplains in their healthcare contexts, the researcher was still very much undecided as to whether to study the religious or faith development of Christian chaplains as it relates to the religious care they provide to patients, families, and staff or the spirituality of Christian chaplains as it relates to the spiritual care they provide to patients, families, and staff. For two very obvious reasons, the decision was made to emphasize spirituality and spiritual care over religious or faith development and religious care.

First, much has been written recently about spirituality. Spirituality means different things to different people and, thus, can be very difficult to define. William

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4 Ibid


6Ibid.
Stringfellow provided a few examples of how the term spirituality was being used by people in the west during the 1980's:

'Spirituality' may indicate stoic attitudes, occult phenomena, the practice of so-called mind control, yoga discipline, escapist fantasies, interior journeys, an appreciation of eastern religions, multifarious pious exercises, superstitious imaginings, intensive journals, dynamic muscle tension, assorted dietary regiments, meditations, jogging cults, monastic rigorous, mortification of the flesh, wilderness sojourns, political resistance, contemplation, abstinence, hospitality, a vocation of poverty, non-violence, silence, the efforts of prayer, obedience, generosity, exhibiting stigmata, entering solitude, or, I suppose, among these and many other things, squatting on top of a pillar.  

Spirituality is complex. It is not adequately defined by any single continuum or by dichotomous classification; rather, it has many dimensions. Spirituality is best understood as multidimensional space in which every individual can be located.  

William R. Miller and Carl E. Thoresen suggest three dimensions, which might be used to measure this multidimensional space, which we have come to know as spirituality. Those three dimensions are practice, belief, and experience. Included in the first dimension of spirituality, practice, are such behaviors as prayer, fasting, meditation, contemplation, worship, dance, Bible study, singing, confessing, giving, and public prayer. The second dimension of spirituality, belief, varies with culture and is concerned with beliefs about transcendence, deity, etc. The third, and final, dimension of spirituality, experience, is interested in the encounters of life transforming experiences the individual has had with the deity.

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9Ibid., 7-8.
Walter Principe presents what appears to be one of the most concise and simple definitions of Christian spirituality: “Spirituality is life in the spirit as brothers and sisters of Jesus Christ and daughters and sons of the Father.”10 Principe then asked, “Can a definition of spirituality be formulated that could be applied more universally, that is, to the lived spiritual life and reality of persons who are not Christians?”11 The answer obviously is yes, and Principe proceeds to suggest a universally applicable definition of spirituality: “The way in which a person understands and lives within his or her religion, philosophy or ethic that is viewed as the loftiest, the noblest, the most calculated to lead to the fullness of the ideal or perfection being sought.”12 In his book, *In Living Color*, Emmanuel Lartey likens spirituality to a vector:

The mathematical metaphor I find helpful for spirituality is that of vector. A vector, in mathematical physics, is a quantity that has both magnitude and direction... Spirituality can be likened to a vector quantity precisely because it has both strength and direction. It is a dynamic concept that conveys the sense of travel, journey, search, quest, purpose, and goal. At the same time, it manifests itself in terms of strength or weakness.13

Lartey interprets spirituality from an intercultural perspective as referring “to the human capacity for relationship with self, others, world, God and that which transcends sensory experience, which is often expressed in the particularities of given historical, spatial and social contexts, and which often leads to specific forms of action in the

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11 Ibid.

12 Ibid.

world.\textsuperscript{14} From Larney's intercultural perspective, he enumerates five dimensions of spirituality:

1. relationship with transcendence
2. relationship with self: (intra-personal)
3. relationship with another: (interpersonal)
4. relationship among people: (corporate)
5. relationship with both place and things: (spatial)

Spirituality as relationship with transcendence refers to the apparently universal human capacity to experience life in relation to perceived dimension of power and meaning beyond us. Spirituality, as intra-personal relationship with self, serves to remind us that the manner of the relationship we have with ourselves is an important aspect of our spirituality. As human beings, we have the capacity of self-transcendence, (to “go beyond” ourselves), and engage in self-criticism. Spirituality as interpersonal relationship refers to our ability to cultivate an I-Thou relationship with another person in which mutuality, respect, accountability and friendship are sustained. Spirituality as corporate are traditions and practices which we are socialized as a group and which determine our beliefs, practices, and experiences. Spirituality as spatial refers to spirituality, which is deeply rooted in the land as in the case of Native Americans and other dislocated people. “This spatiality and landrootedness manifests itself in ceremonies, symbols, architecture, worldviews and views of personhood.”\textsuperscript{15}

Second, regulatory agencies and accrediting bodies for healthcare organizations now require serious attention to the spiritual care of patients. The Joint Commission on

\textsuperscript{14}Ibid., 140-141.
the Accreditation of Healthcare Organizations (JCAHO) mandates that healthcare organizations “respect the cultural, psychosocial, and spiritual values of all patients.” Fear and loneliness experienced by patients during serious illness or when cure is not possible could generate spiritual crises that require spiritual care. Frequently, staff members or employees need spiritual care when dealing with stresses of the workplace, family life, school, etc. A multitude of moral or ethical dilemmas arise daily in technologically advanced healthcare organizations requiring Christian chaplains to provide spiritual care to patients, family members, and staff who might be affected by those complex issues.

Throughout this doctoral study, the word spirituality is inclusive of religion and spiritual care includes pastoral care.

**Motivation for Addressing the Ministry Issue**

In addition to being board certified by the Association of Professional Chaplains (APC), the researcher is formally trained as a professional counselor and currently holds a counseling license issued by the state of Georgia. Over the past several years, the counseling profession has placed increasing emphasis on the need for all counselors in our increasingly culturally diverse society to meet certain minimum standards as cross-cultural or multicultural counselors. Universities and colleges added courses in cross-cultural, intercultural, or multicultural counseling; continuing education workshops provided courses on cross-cultural or multicultural counseling and diversity. During 2006 alone, the author attended the 5th Annual Southeastern Conference on Cross-Cultural Issues in Counseling and Education which was sponsored by Georgia Southern.

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15 Ibid., 150.
University and held at the Coastal Georgia Continuing Education Center in Savannah, Georgia, on February 3-4, 2006, and the 2nd Annual Cultural Competency Conference which was sponsored by Georgia State University and held in Atlanta, Georgia at its main campus, on March 20-21, 2006.

Christian chaplains know that they are being exposed to increasing religious and cultural diversity in healthcare institutions. Many healthcare chaplains graduated from seminary and completed clinical pastoral education (CPE) residencies more than 10, 15, or 20 or more years ago. Is the professional education and clinical training which these chaplains received so many years ago adequate to help them to meet the increasing interfaith and intercultural challenges which they face today? Of course, professional chaplaincy organizations are very much aware of this interfaith and diversity challenge and are providing continuing education opportunities to help chaplains to meet this challenge. In 2004, the Association of Professional Chaplains held its annual conference in Dallas, Texas and the theme was “Bridging Diversity: Communities of Health, Hope, and the Human Spirit.” Nationally known plenary speakers at that conference were Diana Eck, Professor of Comparative Religion and Indian Studies at Harvard University; David Augsburger, professor of Pastoral Care and Counseling at Fuller Theological Seminary; Frederick Schmidt, Director of Spiritual Life, Formation, and Associate Professor of Christian Spirituality at Southern Methodist University, Perkins School of Theology; and Imam W. Deen Mohammed, founder of the American Muslim Mission which has grown into the two million member Muslim American Society. All plenary speakers encouraged

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chaplains in attendance to broaden their theology and practice of ministry with persons of
diverse cultures and faith backgrounds.

Definition of Terms

The following definitions are offered to help facilitate understanding of the terms
and concepts presented in this doctoral dissertation.

Spirituality - the animating force in life represented by such images as breath, wind, vigor, and courage. It is an innate capacity and tendency to move towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion. It includes one’s capacity for creativity, growth, and the development of a values system. Spirituality encompasses the religious, spiritual, and transpersonal.¹⁷

Culture - the particular and distinctive way of life of the group. This includes the ideas, values and meanings embodied in institutions and practices, in forms of social relationship, in systems of beliefs, in mores and customs and in the way objects are used and physical life organized.¹⁸

Multiculturalism - The many cultures, many worldviews, many languages, many values, and many customs, which exist and serve to form human communities.¹⁹

Cultural Diversity - see multiculturalism. In the reminder of this doctoral dissertation, the terms cultural diversity and multiculturalism are used interchangeably.

Pluralism – is not just another word for diversity. It goes beyond mere diversity in an active attempt to engage and understand the other. Pluralism is not simply relativism.


¹⁹Fukuyama and Sevig, “Cultural Diversity, 28.
It does not seek to displace or eliminate deep religious commitment. It is, rather, the encounter of commitments.\textsuperscript{20}

Interfaith - Occurring between persons or groups belonging to two or more different religions. In the reminder of this doctoral dissertation, the terms interfaith and multifaith are used interchangeably.

Multifaith - see interfaith

**Previous Efforts to Address the Ministry Issue**

The earliest recorded efforts to address the ministry issue occurred around 1905 in Boston, Massachusetts. The Emmanuel Movement for medically supervised religious psychotherapy and the medical social service experiment at the Massachusetts General Hospital were both precursors of today’s modern clinical pastoral education (CPE) movement. The Reverend Dr. Elwood Worcester, founder of the Emmanuel Movement, set out to teach scientific methodology and techniques to parish priests so that they might become more effective in dealing with people and performing their pastoral duties.\textsuperscript{21} Dr. Richard C. Cabot, a Boston internist, attempted to organize the Medical Social Service Program at Massachusetts General Hospital around social workers whom he believed to be the “best, wisest, and the most spiritual people in the community.”\textsuperscript{22} Neither the Emmanuel Movement nor the Medical Social Service experiment at Massachusetts General Hospital was considered very successful at the time. Each had its share of problems.

\textsuperscript{20}Eck, *A New Religious America*, 71.


\textsuperscript{22}Ibid.
In 1923, Dr. William S. Keller, a socially concerned physician and an active layperson in the Episcopal Church, organized “The Summer School in Social Science” which allowed a small number of seminarians from Bexley Hall [The Episcopal Seminary] to spend their summers working with various social agencies in Cincinnati, Ohio. Keller’s first students worked in purely secular environments such as juvenile and municipal courts, the children’s home, the social hygiene society, and the juvenile protective association without any specifically theological supervision, although some later students were assigned to institutions where there was at least a chaplain in residence.23

The Rev. Anton Theophilus Boisen, a Congregationalist minister, is widely regarded by many as the father of the modern CPE movement. Rev. Boisen suffered a psychotic break at the age of 45 and was hospitalized as a mental patient at the Westboro State Hospital from October 20, 1920 until January 1922. Afterwards, as a special student at Andover Newton Theological Seminary, he took courses with Dr. Richard Cabot and other professors in the fields of psychology and psychiatry.24 By 1924 Rev. Anton Boisen was employed as a chaplain at the Worcester State Hospital, and by 1925, he had begun teaching seminarians the skills necessary to complete a case analysis.

Each [case analysis] contained a “preliminary history,” including intelligence ratings and reason for commitment, followed by a lengthy “personal history,” covering heredity and early influences, childhood and adolescent development, sexual, family, vocational, and social adjustments, health, personality type, and description of the present illness. Then came the most important part, a section on “characteristic of the psychosis,” in which the student gave the standard “mental status examination,” followed by a detailed analysis of the patient’s thought.

23 Ibid., 6.

content according to “sense of the mysterious and uncanny,” “sense of peril,” etc.²⁵

According to Robert G. Anderson, the clinical pastoral education (CPE) movement, which emerged out of North American liberal Anglo Protestant thought of the early 1900’s and pioneered an exploration of individuals in crisis by acknowledging and utilizing depth psychology and the behavioral sciences using the case study method, has done a good job of preparing Christian chaplains to function as competent intercultural spiritual caregivers in interfaith/intercultural healthcare settings. However, Anderson criticizes the CPE movement for not taking the cultural dimensions seriously. “When culture was acknowledged it was in terms of group identity and custom and not a particularized integrated element.”²⁶ Anderson provides the following concise critique of the CPE movement:

While this century old movement incorporated religious, moral, social and psychological factors in the assessment of the person, culture was an external force contending with religion in the societal arena. A particular cluster of beliefs, values and worldviews based upon cultural and spiritual identity did not weigh in as essential in studying the individual in context. I contend that the cultural and spiritual factors when viewed in a more integrated way enrich the life narrative of the living human document and shape unique meaning. Such attitudes, values and beliefs carried into the life crisis are just as primary as psychological and developmental features to explain and interpret life journey, the surprises, sorrows, and joys that comprise life narrative, and the life juncture one faces, the unfolding chapter of the present.²⁷

While giving credit to the pastoral care movement for its efforts to integrate spirituality and multicultural counseling, Anderson challenges the pastoral care

²⁵Robert C. Powell, Fifty Years of Learning, 10.


²⁷Ibid., 6-7.
movement to continue to revisit and reconsider certain of its exclusionary attitudes and boundaries, such as its Judeo-Christian worldview, gender and racial prejudice, issues of power and resource distribution, etc.²⁷

Finally, Anderson concludes this chapter by sharing his five steps for Spiritual/Cultural Chaplain Competency. The five steps are:²⁸

1. The capacity to know and explain one’s own “spiritual/cultural set,” One’s own spiritual/cultural groundedness

2. The capacity to identify experiences and information that are outside of one’s own spiritual/cultural references, to identify and learn about “otherness”

3. The capacity to demonstrate multi-spiritual/cultural attitudes, approaches, and skills leading to effective communication and relating to those with other cultural sets

4. The capacity to identify contextual or relational barriers, as well as one’s own limitations, in communication and pastoral practice

5. The capacity to demonstrate respect within and willingness to learn from and evaluate the process of multi-spiritual/cultural interaction

Personal awareness is a foundational attention to one’s own social identity and the impact on oneself and others, including dynamics of power. Attention to one’s assumptions, values and interpersonal styles of relating deepens and enriches clinical practice and the self of the caregiver. “What characterizes my view of myself in the world, my beliefs and devotions”?²⁹

²⁸Ibid., 12-15.
²⁹Ibid., 22.
Knowledge is crucial here and is of a particular characteristic, namely information and facts about the history, experience, composition, understanding, and analysis of one's own and other's cultural identity and composition as well as the groups and forces that make up the composition.

Skills are abilities to engage with oneself and others so as to acknowledge and learn about cultural dynamics in relationships and groups, especially methods of communication that facilitate growth and respect.

Passion is the dedication and caring about multicultural learning; the capacity for empathy, constructive work with feelings and the ability to risk.

Action is the integrating factor, the ability to relate and act in a manner consistent with awareness, knowledge, skill and compassion, especially in constructive change.

**Personal History That Informs Writers’ Concern Regarding the Ministry Issue**

The author grew up in the racially segregated south of the 1950's and 60's, and what is remembered most about that era is segregation. Schools were segregated; public parks were segregated; swimming pools and public beaches were segregated; public libraries were segregated; restaurants and hotels were segregated; bus stations and train stations were segregated; even churches were segregated.

The writer grew up in Mitchell County, Georgia which is an extremely rural county having Camilla, Georgia as its county seat. Camilla, Georgia is located about 22 miles south of Albany, Georgia. As he grew up on the family farm in Mitchell County, direct contact with Whites was minimal. At that time, the Burns family owned and
CHAPTER III

THE STUDY CONTEXT

The Ministry Setting

In February 1733, General James Edward Oglethorpe and 120 of his fellow travelers landed on a bluff high along the Savannah River. In honor of England’s King George II, General Oglethorpe named the thirteenth and last colony “Georgia.” Savannah became Georgia’s first city. Savannah was America’s first planned city. Oglethorpe laid the city out in a series of grids that allowed wide open streets to intersect with shady public squares and parks that served as town meeting places and centers of business. Savannah had 24 original squares with 21 still in existence to this day. The Native Yamacraw Indian Chief Tomo-chi-chi aided General Oglethorpe in his settlement efforts. General Oglethorpe and Chief Tomo-chi-chi pledged to each other their friendship and good-will, and the Yamacraw chief granted the new arrivals permission to settle at the mouth of the Savannah River.

Under the original charter, which General Oglethorpe received from King George II of England, slavery was forbidden. However, Georgia’s farmers soon learned that Savannah’s soil was rich and the climate was favorable for the cultivation of rice and cotton. Shortly thereafter, Georgia legalized slavery, and millions of African slaves passed through the port of Savannah forming the Gullah communities in Georgia and South Carolina.
During the Civil War, as Union General William Tecumseh Sherman began his march to the sea, burning the city of Atlanta and everything else in his path on the way to the coast, Savannah avoided destruction, and on December 22, 1864, General Sherman presented the city of Savannah to President Abraham Lincoln as a Christmas present.

Having survived two devastating fires (1796 and 1820), Reconstruction, The Great Depression, and two World Wars, the dawn of the twenty-first century brought with it a resurgence in Savannah’s tourism, with more than 50 million people visiting the city of Savannah during the 1990’s alone.

According to the U.S. Census Bureau, in 2000, the city of Savannah had a population of 131,510 residents, and Chatham County had a population of 232,048. Chatham County is the fifth largest county in the State of Georgia. The Savannah Metropolitan Statistical Area (MSA) is comprised of Chatham County having a population of 232,048; Effingham County having a population of 37,535; and Bryan County having a population of 23,417. Thus, the Savannah MSA has a total population of 393,000. The 2000 census further shows that 3.5% of the population of Savannah MSA was foreign born, and that 6.0% of the population speaks a language other than English.¹

Candler Hospital’s history began in the 1730’s when a Methodist missionary, George Whitfield, brought large quantities of medicine to Savannah for the “Cure of Sickness.” Healthcare evolved in the Savannah area, and on December 12, 1804, Georgia’s colony’s first hospital was chartered. The Savannah Poor House and Hospital was initially created to care for seamen and the poor. In 1872, the hospital changed its name to Savannah Hospital.

From 1872 to 1888, the Savannah Hospital served as the headquarters for the Savannah Medical School and was home to the city’s first nursing school. In 1930, the Savannah Hospital was acquired by the Georgia Hospital Board of the Methodist Episcopal Church South and renamed in honor of Bishop Warren A. Candler. Although no longer owned by The Methodist Church, Candler Hospital continues to bear the bishop’s name. Believed to be the second oldest general hospital in continuous operation in the United States, Candler Hospital has been a Methodist facility and a quality healthcare provider for many generations of South Georgia families.

Catherine McAuley, born in 1778, was the founder of the order of the Sisters of Mercy. Catherine’s mission to the poor included teaching, ministering to the sick, and comforting the elderly and the dying. This was the foundation of the formation of the Sisters of Mercy. The Sisters of Mercy have a long tradition of sponsoring healthcare institutions in the United States and other parts of the world. In addition to St. Joseph’s Hospital in Savannah, the Sisters of Mercy of Baltimore sponsor five other healthcare institutions in their province: St. Joseph’s Health System in Atlanta, Georgia; St. Mary’s Health Care System, Inc., in Athens, Georgia; Mercy Medical, Inc., in Daphne, Alabama; Mercy Medical Center, in Baltimore, Maryland; and Stella Maris, Inc., in Baltimore, Maryland.

In June of 1875, responding to the plight of sick seamen, the Sisters of Mercy under contract with the United States authorities, took over operations of Forest City Marine Hospital. In March 1876, the Sisters of Mercy renamed the hospital the St. Joseph’s Infirmary. It was not until several expansions later that the name was changed to St. Joseph’s Hospital. Ever cognizant of Savannah’s growing health care requirements,
the hospital opened the city’s first psychiatric unit in the 1950’s. Faced with a severe lack of development space, the hospital relocated to Savannah’s southside, an area earmarked with high projections of growth. St. Joseph’s hospital is a 305-bed general acute care facility, which is situated on 28 acres on Savannah’s southside.

On April 1, 1997, St. Joseph’s Hospital, having a Catholic tradition, and Candler Hospital, having a Methodist tradition, merged to form the St. Joseph’s/Candler Health System. This period of merger and transition was filled with much grief and guilt for those who lost their positions; suspicion toward what initially appeared to be primarily a Catholic administration; feelings of powerlessness and apathy; fear of the unknown, etc. The merger brought about many changes; specialization of labor became the norm. All heart surgeries and orthopedic surgeries were done on the St. Joseph’s campus; the children’s hospital and all newborns (births) were moved to the Candler campus; the administrative staff (the President and CEO and all vice presidents) established offices on both campuses; many directors, managers, and some employees were required to travel from campus to campus. Shortly after the merger, the bishop and South Georgia Conference asked Candler Hospital to renew and clarify its “Statement of Relationship” with The United Methodist Church. It was also during this transition period that the South Georgia Conference of The United Methodist Church voted to discontinue its financial support to the pastoral care department at Candler Hospital.

While it is true that the Catholic influence in the St. Joseph’s/Candler Health System is greater than the Methodist influence, there are several possible explanations for this: first, whereas, St. Joseph’s Hospital is owned and sponsored by the Sisters of Mercy of Baltimore, Maryland, The United Methodist Church neither owns nor attempts to
control Candler Hospital; second, whereas the Sisters of Mercy routinely appoint three representatives to the Board of Trustees, The United Methodist Church appoints no representatives to the Board of Trustees. Nonetheless, in order to maintain the relationship between Candler Hospital and The United Methodist Church, the District Superintendent of the Savannah District serves as a member of the Candler Foundation’s Board of Directors. Today the two hospitals are nine years into the merger, and the merger appears to be a success. The two cultures appear to be reasonably well integrated. Currently, St Joseph’s/Candler is the largest healthcare provider in the region, boasting approximately 4,000 employees.

The president and CEO of the St. Joseph’s/Candler Health System is a Euro-American, male, Roman Catholic, who grew up in New England. Of the twelve vice presidents, women claim about one-third of those positions; there’s not one African-American, Hispanic-American, or Asian-American vice president among the executive leadership. At the next level, the director level, women are again heavily represented. Of approximately 35-40 directors, there are three or four African-Americans directors and one Asian-American director. The workforce is comprised primarily of Euro-Americans and African-American employees. There appears to be a significant number of Asian-American and Hispanic-American nurses. Due to the presence of two large military installations and Savannah’s warm southern climate, St. Joseph’s/Candler attracts nurses from throughout the United States and the world. There is a small percentage of nurses from England, Canada, Africa, and the Caribbean Islands. St. Joseph’s/Candler’s General Medical staff is comprised primarily of Euro-American males. However, Euro-American females are also significantly represented. Doctors from such countries as India, Pakistan,
Nigeria, Ghana, Mexico, etc., are also quite visible within the St. Joseph’s/Candler medical community.

Internally as one looks at the composition of the pastoral care departments, one also sees diversity. An African-American male, who is a United Methodist minister, heads the Candler Department of Pastoral Care. Candler has two staff chaplains: one Euro-American male who is a Southern Baptist minister, and one Euro-American Sister of Mercy, Catholic nun. St. Joseph’s Department of Pastoral Care is headed by an Euro-American (Irish) Sister of Mercy, Catholic nun. St. Joseph’s Hospital has six staff chaplains: One Filipino-American male, Catholic priest; two Euro-American males, both of whom are Catholic priests; two Euro-American Catholic nuns; and one African-American, male, Catholic priest who is employed on a part-time basis.

St. Joseph’s/Candler’s patient population is drawn generally from within a one hundred mile radius of Savannah. The patients drawn from this vast region appear to be about equally divided between Euro-Americans and African-Americans. From a religious perspective, of those expressing a religious preference, about one half claim an affiliation with the Baptist tradition, with the other one-half expressing a religious preference for or affiliation with other religions/denominations such as Methodist, Lutheran, Presbyterian, Episcopalian, Roman Catholic, Jewish, Islam, Buddhists, etc. Currently, the system is making every effort to reach out to our large and rapidly growing Hispanic patient population. Materials are being printed in the Spanish language, and Spanish language interpreters are being identified and trained.
Mission and Theological Stance of Candler’s Department of Pastoral Care

The author served as a staff chaplain and director of pastoral care at Candler Hospital for more than twelve years. David Bosch argues in his book, *Transforming Mission: Paradigm Shifts in Theology of Mission*, that mission comes before theology, and that theology grows out of mission. What is the mission and theology of the pastoral care department at Candler Hospital? Why do we do what we do?

First, the mission of the department of Pastoral Care at Candler Hospital is God’s mission. The mission statement for the St. Joseph’s/Candler proclaims: “Rooted in God’s love, we treat illness and promote wellness for all people.” The ministry at Candler Hospital is a ministry, which is open to all people; all religions, all denominations, all races; all socio-economic classes are invited to share in this ministry.

Second, the mission of the department of Pastoral Care at Candler Hospital is an interfaith mission. Our department is prepared to provide spiritual care to Christians, Jews, Muslims, Hindus, and Buddhists, etc.

Third, the mission of the department of Pastoral Care at Candler Hospital facilitates healing and wholeness in body, mind and spirit. The ministry at Candler is very broad, making use of traditional worship services, intercultural prayers, music therapy, meditation and relaxation, the sacrament of Holy Communion, spiritual counseling, and the ministry of presence.

Fourth, the mission of the department of Pastoral Care at Candler Hospital values all life as sacred. For several years now, quarterly Services of Remembrance have been held for family members whose loved ones have died at Candler Hospital.
The fifth, and final, mission of the department of pastoral care at Candler Hospital is an intercultural ministry, providing care to all people, without regard to race, creed, cultural background, social class, sexual orientation, etc.

At this point, the author would like to enumerate some of the ministries, which are provided at Candler Hospital. First, it provides the sacrament of Holy Communion to all staff, patients, and family members on the first Sunday of every month. Although the chaplains function as “intercultural” in an interfaith/intercultural community most of the time, they believe that there are times when they must be faithful to our own respective faith traditions. Every first Sunday, they celebrate the sacrament of Holy Communion, they remember that they are “Christian” ministers who have been called to be faithful followers of Jesus Christ. The sacrament of Holy Communion is a sacrament (means of grace), which was instituted by our Lord and Savior, Jesus Christ: “This is my body, which is given for you. Do this remembrance of me.” Luke 22:19 (NRSV)

Every quarter, there is a Service of Remembrance (Memorial Service) for families whose loved ones have died at Candler Hospital. Christians believe that all life originates with God, and that at the appointed time, all life returns to God and that Jesus is the resurrection and the life. “Those who believe in me, even though they die, will live, and everyone who lives and believes in me will never die.” John 11:25b (NRSV) Christians also believe that not even death will be able to separate us from the love of God in Christ Jesus. Even though we are Christian in our approach, we are open to include the beliefs and practices of other religions.

Third, the chaplains provide interfaith morning and evening prayers for our staff, patients, and family members. These prayers are broadcast twice daily using the
hospital’s overhead paging system. All major religions of the world recognize prayer as a means of communicating with God. In the Christian tradition, Jesus prayed often and fervently. Jesus also taught his disciples to pray. These public prayers, which are offered twice daily by our staff chaplains, are purposefully and intentionally interfaith prayers. These interfaith prayers are intended to be fairly generic. All chaplains obviously understand and agree that neither name of Jesus nor the doctrine of the Holy Trinity is to be invoked in these interfaith prayers. These prayers are not usually closed ‘in the name of Jesus.’ Rather, these prayers are closed by using a variety of other means, including, ‘we pray in the name of our Lord.’ Christians believe that while working in an interfaith/intercultural healthcare environment, they must be sensitive and respectful of others—staff, patients, and family members—who might choose to espouse a different belief system.

Fourth, live music therapy is provided for the benefit of our patients, family members and staff. Currently, our music therapist, a harpist, visits Candler Hospital one day per week providing four hours of music therapy per day. Music is both interfaith and intercultural. It is believed that music therapy enhances healing by promoting relaxation, assisting with analgesia, and decreasing the physiological effects of stress. Stress is believed to be a significant factor in many illnesses and diseases today.

Fifth, a sacred space for the benefit of our patients, family members, and staff is provided. Lientz Chapel is a 25 seat capacity space equipped with a television camera, which telecasts all worship services to all 335 beds in the facility. Lientz Chapel is open from 7:00 am to 7:00 pm and is available and accessible 24 hours a day and seven days per week by calling security. Worship services emanate from Lientz Chapel six days per
week, Monday through Friday and each Sunday morning. In addition to the formal worship services, Lientz Chapel is often used briefly and informally by large families or church groups, usually for information sharing or brief worship experiences. Religious groups of all faiths are welcome to use Lientz Chapel.

Sixth, three full-time chaplains and one part time Catholic priest provide a strong ministry of presence for patients, families, and staff.

Seventh, a pastoral counseling ministry to benefit our patients, families, and staff is provided. In addition to being Board certified (BCC) by the Association of Professional Chaplains, one of our chaplains is also a professional counselor (LPC) and provides counseling especially to staff and their families.

Eighth, a locked prayer box located just outside of Lientz Chapel where patients, families, staff, and visitors are invited to submit prayer requests. These prayer requests are removed regularly from the prayer box by the staff chaplains who routinely lift these requests and concerns in the form of intercessory prayers to God during our daily devotional services.

Ninth, an interfaith diversity bulletin board, which is located just outside of the Lientz Chapel, is available. On the interfaith diversity bulletin board are listed the five major world religions: Buddhism, Christianity, Hinduism, Judaism, and Islam. For each month of the year, a list for each religions high and holy religious days and/or events is displayed.

Tenth, our newest ministry, which was added as recently as the fall of 2006, is our C.A.R.E. channel. C.A.R.E. is an acronym, which means continuous ambient relaxation environment. The C.A.R.E. channel, which was developed to create an environment that
is supportive of recovery and improve comforts and rest, is available on a 24-hour basis and provides beautiful nature images and instrumental music that has been composed and produced specifically to support healing environments. The nurses and other caregivers have been instructed to choose the C.A.R.E channel for patients who are not able to make channel selections for themselves. Thus, if one were to visit the sickest patients in the hospital, the odds are very great that these televisions sets will be attuned to the C.A.R.E. channel.
CHAPTER IV

THE BIBLICAL AND THEOLOGICAL FOUNDATIONS FOR THE STUDY

The Syrophoenician Woman (Mark 7:24-30)

In Mark’s Gospel at Mark 7:24-30, we witness Jesus doing ministry in an Interfaith/intercultural context. According to Mark’s Gospel, Jesus did not come to the Gentile territory to preach but to escape the crowds (v.24).¹ It is unknown why Jesus crossed-over into the Gentile area. Had he entered into the town of Tyre to celebrate the Passover in some comparative calm and quiet or to secure the leisure to think about the goals of his ministry? Whatever his rationale for being in the region of Tyre, Jesus’ presence was discovered. One such person who heard that Jesus was in town was a Greek woman, i.e., a Gentile woman of Syrophoenician origin whose little daughter was demon-possessed. The mother “came and bowed down at his feet” (v.25). This Syrian woman begged the famed rabbi, Jesus, whose reputation as a physician had preceded him, to heal her ailing child. In Matthew’s Gospel Jesus says, “I was sent only to the lost sheep of the house of Israel” (15:24). In addition, both Matthew and Mark record Jesus as saying, “let the children [that is, the Children of Israel] be fed first, for it is not fair to take children’s food and throw it to the dogs.” (Mark 7:27; Matthew 15:26). There can be no question but that Jesus initially refuses to help this Gentile woman. As the woman persists, Jesus provides his rationale for refusing to help her. Jesus’ reasons for refusing to help this

Gentile mother appear to be based upon ethnic, cultural, and religious bias and prejudice. Jesus appears to be as circumscribed by the boundaries of race, ethnicity, culture, religion, and nationality as his Jewish contemporaries. However, in healing the Gentile mother’s daughter, Jesus proves that he is prepared to move beyond racial arrogance, nationalism, and political provincialism. “One noted scholar has suggested that this story should not be considered a miracle of healing at a distance. The miracle is the overcoming of prejudice and boundaries that separate persons.” Pheme Perkins provides an excellent summary of this pericope: “Mark had Jesus enter Gentile territory to be alone, not to engage in a mission. The exchange with the woman points toward the future in which Gentiles will be included; their faith will bring them salvation.”

**The Healing of the Ten Lepers (Luke 17:11-19)**

The story of the healing of the ten lepers is not just another simple healing story. Rather, the story is told in such a manner as to blend elements of a healing miracle and a pronouncement story. Moreover, the story resonates with both the healing of Naaman the Syrian and the parable of the Good Samaritan. The effect is to extend Luke’s portrayal of Jesus’ announcement of the Kingdom (from Luke 4:18-19).

According to Luke’s Gospel, as Jesus was traveling from Galilee to Jerusalem, he entered a village near Samaria where he encountered ten lepers. The ten lepers cried out in unison to Jesus, “Jesus, Master, have mercy on us.” (v.13).

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Elisha’s response to Naaman was a command, “Go, wash in the Jordan seven times” (2 Kings 5:10 NRSV) Similarly, Jesus tells the ten lepers, “Go and show yourselves to the priests” (v.14).  

As these men walked along, all ten of them were made clean. However, only one of the ten ‘seeing that he was healed’ returned glorifying God with a loud voice. The healed leper fell at the feet of Jesus and thanked him. Finally, it was told that the one who turned back glorifying God and falling at the feet of Jesus was a Samaritan. Jesus then proceeded to ask three questions: (1) Were not ten made clean? (2) But the other nine, where are they? (3) Was none of them found to return and give praise to God except this foreigner? This story concludes with Jesus saying to the Samaritan, “Get up and go on your way; your faith has made you well.” (v.19)(NRSV) 

In his commentary, R. Alan Culpepper offers the following explanation: “In this case, the man’s faith was not expressed by his request for help but by his gratitude and praise of God. The other nine had been healed, but only this one received Jesus’ declaration of salvation. They got what they wanted, but this one received more than he had dreamed of asking for.”

Should we equate gratitude with faith? This story answers unequivocally- yes! This story makes it clear that faith was expressed not primarily in the lepers’ collective cry for help but in the Samaritan’s individual act of recognition and his cry of grateful praise. 

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5 Ibid., 326.

6 Ibid., 327.

7 Ibid.
For centuries Jews and Samaritans have hated and despised one another. The antipathy between these two groups had its beginning with the questionable origin of the Samaritan people. The Samaritans claim to have descended from that group of Israelites who were left behind in Israel in 722 BCE after the Assyrian King Sargon II destroyed the northern kingdom and deported many of the people to Babylon. The Jews, on the other hand, contend that the Samaritans were those people whom the king of Assyrian imported from Babylon, Cuthah, Avva, Hamath, and Seharvaim and settled in the towns of Samaria to replace the true Israelites who had been deported to Babylon. Down through the centuries the animosity and hostility between the two groups have ebbed and flowed. One might wonder why a Samaritan leper would be found in the company of nine Jewish lepers. However, history teaches us that common threats, dangers, and disasters often tend to unify a community. In this case, the disease of leprosy in its many forms was so horrible that it, like HIV/AIDS of our time, encouraged husbands to separate from or divorce their wives, and wives to separate from or divorce their husbands. Leprosy caused or encouraged fathers to turn against their sons, and mothers to turn against their daughters. During the time of Jesus’ ministry, lepers were not welcome in the Temple, as HIV/AIDS patients were not welcome in many of our churches, temples, and synagogues thirty years ago when the HIV/AIDS virus was initially diagnosed. Thus, having been publicly ostracized and frequently rejected by their own families, friends, and religious communities in these lepers colonies, lepers affirmed and cared for each other. They protected and looked out for one another. They allowed and encouraged each other to be human again.
Given the undisputed fact that America is rapidly becoming a more religiously and culturally diverse society, coupled with the fact that persons who become patients in hospitals today are often those who present with the more serious medical diagnoses and poorer prognoses, it is easy to understand how hospitals, hospice organizations, and nursing homes have become today’s leper colonies where persons of all faith traditions and cultural backgrounds come to be healed. Within this healing context today, typically are found physicians, surgeons, nurses, social workers, and therapists of many varieties: occupational, physical, respiratory, speech, etc. These clinicians are specially trained to attend to the needs of the physical body. But who helps the patient to address the religious, theological, or spiritual issues, which often accompany serious illness? Within this healing context, chaplains or spiritual healers are often found. Chaplains are in a very unique position to bring spiritual healing and wholeness to the wounded souls and spirits of today’s lepers. Like Jesus in this biblical story, Christian chaplains are much less interested in proselytizing or trying to convert patients and much more interested in helping patients to ‘find their souls.’ In this biblical story, the Samaritan leper was not only healed of his leprosy, but in returning to Jesus with his heart filled with gratitude, he also found his soul. All ten lepers received what they asked for, but the Samaritan leper received much more than he ever could have imagined. He received salvation.

The Good Samaritan (Luke 10:25-37)

The setting for the parable of the Good Samaritan consists of questions asked of Jesus by a lawyer who appears to be interrogating him. The initial question asked (in 10:25) is “What must I do to inherit eternal life?” Although not posed in the context of the passion narrative (as in Matthew 22:34-40) it is asked on Jesus’ journey to the cross
and it is asked a second time at Luke 18:18-30. Here Jesus responds by asking the lawyer what the scriptures say. The lawyer responds appropriately with words from one of the most familiar and revered texts of the Old Testament, namely the schema: “Hear, O Israel: The Lord is our God, the Lord alone. You shall love the Lord your God with all your heart, and with all your soul, and with all your strength” (Deuteronomy 6:4-5) adding “and with all your mind; and your neighbor as yourself.” Jesus affirms the answer but the lawyer presses further by asking the crucial question (recorded only in Luke 10:29), “And who is my neighbor?”

Consider this summary of the parable of the Good Samaritan:

A solitary traveler is mugged, beaten, left for the dead. Two people pass by who, according to their social roles as professionals of high status and righteousness, might be expected to help the injured traveler, but they do not. A third person, approaches; his social identity as a half-breed and outcast suggests that he would pass by also, but he does not; instead he helps the traveler going far beyond standard social expectations of the kind of help offered in such a situation.

The expected sequence would be a priest, a Levite and an Israelite. Shattering all expectations, the third traveler is a Samaritan. By making the hero of the story a Samaritan, Jesus challenged the longstanding enmity between Jews and Samaritans. The latter were regarded as unclean people, descendants of the mixed marriages that followed from the Assyrian settlement of people from various regions in the fallen Northern kingdom (II Kings 17:6, 24). By depicting a Samaritan as the hero of the story, therefore, Jesus, demolished all boundary expectations. Social position – race, religion or region-

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count for nothing. The force of this case drives one to conclude that compassion which transcends legally sanctioned ethnic boundaries and discriminations when faced with real human need is a superior form of human behavior than continuing to live within their limits.

What inferences might Christian chaplains serving in interfaith/intercultural healthcare setting draw from these three scriptures? All three scriptures show Jesus going beyond traditional boundaries of his day to offer help, healing, and salvation to all people who were hurting without regard for race, religion, gender, or cultural concerns.

The story of the Good Samaritan as told by Jesus seems to have particular relevance for Christian chaplains serving in interfaith and intercultural healthcare environments. We Christian chaplains no longer have the luxury of asking—And who is my neighbor? That question has been asked and answered definitively once and for all times. The interfaith/intercultural Christian chaplain, like the Good Samaritan of Old, should be ‘moved with compassion’ when he or she sees the suffering of a fellow human being. We Christian chaplains are commanded by our Lord Jesus to show mercy to those in need regardless of the race, religion, gender, ethnicity, social status, cultural heritage, or sexual orientation of our patients.

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CHAPTER V

REVIEW OF LITERATURE THAT ADDRESSES
THE MINISTRY ISSUE

The ministry issue has been identified, contextually located, and foundationally established biblically and theologically. We shall now look at the existing literature related to this issue. This chapter highlights some of the empirical literature which has attempted to address the issue of how Christian chaplains serving in interfaith/intercultural healthcare settings provide spiritual care to patients, families, and staff and nurture their own spirituality.

Sociological/Political

In his recent book, Mainline To The Future, Jackson Carroll talked much about the post traditional society. Although it appears that Carroll was writing primarily for and to the parish minister, there was no difficulty reading this book as a hospital chaplain and anticipating the pastoral care and counseling needs of patients and family members who might be products of this post traditional society. Because products of the post traditional society are not usually deeply rooted in tradition, they are often tremendous teaching opportunities. For example, on one or more occasions, patients request the sacrament of Holy Communion, only to ask once the ritual has begun – “What are you doing?” “What does it mean?” “Why do you do that?”
Candler Hospital is the home of Telfair Hospital for women as well as “The Birthplace at Telfair.” Rumor has it that more babies are born at The Birthplace at Telfair than anywhere else in the State of Georgia, south of Atlanta. In any case, from time-to-time, a mother will experience a prenatal loss or a stillborn birth. A common request of the parent or parents is that the deceased infant receives the sacrament of baptism. The parent or parents are asked – “Why do you want to have your baby baptized?” “What does baptism mean to you?” The purpose in asking this question is not so that the parents and I can become engaged in a prolonged theological discourse. Quite the contrary, the purpose is to help the parents to think about the meaning of baptism. More often than not, the parent’s response is, “I want him or her baptized so that he/she will go to heaven.”

In order to function effectively and competently as a hospital chaplain in today’s post traditional society, today’s chaplains must not only be prepared to engage and provide pastoral care to “believers” who embrace some form of organized religion. They must also be open to those who profess no religious beliefs at all and might, in fact, consider themselves to be non-religious, or even agnostics or atheists. In other words, hospital chaplains in today’s post traditional society must be prepared to provide spiritual care to a very broad and diverse body of human beings consisting of patients and family members as well as staff and their families.

Diana L. Eck is affiliated with The United Methodist Church and is a professor of Comparative Religion and Indian Studies at Harvard University. Eck’s book is very helpful in the researcher’s attempt to survey the multicultural and multi-religious landscape of America. Eck is an advocate and very strong proponent of multicultural and
multi-religious diversity in America. In fact, Eck sees religious pluralism as the New American dilemma rivaling Gunnar Myrdal’s American dilemma of the late 1940’s.

The New American dilemma is real religious pluralism, and it poses challenges to America’s Christian churches that are as difficult and divisive as those of race. Today, the invocation of a Christian America takes on a new set of tensions as our population of Muslim, Hindu, Sikh, and Buddhist neighbors grows. The ideal of a Christian America stands in contradiction to the spirit, if not the letter, of America’s foundation principle of religious freedom. As long as religious diversity meant Methodists, Congregationalists, Southern Baptists, and Catholics, or as long as it meant, at the most, Christians and Jews, the issues were not so troubling and the tension not so palpable. Today, however, America is in the process of coming to terms with this deep contradiction, this very complex form of hypocrisy.

According to a reputable 2002 source, the best estimate of the Muslim population in America with adjustments for non-English speakers was about 0.67 percent. This comes to about 1.4 million adults or a total population of about 1.9 million. However, Diana Eck argues that the Muslim population in America today is in excess of six million. There is no consensus on the number of Buddhist in America. Taking the range of estimates of 0.5 - 1.0 percent would mean that Buddhist would account for 1.0 — 2.1 million adults and 1.4 - 2.8 million in total population. Given that several general population surveys point toward the lower end of this range and only the student samples toward the higher end, it is likely that the total number of Buddhist is closer to 1.4 million than 2.8 million. In contrast to the Buddhist figures, there is great consensus that the Hindu population is a little over 1,000,000.

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4Religious Diversity in America. 579
5Ibid.
In chapter two of her book, to which she provides the caption "From Many, One," Eck further clarifies her vision of *A New Religious America*.

One thing E pluribus Unum clearly does not mean is "From many religions, one religion." Our oneness will not mean the blending of religions into a religious melting pot, all speaking a kind of religious Esperanto. Of course, there will be conversions, intermarriages—probably plenty of them—and forms of public and private syncretism, but there will never be a widespread melting pot of religions or unanimity on matters of religious truth. The Unum will be civic—a oneness of commitment to the common covenants of our citizenship out of the manyness of religious ways and worlds. Creating and sustaining this civic oneness is a challenge for any nation and a new challenge for ours.  

I found Eck’s book to be extremely helpful in setting the larger social, political and economic context in which Christian chaplains in America do ministry. Eck’s book provides invaluable contemporary information about America’s Hindus, Buddhists, and Muslims.

**Pastoral Care And Counseling**

In chapter one, Lartey proposes a detailed definition of [intercultural] pastoral care:

Pastoral care consists of helping activities, participated in by people who recognize a transcendent dimension to human life, which, by the use of verbal or non-verbal, direct or indirect, literal or symbolic modes of communication aim at preventing, relieving or facilitating persons coping with anxieties. Pastoral care seeks to foster people’s growth as full human beings with development of ecologically and socio-politically holistic communities in which all persons may live humane lives.  

Lartey also moves immediately to define how he is using the concept culture:

By culture I shall be referring to the way in which groups of people develop distinct patterns of life and give ‘expressive form’ to their social and material life experience. This way of speaking of culture has been described as an

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anthropological one. In this sense, the culture of a group of persons is the particular and distinctive 'way of life' of the group. This includes the ideas, values and meaning embodied in institutions and practices, in forms of social relationship, in systems of belief, in mores and customs, in the way objects are used and physical life organized.8

Having proposed a detailed definition of intercultural pastoral care and defined culture as he will be using the term in his book, Lartey then proceeds to offer a third term for our consideration—“interculturality.” Lartey recommends interculturality as ‘a creative response to pluralism.’ 9 Three basic principles are associated with interculturality: contextuality, multiple perspectives, and authentic participation.10 The principle of “contextuality” simply means that every behavior or belief must be interpreted in the context (place, time, and circumstance) in which it is given. The principle of “multiple perspectives” simply means that any two or more rational people having seen, heard, or examined the very same data might arrive at different conclusions. Finally, the principle of “authentic participation” simply affirms the right of all to sit at the table together and to participate in the discussion of the issue(s) at hand. Interculturality affirms a Trinitarian formulation of human personhood expressed by Kluckholn and Murray as far back as 1948:

Every human person is in certain respects:

1. like all others
2. like some others
3. like no other11

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8Ibid., 31.
9Ibid., 33.
10Ibid.
11Ibid., 34.
Consequently, the intercultural pastoral caregiver must ask three questions of all persons and situations which he/she encounters:

1. What of the universal experience of humanity is to be found here?
2. What is culturally determined about this way of thinking, feeling or behaving?
3. What in this experience can be said to be uniquely attributable to this particular person?

From the very outset of his book, Lartey is quite clear that his primary purpose in writing *In Living Color* is to propose an intercultural approach to pastoral care and counseling. In chapter four of his text, Lartey casually enumerates the four classic functions that pastoral care has been seen as serving: *healing, sustaining, guiding,* and *reconciling.* To this list, he adds a fifth function, *nurturing,* which he attributes to Howard Clinebell. It is at this point that Lartey boldly and unapologetically adds two new functions that intercultural pastoral care and counseling clearly serve, *liberating* and *empowering.* First, Lartey makes a very strong and convincing argument that the intercultural pastoral care practitioner must be involved in helping to liberate those who are oppressed:

Liberating involves the intricate and delicate processes of raising awareness about the source and cause of oppression and domination in society. This entails the critical and analytic examining of both personal and structural sources, causes and developments in the establishment of current situations of inequality. In addition to awareness raising, there is the important task of considering options available for change. There is then the need for choice and action followed by reflection and evaluation!  

Next, Lartey turns to the second of his two new intercultural pastoral care functions, *empowering*:

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12*ibid.*, 36.
It is seen most often as a communal affair. Some of the ways in which it expresses itself include: working together with people to attempt to restore community spirit; trying to make governments more responsive to people’s needs; encouraging groups based on one or other identity issue; political education and consciousness-raising; and organizing user or service groups and encouraging groups to develop their own alternative economic power base. Supporting and working with people in these ways can make the difference between personal well being and psychiatric illness.  

Lartey begins chapter six of *In Living Color* by giving a brief history of liberation theology. Such renowned pioneers in the field as Gustavo Gutierrez, the Peruvian Catholic priest who offered the first outlines of liberation theology at a pastoral conference in Chimbote, Peru, in July 1968; Rubem Alves, a Brazilian protestant who completed his doctoral dissertation at Princeton Theological Seminary and later published that manuscript under the title *A Theology of Hope* (1969), and James H. Cone, professor of systematic theology at Union Theological Seminary in New York City and the author of several books on Black Theology, set the background for chapter six which carries the title—“Liberation as Pastoral Praxis.”

In chapter nine, Lartey examines four approaches utilized by pastoral caregivers working in interfaith/intercultural settings: Monoculturalism, cross culturalism, multiculturalism, and interculturalism.

1. Monoculturalism: The monoculturalist basically claims to work in a “color-blind culture.” The basic anthropological and cultural assumptions can be subsumed in the maxim “we are all really the same.”  

Lartey criticizes monoculturalism on the ground that it is non-neutral. Lartey summarizes his critique of monoculturalism as

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13Ibid., 67.
14Ibid., 68.
15Ibid., 163.
follows: “In terms of our earlier Trinitarian formulation, monoculturalists err through an exclusive emphasis on the ‘universal’ dimension (we are like all others). They fail to take seriously enough the cultural and individualist aspects of the threefold statement.” 16

2. Cross-culturalism: Cross-culturalists recognize cultural difference based on identifiable physical, geographical or cultural characteristics. Cross-culturalists believe the real differences exist between groups, that boundaries around groups are fixed, and that identity is shared by all that belong to the group. Larney criticizes cross-culturalism on three grounds:

First, is the difficulty that it encourages a ‘them’ and ‘us’ mentality that creates problems in any pluralistic society. It is we (invariably the dominant, white European/American) who crossover to them (the ‘rest’) and then return. We do things to them. We learn about them. They are different from us. 17

The second reason for Larney’s criticism of cross-culturalism is that it is generally assumed that the caregiver is a member of the dominant majority group and that the person receiving the care is a member of the other group. Third, Larney criticizes the cross-culturalists for encouraging division through the essentializing of cultural difference. Essentializing occurs when we make particular characteristics the only true or real expression of a people. The assumption is that there exists an authentic African, Asian, African-Caribbean or black ‘other’ who is totally different from the dominant one in every respect. 18

3. Multiculturalism: The fundamental premise upon which this approach is based is the need for accurate and detailed information to provide the basis for relevant policy

16 Ibid., 165
17 Ibid., 167.
18 Ibid., 168.
and social action. Detailed information such as social customs, religious rites, food habits, leisure activities, family patterns, gender roles, identifiable ethnic group. Larney commends multiculturalists for the level of success they have achieved in building an accurate and scientific database of relevant information. However, Larney criticizes multiculturalism on the ground that the information which is generated about ethnic/minority groups is often used and understood in a reductionistic and individualized way against the very people whom the information was intended to help. Moreover, Larney further charges that this very same information is often used to form stereotypes or to categorize and often place ethnic groups in hierarchical order of value or preference. Finally, Larney charges that multiculturalism fails to appreciate the complexity of culture or to appreciate individual differences within cultural groups.

4. Intercultural Pastoral Care and Counseling: Of course, Larney concludes by strongly suggesting that intercultural pastoral care and counseling is the only real option for pastoral counselors in today’s interfaith and intercultural world. Again, using the Trinitarian formulation of human personhood as expressed by Kluckholn and Murray in 1948, Larney summarizes his model for doing intercultural pastoral care and counseling:

1. Like all others: All human beings are created in the image of God, and the intercultural pastoral counselors must always remember and never forget to recognize and affirm the “humanity” of every human being.
2. Like some others: Intercultural pastoral caregivers attempt to figure out what in the experience being dealt with is the result of social and cultural forces.
3. Like no other: The intercultural pastoral counselor must always remember and never forget that each and every individual is unique unto him or herself. He or she is one of a kind.  

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19 Ibid., 169.

20 Ibid., 172 - 174.
Anthropological

In his book, *Pastoral Counseling Across Cultures*, David Augsburger defines pastoral counseling as follows:

Pastoral counseling is a liberating and healing ministry of the faith community that is based on a relationship between a pastor (or a pastoring team) with counseling skills and a family or person who come together to engage in conversation and interaction. The relationship is a dynamic process of caring and exploration, with a definite structure and mutually contracted goals, and occurs within the tradition, beliefs, and resources of the faith community that surrounds and supports them.  

In chapter one, Augsburger sets forth five characteristics of culturally capable counselors:

1. Culturally aware counselors have a clear understanding of their own values and basic assumptions.
2. Culturally aware counselors have a capacity for welcoming, entering into, and prizing other worldviews without negating their legitimacy.
3. Culturally aware counselors seek sources of influence in both the person and the context, both the individual instance and the environment.
4. Culturally aware counselors are able to move beyond counseling theory, orientation, or technique and be effective humans.
5. Culturally aware counselors see themselves as universal citizens, related to all humans as well as distinct from all of them.

Augsburger’s book is comprised of more than 400 pages and introduces numerous novel phrases and concepts. My purpose now is to revisit at least three phrases or concepts, which were used decisively by Augsburger.

First, Augsburger defines the “intercultural person” as follows:

The intercultural person is not culture-free (a hypothetical and undesirable state). Rather, the person is culturally aware. Awareness of one’s own culture can

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22 Ibid., 20-21.
free one to disconnect identity from cultural externals and to live on the boundary, crossing over and coming back with increasing freedom. Disidentification of the self from old cultural identifications leads to rediscovery of the self in at least three contexts—one’s own culture, a second culture, and in that unique third culture that always forms on the boundary between the two. This third-culture perspective enables the intercultural person to make communication easier, interpret cultural conflict, and function with acceptable competence without any inappropriate switching or confusing behavior.23

Secondly, Augsburger coins the term “interpathy” in an effort to explain the special skill, which the intercultural pastoral counselor develops to enable him or her to enter a second culture. Augsburger defines interpathy as follows:

Interpathy is an intentional cognitive envisioning and effective experiencing of another’s thoughts and feelings, even though the thoughts rise from another process of knowing, the values grow from another frame of moral reasoning, and the feelings spring from another basis of assumptions... In Interpathic caring, the process of “feeling with” and “thinking with” another requires that one enter the other’s world of assumptions, beliefs, and values and temporarily take them as one’s own. Bracketing my own beliefs, I believe what the other believes, see as the other sees, value what the other values, and feel the consequent feelings as the other feels them.24

Thirdly, in the final chapter of his book, Augsburger examines eleven metaphors for healing in cross-cultural pastoral counseling. The researcher will briefly revisit each metaphor making very succinct statements about each:

1. Hide and seek: The first metaphor indicates that the patient is encouraged by the therapist to look within himself or herself for the cure.
2. Choice and change: The second metaphor reminds us that, ultimately, it is the patient’s decision to change or not to change.
3. Sanctioned Retreat: This third metaphor indicates that therapy allows the patient a second opportunity to get it right.

23Ibid., 13-14.
24Ibid., 29-30.
Therapy gives a time of release from the structural demands of the social-occupational-religious-moral institutions so the person can have the distance and leisure to reconstruct life, regather energies, and assimilate new learning for a more effective reentry.25

4. Teacher and student: The fourth metaphor sees therapy as primarily the imparting of knowledge with the therapist as teacher and patient as pupil.

5. Scientific Technique and skill: The fifth metaphor sees therapy as a matter of applying certain scientific techniques and skills. However, recent research indicates that effective counseling has less to do with the application of certain scientific techniques and skills and more to do with the quality of the therapeutic relationship which was established between the therapist and the patient.26

6. Therapeutic Communication: This sixth metaphor for cross-cultural counseling reminds us that communication is at the heart of all counseling.

7. Healing Relationship: The seventh metaphor for cross-cultural pastoral counseling is healing relationship. The client seeks out the therapist for the same reason that the patients seek out the physician. They are both sick and want to be healed.

8. Human Transformation: The eighth metaphor for cross-cultural pastoral counseling seems to suggest that sometimes the change in the human personality is so deep and so traumatic that it is nothing less than a human transformation.

9. The Healing Community: The ninth metaphor, the healing community, is a phrase used to describe those family systems, neighborhood groups, healthcare systems, committed support groups, and creative churches that surround persons with care.

25 Ibid., 352.

As a reality, healing community is any positive network of persons that enables health, growth, or human transformation.  


In the final chapter of his book, *The Wounded Healer*, Henri Nouwen is convinced that personal and professional loneliness is the most serious “woundedness” with which contemporary ministers struggle. If today’s ministers are to be sources of strength and healing for others who come to them for help, these ministers must first bind-up their own wounds. Only after he or she has bound his or her own wounds, can help and healing then be extended to others.

So we see how loneliness is the minister’s wound not only because he shares in the human condition, but also because of the unique predicament of his profession. It is this wound that he is called to bind with more care and attention than others usually do. For a deep understanding of his own pain makes it possible for him to convert his weakness into strength and to offer his own experience as a source of healing to those who are often lost in the darkness of their own misunderstood suffering.

11. Host and Guest: The eleventh, and final, metaphor for cross-cultural pastoral counseling is that of host and guest.

In all counseling and psychotherapy, it is the counselee who is the host and the counselor who is the guest. It is the host, not the guest, who owns the life story and human experience that are shared in the counseling situation. The boundaries, the center, the possibilities, the pain are all possessions of the host, not the guest... The guest is present by invitation, not intrusion, so honoring the rules of the house (cultural values) and rules of the community (moral values) are necessary... The guest does not overstay his or her welcome; the privilege of being in another’s world is not taken lightly.

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27Augusburger, 365.


Of the various metaphors which are offered by Augsburger, one in particular appears to stand out as having particular relevance and significance for Christian chaplains serving in interfaith/intercultural healthcare settings, the metaphor of host and guest. The healthcare arena has changed a lot over the last fifty or sixty years. Fifty or sixty years ago, most patients probably deferred to their white male physicians to make most relevant healthcare decisions for them. Today, however, with the advent of the computer age and Internet access, more and more patients are gaining the knowledge and information they need so as to be equal partners in their own healthcare. Today is the day of patient rights.

At the hospital where the researcher serves as chaplain and director of pastoral care, patient rights and responsibilities posters hang in every work area and every patient care area throughout the hospital. On this particular Patient Bill of Rights poster there are listed 21 rights and 6 responsibilities. The author has chosen to emphasize five patient rights, which seem to have particular relevance for Christian chaplains serving in interfaith/intercultural healthcare contexts:

- Patients have the right to be treated with comfort, dignity and respect including the final stages of life;
- Patients have a right to bring to the attention of the appropriate hospital representative any concerns regarding their right to care and to have those complaints reviewed and, when possible resolved;
- Patients have a right to be free from all forms of abuse, harassment and discrimination, the right to file a complaint with the state survey or certification agency if the patient has a concern about patient abuse, neglect or misappropriation of the patient’s property in the facility;
- Patients have the right to recognition of spiritual, cultural and social beliefs;
Patients have the right to effective communication from the health system, including appropriate accommodation for disabled patients, and the rights to unrestricted access to communication with others outside the health system.\textsuperscript{30}

In this day of patient rights, Augsburger’s metaphor of host and guest is all the more appropriate. Once the patient is assigned to a certain hospital room, the room becomes in essence the patient’s “castle.” The patient has the right to control that assigned space. According to the researcher’s personal knowledge, doctors, nurses, chaplains, etc., have been ejected by patients from patients’ rooms. However, in the author’s twelve-year chaplain career, he has been ejected no less than three times. At other times, he has been stopped at the door by the patient and asked not to enter. Thus, whenever he approach a patient’s room, he is under no illusion that he has a right to enter. Rather, to the contrary, the writer knocks at every door and requests permission to enter. As a chaplain, he is always the invited guest, and the patient is the host who might choose to deny the right of entry or terminate the pastoral visit at any time, for any reason, or for no reason.

**Historical**

In his article, “The DeChristianization of Christian Hospital Chaplaincy,” Engelhardt makes a rather convincing argument that the recognition and professionalization of Christian Hospital Chaplaincy is directly related to the demise of Christendom and the blurring of denominational lines as well as lines between Christianity and other religions.

The result is a profession of chaplaincy that has its identity outside of any particular denominational or religious commitments and whose institutional locus aims the chaplain at a variety of health care service or ministry. The primary goal

of the chaplain ceases to be that of guiding patients toward repentance, conversion, and salvation, and instead becomes that of bringing patients to spiritual and psychological peace toward the goal of successful health... The result is a profession of chaplaincy that unites not just Christians of various denominations but religious ministers of all faiths around goals transcending particular denominational and religious identities. As such, chaplaincy presupposes a moral as well as “spiritual” identity independent of what the traditional Christian chaplain’s identity once involved: a ministry dedicated to bringing patients a clear message of the cardinal importance of right worship and right belief. The professionalization of chaplaincy involves a relocation of the chaplain’s ministry from an identity and goals directed beyond the horizon of the finite and defined within the social context of a particular religion, to goals set within the therapeutic horizon of an effectively secular health care and the social context of a robustly ecumenical professional body.31

Engelhardt concludes that the cardinal tasks of Christian chaplains serving in today’s healthcare environments are twofold: first, to understand and recognize the threat to his/her traditional Christian identity, and, second, to take steps to strengthen or maintain their authentic Christian identity.

Theological

In his essay, “Dumbing Down the Spirit,” Stephen Pattison compares and contrasts Spirit and spirituality in the Christian tradition with spirituality in the healthcare environment. Looking first at Spirit and spirituality in the Christian tradition, Pattison makes the following observations:

1. Spirit and spirituality in the Christian tradition is divine and transcendent;
2. Spirit and spirituality in the Christian tradition is not passive, but active;
3. The effects of the Spirit’s work are not wholly confined to human beings;
4. The work of the Spirit has a material reality;

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5. the Spirit has power to effect change in people, places, things, and circumstances;

6. Spirit in the Christian tradition cannot be controlled or manipulated by human beings.

Next, Pattison turns to ‘spirituality’ in healthcare and using Cobb and Robshaw’s book, *The Spiritual Challenge of Healthcare*, makes the following observations:

1. In healthcare settings today, spirituality is a good thing:

   It is universally valid and valued. Everyone does and should have it, and because they do, they should have their spiritual needs however defined, met. There appears to be no such thing as a dubious spirituality, a harmful spirituality, or one that should not be indulged.  

2. The spiritual needs of patients should be identified, measured, and met;

3. Spirituality is an individual matter;

4. There is no kind of well-founded and tried community, practice or discipline that surrounds and sustains the seeker after spiritual reassurance or wisdom. It is up to the individual to find his/her own way to transcendence and connection, preferably quickly so existential angst can be avoided in the context of illness.

5. There should be professionals within the healthcare environment who are capable of expertly diagnosing and meeting spiritual needs of patients;

6. Spirituality is primarily concerned with helping one to adjust to one’s life situation and seeking/meaning and purpose in life.

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33 Ibid.
Pattison is highly critical of spirituality in the healthcare context which he refers to as "generic" spirituality. Moreover, Pattison emphatically warns Christian chaplains of the dangers which they face daily as brokers of this generic spirituality:

Due to the muddled usage of the term 'spirituality', and the fact that in the West this has often been associated directly with the Christian tradition, it is not surprising that Christian chaplains have allowed themselves to become brokers of 'spirituality' generally and not just representatives of their own tradition. There is much to be commended in this open-minded, concerned attitude for people of all faiths and none. It is a great advance on tribalism, exclusivism, and xenophobia. However, there is much that may be glossed over and lost here. In particular, chaplains may be tempted to downplay the importance of their own tradition and identity within that tradition in the interests of being universally accepting and acceptable. In the long term, this can only weaken their value as speakers of a particular language and representatives of a particular religious community and tradition......At stake here is the issue of religious identity and integrity. As long as Christian chaplains see themselves as generic brokers of spiritual care of all kinds, they are in danger of forsaking what they most distinctly and usefully have to offer; their lived experience of dwelling within a historic religious tradition by which people over centuries have lived and died. Furthermore, as 'universal' spiritual brokers, they may risk distorting and misrepresenting the faith traditions of others whom should be allowed to speak and minister for themselves.34

In conclusion, Pattison's main purpose in writing this essay is to suggest to Christian chaplains who function in healthcare environments that they might best prepare themselves to provide generic 'spiritual care' to all faiths. First by revisiting and strengthening their connections with their own respective faith traditions then by not abandoning or disclaiming their own faith traditions. Like Engelhardt, Pattison warns Christian chaplains of the inherent dangers, which await them as they seek to provide "generic spiritual care" in today's interfaith and intercultural healthcare environments.

In the next article, which I will highlight, Corinna Delkeskamp-Hayes uses the simple classification of Generic versus Catholic to classify hospital chaplains who serve

34Ibid., 41.
within interfaith/intercultural healthcare settings. She begins by acknowledging that both share certain common claims:

To be sure catholicity and genericity have certain claims in common: Both assume that an infinitely superior, benevolent being exists, that it has created the world, and that approaching it in prayer has a salvific effect. Within the narrow Christian context of genericism, both positions also assume that this being is a Unity of three persons, one of whom became incarnate in order to redeem this fallen world.35

Next, Delkeskamp-Hayes proceeds to emphasize the differences between catholicity and genericity:

The difference between both position[s] concerns ecclesiological implications: Catholicists hold that the fullness of the Truth regarding that redemption was trusted to and has been preserved by the one catholic and apostolic church. Genericists, on the other hand, hold that churches are human institutions which regulate and orient, in their respectively different ways, individuals’ salvific ways of worshipping the Tri-une God. The difference thus lies between recognizing the visible church as the body of Christ in the Holy Spirit and thus endowed with the wholeness of catholicity of spiritual therapeutic power or, instead, considering the class of persons who are appropriately directed in matters of religion to constitute some invisible church which transcends any particular “visible church” assembly of worshipers. The former understanding insists on the catholicity of visible church, the latter accepts a broader generic religiosity and spirituality. In that latter case, the Christian truth any one church proclaims is a culturally fragmented truth, and different individuals, depending on their socialization, character, or life history, will and ought to assume any one such ecclesial perspective as their own personal truth.36

Finally, Delkskamp-Hayes summarizes the differences between genericity and catholicity:

The difference between Christian (either implicit or explicit) genericity and (either cautiously implicit or boldly explicit) catholicity then amount to the difference between acknowledging the salvific value (and mutual complementarity) of such different perspectives (thus endorsing ecclesial

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36 Ibid., 6-7.
pluralism), or reserving that value and standing for the one true church (thus endorsing ecclesial monism). 37

One might ask, “What difference does it really make? Does it really matter? Isn’t this all academic?” Delkskamp-Hayes believes that whether the Christian chaplain is generic or catholic in his or her orientation is reflected in the way the hospital chaplain both ministers (through prayer or ritual) to patients of faith backgrounds different from his or her own and cooperates with other chaplains with such different orientations.

Regarding the hospital chaplain’s ministry of prayer and the celebration of the sacraments and other rituals, Delkskamp-Hayes seems to suggest that hospital chaplains who espouse catholicity are in danger of being too narrowly focused in their practice of ministry, and hospital chaplains who espouse genericity are in danger of being too broad in their understanding and practice of ministry. However, it is apparent from this article that Delkskamp-Hayes displays decided bias in favor of catholicity and against genericity.

Note that Delkskamp-Hayes goes to great lengths to describe the dangers of genericism:

It is precisely this unwillingness to recognize the bond among Truth, the wholeness or catholicity of the church, and her spiritual therapeutic power as the body of Christ in the Holy Spirit, which renders it impossible to keep such meaning – impoverished genericised spirituality effectively within even merely the range of Christianity. Once the question of visible church-based Truth is evaded, no conceptual resources remain for precluding “enhanced” genericism (acknowledging the Christian God to be blended with the God of Abraham as confessed by Muslims and Jews), or even “XXX” genericism (permitting prayer with Hindus and Unitarians). Nor are there any resources left for keeping one’s acknowledging dispositions within the bounds of the more (culturally) respectable (because well established) world religions. As ever more idiosyncratic new age esoteric, updated shamanist, feminism-exploiting witch crafty, magic acts oriented and benevolent demon worship endorsing clientele make their needs concerning spiritual accompaniment felt in public health care institutions, even denominationally profiled Christian chaplains will have a hard time explaining to such clients why they are willing to invoke the spirit as permeating all creation

37Ibid.
when praying with Muslims and Buddhists, but refuse engaging His aid in support of ailing members of such more radically “minority” faith groups.  

Regarding cooperation among hospital chaplains from different faith backgrounds, Delkskamp-Hayes comes to the following conclusion:

To summarize our survey of how the difference between genericity and catholicity orientation affects hospital chaplains’ ability to cooperate ecumenically in the areas of client ministry and work sharing: both positions run spiritual risks. When serving clients of different faiths, denominational pluralists were found defenseless against an indiscriminate acceptance of “qualitatively uncertified” spirit-invocation, while catholicity oriented monists would compromise the integrity of their commitments by endorsing such invocations when cooperating with pluralists in the hospital.  

The question might be asked, “Is Delkskamp-Hayes’ distinction between generic Christians and catholic Christians fully thought out, or is it superficial?” The researcher is currently serving as a director of Pastoral Care and Church Relations at Candler Hospital in Savannah, Georgia. In addition to him, there are two other full-time chaplains on staff. One is a Catholic nun (Sister of Mercy) and the other is a Southern Baptist ordained minister. Candler has a long tradition of serving the sacrament of Holy Communion to all patients, family members and staff each First Sunday of every month. Shortly after our Catholic chaplain (nun) joined the staff, she approached the researcher and the Southern Baptist chaplain and advised us that she would not be available to provide the Sacrament of Holy Communion to Protestant patients, family members or staff because such duties would place her in violation of the Catechism and teachings of the Roman Catholic Church. Moreover, this Catholic chaplain reminded them that she was not ordained and, therefore, should not be serving the Sacrament of Holy Communion to Protestants. However, this very same Catholic chaplain insisted that one of her primary duties and

38Ibid., 8-9.
responsibilities for being assigned to Candler Hospital was to visit all Catholic patients, family members, and staff and provide the Sacrament of Holy Communion as needed. In addition to the Catholic nun, the Catholic Diocese has assigned a Catholic priest to Candler Hospital to provide pastoral care to Catholic patients and to provide for other sacramental needs. Catholic Mass is celebrated weekly at Candler Hospital primarily for the benefit of staff. In the researcher’s opinion, this Catholic (Sister of Mercy) chaplain would be labeled a ‘catholic’ Christian by Delkskamp-Hayes.

On the other hand, during Pastoral Care Week 2004, our Southern Baptist chaplain did not see anything at all wrong with praying a “Muslim prayer” over the mass communication system in honor and recognition of our Muslim patients, family members, and staff. Unfortunately, at least one of our more prominent Roman Catholic physicians did not agree with this staff chaplain and placed a call to the President and Chief Executive Officer complaining that he did not believe that our Christian chaplains should be permitted to pray Muslim prayers over the hospital mass communication system. A copy of the Muslim prayer, which was prayed by the Christian chaplain on the morning of October 28, 2004, is printed below:

Morning Prayer  
October 28, 2004

Good morning... We are continuing today and tomorrow—as we have throughout this week — in Pastoral Care Week and our theme of “Imagining Peace.” We have shared with you several prayers from various faith traditions that make up our hospital community — both staff and patients — and this morning I would like for us to share a Muslim prayer for peace. Let’s pray together...

O God! O our Master! You are eternal life and everlasting peace by your essence and attributes. The everlasting peace is from you and it returns to you. O our Sustainer! Grant us the life of true peace and usher us into the abode of peace. O Glorious and Bounteous One! You are blessed and sublime.

39Ibid., 10.
The Southern Baptist staff chaplain would be labeled a ‘generic’ Christian using Delkskamp-Hayes’ classification system. Delkskamp-Hayes’ classification and description of the two orientations of Christian chaplains might prove helpful as they continue to learn more about how Christian chaplains function in interfaith/intercultural healthcare contexts.

**Biblical**

In their journal article, “Surrendering the Self: Pastoral Counseling at the Limits of Culture and Psychotherapy,” John and Gregory Hinkle use The Parable of The Good Samaritan to teach Christian chaplains that it is absolutely essential that they continue to develop their spiritual/cultural competency skills. John and Gregory Hinkle begin by summarizing the parable of the Good Samaritan as follows:

A solitary traveler is mugged, beaten, left for the dead. Two people pass by who, according to their social roles as professionals of high status and righteousness, might be expected to help the injured traveler, but they do not. A third person approaches; his social identity as a half-breed and outcast suggests that he would pass by also, but he does not; instead he helps the traveler, going far beyond standard social expectations of the kind of help offered in such a situation.41

For the Samaritan there was only one response, an immediate one - when he saw the man ‘he was moved with compassion’. It was, moreover, compassion with few limits, as shown in the rich and loving detail, which Jesus provides:


He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him. The next day he took our two denarii, gave them to the innkeeper, and said, ‘Take care of him: and when I come back, I will repay you whatever more you spend.’ (10:34-35) (NRSV)

In the structure of the parable, the character whose work most resembles that of the modern hospital chaplain is the innkeeper, a professional who receives compensation to provide a healing context. Race, religion, region, or trade does not classify the wounded traveler. The wounded traveler could be either Jewish or Samaritan, or he could be neither Jewish nor Samaritan. He could be Parthian, Mede, Elamite, Mesopotamian, Cappadocian, Asian, Egyptian, Libyan, Cretan, Arab, or Ethiopian. We simply do not know anything about the wounded traveler’s race, religion, region, or trade, nor are we told anything about the innkeeper’s race, religion, or region. It is not known if the innkeeper is in the business of operating an inn or hotel for profit. In this particular case, the innkeeper contracts with the Samaritan to provide for the traveler who is also sick and wounded. Thus, the innkeeper agrees to provide a safe environment with a healing context for the wounded traveler. Not only will the traveler need a place, which is safe from robbers and thieves, but he also needs a healing environment. He will need clean linen for his bed; he will need nutritious meals to eat; his wounds will need to be attended to and dressings changed, if necessary. But what if, during the course of his stay, our wounded traveler should ask, “Why did this happen to me?” It is at this point that the innkeeper will be called upon to also provide pastoral/spiritual care to the wounded traveler. According to John and Gregory Hinkle, how the innkeeper responds to this question or whether he responds at all will depend on whether his orientation is
monocultural, multicultural, or metacultural. At the first level, John and Gregory Hinkle summarize their understanding of the monocultural (ethnocentric) innkeeper as follows:

The ethnocentric innkeeper is an unwitting servant of culture, working — without being aware of it — to reintegrate the traveler into cultural meaning. This reintegration typically involves helping the traveler understand how she or he, not the culture, is the problem. This approach to care involves the ethnocentric (whether unconscious or intentional) application of cultural (including perhaps theological) resources to the crisis of meaning, i.e., “why did this happen (to me)?”  

If the monocultural innkeeper were uncomfortable with strong affect, he or she might say, “just forget about it.”

At the second level, the multicultural innkeeper would respond to the question (“why did this happen to me?) by stating: “You are troubled about why this has happened to you. There are many ways of trying to answer that question.”

The goal would be to help the traveler come up with a response that fits his or her personal needs, that is respectful of her or his cultural heritage, and that would help him or her adapt effectively to the situation as she or he defines it.

At the third and highest level, the metacultural innkeeper would make no attempt to answer the traveler’s question (“Why did this happen to me?”).

As Jesus, with his life on the line, did not answer Pilate’s question (“What is truth?” John 18:38), so the metacultural innkeeper might witness to the inadequacy of cultural answers rather than to reintegrate the traveler into a sense of comfort with culture. In the robbery beating by culturally despised persons, as well as in the indifference of culturally esteemed persons, the traveler experiences the break with culture. The incident precipitates a crisis of meaning. Life is experienced not as safe, meaningful, coherent (“life as it ought to be”), but rather as unpredictable, uncontrollable, frightening, and chaotic (“life as it is”).

John and Hinkle summarize their thoughts about the metacultural innkeeper as follows:

42Ibid., 114.
43Ibid.
44Ibid.
With these insights, the metacultural innkeeper is most truly free to be present with the traveler. This innkeeper is most liberated from the constraints of self and culture; she or he can most fully encounter the traveler without feeling a need for the traveler to behave in certain ways for the innkeeper's gratification. The metacultural holding environment allows both participants to cooperate in a process by which the self's cultural meaning (self as the culture defines and rewards it) is surrendered so that the soul (the I — thou relationship) emerges as the dominant experienced reality. Hope shifts from the culture’s promises about the future to the profound and terrifying intimacy and realized promise of the present moment. The faith that grows out of the soul’s encounter with the Lord emerges as a deep bondedness, a trust beyond all reason and expectation in the words of the translators of the King James Version, “Though [the Lord] slay me, yet will I trust [the Lord]” Job 13:15.\(^{46}\)

It is understood that the terms *monocultural, multicultural, and metacultural*, as used by John and Gregory Hinkle, these terms are arranged in hierarchical order, The ethnocentric or monocultural innkeeper is a strong proponent of culture (knowingly or unknowingly) but is not aware of the negative influences of culture. The multicultural innkeeper is aware of and sensitive to the diversity of cultures, races, religions, etc., and is very much aware of the negative and positive influences of cultures and uses these cultural influences effectively when working with culturally, religiously, and racially diverse populations. According to John and Gregory Hinkle, the metacultural innkeeper has moved beyond culture. The metacultural innkeeper embraces faith as the metacultural stance. He or she no longer seeks cultural answers to life’s most difficult problems but seeks answers outside of and beyond culture. The metacultural innkeeper has experienced his or her own personal and life transforming encounter with God and is continually trying to move others toward a similar experience. Hope is the mainstay in the metacultural innkeeper’s vocabulary.

\(^{46}\)Ibid.
John and Gregory Hinkle’s analogy of the innkeeper and the Christian chaplain is found to be very helpful. Their terms monocultural, multicultural, and metacultural are also helpful. By definition Christian chaplains are trained and encouraged to teach, preach, and behave as though they are “resident aliens” having eternal privileges, rights, and citizenship in heaven but are momentarily ‘passing through’ this present age. Thus, the Christian chaplain is outside of and beyond this culture. They are followers of Jesus Christ. Of course, they are metacultural. Jesus was metacultural. Nonetheless, we are all constrained or restricted by our respective cultures. Christian chaplains can never truly be acultural, but they can be trained to become more aware metacultural or intercultural chaplains.
CHAPTER VI

PURPOSE, DESCRIPTION, AND METHOD OF THE ACT OF MINISTRY

The Ministry Question

How Do Christian chaplains serving in interfaith/intercultural healthcare settings provide spiritual care to patients, families, and staff and nurture their own spirituality?

In an attempt to answer the aforementioned ministry question, the researcher traveled throughout the state of Georgia interviewing Christian chaplains who serve in a variety of healthcare settings.

The first major challenge was developing a structured interview guide, which would allow a collection of pertinent data from the selected interviewees. The researcher was initially impressed by the Faith Development Interview Guide which was developed by Dr. James W. Fowler and can be found in his classic work, Stages of Faith: The Psychology of Human Development and The Quest For Meaning. However, it became obvious after studying Dr. Fowler’s interview guide for only a brief period of time that it would not suffice for my specific purposes for at least two reasons:

First, Fowler’s interview guide was designed to solicit information about one’s faith development. Secondly, Fowler’s interview guide was much too long and cumbersome to be used to conduct face-to-face (30-45 minute) interviews with busy
Fowler’s four-part interview guide asks a total of thirty-four questions.¹

Next, the author studied Benson, Donahue, and Erickson’s Faith Maturity Scale and Marthai’s Religious Index of Maturing Survey, but neither proved adequate for research purposes. Benson, Donahue, and Erickson’s 38 item Faith Maturity Scale was too long and cumbersome to be adapted to a 30-45 minute face-to-face interview with busy Christian chaplains and was also too general in its focus.² Although Marthai’s survey was more compatible with my anticipated 30-45 minute interview, it also was too general in its focus.³

Reluctantly and with the encouragement of certain Interdenominational Theological Center (ITC) faculty, the writer developing his very own interview guide. Gradually and with feedback from several local Christian chaplains, he developed a twenty-two (22) item Christian chaplain interview guide (see Appendix A).

**Description of The Act of Ministry**

Having developed this interview guide, the next major challenge was determining which healthcare institutions to include in this study. The researcher strongly felt that from the very beginning of this study that a cross-section of healthcare institutions is required if the results of this doctoral study is to have relevance for its intended reading audience. Thus, the original plan was to interview Christian chaplains who serve in a

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³Ibid., 174-176.
variety of healthcare settings. First, the researcher was determined to include healthcare institutions of the following variety:

- three or more faith-based civilian hospitals
- three or more non-faith-based civilian hospitals
- one or more U.S. military (active duty) hospital
- one or more Veterans Administration hospital
- one or more nursing home facility
- one or more hospice healthcare organization.

Secondly, he was determined that there should also be variety in terms of the locations of the various healthcare institutions. Consequently, his original plan was to include in these doctoral study healthcare institutions, which are situated in communities of various sizes:

- large metropolitan areas, with populations in excess of 500,000
- smaller urban areas, with population less then 500,000
- small towns or rural areas.

Thirdly, the researcher desired diversity among the Christian chaplains who were selected to participate in this study, and insisted upon diversity among the Christian chaplains in the following areas:

- denomination
- gender
- race and ethnicity
A total of twenty (20) Christian chaplains were interviewed for this doctoral project, representing a total of fifteen healthcare institutions. The institutions represented in this doctoral study are listed below:

1. Beverly Nursing Homes (Atlanta, GA)
2. Columbus Regional Medical Center (Columbus, GA)
3. East Georgia Regional Medical Center (Statesboro, GA)
4. Hospice Savannah (Savannah, GA)
5. Medical College of Central Georgia (Macon, GA)
6. Memorial Health University (Savannah, GA)
7. Northside Hospital (Atlanta, GA)
8. Piedmont Hospital (Atlanta, GA)
9. St. Francis Hospital (Columbus, GA)
10. St. Joseph’s Hospital (Atlanta, GA)
11. St. Joseph’s Hospital (Savannah, GA)
12. Southeast Regional Medical Center (Brunswick, GA)
13. Southern Regional Medical Center (Riverdale, GA)
14. Veterans Administration Hospital (Dublin, GA)
15. Winn Army Community Hospital (Hinesville, GA)

The researcher traveled throughout the state of Georgia gathering data for this doctoral project. The following Georgia cities or communities are represented in this doctoral project: Atlanta, Columbus, Macon, Savannah, Hinesville, Statesboro, Dublin, and Brunswick.
Atlanta, Georgia: Atlanta, the capital city of the southeast, was founded in 1837. Atlanta is the transportation hub, not just for the country but also for the world. Atlanta’s Hartsfield-Jackson International Airport is one of the nation’s busiest in daily passenger flights. Thirteen (13) fortune 500 companies have made Atlanta their home. In the past two decades, Atlanta has experienced unprecedented growth. While the official city population has remained steady, at about 420,000, the fourteen-(14) county metro population has grown in the past decade by nearly 40%, from 2.9 million to 4.1 million people.

Of the fifteen healthcare institutions which are represented in this doctoral project, five (5) are located in the metro Atlanta area: (1) Beverly Healthcare, (2) Northside Hospital, (3) Piedmont Hospital, (4) St. Joseph’s Hospital (Atlanta), and (5) Southern Regional Medical Center (Riverdale).

- Beverly Healthcare-Glenwood, 2787 North Decatur Road, Decatur, Georgia,: Beverly Healthcare began in 1963 with a single nursing home and today has become one of the leading providers of nursing home care in the United States. Beverly Healthcare operates 19 facilities in the Metro Atlanta area. Beverly Healthcare Glenwood provides the following continuum of care for its 200 plus residents: Alzheimer’s care, cardiac care, diabetic care, dialysis support, hospice care, infusion (IV) therapy, joint replacement therapy, mental health care, occupational therapy, pain management, physical therapy, resident care, respiratory therapy, respite care, speech therapy, stroke care, and wound management. One Christian chaplain at this healthcare facility was interviewed.

- Northside Hospital, 1000 Johnson Ferry Rd., N.E., Atlanta, Georgia 30342: Northside Hospital is a 444 bed, general medical and surgical, not-for-profit hospital. Northside Hospital has no parent system affiliation. Northside Hospital provides the following key services: general medical and surgical care, general intensive care, cardiac intensive care, cardiology, neurology, obstetrics, orthopedics department, and emergency department. Northside Hospital provides care to more than 300,000 patients annually. One Christian chaplain at this healthcare facility was interviewed.
• Piedmont Hospital, 1968 Peachtree Rd., N.W., Atlanta, Georgia 30309: Piedmont Hospital is a 458 bed medical and surgical hospital, which has served the Atlanta community for one hundred (100) years. Piedmont Hospital currently provides the following services: Fuqua Heart Center of Atlanta, neurosciences, oncology services, orthopedic services, women’s services, Doris Shaheen Breast Health Center, diagnostic imaging services, and Sixty Plus Older Adult Services. Piedmont Hospital is the official healthcare provider of the Atlanta Falcons and the preferred healthcare provider of the Atlanta Braves. One Christian chaplain at this healthcare facility was interviewed.

• St. Joseph’s Hospital, 5665 Peachtree Dunwoody Road, N.E., Atlanta, Georgia: Father James O’Brien, the pastor of Immaculate Conception parish, is recognized as having greatly encouraged the Sisters of Mercy in their efforts to established Atlanta’s first permanent hospital on Courtland Street. Its name was later changed to St. Joseph’s Infirmary and today is St. Joseph’s Hospital. St. Joseph’s Health Systems is a member of Catholic Health East and is sponsored by the Sisters of Mercy of Baltimore, Maryland. Three Christian chaplains at St. Joseph’s Hospital (Atlanta) were interviewed.

• Southern Regional Medical Center, 11 Upper Riverdale Road, Riverdale, Georgia 30274: Southern Regional Medical Center is a 410-bed medical and surgical facility which was established only 35 years ago, in 1971. Nonetheless, today Southern Regional offers a full range of patient care services: anesthesiology, community care center, diagnostic imaging, emergency department, food and nutrition services, heart and vascular care, home health, laboratory, oncology, PET imaging, pain management, pastoral care, pharmacy, substance abuse and mental health treatment, respiratory therapy, sleep center, special care nursery, surgical services, women’s life center, women’s community care, and wound, ostomy and continence nursing. One Christian chaplain at the Southern Regional Medical Center was interviewed.

2. Columbus, Georgia: Columbus, Muscogee County, was Georgia’s first consolidated city-county government, and is Georgia’s second largest city being comprised of 216.3 square miles and having a population of 186,880 residents. Muscogee County, named for the Muscogee Indians, was acquired from the Creek Indian Territory in 1826 and became the 69th county to be established in the state of Georgia. Of the fifteen (15) healthcare institutions to be included in this doctoral project, two are located in Columbus, Georgia. Columbus is located 90 miles southwest of Atlanta.
• Columbus Regional Medical Center, 707 Center Street, Columbus, Georgia 31901: Columbus Regional Medical Center, a 417 bed non-profit teaching hospital, was established in 1841. Columbus Regional provides complete acute care services in the following specialties: Medicine, general surgery, critical care, geriatrics, OB-GYN, neonatology, pediatrics, oncology, and emergency medicine. Columbus Regional also provides care in the following subspecialties: Cardiology, infectious disease, pulmonology, nephrology, rheumatology, gastroenterology, neurology, orthopedics, neurosurgery, vascular surgery, and ophthalmology. One Christian chaplain at this healthcare facility was interviewed.

• St. Francis Hospital, 2122 Manchester Expressway, Box 7000, Columbus, Georgia 31995: St. Francis Hospital opened in 1950 as a 154-bed facility on 21 acres of farmland. Today, St. Francis Hospital is a 292-bed facility offering a full range of patient care services to the residents of west Georgia and surrounding areas, including emergency services, rehabilitation, home medical equipment, women’s services, an outpatient center, and a cancer resource center. The Bradley Center of St. Francis Hospital is an 84-bed mental health facility, which provides outpatient counseling, addiction treatment, inpatient and day treatment, support groups and educational programs. One Christian chaplain at St. Francis Hospital was interviewed.

3. Macon Georgia: Named for North Carolina statesman, Nathaniel Macon, the city of Macon was laid out and incorporated in 1823. In 1836, Wesleyan College, the first college in the world chartered to confer degrees upon women, was established in Macon, Georgia. In 1871, Mercer University moved from Penfield, Georgia to Macon. On December 5, 1932, Richard Wayne Penniman, better known to the world as “Little Richard,” was born in Macon. In July 1999, C. Jack Ellis became the first African American Mayor of the city of Macon, Georgia. Today, the city of Macon has a population of approximately 97,255 residents, and Bibb County, of which Macon is the county seat, has a population of approximately 153,887 residents. Only one healthcare facility in the Macon area is represented in this doctoral project-The Medical Center of Central Georgia (MCCG).
The Medical Center of Central Georgia, 777 Hemlock Street, Macon, Georgia 31201: The Medical Center of Central Georgia (MCCG) is the second largest hospital in the state of Georgia with 637 licensed beds, and serving an estimated population of 750,000 residents. MCCG is a full service acute care hospital and is one of the premier teaching hospitals in Georgia. MCCG has a level one-trauma center and has earned five-star national ratings for three programs—cardiac care, neurology, and orthopedics. One Christian chaplain at The Medical Center of Central Georgia was interviewed.

4. Savannah, Georgia: In February, 1733, General James Edward Oglethorpe and 120 co-travelers of good ship “Anne” landed on a bluff high along the Savannah River. General Oglethorpe named the thirteenth and last colony, Georgia, in honor of England’s King George II. Savannah became Georgia’s very first city. In 1864, Union General William Tecumseh Sherman began his march to the sea, burning the city of Atlanta and destroying everything else in his path as he marched to the sea. Upon entering Savannah, Sherman was so taken aback by its beauty that on December 22, 1864, General Sherman sent a telegram to President Abraham Lincoln presenting the city of Savannah to the President as a Christmas present.

According to the U.S Census report, in 2000, the city of Savannah had a population of 131,510 residents, and Chatham County, of which Savannah is the county seat, had a population of 232,048 residents. The Savannah Metropolitan Statistical Area (MSA) which is comprised of Chatham County, Effingham County, and Bryan County had a total population of 393,000 residents or almost 400,000 people. Savannah is experiencing resurgence in tourism. During the 1990’s alone, more than 50 million people visited Georgia’s first city. Three healthcare institutions in the Savannah area participated in this doctoral project – Hospice Savannah, Memorial Health University, and St. Joseph’s/Candler Hospital.
Hospice Savannah Inc., 1352 Eisenhower Drive, P.O. Box 1319, Savannah, Georgia 31416: Hospice Savannah is Savannah’s original hospice having begun operations in January 1984. Hospice Savannah is the only not-for-profit hospice in Savannah serving eight (8) counties in Coastal Georgia. Hospice Savannah also has the area’s only inpatient option, Hospice House, which is newly renovated, expanded, and located at 1352 Eisenhower Drive. The mission of Hospice Savannah is to provide palliative and interdisciplinary support to individuals and their families who are facing life-threatening illnesses. Hospice Savannah is also a community resource, providing education to the community about death, dying, grief and loss. Two Christian chaplains were interviewed at Hospice Savannah.

Memorial Health University Medical Center, 4700 Waters Avenue, Savannah, Georgia 31404: Memorial Health University Medical Center (MHUMC) is a large integrated healthcare organization with a 530-bed teaching hospital. Memorial Health serves a 35 county area in southeast Georgia and southern South Carolina and is the only teaching and research hospital in the area, the only level one trauma center in the area, and is the home of the only designated children’s hospital in the area. Memorial Health provides a full continuum of community and other healthcare services, including primary and specialty physician services, ground and air ambulance, home care, and managed care services. MHUMC also serves as the Savannah campus for Mercer University School of Medicine, which has its home campus in Macon, Georgia. One Christian chaplain at Memorial Health University Medical Center was interviewed.

St. Joseph’s/Candler Health System, 11705 Mercy Boulevard, Savannah, Georgia 31419:
Candler Hospital, 5353 Reynolds Street, Savannah, Georgia 31405: Candler Hospital is one of the longest continuously operating hospitals in the United States. Founded in 1804, Candler hospital was chartered as Savannah Poor House and Hospital. In 1872, the name was changed to Savannah Hospital. In 1930, the Georgia Hospital Board of the Methodist Episcopal Church South purchased the Savannah Hospital from the city of Savannah for $1,000.00, and, once again, changed its name to “Warren A. Candler Hospital” in honor of the Methodist Bishop. In 1980, Candler Hospital relocated to its present site at Derenne Avenue and Reynolds Street. Today, Candler Hospital is a 335-bed facility and is one of two hospitals which comprise the St. Joseph’s/Candler Health system the other is St. Joseph’s Hospital.

St. Joseph’s Hospital, 11705 Mercy Boulevard, Savannah, Georgia 31419: St. Joseph’s Hospital is a 305-bed, general acute care facility located on Savannah’s Southside. In June, 1875, responding to the plight of sick seamen, the Sisters of Mercy, under contract with the United States government, took over operations of Forest City Marine Hospital. In March 1876, the Sisters of Mercy renamed the hospital St. Joseph’s infirmary. It was not until several expansions later that the name was changed to St. Joseph’s Hospital.
On April 1, 1997, St. Joseph's Hospital, having a Catholic tradition and Candler Hospital, having a Methodist tradition, entered into a joint operating agreement and thus establishing the St. Joseph’s/Candler Health System. St. Joseph’s/Candler of Savannah, Georgia is the largest healthcare system in southeast Georgia and the only faith based facility in the region providing the following services: cardiology, oncology, digestive diseases, neurosensory disorders, orthopedics, women’s and children’s services, diabetes, etc. Three Christian chaplains at the St. Joseph’s/Candler Health System in Savannah, Georgia were interviewed.

5. Hinesville, Georgia: Hinesville is the county seat and the largest city in Liberty County. Hinesville is also the home to Fort Stewart where the U.S. Army’s Third Infantry Division is based. The city of Hinesville covers a landmass of 16.31 square miles and has a population of 30,392 residents. Liberty County, first settled in 1752 by Puritans from South Carolina, covers a landmass of 602.52 square miles and has a population of 61,610 residents. Ft. Stewart, where Winn Army Community Hospital is located, has its own military population of 11,205 soldiers and their dependents. One healthcare institution in Hinesville (Winn Army Community Hospital) is represented in this doctoral project.

- Winn Army Community Hospital, 1061 Harmon Avenue, Fort Stewart, Georgia 31314-5111. Winn Army Community Hospital has three sites and provides patient care services in the following medical specialties: allergy, audiology/speech pathology, dermatology, dietetics, emergency services, family medicine, internal medicine, OB/GYN, occupational therapy, ophthalmology, optometry, orthopedics, otolaryngology (ENT), pediatrics, physical medicine, psychiatry, surgery, urology, cardiology, gastroenterology, infectious disease, nuclear medicine, developmental pediatrics, podiatry, population health (wellness), psychology, social work, and substance abuse. One Christian chaplain at Winn Army community Hospital was interviewed.
6. Statesboro, Georgia: Statesboro was incorporated on December 19, 1803 with a population of less than 25 residents. In 2000, Statesboro had a population of 22,698 residents. Today, the city of Statesboro covers a landmass of 12.5 square miles and has an estimated population of 24,604 residents. Statesboro is the largest city and county seat of Bullock County. Bullock County has a population of 55,983 residents. One healthcare institution in Statesboro is represented in this doctoral project, East Georgia Regional Medical Center.

- East Georgia Regional Medical Center, 1499 Fair Road Statesboro, Georgia 30458: East Georgia Regional Medical Center is a 150-bed healthcare facility located within the city of Statesboro and providing a full range of services, including a 24-hour physician-staffed emergency department, a level II neonatal center, and outpatient services, including same day surgery and ambulatory care, a pain center, a cardiac catheterization lab, and state-of-the-art diagnostic procedures, including MRI and CT. One Christian chaplain at the East Georgia Regional Medical Center was interviewed.

7. Dublin, Georgia: Dublin was incorporated by the Georgia General Assembly on December 9, 1812 and became the county seat of Laurens County. Laurens County, named in honor of Colonel John Laurens who was an aide to General George Washington, was established by taking a part of Wilkinson County in 1807 and a part of Washington County in 1811. Dublin is strategically located at the crossroads of Interstate 16, U.S highways 441 and 319 in middle Georgia. In 2000, Dublin had a population of 15,857 residents, and Laurens County had a population of 44,874 residents. Today, Dublin is estimated to have a population of 16,689 residents. One healthcare facility in Dublin is represented in this doctoral project, the Carl Vinson Veteran Administration Medical Center.

- Carl Vinson VA Medical Center, 1826 Veteran's Boulevard, Dublin, Georgia 31021: The Carl Vinson VA Medical Center is a 340-bed facility
located on a 75 acre tract in Dublin, Georgia and provides both acute and extended care services to veterans in middle and south Georgia. The Carl Vinson VA Medical Center provides the following services to its veterans: ambulatory and primary care optometry, women’s health, extended care, and nursing home services. Specialized programs offered include cardiology, pulmonary, general surgery, podiatry, urology, and physical therapy. Mental health services available include treatment for substance abuse, post traumatic stress disorder, and general psychiatric care. Of the medical center’s 340 operating beds, they are assigned as follows:

34 medical and surgical
161 Nursing Home Care
145 Domiciliary Care (including homeless veterans program)

One Christian chaplain at the Carl Vinson VA Medical Center was interviewed.

8. Brunswick, Georgia: General James Oglethorpe designed and laid out the city of Brunswick in 1771, using essentially the same grid pattern he had used earlier to lay out the city of Savannah. Brunswick has the second largest concentration of documented historic structures in Georgia, second only to Savannah. In 2000, the city of Brunswick had a population of 15,600 residents, and Glynn County had a population of 67,568 residents. In addition to the city of Brunswick, the nearby islands of St. Simons Island, Jekyll Island, and Little St. Simons Island lure visitors from far away places with the promise of beaches, resorts, and historic sites. One healthcare institution in Brunswick, Georgia participated in this doctoral project-Southeast Georgia Health System.

- Southeast Georgia Health System, Brunswick Campus, 2415 Parkwood Drive Brunswick, Georgia 31520: The Southeast Georgia Health System is a 356-bed not-for-profit institution which is located in the historic port city of Brunswick, Georgia. Established in 1888 as Brunswick City Hospital; in 1991, the Glynn-Brunswick Memorial Hospital Authority voted unanimously to change the name of the Hospital to Southeast Georgia Regional Medical Center. Located approximately 70 miles north of Jacksonville, Florida and 75 miles south of Savannah, Georgia, the Brunswick campus is the only major medical facility in a 150-mile area. Southeast Georgia Regional Medical Center serves the healthcare needs of Georgians from eight counties in southeast Georgia: Brantley, Camden,
Charlton, Glynn, Long, McIntosh, and Wayne. The Southeast Georgia Health System has two campuses (Brunswick and Camden), three immediate care centers, an ear, nose and throat (ENT) surgical center, and two-sleep management care centers. One Christian chaplain at the Southeast Georgia Regional Medical Center was interviewed.

Of the twenty Christian chaplains who were interviewed for this doctoral project, the following demographics were noted:

**Figure 1: Gender**

![Pie chart showing gender demographics]

Note: 14 were male and 6 were female

**Figure 2: Race or Ethnicity**

<table>
<thead>
<tr>
<th>Race or Ethnicity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian or White</td>
<td>16</td>
</tr>
<tr>
<td>African American</td>
<td>3</td>
</tr>
<tr>
<td>Asian American</td>
<td>1</td>
</tr>
</tbody>
</table>

**Figure 3: Faith Traditions**

Although all chaplains interviewed were Christians, they represent a variety of faith traditions.

<table>
<thead>
<tr>
<th>Faith Tradition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist</td>
<td>6</td>
</tr>
<tr>
<td>Catholic</td>
<td>4</td>
</tr>
<tr>
<td>Church of the Nazarene</td>
<td>1</td>
</tr>
<tr>
<td>Disciples of Christ</td>
<td>2</td>
</tr>
<tr>
<td>United Methodist</td>
<td>2</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>4</td>
</tr>
<tr>
<td>Seventh Day Adventist</td>
<td>1</td>
</tr>
</tbody>
</table>
Figure 4: Place of Birth

The twenty chaplains participating in this doctoral project were born in eleven states and two foreign countries:

<table>
<thead>
<tr>
<th>State</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1</td>
</tr>
<tr>
<td>California</td>
<td>1</td>
</tr>
<tr>
<td>Florida</td>
<td>1</td>
</tr>
<tr>
<td>Georgia</td>
<td>7</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1</td>
</tr>
<tr>
<td>New York</td>
<td>1</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>1</td>
</tr>
<tr>
<td>Philippines</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 5: The ages of Christian chaplains

The following chart best illustrates the ages of the Christian chaplains:

<table>
<thead>
<tr>
<th>Age Range Of Chaplains</th>
<th>Number Of Chaplains</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>under the age of 35</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Between 35-45</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Between 46-55</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>Between 56-65</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>over 66</td>
<td>2</td>
<td>10%</td>
</tr>
</tbody>
</table>

The youngest chaplain interviewed was 34 years old; the oldest chaplain interviewed was 67 years old; the average age of the Christian chaplains was 52.7 years.

Years in Ministry/Years in Healthcare Chaplaincy:

Of the twenty Christian chaplains interviewed, two had served as few as twelve years in ministry, and two had served as many as 36 years in ministry, but the average number of years in ministry for the chaplains was 23.25 years.
Of the twenty Christian chaplains interviewed, two had served as few as two years as a healthcare chaplain, and two had served as many as 27 years as a healthcare chaplain, but the average number of years in healthcare chaplaincy was 11.5 years.

As indicated previously in this doctoral study, in order to collect the data, which was believed to be necessary to answer the question, which was posed, the researcher felt compelled to devise my very own research tool. That research tool began taking shape very slowly but eventually evolved into a 22-item structured interview guide. Because this interview guide was designed especially for the purpose of interviewing Christian chaplains, it was labeled the “Christian Chaplain Interview Guide.” The Christian Chaplain Interview Guide can be found in Appendix A.

Turning next to the interview process itself, each of the twenty (20) Christian chaplains was interviewed separately, usually at the healthcare institution where he or she was employed as a chaplain. However, two Christian chaplains were interviewed during an annual fall retreat of the Georgia Society of Healthcare Chaplains. In any case, for each interview, the researcher met individually with each Christian chaplain and asked the questions as they are listed in the Christian Chaplain Interview Guide. With the knowledge and verbal consent of each chaplain, each interview was recorded for further study and analysis, using a small cassette recorder. Immediately following each interview, using pen and a yellow pad, answers were carefully recorded to each question. Later, the information was recorded in the doctor of ministry journal for further analysis.

For the next several pages, the researcher will now share with the reader the questions, which were asked, and the answers, which were, provided by the twenty (20) Christian chaplains who were interviewed. Referring again to the Christian Chaplain
Interview Guide, the reader will note that questions 1-5 requested personal factual data about each Christian chaplain, such as date of birth, age, race/ethnicity, denomination, years in ministry, years as a healthcare chaplain, etc. For all intents and purposes, the series of questions which follow will begin with questions five and six of the Christian Chaplain Interview Guide and proceed consecutively through question 22 or until all pertinent questions have been answered.

What are some advantages and disadvantages of serving in an interfaith/intercultural healthcare context? The top four advantages of serving in an interfaith/intercultural healthcare context as reported by the Christian chaplains are:

The opportunity to learn about other faith traditions and to grow spiritually. Over ½ of the respondents listed this as an advantage.

The opportunity to become more aware has and develops sensitivity to other faith traditions. Four respondents listed this advantage.

The opportunity to develop respect and appreciation for other faith traditions. Four respondents listed this as an advantage.

Enrichment received by meeting people of other faith traditions. Four respondents listed this advantage.

The top three disadvantages of serving in an interfaith/intercultural healthcare context as reported by the Christian chaplains are:

Christian chaplains are very often limited by their lack of knowledge or familiarity with the tenets of other faith traditions. More than 1/3 of the Christian chaplains listed this as a disadvantage.

Danger of stereotyping members of other faith traditions or cultural groups. Three chaplains listed this as a disadvantage.

Christian chaplains are often not accepted by members of other faith groups. Three chaplains listed this as a disadvantage.

What is Christian spirituality, and what does this phrase mean to you?
The Christian chaplains’ responses to this question were so varied that all twenty (20) responses are included.

1. Christian spirituality is that which one practices according to the Christian faith, traditions, and doctrines.⁴

2. Christian spirituality is the whole realm of working out salvation, individually and collectively. Christian spirituality is an individual’s walk and collectively being part of God’s Kingdom.⁵

3. Christian spirituality is basically how we relate to Jesus Christ as our God.⁶

4. Christian spirituality for me means how in our lives we best embrace Christ’s example. Christian spirituality is about connecting one’s head with one’s heart with one’s actions. Christian spirituality is what we do with what’s inside of us and how we feed our souls.⁷

5. Spirituality means filled with the spirit; led by the spirit; aware of the spirit. Christian spirituality is the motivation to get up and to do something, to come and be able to be a servant.⁸

6. Christian spirituality deals with the spirit, and this is imbued with the philosophy and spirit of Jesus Christ. So you think of the mind of Jesus, of Christ.⁹

7. Christian spirituality is a set of values, norms, practices, attitudes that are based in, flow from, and feed into the reality and paschal mystery of the life, death, and resurrection of Jesus Christ. Everything that one attempts to do is built on that, and everything that one attempts to do and be feeds into that. For me, the older I get, the Eucharist becomes the center. That thing we do together; that prayer we pray together.¹⁰

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⁴Columbus Burns, Doctor of Ministry Journal, 51.
⁵Ibid., 53.
⁶Ibid., 57.
⁷Ibid., 62.
⁸Ibid., 70.
⁹Ibid., 76.
¹⁰Ibid., 80.
8. Christian spirituality would mean a connection to God as experienced in the person of Jesus Christ. Christian spirituality is wrapped in the sense that the fabric of life is given to us through the God who created us. My experience of that God is through a very Christian understanding through the person of God’s son, Jesus Christ.\(^\text{11}\)

9. Christian spirituality is what I pattern my life on. I just keep on keeping on, trying to get it right, like Jesus did. Some days are better than others. I think that is something we are always striving toward and with that comes a huge responsibility. It didn’t matter to Jesus Christ who you were. You were the beloved. He cared for the sickest of the sick, the lepers, etc. It is just so much bigger than Christian spirituality. If we limit it just to the Christian modality, we eliminate Christ because Christ did not do that.\(^\text{12}\)

10. Christian spirituality means anyone who finds core values and ultimate meaning based on an understanding of themselves as a person who is a follower of Jesus Christ. It is a functional way in which people act and believe that is related to core beliefs and values.\(^\text{13}\)

11. Christian spirituality would be our relationship with God, with Christ. It would be similar to the relationship I have with my wife or any other person. It has dynamics. It’s not just a law. It’s a relationship, which has to be nurtured and lived every day.\(^\text{14}\)

12. Christian spirituality for me is a spirituality that believes that the second person of the Blessed Trinity became a human being in the person of Jesus Christ and came down here on earth, and because of what he did, he redeemed humankind. That is what Christian spirituality means to me. He came on earth; he saved us from our sins. He calls us to follow him, like in the Ten Commandments.\(^\text{15}\)

13. I see religion as props, symbols, rituals, sets of beliefs, etc., and that’s very real. I see religion as the gateway into a deeper spirituality. I love rituals. We need props, symbols, and rituals. Good rituals point us to a deeper spirituality...So in terms of what it means to me- Christianity. It means being Christ like, and how can I do that except by accepting Christ as my savior. I need the religion, the rituals, and sets of beliefs to help guide me in my Christianity. But if it stops right there, it’s meaningless. God has called us to be in relationship with him. Spirituality takes

\(^{\text{11}}\)Ibid., 86.  
\(^{\text{12}}\)Ibid., 92.  
\(^{\text{13}}\)Ibid., 98.  
\(^{\text{14}}\)Ibid., 104.  
\(^{\text{15}}\)Ibid., 108.
us there.... That’s what spirituality means to me – a connection with the sovereign God. It’s like, I can really experience Him. I can really know Him. He is present with me and in me.\textsuperscript{16}

14. When I think of Christian spirituality, the word, which comes to mind, is hope. I think of that word when I think of Christian spirituality and how as Christians we have a faith that feels so redemptive to me. Christian spirituality is not something you can put your finger on or see or feel, but is very real. It’s sure something you can feel or touch.\textsuperscript{17}

15. Christian spirituality is the way we link with a higher power, as Christians. When you put the word Christian in there, then I assume that Jesus Christ is a part of that spirituality. You can define it very broadly but to include Jesus in the picture somehow.\textsuperscript{18}

16. I think that Christian spirituality is being connected with the spirit of Christ through the Holy Spirit. Connected to that spirit; led by the spirit; being open to the spirit’s leading and direction. That connectedness is what gives you the confidence to lean and depend on it. And that’s a challenge sometimes, to know when and where and how the spirit is leading and trusting the voice.\textsuperscript{19}

17. My first flush, when I hear Christian spirituality is more, ‘I wonder why it’s not ecumenical?’ And if we were to use that phrase, I would have a struggle because I personally move very strongly into spirituality and Christian then would be one support system under the term spirituality and because, again, of the wide diversity we have here. For me personally, Christian spirituality means three things: First, Christian spirituality speaks to me of a belief system; second, Christian spirituality speaks to me of maturity in faith; third, Christian spirituality speaks also to the term of a defining because I feel that we all have a faith background; we all have a spiritual nature about us. Christian spirituality would then further those two aspects of who the individual was.\textsuperscript{20}

18. I am a Christian and appreciate the spirituality. And I will always remember my New Testament professor, Dr. Will Ormond, who talked about studying the Gospels and selecting one to really learn and know, and then you could study the others in relationship to that one that was home base for you. I think Christianity

\textsuperscript{16}Ibid., 113.

\textsuperscript{17}Ibid., 122.

\textsuperscript{18}Ibid., 128.

\textsuperscript{19}Ibid., 133.

\textsuperscript{20}Ibid., 141.
is home base for me, and Christian spirituality is home base and enables me to dialogue with other faiths.\textsuperscript{21}

19. It is hard for me to put a tag on spirituality. I see it as much broader than the Christian faith or any other faith group. I tend to think of spirituality as being analogous to a generic medication; whereas Christianity, Islam, Hindu, etc., are the brand names. Any one of these religions is capable of meeting an individual’s spiritual needs as long as that individual is comfortable with that particular religious faith.\textsuperscript{22}

20. Well, I certainly meet a lot of people. There are those who believe that the only way into heaven is by being a Christian. And I am very much a Christian, but I don’t necessarily interpret scripture that way. Scripture is, I don’t know. God is God. God of the universe is creator. God is the one who brings order out of chaos. So, to me that is the spirituality of this. It is coming to understand that there is this eternal God who has a relationship with this third rock from the sun and those who inhabit it. I do believe that Jesus was God incarnate....Jesus saw things that the faith community of his day had become blind to. So, he went to the well at Samaria; he went to the women; he went to the mentally ill; he went to the lepers; he went to the dead; he went to those who were on the outside, as the culture of that day identified them, and he affirmed them. To me, to be Christian means to make a faithful and conscientious effort to follow Jesus. Well, if I follow Jesus, then that means I have got to go to the well in Samaria; I have to go to those who do not think the way I think or act the way I act and who might be considered as unclean or outcasts or whatever and be willing to touch and not have to worry about manipulating, but just loving a person because they are one of God’s children too, regardless of age, race, class, socioeconomic level, or whatever.\textsuperscript{23}

While the Christian Chaplains’ definitions of Christian spirituality are quite varied, there are a few noticeable tendencies among them. Basically, the Christian chaplains’ definitions of Christian Spirituality appear to fall into one of three primary categories: (1) Christian behaviors and practices, (2) personal relationship with Jesus Christ, or (3) right Christian beliefs. Of the twenty responses, seven appear to place primary emphasis on having a personal relationship with Jesus Christ; seven emphasize Christian behaviors and practices; two emphasize Christian beliefs, and two provide a combination of all

\textsuperscript{21}Ibid., 152.

\textsuperscript{22}Ibid., 158.
three categories. Two of the responses were not responsive in that they failed to answer the question, which was asked. The researcher was unable to detect any meaningful patterns or trends in defining Christian spirituality, which might be attributed to the age, ethnicity/race, gender, faith traditions, or years in ministry of the chaplains.

- How is your spirituality nurtured or hindered in your current interfaith/intercultural setting?

According to the top three responses of the twenty Christian chaplains, they believe that their spirituality is nurtured by the following:

1. Encountering people of varied religious and cultural backgrounds. Almost half [9] of the respondents provided this response.

2. Co-workers, chaplains, patients, and families. Four Christian chaplains provided this response.

3. Dealing with end of life issues. Three Christian chaplains provided this response.

There was no consensus at all as to what factors or forces might tend to hinder one’s spirituality in an interfaith/intercultural setting. The majority [14] of the chaplains acknowledged no hindrance at all.

- How helpful is your denomination or community of faith in helping you to nurture your spirituality?

Of the twenty Christian chaplains responding to this question, eighteen (90%) believe that their denominations or communities of faith are “very helpful” or “helpful” in helping them to nurture their own spirituality.

Only two chaplains (10%) believe that their denominations or communities of faith are “not helpful” in helping them to nurture their spirituality.

\[23\text{Ibid., 167.}\]
What are the denominations or communities of faith doing which the Christian chaplains perceive as helpful in helping them to nurture their spirituality?

1. Denominations and denominational hierarchies were perceived to be helpful if they provided the organizational structure, which facilitated the chaplain’s spiritual growth and development.

2. Denominations were perceived as helpful if they provided conferences, seminars, or workshops on a national, state, or local level.

3. Denominations were perceived as helpful if they provided printed or recorded materials for its chaplains.

4. Denominations were perceived as helpful if its chaplains were required to complete and submit annual written evaluations to a denominational representative.

What is quite apparent from the chaplains’ responses is that although denominations might provide both the organizational structure and other resources to help its chaplains to nurture their spirituality, ultimately the Christian chaplains decide for themselves how they will nurture their spirituality. Several of the chaplains participating in this study admitted that they have consistently failed to take advantage of the spiritual growth opportunities, which were made available to them by their denominations.

Whether or not the denomination was perceived as helpful in helping the chaplain to nurture his or her spirituality, all of the Christian chaplains participating in this study found a “community of faith” which provided spiritual care and nurture.

1. H is a hospital chaplain in a small rural community in southeast Georgia. Although H does not feel supported by her denominational hierarchy, she is very active in her local church where she teaches Sunday school, Disciple Bible Study, and teaches at Wednesday night suppers.

2. J is a hospital chaplain and clinical pastoral education (CPE) supervisor in a small metropolitan area in west Georgia. Although J does not feel supported
by his denominational hierarchy, he finds nurture and support through informal associations with other chaplains, ministers, peers, and colleagues.

3. L is a longtime hospital chaplain and director of pastoral services in the Atlanta metropolitan area. Although L does not feel supported by his denominational hierarchy, he finds nurture and support through a national chaplains’ association (Association of Professional Chaplains) and a local ministers’ consultation group with which he has been affiliated nearly 30 years.

- How helpful is your healthcare institution [employer] in helping you to nurture your spirituality?

Thirteen (13) of the Christian chaplains, 65% of those responding to this question, believe that their institutions or employers are helpful in helping them to nurture their spirituality.

Seven chaplains, or 35%, do not believe that their institutions or employers are helpful in helping them to nurture their spirituality.

Those chaplains who believe that their institutions or employers are helpful in helping them to nurture their spirituality provided two primary reasons for taking this position:

1. First, chaplains felt supported by their institutions or employers if a representative from administration and/or the chaplains’ immediate supervisors regularly and consistently gave affirmation for the work the chaplains were doing. This response was provided by more than half (eleven) of the chaplains responding to this question.

2. Second, chaplains felt that their institutions or employers were helpful in nurturing their spirituality if the institutions or employers allowed or enabled them to attend continuing education events often at the institutions’ or employers’ expense. Eight of the chaplains responding to this question, or 40%, provided this response.

- How helpful are your co-workers, especially other staff chaplains, in helping you to nurture your spirituality?
Of the twenty (20) chaplains responding to this question, nineteen (19), 95%, believe that co-workers or other staff chaplains are helpful in helping them to nurture their spirituality.

- How do Christian chaplains nurture the spirituality of each other?
  1. by gathering regularly for prayer, sharing and caring sessions;
  2. by providing mutual support and encouragement;
  3. by leading and attending daily prayer services (Mass);
  4. by showing mutual respect for each other, even when they might disagree on an issue or concern.

Generally, chaplains believe that other healthcare professionals with whom they interact daily nurture their spirituality: doctors, nurses, therapists, social workers, etc.

- Do you have available to you the necessary resources to help you nurture your own spirituality?

Of the twenty (20) Christian chaplains responding to this question, nineteen (19), 95%, believe that they have the necessary resources to help them nurture their spirituality.

- How do you currently nurture your spirituality within your interfaith/multifaith context?

The top five responses provided by the chaplains indicate that Christian chaplains nurture their spirituality in a variety of different ways:

1. personal prayer time, Bible reading, and meditation; nine of the Christian chaplains provided this response. More Christian chaplains nurture their spirituality by personal prayer time, Bible reading, and meditation than by any other means.

2. personal quiet time with God; four of the Christian chaplains provided this response.
3. through interactions and encouragement from professional colleagues and staff; four of the Christian chaplains provided this response.

4. by preparing to lead worship or Mass; three of the Christian chaplains provided this response.

5. by listening to the faith journeys of others; three of the Christian chaplains provided this response.

Thirteen (13) of the twenty (20) Christian chaplains, or 65%, appear to nurture their spirituality by Bible reading, meditation, personal prayer, or personal quiet time with God. Some might ask, “Is there a difference between prayer, meditation, and personal quiet time with God?” Although the responses of the Christian chaplains tend to combine prayer and meditation, personal quite time with God is usually presented as distinctively separate and apart from prayer and meditation. A few examples might prove helpful at this point: one chaplain responded:

Well, I am a great believer in giving the first fruits to the Lord. Each morning, I get up with my cup of coffee and prayer. I do my journaling and meditation in the morning, and I do the rosary beads at night.24

Another Christian chaplain said,

As I think about it and as I look at it; first, I try to find some quiet time in the middle of the day. But the biggest point occurs prior to arriving at work. Even before getting there [at work] in the morning, the study, meditation, and prayer which I engage in early in the morning is nurturing.25

Moreover, quiet time with God does not necessarily mean that the Christian chaplain is dormant or not engaged. While some Christian chaplains might define quiet time with God as a time of inactivity or non-activity, others tend to define quiet time with God as time when they are actively engaged in some activity, which causes them to feel

24Ibid., 109-110.
25Ibid., 136.
especially close to God. Again, a few examples might be helpful. One Christian chaplain responded: “My own quiet time with God, and I am a strong believer in prayer. I love to get out in the yard and just be alone with God...” 26 Another Christian chaplain said,

I just do a whole lot of things, even reading. The things I choose to do in my spare time, my daily prayer life, my liturgy, etc. All of these things help to nurture me. Even listening to other people’s stories and their faith journeys nurture me. The life of the saints, not just Catholic saints, but people of all faith traditions who have lived lives of great faith nurture me. Sometimes my greatest sustenance come from going home and getting my hands in dough and making a wonderful meal for my family. 27

Another Christian chaplain finds that listening to music in the quiet of his office nurtures his spirituality. “I also have music on my computer which I listen. I like my quiet time. I usually come here to the office where I close my door and turn the lights off.” 28

- How would you rate your level of spirituality at this time? Please circle one:


Nineteen of the twenty chaplains responded to this question by selecting one of the five possible responses (see Figure 6). Only one chaplain declined to answer this question. Of the nineteen chaplains who responded, their choices are listed below:

Figure 6: Chaplain Spirituality Rating Responses

<table>
<thead>
<tr>
<th>Spirituality Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>1</td>
</tr>
<tr>
<td>Fair</td>
<td>1</td>
</tr>
<tr>
<td>Good</td>
<td>6</td>
</tr>
<tr>
<td>Very Good</td>
<td>7</td>
</tr>
<tr>
<td>Excellent</td>
<td>4</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19 responses</strong></td>
</tr>
</tbody>
</table>

26 Ibid, 108.

27 Ibid., 94.

28 Ibid., 124-125.
More than half of the Christian chaplains rate their spirituality as either very good or excellent, six chaplains rate their spirituality as good, two chaplains rate their spirituality as either fair or poor, and one chaplain declined to answer this question.

- Are you comfortable with the present level of your spirituality?

1. Eleven, more than half, of the Christian chaplains indicated that they are comfortable with the present level of their spirituality;

2. Nine of the chaplains indicated that they are not comfortable with the present level of their spirituality.

Although more than half of the Christian chaplains indicated that they are comfortable with the present level of their spirituality, virtually, all of the chaplains acknowledged their need for continued spiritual growth and development.

- As a Christian chaplain, are you aware of peculiar risks or dangers of serving in an interfaith/multifaith context?

1. Four of the Christian chaplains (20%) indicated that they are not aware of any peculiar risks or dangers of serving in an interfaith/multifaith context.

2. Sixteen of the Christian chaplains, 80% of those responding to this question, indicated that they are aware of at least one or more peculiar risk or danger of serving in an interfaith/multifaith context.

- The peculiar risks or dangers as enumerated by the chaplains are listed below:

1. risk or danger of offending or being insensitive to persons of other faiths or cultural traditions; five Christian chaplains (25%) provided this response.

2. risk or danger of being physically hurt or seriously injured by patients or family members: four Christian chaplains (20%) provided this response.

3. risk or danger of losing or, at least, “watering down” one’s Christian faith in order to blend in; three Christian chaplains (15%) provided this response.

4. risk or danger that other Christian pastors might dismiss or discount the ministry of the health chaplain as not being “real ministry;” two Christian chaplains (10%) provided this response.
5. risk or danger of exposure to infectious diseases; two Christian chaplains (10%) provided this response.

6. risk or danger of being a female chaplain in South Georgia; two Christian chaplains (10%) provided this response.

7. risk or danger of burnout; one Christian chaplain provided this response.

8. risk or danger of being summarily dismissed by patients who have been hurt by religious figures or congregations in the past; one Christian chaplain provided this response.

9. risk or danger that some community clergy might misuse their clerical authority to hurt or abuse our patients; one Christian chaplain provided this response.

- Thus, from the perspective of the Christian chaplains, the number one risk or danger of serving in an interfaith/multifaith context is the risk or danger that the Christian chaplain might say or do something which might be perceived as insensitive or offensive by persons of other faith traditions. One “seasoned” Christian chaplain shared the following experience:

  However, there have been times when I was insensitive to other faith traditions. There was one occasion in particular when I touched a Muslim woman by patting her on her back or shoulder, and she jerked quickly away from me. She indicated that she now had to go and wash because a man had touched her. Her tradition did not allow or permit a man to touch her. 29

- The number two risk or danger of serving in an interfaith/multifaith context is the risk or danger of being physically hurt or seriously injured by a patient or family member. One Christian chaplain shared the following observation:

  Oftentimes, we do not know what we are walking into. If a person can walk into a church and shoot the mother of Dr. Martin Luther King, Jr., they can walk into this place and shoot me... A father who experienced the death of his child on the third floor took his fist and knocked a hole in the wall... We had an ex-con threatening the doctors who were caring for

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29 Ibid., 125.
his mother. He said, ‘if my mother dies, someone else is also going to die’.  

The chaplains are addressing this number two risk or danger by gathering as much information as possible about the possible threat in advance, staying alert and being attentive to their surroundings, and alerting security when additional security is believed to be warranted.

The number three risk or danger of serving in an interfaith/multifaith context is the risk or danger that Christian chaplains might be tempted to “water down” their own faith in order to accommodate their diverse clientele. This, indeed, is the essence of the arguments made by H. Tristram Engelhardt in his article, “The DeChristianization of Christian Hospital Chaplaincy: Some Bioethics & Reflections on Professionalization, Ecumenization, and Secularization” and Stephen Pattison in his article, “Dumbing Down the Spirit.”

Contrary to the positions taken by Engelhardt and Pattison, both of whom appear to rate this issue as if it were the most urgent issue or concern for Christian chaplains serving in interfaith healthcare contexts, the Christian chaplains themselves seem to rate this issue only nominally. Of the twenty Christian chaplains who were interviewed and responded to this question, only three even acknowledged that the temptation to “water down” their own faith might be a risk or danger for them. Seventeen of the Christian

30 Ibid., 117.


chaplains did not even see this as an issue. In fact, during the interview process, several Christian chaplains stated rather emphatically that their Christian faith was not threatened or weakened by the presence of or interactions with other faith traditions. When asked this question during the interview process, one Christian chaplain provided the following response:

I don’t know what is implied in the question unless I am fearful that I might become a Muslim Imam or something. I don’t think so. For me personally, I think that getting to know and understand persons of other faith traditions actually strengthens my own faith rather than weakening it. ³³

Responding to this very same question during the interview, another Christian chaplain provided the following response:

I never worried about my faith being in danger. The danger for me is other pastors discounting my ministry because I embrace the multifaith/multicultural perspective so fully or the thought that ‘you have to water down your Christian faith to meet these people’s needs. I don’t ever feel that my faith is watered down.³⁴

In conclusion, here is one final response by a Christian chaplain to this very same question:

I have arrived at the conclusion that all of this points to one God. I don’t care whether it’s Eastern, Buddhists, or whatever. In other words, other religions do not distract me, but, on the contrary, they strengthen my belief. It does not tear me apart. My conviction is that there is only one God. Call it what you want. There is only one Supreme Being for the whole wide world... Other religions convince me even more that I am standing on solid ground. I believe that every religion has a part of the truth.³⁵

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³³Columbus B. Burns, III, Doctor of Ministry Journal, 110.

³⁴Ibid., 66.

³⁵Ibid., 78.
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33 Columbus B. Burns, III, Doctor of Ministry Journal, 110.

34 Ibid., 66.

35 Ibid., 78.
Those Christian chaplains who believe that one of the risks or dangers of serving in an interfaith/multifaith healthcare context is that they might be tempted to “water down” their own faith in order to accommodate their diverse clientele are also unanimous in their position that in order to successfully resist this temptation, they must remain deeply devoted and stay connected to their respective faith traditions. The reader might remember that both Engelhart and Pattison cautioned Christian chaplains working in interfaith healthcare settings that if they are to successfully resist this temptation to “water down” their own faith, they must both revisit and strengthen their ties with their own respective communities of faith.

- The fourth risk or danger of serving in an interfaith/multifaith healthcare context is the risk or danger that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry.” Only two chaplains identified this as a possible risk or danger. One Christian chaplain provided the following response:

  I am never worried about my faith being in danger. The danger for me is other pastors discounting my ministry because I embrace the multifaith/multi-cultural perspective so fully or the thought that ‘you have to water down your Christian faith to meet these people’s needs.’ I don’t ever feel that my faith is watered down...36

A second Christian chaplain also expressed concern that his minister colleagues tend to discredit what he does as a healthcare chaplain:

Yes, I would have to say risks, risks in the sense of how your colleagues view what you do. Many of my colleagues in the church say to me ‘I can’t do what you do because I have got to preach Jesus...’ The danger would be in taking on what people are saying and trying to be what they want you to be. That’s why it’s important to be in collegiality with

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36Ibid., 66.
others who do what you do so that you might set some affirmation from them.\textsuperscript{37}

Of the two Christian chaplains who identified this as a possible risk or danger, only one chaplain suggested a plan or strategy to address this problem. The suggestion was that healthcare chaplains might consider connecting or associating with other healthcare chaplains so as to provide affirmation and support for one another’s ministry.

- The fifth risk or danger of serving in an interfaith/multifaith healthcare context is the risk or danger of exposure to infectious diseases. Only two chaplains identified this as a possible risk or danger. However, the two Christian chaplains who identified this as a possible risk or danger both presented a very similar plan or strategy for protecting themselves from this risk or danger.

1. Both warned that the Christian chaplain must remain alert and vigilant at all times;

2. be particularly alert to signs which are posted to protect patients, staff, and visitors;

3. gather as much information as possible prior to visiting patients;

4. maintain a good relationship and communication with the staff nurses who will then be more inclined to alert the chaplain to possible risks or dangers.

- The sixth risk or danger of serving in an interfaith/multifaith healthcare context is the risk or danger related to being a female chaplain, especially in South Georgia.

1. Of the six female chaplains who were interviewed by me, three served as chaplains in the Atlanta metropolitan area, and three served as chaplains in south Georgia.

2. Two of the three female chaplains serving in the south Georgia area complained about the additional challenges they face as female chaplains.

\textsuperscript{37}Ibid, 137.
The first respondent comments about the challenges she encounters in general as a female chaplain is Savannah, Georgia:

There is a certain risk being a female chaplain in a predominantly patriarchal society. I was raised in a very open multifaith/multicultural and multiracial society in California. I never knew that there were issues with women serving as pastors or ministers until I moved to Savannah. I didn’t really experience it in Atlanta, very much. It was not until I moved to Savannah that I encountered this problem. So the danger of being a female chaplain in Savannah is that I never know how I am going to be received.38

This female Christian chaplain proceeded further to explain how she copes with the sexism which she encounters:

I try to center myself. I think if I had come to Savannah and immediately become a chaplain, I don’t think I would have been equipped to handle it. But I am blessed that I served in the parish as a pastor before becoming a chaplain. I have this Plexiglas shield that I sometimes put in front of me. What is interesting is that I have had more challenges being a female minister with other women than I have had with men. Every man has a mother, aunt, or daughter, and if you can help him to see that you could be his mother, aunt, or daughter, you are o.k. However, with women, I get the message ‘if I can’t have that privilege then why should you?’ I have received more acceptance and encouragement from men than from women, which helps me to help other women who seek to become ordained clergy.39

A second female chaplain also complained of having been sexually harassed by a certain male patient. Although this female chaplain declined to provide elaborate detail of the sexual harassment, she indicated that after visiting a certain male patient several times, she concluded that this patient was not serious about wanting pastoral care, but that he pretended to want pastoral care in order to abuse and exploit her sexually.

38Ibid., 66.

39Ibid., 67.
This chaplain refused to continue visiting this particular male patient after she sensed that he was using her. She informed administration at her hospital that she would not visit this patient again. This chaplain’s strategy allowed her to enlist other volunteer chaplains and others from administration to visit this patient. Although this chaplain indicated that this plan or strategy worked well for her, she declined to recommend that other female chaplains pursue a similar strategy to address similar problems.
CHAPTER VII

EVALUATION, IMPLICATION FOR FUTURE MINISTRY AND CONCLUSION

Generally, Christian chaplains serving in interfaith/intercultural healthcare contexts consider themselves blessed and highly privileged to do ministry in these settings. When asked to reflect upon the advantages and disadvantages of doing ministry in these diverse settings, Christian chaplains overwhelmingly extolled the advantages and minimized the disadvantages. Turning now to the disadvantages, two of the top three disadvantages of doing ministry in these diverse settings highlight the fact that Christian chaplains do not feel themselves to be adequately trained and prepared to provide quality pastoral care in these interfaith/intercultural settings. They tend to question or second-guess their competency, perhaps for very good reasons.

What can seminaries, clinical pastoral education training programs, or other chaplaincy training programs do to better prepare and equip chaplains to provide quality pastoral care in these diverse interfaith/intercultural settings? Several seminaries and denominations are now requiring its seminarians and candidates for the ordained ministry to complete at least one unit of clinical pastoral education (CPE) as part of the master of divinity curriculum. One seminary, Lutheran Theological Southern Seminary, which is located in Columbia, South Carolina, requires all students in its master of divinity and master of arts in religion programs to fulfill a cross-cultural requirement, usually in January of the first or second year of seminary. This cross-cultural experience lasts from
two to three weeks and is intended to be a significant immersion in a ministry setting which is quite different from the student’s customary environment.

The reader might recall having been previously introduced to Robert G. Anderson’s five steps for spiritual/cultural chaplain competency in Chapter II. Anderson praised the pastoral care movement for having made tremendous strides in its efforts to integrate spirituality and multicultural counseling but criticized the pastoral care movement for not having gone for enough. Specifically, Anderson criticized the pastoral care movement for its reluctance to move beyond its Judeo-Christian worldview, its reticence to address issues of gender and racial inclusiveness, and issues of power and resource distribution. Anderson challenged the pastoral care movement to strengthen or reinvent its identity and show that it is capable of a multifaith perspective.

The researcher says with a reasonable degree of certainty that individuals who are making application for and actually filling healthcare chaplaincy positions today have been exposed to Anderson’s five steps for spiritual/cultural chaplain competency through their clinical pastoral education (CPE) experience. The minimum requirements one must meet today to be considered for a healthcare chaplaincy position are: 1. Possess a master of divinity degree from a seminary which is accredited by the Association of Theological Schools; 2. have a minimum of four units (1600 hours) of clinical pastoral education (CPE) from a site which is recognized by the Association for Clinical Pastoral Education (ACPE). Thus, the typical chaplain will have begun this work in CPE, but how can Christian chaplains further develop their skills in spiritual/cultural competency?

At the healthcare institution where the writer currently serves as director of pastoral care, our pastoral care department is responsible for planning our annual “in
"Martin Luther King celebration to commemorate the life and legacy of Dr. Martin Luther King, Jr. Although all three staff chaplains and other lay and clergy volunteers participate in this annual prayer service, the staff chaplain who has been primarily responsible for planning and coordinating this celebration for the last three years has been a southern born, middle-aged, white male, Southern Baptist minister who received his undergraduate, seminary, and clinical pastoral education training in southern states. He brings new insight and creativity to our annual Martin Luther King, Jr. celebration.

This doctoral research seems to indicate that the majority of chaplains believe that their denominations or communities of faith are helpful in helping them to nurture their spirituality. Apparently, denominations can be helpful in nurturing the spirituality of its chaplains by providing proper organizational structure; offering conferences, seminars, and workshops; providing printed or recorded materials; or providing a process for periodic or annual evaluation of the chaplain’s competency or progress. Trying to nurture the spirituality of Christian chaplains is much like trying to feed a large crowd of hungry and yet busy people. As the cafeteria provides a smorgasbord or buffet, the denominations must also provide a wide variety of choices. Ultimately, the Christian chaplain will choose from the available selections those portions which best fit his or her needs and preferences. Some Christian chaplains might actually need the guidance of spiritual mentors to help them to make better selections. Thus, denominations or communities of faith should encourage camaraderie and fellowship among its Christian chaplains so that those needing and desiring mentors will have an opportunity to find them.
This doctoral research seems to indicate that the majority of chaplains believe that their institutions or employers are helpful in helping them to nurture their spirituality. Chaplains feel that their spirituality is nurtured when the president and chief executive officer or other high ranking officials provide frequent affirmation to the chaplains, letting them know that pastoral care is a valued part of the healthcare institution. Chaplains also feel nurtured in their spirituality when their institutions or employers make it possible for them to attend continuing education events, especially at the employer’s expense.

This doctoral research seems to indicate that the majority of Christian chaplains believe that their co-workers, including other staff chaplains, are helpful in helping them to nurture their spirituality. Turning now especially to other staff chaplains, this research project indicates that Christian chaplains can help to nurture the spirituality of each other by doing the following: gathering regularly for prayer and sharing sessions; providing mutual support and encouragement; leading and/or attending daily prayer services or Mass; and by showing mutual respect for one another, even when they might disagree on a particular issue or concern. This research seems to indicate that something as simple and routine as a regular bi-weekly or monthly gathering of chaplains to discuss pastoral concerns or issues tends to nurture their spirituality. Thus, for those pastoral care departments which choose not to have daily or weekly worship services or Mass, they might, at least, seek to encourage regular gathering of its chaplains.

This doctoral research seems to indicate that the majority of Christian chaplains tend to nurture their spirituality by making use of personal prayer, Bible reading, meditation, and personal quiet time with God. Thus, Christian chaplains should not be
expected to spend all of their time on the floors interacting with patients, family members, and staff. Rather, chaplains should be encouraged to close the doors to their offices for a few minutes each day and spend some quality time in prayer, Bible study, meditation, or quiet time with God.

Although the overwhelming majority of the Christian chaplains rate their spirituality as good, very good, or excellent, virtually, all of the chaplains acknowledge their need for continued spiritual growth and development. Healthcare institutions and chaplains' organizations or associations must never forget that professional chaplaincy education is a life long process and is never complete. Chaplains and their spiritual growth and development are always a work in process. The spiritual growth of the Christian chaplain is never complete.

Eighty percent, 80%, of the Christian chaplains are aware of at least one or more peculiar risk or danger of serving in an interfaith/intercultural healthcare context. The number one risk or danger of serving in an interfaith/intercultural healthcare context is that the Christian chaplain might say or do something which might be perceived as insensitive or offensive by members of other faith traditions or cultural backgrounds. The fact that the Christian chaplains rate this issue as the number one risk or danger indicates that Christian chaplains themselves are questioning their competency to function adequately in these interfaith/intercultural settings. Frankly, the researcher is favorably impressed and simply overcome with joy that the Christian chaplains participating in this doctoral study overwhelmingly agreed that the first and foremost ethical principle to be followed when working in interfaith/intercultural settings is to “do no harm.” In their article, “Cultural Diversity in Pastoral Care,” Mary Fukuyama and Todd Sevig suggest at
least six ethical considerations to which Christian chaplains should adhere when working with culturally diverse populations:

1. do no harm;
2. do not proselytize;
3. be aware of power and privilege issues in how religion has been enacted in this country (e.g., protestant Christian traditions being seen as the norm);
4. have a pluralistic worldview—no one tradition has the ‘corner on the truth’;
5. avoid an “either/or” dichotomy in viewing these issues;
6. embrace a “both/and” perspective, e.g., “I can be a strong Christian, and value someone else’s experience in being Islamic.”

Obviously, Christian chaplains need to further develop their skills in spiritual/cultural competency. What can Christian chaplains do to further develop their skills in spiritual/cultural competency?

Mary A. Fukuyama and Todd D. Sevig provide the following ten suggestions:

1. Attend continuing education programs.
2. Participate in supervision and training groups,
3. Engage in peer supervision and case discussion,
4. Conduct community visits,
5. Interview cultural informants,
6. Participate in consciousness raising discussion,
7. Do personal racial identity work
8. Other ideas include attending cultural events,
9. Experiencing “being the other” in both minority and majority roles, and
10. Reading books and viewing videos with multicultural themes

Healthcare institutions and chaplains’ organizations must do more to help Christian chaplains to respond to the increasing religious and cultural diversity in our healthcare institutions. As a direct result of the findings of this doctoral project, the researcher is in the process of organizing an interfaith healthcare council within the St. Joseph’s/Candler Healthcare System which will be comprised of physicians, nurses, and

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1Fukuyama and Sevig, 37-38.

2Ibid., 38-39.
other allied health professionals from diverse religious and cultural backgrounds. As the writer envisions using this interfaith healthcare council, it will have two primary functions:

1. to advise the healthcare institution and certain designated leaders as to how we might best provide for the spiritual and cultural needs of an increasingly diverse patient and staff population;

2. to provide timely and appropriate religious and cultural diversity training to doctors, nurses, chaplains, social workers, and other allied health professionals so that they might be better prepared to care for patients, families, and staff from diverse religious and cultural backgrounds.

Cultural diversity training is not new. In fact, the U.S. military, corporate America, and public and private higher education have been directing attention to diversity, or in many cases, the lack of diversity, within its ranks for several decades now. Healthcare institutions are now being compelled by the federal government, the Joint Commission for Accreditation of Healthcare Organizations, and other certifying bodies to deal with cultural diversity in its many forms—gender, sexual orientation, ageism, race/ethnicity, physical/cognitive ability, religious/spirituality, language, and socioeconomic status. Healthcare institutions simply must do more to help its Christian chaplains and all healthcare professionals to provide culturally competent healthcare to an increasingly religious and culturally diverse patient population. Over the last two or three years, the writer had the privilege of participating in several distance learning seminars which focused on cultural diversity in healthcare. He foresees that in the not too distant future, healthcare institutions will designate specialists in cultural diversity whose primary
responsibilities will be to ensure that all healthcare professionals are “culturally competent” to provide culturally appropriate quality healthcare to all patients, without regard to gender, sexual orientation, age, race/ethnicity, physical/cognitive ability, religion/spirituality, or socioeconomic status of the patient.

The number two risk or danger of serving in an interfaith/intercultural healthcare context is the risk or danger of being physically attacked or seriously injured by a patient or family member. Currently, chaplains are addressing this risk or danger by gathering as much information as possible about the possible threat in advance, staying alert and being attentive to their surroundings at all times, and alerting security as warranted. Although the chaplains who reported this concern as a risk or danger seem to have developed a workable strategy to minimize their risk and protect themselves, we might still ask - what might healthcare institutions do differently to protect its chaplains and other healthcare workers from violence in the workplace? As part of the Centers for Disease Control and Prevention (CDC), the National Institute for Occupational Safety and Health (NIOSH) conducts research and makes recommendations to prevent work-related illness and injury. According to estimates of the Bureau of Labor Statistics (BLS), 2,637 nonfatal assaults on hospital workers occurred in 1999 a rate of 8.3 assaults per 10,000 workers. This rate is much higher than the rate of nonfatal assaults for all private sector industries, which are 2 per 10,000 workers. NIOSH, not to be confused with OSHA, defines workplace

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3Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Violence: Occupational Hazards in Hospitals (Cincinnati, OH, 2002), 1.
violence as violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty.\(^4\) Examples of violence include the following:

- **Threats:** Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.

- **Physical Assaults:** Attacks ranging from slapping and beating, to rape, homicide, and the use of weapons such as firearms, bombs, or knives.

- **Muggings:** Aggravated assaults, usually conducted by surprise and with intent to rob.\(^5\)

**Who is at risk of becoming a victim of violence in the hospital?**

- Although anyone working in the hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk.\(^6\) While violence may occur anywhere in the hospital, violence occurs most frequently in psychiatric wards, emergency rooms, waiting rooms and geriatric units.\(^7\)

**NIOSH has identified common risk factors for hospital violence:**

- Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnosis;
- working when understaffed—especially during meal times and visiting hours;
- transporting patients;
- long waits for service;
- overcrowded, uncomfortable waiting rooms;
- working alone;
- poor environmental design;
- inadequate security;
- lack of staff training and policies for preventing and managing crises with potentially volatile patients;
- drug and alcohol use;
- access to firearms;
- unrestricted movement of the public;

\(^4\)Ibid.

\(^5\)Ibid., 2.

\(^6\)Ibid., 3.

\(^7\)Ibid.
poorly lit corridors, rooms, parking lots, and other areas.\textsuperscript{3}

If healthcare institutions are really serious about preventing or reducing the risk or danger of violence in the workplace, they must develop safety and health programs that include management commitment, employees' participation, hazard identification, safety and health training, and hazard prevention, control, and reporting. NIOSH recommends at least three violence prevention strategies which concerned employers should implement—environmental designs, administrative controls, and behavior modifications.

1. Environmental Designs:

- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the hospital.
- Install other security devices such as cameras and good lighting in hallways.
- Provide security escorts to the parking lots at night.
- Design waiting areas to accommodate and assist visitors and patients who may have a delay in service.
- Design the triage area and other public areas to minimize the risk of assault:
  - Provide staff restrooms and emergency exits.
  - Install enclosed nurses' stations.
  - Install deep service counters or bullet-resistant and shatter proof glass enclosures in reception areas.
  - Arrange furniture and other objects to minimize their use as weapons.\textsuperscript{9}

\textsuperscript{8}ibid., 4.

\textsuperscript{9}ibid., 5,6.
2. Administrative Controls:

- Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
- Restrict the movement of the public in hospitals by card-controlled access.
- Develop a system for alerting security personnel when violence is threatened.¹⁰

3. Behavior Modifications:

Finally, NIOSH concludes with a strong recommendation that all healthcare workers receive proper training to recognize and manage assaults, resolve conflicts, and maintain hazard awareness.

On September 8, 2006, the researcher sat down with the security manager, Mr. Ed Proctor, as he explained the vast array of security measures which are already in place at St. Joseph's/Candler Health System. As he has been with the healthcare system for almost thirteen years, he was already aware of many of the security measures which are in place. However, he was surprised to learn that our security personnel have hand held metal detectors which they use to screen for weapons as necessary. Although Mr. Proctor is pleased to have available to his staff many of the latest high tech security gadgets, in the final analysis, Mr. Proctor, like NIOSH, believes that the real strength of any security system lies with its personnel. Mr. Proctor made the following recommendations:

- All healthcare personnel should be trained in behavioral management;
- communication is key; nurses must communicate with patients and family members and make a risk assessment in each case;

¹⁰Ibid.
• nurses and other staff must be proactive, not reactive;

• more mental health professionals are needed in hospitals to intervene with patients, families, and staff.¹¹

The number three risk or danger of serving in an interfaith/intercultural healthcare context is the risk or danger that Christian chaplains might be tempted to “water down” their own faith in order to accommodate their diverse clientele. The reader might remember that both Engelhardt and Pattison cautioned Christian chaplains working in interfaith/intercultural healthcare settings that if they are to successfully resist the temptation to “water down” their own faith, they must both revisit and strengthen their ties with their respective communities of faith. Moreover, the Christian chaplains who identified this issue as a potential risk or danger were also unanimous in their suggestion that in order to successfully resist this temptation, they must remain deeply devoted and stay connected to their respective faith traditions. Hence, healthcare institutions, chaplains’ organizations, and pastoral care departments must be intentional about encouraging its Christian chaplains to “stay connected” to their particular denominations or communities of faith. Christian chaplains should be encouraged to attend denominational gatherings, retreats, conferences, etc. Generally, chaplains are required to be endorsed by some recognized religious body prior to being employed as a healthcare chaplain. My doctoral research indicates that all twenty Christian chaplains who were interviewed are affiliated with some recognized religious body, and all have various opportunities to gather, worship, and fellowship with their respective religious bodies. Unfortunately, not all Christian chaplains take full advantage of these opportunities. The

¹¹Mr. Ed Proctor, Security Manager of St. Joseph’s/ Candler Health system, interview by author, 8 September 2006, Savannah, tape recording, St. Joseph’s/ Candler, Savannah, Georgia.
researcher will be among the first to admit that he is not taking full advantage of the various retreat opportunities which are being provided by the General Board of Higher Education and Ministry of The United Methodist Church. These retreat opportunities are provided free of charge to all active duty chaplains and pastoral counselors serving full-time appointments in The United Methodist Church. Although the chaplain or pastoral counselor is responsible for transportation and travel expenses, once the chaplain or pastoral counselor arrives at the retreat site, all expenses are covered by The United Methodist Church. Why doesn’t he take full advantage of these retreat opportunities? Time constraints and the distances he would have to travel are two very obvious reasons. Limited resources is also a reason. There is only so much time, and the writer is operating on a budget.

Another major concern for this writer as a Board Certified chaplain and licensed professional counselor is that there is an abundance of continuing education opportunities from which he may choose. As a licensed mental health professional (LPC), he regularly receives continuing education information, not only from licensed professional counselors, but also from marriage and family therapists and licensed clinical social workers. Many of these organizations hold annual educational events at the same time each year and send out information about these planned events as much as 6-12 months in advance. To the contrary, the General Board of Higher Education and Ministry of The United Methodist Church appear to plan its retreats rather spontaneously. Therefore, prior to receiving retreat information from the General Board of Higher Education and Ministry, the author usually has already planned the continuing education events for the year. Consequently, it would be helpful if the General Board of Higher Education and
Ministry could plan and announce its retreat opportunities earlier and possibly make this information available to its endorsed chaplains and pastoral counselors several months in advance.

The fourth risk or danger of serving in an interfaith/intercultural healthcare context is the risk or danger that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry.” The one Christian chaplain who shared his strategy for addressing this issue insists that Christian chaplains must maintain collegial relationships with other Christian chaplains so that chaplains might gain affirmation and approval from other chaplains. One of the primary purposes of the Association of Professional Chaplains (APC), a national interfaith chaplaincy organization, is to certify chaplains and encourage and facilitate collegiality among chaplains of all faiths throughout the United States of America. The APC, of which the researcher is a board certified member, holds its annual conference each year during the spring of the year, always in a different region of the United States.

Most state and local chaplains’ organizations also place tremendous emphasis on encouraging and facilitating collegiality among healthcare chaplains. The Georgia Society of Healthcare Chaplains, of which the researcher is an active member, holds its annual fall retreat during the month of September and places tremendous emphasis on education, collegiality, and fellowship among its members.

The fifth risk or danger of serving in an interfaith/intercultural healthcare context is the risk or danger of exposure to infectious diseases. The Christian chaplains who identified this issue as a possible risk or danger also unanimously recommended a strategy to minimize or protect chaplains from exposure to infectious diseases:
1. remain alert and vigilant at all times;
2. remain alert to signs which are posted to protect patients, families, staff, and visitors;
3. gather as much information as possible about each patient prior to visiting the patient;
4. maintain a good relationship and communication with staff nurses who will be more inclined to alert the chaplain to possible risks or dangers;

What more can be done by healthcare institutions to protect patients, family members, staff, and visitors from possible exposure to infectious diseases? At the healthcare institution where the researcher currently serves as chaplain and director of pastoral care, he was recently recommended for reapproval a comprehensive infectious control policy especially for chaplains which was originally approved on January 12, 2004 (see Appendix B).

One of the primary advantages of this comprehensive infection control policy is that it consolidates all other infection control policies which are scattered throughout the Intranet into this one comprehensive infection control policy for pastoral care. Chaplains will be more inclined to read and adhere to this single comprehensive infection control policy than to read and attempt to follow several clinically oriented policies which are scattered throughout the intranet. If the chaplain adheres strictly to this policy, he or she will be protected from the patient, and patients, family members, staff, and visitors will be protected from the chaplain and from each other.

The sixth risk or danger of serving in an interfaith/intercultural healthcare context is the risk or danger related to being a female chaplain, especially in south Georgia. What
can denominations, healthcare institutions, chaplains' organizations, and pastoral care departments do to protect, support, and encourage its female Christian chaplains?

In 2006, The United Methodist Church celebrated fifty (50) years of full clergy rights for women in ministry. The South Georgia Annual Conference was held in Savannah, Georgia on June 4-7. During the four-day celebration, the accomplishments and achievements of women clergy were highlighted. All of the preaching was done by clergywomen, and a clergywoman led all Bible Study sessions. A number of “firsts” were recognized: Annie Louise Johnson was the first woman to be ordained deacon in 1975; in 1978, Marcia Cochran and Allison Rhodes were the first two women to be ordained elders; in 1985, Essie Simmons was the first African-American woman to be ordained deacon, and, in 1991, Beverly Flowers was the first African-American woman to be ordained elder. In 1999, the Rev. Cynthia Autry was the first female appointed district superintendent to the Macon District by the South Georgia Conference of the United Methodist Church.

Healthcare institutions and pastoral care departments must be prepared to provide whatever additional support or assistance which might be required by its female chaplains. If a female chaplain feels particularly threatened when visiting certain male patients, she should feel free to ask one of her male counterparts or another female chaplain to visit for her. If need be, she should be encouraged to go to the director of her pastoral care department to seek relief in the most difficult situations. If the female chaplain happens to be the only chaplain in the pastoral care department, she should be encouraged to call upon other co-workers, peers, or supervisors for assistance. Sexism has been around for centuries, and notwithstanding the incredible advances women throughout the world have
made during the last seventy-five (75) years, vestiges of sexism will probably be around for many more years to come. Thus, it is important that older and more experienced women clergy be prepared to nurture and mentor younger or less experienced women clergy.

**Conclusion**

In summary, in pursuing responses to a twenty-two item structured interview guide, the researcher traveled throughout the state of Georgia interviewing Christian chaplains. Beginning in the Atlanta metropolitan area, which has a population in excess of four million people, he traveled to Columbus, Macon, Statesboro, Dublin, Brunswick, Hinesville, and Savannah. He can honestly say that he was privileged to sit (for about 45 minutes per visit) with twenty of Georgia’s finest healthcare chaplains. With each chaplain’s knowledge and permission, all interviews were recorded for future reference and further analysis.

What was learned? Although the saints are aging, Christian chaplains are overwhelmingly positive, optimistic, and hopeful about the future possibilities of doing ministry in these interfaith/intercultural settings.

First, let us look at the spirituality of the Christian chaplains. What is Christian Spirituality? Although the Christian chaplains tend to define Christian spirituality rather variedly, all Christian chaplains agree that their spirituality is currently being nurtured in their respective settings. Most Christian chaplains nurture their spirituality using Bible reading, personal prayer and meditation, and quiet time with God, and believe that their denominations or communities of faith, healthcare institutions or employers, and co-workers-including other staff chaplains, help them to nurture their spirituality. Most
Christian chaplains believe that they have available to them the necessary resources to help them to nurture their spirituality and rate their spirituality as good, very good, or excellent.

Second, let us now look at the perceived risks or dangers to Christian chaplains working in interfaith/intercultural settings. The reader will recall that eighty percent (80%) of the Christian chaplains interviewed indicated that they are aware of at least one or more risk or danger of serving in an interfaith/intercultural healthcare context. The top six risks or dangers as reported by the Christian chaplains are listed below:

1. that the Christian chaplain might say or do something which might be perceived as insensitive or offensive by persons of other faith traditions;
2. that Christian chaplains might be physically hurt or seriously injured by a patient or family member;
3. that Christian chaplains might be tempted to “water down” their own faith in order to accommodate their diverse clientele;
4. that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry;”
5. that Christian chaplains might be exposed to infectious diseases;
6. that female chaplains might be sexually harassed, especially in south Georgia.

Of the six risks or dangers listed above, two (numbers 2 and 5) are not peculiar to Christian chaplains. In fact, our own research indicates that there is a risk to those working in hospitals of becoming a victim of violence, but that nurses and aides who work more directly with patients and family members are at greater risk than chaplains. Likewise, Christian chaplains are not the only healthcare workers who run the risk of
exposure to infectious diseases. In fact, infection control data consistently indicate that the greater risk of exposure to infectious diseases is borne by those who regularly handle sharp objects, like needles or blood and body fluids of patients. Of course, Christian chaplains are still also at risk of being physically hurt or seriously injured by a patient or family member and of being exposed to infectious diseases, but, as indicated previously, these risks are not peculiar to chaplains. Nonetheless, what can healthcare chaplains do to eliminate or minimize their risks? Education is the key. Hospital security personnel can help to educate Christian chaplains and other healthcare personnel as to how they might reduce their chances of becoming a victim of violence in the hospital, and infection control personnel can help the healthcare chaplain to reduce his or her chances of being exposed to infectious diseases. Now that the second and fifth risks have been excluded, as not being peculiar to healthcare chaplains, Christian chaplains can now proceed with the four remaining risks or dangers:

1. That the Christian chaplain might say or do something which might be perceived as insensitive or offensive by persons of other faith traditions; 
2. that Christian chaplains might be tempted to “water down” their own faith in order to accommodate their diverse clientele; 
3. that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry”; 
4. that female chaplains might be sexually harassed, especially in south Georgia.

The first risk—that the Christian chaplain might say or do something which might be perceived as insensitive or offensive by persons of other faith traditions.
Obviously, Christian chaplains need to further develop their skills in spiritual/cultural competency. What can Christian chaplains do to further develop their skills in spiritual/cultural competency? In their article, “Cultural Diversity in Pastoral Care,” Mary Fukuyama and Todd Sevig provide a list of ten recommendations of what Christian chaplains might do to further develop their spiritual/cultural competencies. See page 100 of these materials. Some pastoral care departments are already taking the initiative to plan or coordinate religious or cultural events for their respective healthcare institutions. For example, at the healthcare institution where he currently serves as director of pastoral care, for the last several years, the pastoral care departments at both hospitals have taken the initiative to plan and coordinate our annual Martin Luther King Jr., celebrations. Approximately two years ago, our department of pastoral care also took the initiative to order and install our diversity bulletin board. On our diversity bulletin board are listed the five major religions of the world with their respective holy days.

As a direct result of this doctoral project, the researcher is in the process of organizing an Interfaith Hospital Council which is made up of representatives from the major religious and cultural groups within the region. The purpose of the Interfaith Hospital Council is to provide counsel to the hospital staff and to train and prepare doctors, nurses, social workers, chaplains, and others to provide culturally sensitive care to patients, families, and staff from diverse religious and cultural backgrounds.

The second risk—that Christian chaplains might be tempted to “water down” their own faith in order to accommodate their diverse clientele. Of the twenty Christian chaplains who were interviewed and responded to this question, only three acknowledged that the temptation to “water down” their own faith might be a risk or danger for
themselves or others. Seventeen of the Christian chaplains did not even see this as an issue. Nonetheless, Engelhardt and Pattison are persistent in warning Christian chaplains working in interfaith/intercultural settings that if they are to successfully resist the temptation to “water down” their own faith, they must both revisit and strengthen their ties with their respective faith traditions. For most Christian chaplains, this can be done quite easily. Of course, many Christian chaplains will think this whole idea to be ludicrous and will be tempted to ignore it. Although my own research did not exactly sound the Titanic alarm, nonetheless, the researcher would err on the side of caution and urge all Christian chaplains to both revisit and strengthen their ties with their own respective faith traditions. One of the greatest surprises or unexpected results, for me personally, of having engaged in this doctoral study is the great sense of pride and accomplishment I feel being an ordained elder in The United Methodist Church. The researcher had forgotten how much time, effort, and energy was required to become an ordained elder in The United Methodist Church, especially as an African-American in south Georgia. He is honored to be associated with The United Methodist Church and to be referred to as a “United Methodist minister.” During the last several months, extra effort was put forth to review Methodist history, theology, doctrine, and policy. This writer can honestly say that he is proud to be a United Methodist Christian chaplain.

The third risk—that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry.” Of the twenty Christian chaplains who were interviewed and responded to this question, only two chaplains identified this as a possible risk or danger. Nevertheless, how should Christian chaplains respond to this risk or danger? Christian chaplains must be permitted
and encouraged to network with other chaplains so as to support, affirm, and facilitate the work of chaplaincy wherever it is being done. Virtually, all chaplains’ organizations coordinate education, collegiality; and fellowship among its members. Thus, chaplains should be encouraged to affiliate with chaplains’ organizations at the local, state, national, and even international levels.

Fourth, in conclusion the researcher looks at the fourth risk of being a female chaplain, especially in south Georgia. The reader might remember that of the six female chaplains who were interviewed by me, three served in the Atlanta metropolitan area, and three served in south Georgia. Two of the three female chaplains serving in south Georgia complained about the additional challenges they face as female chaplains. What can denominations, chaplains’ organizations, healthcare institutions, and pastoral care departments do to help female chaplains to respond to this risk or danger? Denominations must stand firm in insisting that its female clergy be granted full clergy rights and privileges. If full clergy rights and privileges have already been granted to female clergy, these rights and privileges should be protected and celebrated often. Chaplains’ organizations at the local, state, and national levels must be open and receptive to its female chaplains and should invite and encourage them to seek leadership positions within the various organizations. Healthcare institutions and pastoral care departments must affirm and support and, if necessary, be prepared to protect its female chaplains from sexual harassment or abuse by patients, family members, or staff.
APPENDIX A

CHRISTIAN CHAPLAIN

INTERVIEW GUIDE

1. Factual Data: Date and place of birth? Ethnic religious identification?
2. How long have you been in ministry?
3. How long have you served as a healthcare chaplain?
4. What is your denominational affiliation?
5. Is the setting in which you do ministry an interfaith/multifaith context? If yes, why? If no, why?
6. What are some of the advantages of serving in an interfaith/multifaith context?
7. What are some of the disadvantages of serving in an interfaith/multifaith context?
8. What is your understanding of the phrase “Christian spirituality,” and what does this phrase mean to you?
9. How is your own spirituality nurtured or hindered by your experiences and/or interactions in your interfaith/multifaith ministry setting?
10. How helpful is your own denomination or community of faith in helping you to nurture your spirituality?
11. How helpful is your healthcare institution [employer] in helping you to nurture your spirituality?
12. How helpful are your co-workers, especially other staff chaplains, in helping you to nurture your spirituality?
13. Do you have available to you the necessary resources to help you nurture your own spirituality?
A. If yes, what are those resources, and who provides them?
B. If no, what resources do you need, and how might you acquire or obtain them?

14. How do you currently nurture your spirituality within your interfaith/multifaith context?

15. How would you rate your level of spirituality at this time? Please circle one:

1. Poor  
2. Fair  
3. Good  
4. Very Good  
5. Excellent

16. Are you comfortable with the present level of your spirituality? If yes, why? If no, where would you like the present level of your spirituality to be?

17. As a Christian chaplain, are you aware of peculiar risks or dangers of serving in an interfaith/multifaith context? If yes, what are some of these risks of dangers?

18. Have you devised a plan or strategy to protect yourself against or at least minimize the effect of these peculiar dangers or risks?

19. If so, what is your plan or strategy?

20. Is your plan or strategy working for you? If yes, how is it working? If no, why not?

21. Do you have reason to believe that your plan or strategy might work for other Christian chaplains serving in interfaith/multifaith settings?

22. Are there other insights or wisdom you have gained as a Christian chaplain serving in an interfaith/multifaith context which you care to share at this time?
Policy Statement

It shall be the policy of the St. Joseph's/Candler Health System, Inc. to provide for the spiritual needs of the hospitals' patients, their families and visitors, and personnel using sound infection control practices based on Standard Precautions.

Purpose of Policy

1) To increase awareness of the means of disease transmission
2) To provide guidelines for infection control and prevention

Entities to Whom this Policy Applies

Members of the Pastoral care Department of St. Joseph's/Candler Health System, Inc.

Definition of Terms

Standard Precautions; An approach to infection control in which all body substances (as defined by the CDC) are considered potentially infectious in all patients

Procedures
I. Personnel

A. Personnel who visit patients should be free from obvious communicable disease. Personnel with colds, fever blisters, sinus infections, dermatitis of the hands, etc. should not visit immunocompromised patients, especially neonates and patients on the oncology floor.

B. In addition to initial orientation to the Infection control Program upon hire, all Pastoral Care personnel should attend an annual inservice related to infection control. Annual requirements may be met by completing a Netlearning computer-based learning module related to Infection control.

C. Good basic personal hygiene is required.

D. All cuts/scrapes! punctures/lacerations/splashes of blood or other body fluids to the eyes, nose or mouth that occur while on duty shall be reported as soon as possible (and in less than 2 hours) after the exposure to Occupational Health Services. A report of occurrence (REO) shall be filed and the exposed employee shall report to the Emergency Department for assessment of any necessary treatment.

II. Patients

A. Hand washing, using soap and running water, shall be performed after any patient visit.

B. Blood and body fluid precautions, Standard Precautions,” shall be used consistently for ALL patients regardless of their infection status. Established infection control policies shall be followed consistently for ALL patients.

1. All personnel shall routinely use appropriate barriers (gowns, gloves, mask, protective eyewear) to prevent skin and/or mucous membrane exposure when contact with blood or body fluids of any patient is anticipated.

2. Personnel with exudative lesions or weeping dermatitis shall refrain from all direct patient contact until the condition resolves.

C. Special care shall be taken when visiting patients in isolation to avoid cross-contamination and exposure.

1. Infection control guidelines outlined on the posted door card (red STOP sign) shall be followed.

2. Personnel may enter the room of a patient in isolation only after applying gown, gloves, and mask as stipulated on the patient’s door card before entering the room.

3. Hands shall be washed after removing protective clothing and before leaving the patient’s room.

III. Special Procedures

In administering or assisting with the administration of the Sacraments, care shall be taken to void inadvertent contamination of self or the vessels used.
A. If the minister’s fingers touch the lips or tongue of the patient or become contaminated with saliva during the administration of Holy Communion, the minister’s hands shall be washed before distributing Communion to the next patient.

The minister’s hands shall be washed after administering the Sacrament of the Sick to any patient.

Approved:

Infection control committee co-chair

Infection control Committee Co-chair

Vice President, Patient Care Services

Vice President, Mission Services

Original Implementation Date: 7/91
Next Review Date: 05/2007
Originating Department/committee; Infection Control
Reviewed, 10/98, 7/01, 01/04, 12/04
Revised; 2/98, 2/99, 01/04
Rescinded:
Policy Number(s): IC - 623
APPENDIX C

PATIENT RIGHTS AND RESPONSIBILITIES

Consistent with this institution’s Mission and Values, its corporate obligations and policies and its moral and religious beliefs, a patient in this institution enjoys the following rights and responsibilities:

... Patients have the right to be treated with comfort, dignity and respect including the final stages of life;

... Patients have a right to health professionals' appropriate assessment and management of the pain (pain information, prevention of pain and relief of pain) upon a report of pain by the patient;

... Patients have a right to obtain information regarding the benefits, risks, and alternatives of any proposed treatments or procedures to the patient and to make an informed decision regarding care including participation in research studies;

... Patients and their families, when appropriate, have the right to be informed about the outcomes of care, including unanticipated outcomes which differ significantly from the anticipated outcome;

... Patients have a right to refuse to participate in research studies which will not compromise the patient’s right to care;

... Patients have a right to include or exclude any or all of their family members from anticipating in their care;

... Patients have a right to be involved in resolving dilemmas about their care by requesting the hospital to address any ethical issues in providing patient care through the Bio-ethics Committee;

... Patients have a right to initiate an advance directive;

... Patients have a right to refuse treatment including refusal of resuscitative services or protected health information.

... Patients have a right to privacy & security, the right to confidentiality of their protected health information.

... Patients have a right to bring to the attention of the appropriate hospital representative any concerns regarding their right to care and to have those complaints reviewed and, when possible resolved;

... Patients have a right to be free from all forms of abuse, harassment and discrimination, the right to file a complaint with the State survey or certification agency if the patient has a concern about patient abuse, neglect or misappropriation of the patient’s property in the facility;

... Patients have the right to recognition of spiritual, cultural and social beliefs;

... Patients have the right to obtain appropriate protective service information;
... Patients have the right to have a family member or representative of the Patients’ choice notified promptly of their admission to the hospital;
... Patients have the right to access information contained in the Patients’ clinical records within a reasonable time frame;
... Patients have the right to be free from restraints and seclusion which are not medically necessary;
... Patients have the right to be informed of participation for the procuring and donation of organs and other tissues;
... Patients have the right to receive an explanation of charges;
... Patients have the right to the name of the individuals providing care to them;
... Patients have the right to effective communication from the health system, including appropriate accommodation for disabled patients, and the right to unrestricted access to communication with others outside the health system, except in circumstances in which it is necessary to restrict access to visitors, mail, telephone calls, or other forms of communication for reasons related to patient care, and any such restrictions will be fully explained to you and your family and will be determined with your participation.

PATIENT RESPONSIBILITIES

... Cooperate with the health care team in their treatment program;
... Inform the physician or healthcare provider of any pain and cooperate with the healthcare team to develop a plan for the management of pain;
... Follow the usually accepted rules of courtesy and etiquette;
... Be considerate of the right and privacy of other patients;
... Make adequate financial arrangements for debts owed to this health system;
... Bring to the attention of the appropriate health system supervisor those occasions when in your opinion your rights are not being respected.
SELECTED BIOGRAPHY


themselves or others. Seventeen of the Christian chaplains did not even see this as an issue. Nonetheless, Engelhardt and Pattison are persistent in warning Christian chaplains working in interfaith/intercultural settings that if they are to successfully resist the temptation to “water down” their own faith, they must both revisit and strengthen their ties with their respective faith traditions. For most Christian chaplains, this can be done quite easily. Of course, many Christian chaplains will think this whole idea to be ludicrous and will be tempted to ignore it. Although my own research did not exactly sound the Titanic alarm, nonetheless, the researcher would err on the side of caution and urge all Christian chaplains to both revisit and strengthen their ties with their own respective faith traditions. One of the greatest surprises or unexpected results, for me personally, of having engaged in this doctoral study is the great sense of pride and accomplishment I feel being an ordained elder in The United Methodist Church. The researcher had forgotten how much time, effort, and energy was required to become an ordained elder in The United Methodist Church, especially as an African-American in south Georgia. He is honored to be associated with The United Methodist Church and to be referred to as a “United Methodist minister.” During the last several months, extra effort was put forth to review Methodist history, theology, doctrine, and policy. This writer can honestly say that he is proud to be a United Methodist Christian chaplain.

The third risk—that other Christian pastors or ministers will “dismiss” or “discount” the ministry of the healthcare chaplain as not being “real ministry.” Of the twenty Christian chaplains who were interviewed and responded to this question, only two chaplains identified this as a possible risk or danger. Nevertheless, how should Christian chaplains respond to this risk or danger? Christian chaplains must be permitted
and encouraged to network with other chaplains so as to support, affirm, and facilitate the work of chaplaincy wherever it is being done. Virtually, all chaplains’ organizations coordinate education, collegiality, and fellowship among its members. Thus, chaplains should be encouraged to affiliate with chaplains’ organizations at the local, state, national, and even international levels.

Fourth, in conclusion the researcher looks at the fourth risk of being a female chaplain, especially in south Georgia. The reader might remember that of the six female chaplains who were interviewed by me, three served in the Atlanta metropolitan area, and three served in south Georgia. Two of the three female chaplains serving in south Georgia complained about the additional challenges they face as female chaplains. What can denominations, chaplains’ organizations, healthcare institutions, and pastoral care departments do to help female chaplains to respond to this risk or danger? Denominations must stand firm in insisting that its female clergy be granted full clergy rights and privileges. If full clergy rights and privileges have already been granted to female clergy, these rights and privileges should be protected and celebrated often. Chaplains’ organizations at the local, state, and national levels must be open and receptive to its female chaplains and should invite and encourage them to seek leadership positions within the various organizations. Healthcare institutions and pastoral care departments must affirm and support and, if necessary, be prepared to protect its female chaplains from sexual harassment or abuse by patients, family members, or staff.
APPENDIXES
APPENDIX A

CHRISTIAN CHAPLAIN

INTERVIEW GUIDE

1. Factual Data: Date and place of birth? Ethnic religious identification?
2. How long have you been in ministry?
3. How long have you served as a healthcare chaplain?
4. What is your denominational affiliation?
5. Is the setting in which you do ministry an interfaith/multifaith context? If yes, why? If no, why?
6. What are some of the advantages of serving in an interfaith/multifaith context?
7. What are some of the disadvantages of serving in an interfaith/multifaith context?
8. What is your understanding of the phrase “Christian spirituality,” and what does this phrase mean to you?
9. How is your own spirituality nurtured or hindered by your experiences and/or interactions in your interfaith/multifaith ministry setting?
10. How helpful is your own denomination or community of faith in helping you to nurture your spirituality?
11. How helpful is your healthcare institution [employer] in helping you to nurture your spirituality?
12. How helpful are your co-workers, especially other staff chaplains, in helping you to nurture your spirituality?
13. Do you have available to you the necessary resources to help you nurture your own spirituality?
A. If yes, what are those resources, and who provides them?
B. If no, what resources do you need, and how might you acquire or obtain them?

14. How do you currently nurture your spirituality within your interfaith/multifaith context?

15. How would you rate your level of spirituality at this time? Please circle one:

16. Are you comfortable with the present level of your spirituality? If yes, why? If no, where would you like the present level of your spirituality to be?

17. As a Christian chaplain, are you aware of peculiar risks or dangers of serving in an interfaith/multifaith context? If yes, what are some of these risks of dangers?

18. Have you devised a plan or strategy to protect yourself against or at least minimize the effect of these peculiar dangers or risks?

19. If so, what is your plan or strategy?

20. Is your plan or strategy working for you? If yes, how is it working? If no, why not?

21. Do you have reason to believe that your plan or strategy might work for other Christian chaplains serving in interfaith/multifaith settings?

22. Are there other insights or wisdom you have gained as a Christian chaplain serving in an interfaith/multifaith context which you care to share at this time?