**Chapter 8 – Interpersonal Competence in Contextualizing Power Dynamics in Socially Just**

**Spiritual Care**

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*Abstract: Social justice is a core facet of spiritual care because contextual power dynamics and systemic disparities within the institutions where chaplains work impact the well-being of their care seekers. In order to gain competency in socially just spiritual care, chaplains must grasp the basic vocabulary, trends, and history of these dynamics. While the meaning and specifics of power dynamics and systemic disparities will change depending on each chaplain’s context, this chapter serves as an introduction to the knowledge and skills necessary for competence in socially just spiritual care. The chapter introduces core terms in their relation to chaplaincy: power, social location, patriarchy, and systemic racism, and then provides an overview of the history of the communal contextual shift in spiritual caregiving. Finally, through two case studies, the chapter illustrates how chaplains can employ this competency towards immediate care for their care seekers as well as shifting systemic dynamics within their home institutions towards greater well-being and justice.*

**Introduction**

For chaplains, systemic justice and spiritual caregiving are linked because they do not meet their care receivers in a vacuum without context or power dynamics. Rather, by definition, their work is institutional. Chaplains work for and are a part of organizations such as the hospital, prison, military, long-term care facility, or college campus. Even chaplains who work on the street with populations experiencing homelessness nonetheless maintain close ties to non-profits and denominations or faith communities. Likewise, the care receiver is generally under the care or authority of the same institution that employs the chaplain, but as patient, inmate, soldier, resident, student, staff, etc. Inherent in each of these settings and designations is a complex network of relationships, procedures, boundaries, and possibilities that chaplains must understand and navigate in order to provide care. Moreover, intertwined with these institutional systems is a broader, even more abstract network of social systems that transcend but also have direct bearing on all chaplaincy settings. These involve differing experiences and social outcomes linked to identity, including but not limited to one’s race, gender, class, sexuality, ability, and religion. Chaplains must have interpersonal competency in navigating these wider social systems and the differing power dynamics that come with them, because these layers of systems have direct influence on the overall wellness of their care receivers.

The interconnection between systemic justice and spiritual caregiving is encoded in both chaplaincy training and certification. For example, ACPE mandates competency in “initiat[ing] helping relationships within and across diverse populations”[[1]](#endnote-1) in Level I. With relationships across diverse populations, of course, come the power dynamics between the differing social locations of the care seeker and chaplain that the caregiver must understand and account for in order for the relationship to be, in fact, helpful. This curricular focus on just relations and systems is more explicit and detailed for Level II CPE, where the student demonstrates competency in “provid[ing] pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one’s own perspectives.”[[2]](#endnote-2) The focus here thus expands to the wider institutional and social systems in which the caregiving relationship takes place. The BCCi “Common Qualifications and Competencies for Professional Chaplains” then echo the connection between care and justice, or rather, the reality that justice is an integral part of care.[[3]](#endnote-3)

This chapter serves as an introduction to the basic vocabulary, frameworks, and quandaries that a chaplain must know and consider in order to provide competent socially just spiritual caregiving. Throughout, we ground our overviews of these competencies with caregiving case studies in order to show the contextual nature of just caregiving. We begin with a return to Angie, a case study covered by Carrie Doehring and Allison Kestenbaum above in chapter 6.

Angie’s case is illustrative of how power imbalances and systemic oppression can function in the hospital setting, and what chaplains may do in response. Angie is a 25-year-old, single African American woman with advanced Hodgkin’s lymphoma, who is expected to die during her current hospitalization. She is also a recovering addict and a practicing Pentecostal Christian. Angie has had episodes of being unresponsive, likely because the systems of her body are shutting down as she nears the end of her life. During a visit with her chaplain, Angie relates an experience she had during one of these episodes, of the presence of God, dancing with Angie and making her whole in the midst of her fatal cancer prognosis. After this conversation, the chaplain consults with a nurse with expertise on how dying patients may experience perceptions or sensations that are comforting in ways similar to Angie’s description. When the chaplain relates this experience to the care team, a white male, agnostic physician dismisses Angie’s religious experience and sense of wholeness as a drug induced delirium that should be disregarded by the care team. As Doehring and Kestenbaum point out, this dismissal endangers Angie, because it rejects her religious positive coping, an empirically proven aid for enhancing physical, emotional, and spiritual wellbeing.

What is the chaplain to do? In order to navigate this situation competently, there are a number of core issues that the chaplain must be familiar with prior to the encounter. However, competency here is not simply a cognitive understanding of a group of terms and trends. Not only must chaplains comprehend the terms outlined below; they must also employ this knowledge to contextualize each individual spiritual care situation within wider socio-political trends and dynamics in order to fully grasp what is happening and to access what interventions to take. In the case of Angie, the chaplain must set the physician’s dismissal within wider issues and trends of power, social location, patriarchy, and racism in order to determine the most life-giving intervention as the patient’s spiritual caregiver.

First, is the issue of power. In relationships, power is simply the ability to determine what happens to oneself and the ability to influence others. There is nothing inherently wrong or bad about power. It is a morally neutral term. In fact, everyone has a certain amount of power in any given relationship. In the context of spiritual caregiving, however, there is necessarily a complex imbalance of power. Simply by being part of the organizational structure of the institution in which they work, chaplains have a higher degree of power than the care receiver. As Doehring helpfully explains, “Equal relationship of mutual give-and-take can occur among those who are peers, such as friends, marital partners, peer colleagues, and siblings. When one person in a relationship is in the role of minister, rabbi, imam, or teacher there is a difference in power…Caregivers are responsible for monitoring power dynamics, which can easily slip and slide between life-giving and life-limiting power dynamics.”[[4]](#endnote-4) As Doehring points out, the imbalance of power between spiritual caregiver and care receiver does not necessarily turn into domination, though there is a possibility for such a life-limiting abuse of power when it is used improperly.

There is a clear misuse of power in the case of Angie. The physician, as a leader of the care team, uses his power to silence Angie’s spiritual experience, saying that it does not pertain to the work of patient care. The chaplain, however, also has power in this situation. Because of the natural imbalance of power between the chaplain, as a member of the institutional care team, and Angie, as a patient in the hospital, the chaplain has the opportunity – and in fact, the obligation – to empower the patient by reiterating the importance of her spiritual health and experience.

However, the case becomes more complex when examining the **social location** of those involved.Institutional affiliation, where one person in a relationship is designated the “spiritual caregiver” or “chaplain” and the other the “care receiver” (or “patient,” “soldier,” “inmate,” etc.), is only one of several identity markers that make up one’s social location. These markers also include one’s race, gender identity, class, ability, sexuality, and religion. Each designation within these categories has a level of power adhering to it based on the general way it is recognized and treated in a given context. Moreover, the identity categories that make up one’s social location interact and intersect with one another. Critical race theorist Kimberlé Crenshaw was the first to use the term “intersectionality” to denote how these varying markers interact together in terms of social power. In Crenshaw’s words, “Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It’s not simply that there’s a race problem here, a gender problem here, and a class or LBGTQ+ problem there.”[[5]](#endnote-5) Rather, these issues intersect because we each stand in multiple identity categories, and these markers hold varying levels of power based on the context in which we find ourselves, as Doehring and Kestenbaum explore in their discussion of spiritual reflexivity in chapter 6.

The differing social locations of the physician and the patient in this case increase the power differential already in place by their institutional locations. In order to unpack this imbalance, we must explore two further terms: First,patriarchy is defined as the dominance of men over women.[[6]](#endnote-6) This power imbalance remains today. For example, according to the Pew Research Center, women made only about 85% of the wages that men made when doing the exact same job in 2018.[[7]](#endnote-7) Moreover, though women earn more undergraduate and graduate degrees, and account for nearly half of the American labor force, they are disproportionately underrepresented in positions of power. For example, women make up 40 percent of physicians and surgeons but only 16 percent of med school deans. Likewise, they earned the majority of doctorates for eight successive years but make up only 32 percent of full professors.[[8]](#endnote-8) These numbers show the persistence today of the wide-ranging structural advantage of men over women known as patriarchy.

The chaplain must put the male physician’s dismissal of Angie’s spiritual experience within the wider context and trends of patriarchy. Such trends are operative in healthcare, where, following patriarchal norms of masculine stoicism and individualism, men have higher death rates than women, spend less time with their healthcare providers, receive less advice, and are asked less by their doctors to change their behavior.[[9]](#endnote-9) The dismissal of Angie’s experience is in line with wider trends within healthcare that prioritize men’s agency. In contrast, in the hospital, women are told what to do rather than heard. Angie’s case is a stark example of such dismissal of women’s experience.

However, as we saw in the definition of social location above, we cannot look at gendered power dynamics simply in the binary of men over women. Such a narrow focus excludes intersectional power differentials such as race and class. Therefore, black feminist scholars such as bell hooks have critiqued employing of the term patriarchy alone to name oppression while excluding other intersectional factors. In hooks’s words, “Since all forms of oppression are linked in our society because they are supported by similar institutional and social structures, one system cannot be eradicated while others remain intact. Challenging sexist oppression is a crucial step in the struggle to eliminate all forms of oppression.”[[10]](#endnote-10) Patriarchy is thus a critical but not the sole name for systemically imbalanced power dynamics.

In addition, the chaplain must examine how systemic racismplays into Angie’s case. Often, racism is associated with individual or group prejudice based on skin color, such as with fringe, radical groups such as the Ku Klux Klan who espouse the superiority of the white race over other races. However, when thinking systematically about the institutions in which chaplains operate, such associations and definitions hide the much more widespread, systemic advantage that white identifying people and the cultural customs associated with them hold in western society.[[11]](#endnote-11) Systemic racism is a complex set of bias, norms, laws, and trends that fosters differing social outcomes based on racial identity.[[12]](#endnote-12) In the hospital system, one way that systemic racism shows up is in the persistence of racist understandings of physical differences between the races among medical professionals. Journalist Linda Villarosa recently reported in the *New York Times*, “A 2016 survey of 222 white medical students and residents published in *The Proceedings of the National Academy of Sciences* showed that half of them endorsed at least one myth about physiological differences between black people and white people, including that black people’s nerve endings are less sensitive than white people’s. When asked to imagine how much pain white or black patients experienced in hypothetical situations, the medical students and residents insisted that black people felt less pain. This made the providers less likely to recommend appropriate treatment. A third of these doctors to be also still believed…that black skin is thicker than white skin.”[[13]](#endnote-13) Such widespread racist beliefs even among well-educated medical students and physicians play an integral part in divergent healthcare outcomes between African Americans and their white counterparts. Black men have a 26% higher death rate than white men and black women a 19% higher rate than white women.[[14]](#endnote-14) These disparities are lessened, but nonetheless persist when controlling for other systemic disparities in education level and income rates. The physician’s dismissal of Angie then is in line with wider medical trends that dismiss African American patient experience in general.

 Set in this wider context, the case study is not simply about isolated behavior; the physician’s dismissal is a microcosm, rather, of wider power dynamics and inequalities. The competency necessary for socially just care in this situation is the ability to contextualize individual actions within such a wider social frame. In doing so, the chaplain may now access what action is needed. In this case, it is not enough for the chaplain to say they are not personally sexist or racist (or ableist, classist, etc.). As a clear example of the persistent inequalities examined above, Angie’s case calls for more overt action if the chaplain is truly going to offer effective care. A chaplain with competency in socially just care would be ready to set the physician’s remark within the oppressive context in which it takes place, and therefore engage the medical team in a more thorough discussion about the positive health outcomes of spiritual experiences. This would include engaging the physician himself to understand more of the motivations, blind spots, and possible stressors that lead to his dismissive remark. In doing so, the chaplain would be employing their own power as a part of the hospital and a member of the care team to resist these structural inequalities. The chaplain would, in fact, be working to change the power dynamics of the institution itself, making it a more just place.

 The chaplain’s ability to contextualize these power dynamics while also employing active listening in order to understand the actions of the care team is an illustration of the dynamic interplay between individual care and broader systemic awareness at the root of competent, socially just spiritual care. This dynamic interplay between individual care and broader systemic awareness and change actually has its roots in the historic development of the discipline of spiritual caregiving. In order to understand the roots of this competency, we turn now to this history.

**Between Two Paradigms**

The understanding of spiritual care as taking place within a wider network of power relationships that the caregiver must understand and navigate along with the care receiver is a relatively recent innovation in the field of spiritual care and counseling. It is a move from what scholars in the field term the therapeutic paradigm to the communal contextual paradigm.[[15]](#endnote-15) In the early days of Clinical Pastoral Education and the teaching of care and counseling in theological schools in the first half of the 20th century, spiritual care held a narrower focus on the individual relationship between caregiver and care receiver. An early champion and educator in the CPE movement was a Presbyterian minister named Anton Boisen (1876-1965), who himself had suffered from what was then diagnosed as reoccurring catatonic schizophrenia. After finding a dearth of spiritual care in his own hospitalizations, Boisen went on to promote spiritual caregiving in clinical settings. Moreover, he saw such work as a necessity for training in religious leadership. As he said in one of his memoirs, “In a time when students of religion were making little use of methods of science, and scientists were failing to carry their inquiries to the level of the religious, we were seeking to make empirical studies of living human documents.”[[16]](#endnote-16) Boisen’s term “living human documents” became central to the early CPE movement and to what became known as the therapeutic paradigm. It meant that spiritual caregivers and seminary students could learn about the human condition and the divine by studying human experience in the caregiving relationship.

 As the therapeutic paradigm evolved in the early decades of the discipline, its specialized focus on the caregiving relationship often excluded wider attention to the social context in which it takes place. Pastoral theologians Rodney Hunter and John Patton’s overview of the paradigm’s characteristics record this omission. Among others, they highlight the following characteristics:

* *Priority of What Human Beings Have in Common over Ways in Which They Differ from One Another*…The pastoral field and its related therapeutic psychologies accented the idea of the ‘common core’ of experience, and assumed that psychological and pastoral knowledge is equally applicable to either gender and to all races and classes of persons.
* *Priority of Personal Needs over Institutional Needs*…The secular institutional setting in which most pastoral care and counseling has occurred has enabled it to focus almost exclusively on matters of personhood and relationship through its singular attention on the one role function of ministry (pastoral care) with relatively little attention to those functions that more directly represent collective, institutional claims and agendas.[[17]](#endnote-17)

This emphasis on the caregiving relationship itself was a reaction against earlier trends in theological education that focused more squarely on systematic theology and biblical scholarship to the omission of interpersonal relationships and caregiving.[[18]](#endnote-18) The therapeutic paradigm’s omission of wider contextual and systemic issues, recorded by Hunter and Patton, was the result of a push toward the interpersonal nature of care and the employment of empathy, to ensure that care receivers can feel heard and understood, experiencing the healing that is possible in attuned relationships. These central values of the therapeutic paradigm continue into chaplaincy practice today and are central to the competencies of the profession.[[19]](#endnote-19)

 However, while not eschewing the centrality of empathy, the field expanded its understanding of the scope of caregiving starting in the 1980s and 90s as it became more influenced by movements in feminism and critical race theory. Pastoral theologian Bonnie Miller-McLemore’s article, “The Living Human Web,” which itself drew on the earlier work of scholars Archie Smith and Catherine Keller among others, was a key early work tracing this shift. Miller-McLemore expanded Boisen’s early image of the “living human document” to the image of the web in order to illuminate the growing attention to context and power dynamics within caregiving relationships.[[20]](#endnote-20) In another article, one of our authors, Richard Coble, outlines Miller-McLemore’s contribution in this way:

Miller-McLemore’s innovation then is in employing the web of selfhood to critique and modify the practices of care that Boisen’s image inaugurated. In proposing the living human web, she draws together past scholarship critiquing the individualism of Boisen’s generation while also pushing towards a more overt political agenda for care: “In the past decade, several feminist pastoral theologians have modified the individualistic leaning of Anton Boisen’s metaphor by turning to an alternative, related image of the living web...It simply means that the individual is understood in inextricable relationship to the broader context.” By challenging Boisen’s sense of individuality and objectivity, Miller-McLemore critiques the ideal of decontextualized empathy that is assumed by the image of the living human document, lest care unknowingly omit and reinforce wider structural inequalities and oppressive forces.[[21]](#endnote-21)

Throughout the last three to four decades, caregivers coming from social locations beyond that of white, heterosexual men, who made up the vast majority of the scholarship of the therapeutic paradigm, have likewise stressed the need for education about the particular experiences, needs, and outcomes of care receivers based on their social location in order for caregivers to provide competent, socially just care. One of the central images from Miller-McLemore’s early article is that of a male caregiver offering “too much indiscriminate empathy” to a female survivor of sexual assault. Miller-McLemore demonstrates that if such a caregiver downplays the power differential and differing experiences rooted in gender, then such caregiving might actually only “foster further damage and violence” as he further disempowers the assault survivor by refusing to hear or acknowledge her particular experiences.[[22]](#endnote-22)

 The current communal contextual paradigm thus teaches us that competency in spiritual caregiving today includes ongoing education about the unique experiences of care receivers, especially those coming from differing social locations than one’s own. In addition to reading the ever-expanding scholarship about the particularities of care for varying social groups, much of this knowledge can also be gained by a close, listening ear. However, in reverse of the therapeutic paradigm’s practice to prioritize commonalities over differences, chaplains must, in fact, listen for differences. As intercultural pastoral theologian Emmanuel Lartey puts it, caregivers must be attuned to the way, “Every human person is in certain respects 1. Like all others 2. Like some others 3. Like no other.”[[23]](#endnote-23) This means that while there are basic similarities that connect us all and allow for the possibility of empathy, caregivers must also pay close attention to social group and individual differences. Beyond indiscriminate empathy that assumes only similarity, this attention to context calls for a deeper listening, gaining trust by seeking out the unique experiences of our care receivers.

 Thus, it would be a mistake to characterize the shift to the communal contextual paradigm as a way of forgetting the original concerns of the therapeutic. Of course, the central work of the chaplain is precisely in the caregiving relationship that is still marked by the use of empathy and active listening techniques to ensure the care receiver feels heard and that their experience is appreciated. As pastoral theologian Edward Wimberly names in his introduction to *African American Pastoral Care*, “Story-listening involves empathically hearing the story of the person involved in life struggles.”[[24]](#endnote-24) Given the growing awareness of systemic power dynamics within spiritual caregiving, in order truly to understand such struggles and thus have access to the empathy Wimberly names, spiritual caregivers must extend interpersonal capacities for empathy and psychological self-reflection to include social empathy and self-reflexivity. These interpersonal capacities integrate knowledge of social location and contextual power disparities into whether and how spiritual trust is possible, given the ways all caregiving relationships are entangled in systems of social injustice.

The necessity of such competency is illuminated by the case study with Angie. Womanist practical theologian Evelyn Parker describes the unique needs and contributions of black women in the fields of spiritual care:

How must we care for the body and soul of a black woman? How is she God’s unique gift to herself, her community, and the global society? What is the nature of care and counseling that gives her life in abundance? What are her experiences and how are her stories fundamental to life-giving pastoral care practices? These are questions womanist pastoral theologians seek to answer as scholars in ministry with black women.[[25]](#endnote-25)

Spiritual caregivers of all social locations must then learn about such particularities of social location and care needs through scholarship coming from differing communities, employing these lessons as a means of connection with our care seekers, while also listening for the unique ways these experiences are lived out by care seekers such as Angie. In this way, the more recent communal contextual paradigm is an expansion and deepening of the original emphasis on interpersonal relations by the field’s founders such as Boisen.

**Return to Angie**

 Returning to the case study with Angie, the communal contextual paradigm thus brings our attention to the particular spiritual experiences of African American women. Womanist pastoral theological literature offers a repeated critique of the silencing of Black women’s voices both as care receivers and also in basic understandings of the role and outcome of caregiving. In one of the first book length works of Womanist pastoral theology, Carroll Watkins Ali writes that, “Theological reflection for the African American context… acknowledges that the people indigenous to the context are the subjects of their own stories rather than the objects of projections and/or perspectives formed by other worldviews.”[[26]](#endnote-26) In Angie’s case, this means that the value of her spiritual experience should be determined from her own standpoint, rather than dismissed from another’s. Indeed, in a more recent article, CPE educator and Womanist pastoral theologian Teresa Snorton writes about the constant dismissal of black women’s experience in chaplaincy care and training, explaining, “I am convinced that black women and their liberation are dependent upon the freedom to give voice to the pain of their individual and collective lives.”[[27]](#endnote-27) This point is echoed by another Womanist CPE educator Jacqueline Kelley, “From a womanist theological perspective, women must learn to value their personal story enough to use it as a tool to measure and evaluate their personal experience.”[[28]](#endnote-28) These Womanist authors point to the positive contribution of Black women’s spiritual experience in their own healing and wholeness.

In light of this literature, contextualizing Angie’s experience means seeing it in both negative and positive valence. First, the chaplain must put the dismissal of the experience within much broader oppressive trends in which Black women’s experience in general is denied and unheard within healthcare. However, the chaplain must also see the positive, which is that within the experience itself, Angie is expressing her spiritual movement towards wholeness, not from an outside, putatively objective measure of health, but rather from a subjective experience of the divine, holding and dancing with her in her final days. The chaplain competent in socially just care must also set Angie’s comment in a Womanist spiritual frame that sees the positive individual experiences of Black women as expressions of their movement toward healing in an otherwise oppressive environment. Knowing this, the chaplain can not only inquire into the reasons behind the care team’s dismissal but can also help them see purpose and the positive work of Angie’s experience in a fuller understanding of health and wholeness.

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**Case study II: Empowerment in the conflict between religious needs at the end-of-life and COVID-19 safety precautions**

 Having examined Angie’s case study from a contextual and historical point of view, we turn now to a longer case study in order to examine the complexity of socially just care in the midst of the opportunities and limitations of the hospital system. The following study outlines how systemic power dynamics, boundaries, and safety precautions within the hospital system can be in tension with the religious needs of a patient and family, and how the chaplain can employ power in ways that expand the empathy and possibilities of the care seekers, care team, and the very system itself.

During COVID-19, when visitation in hospitals was suspended, many chaplains received frantic phone calls from family members asking for help (see the Introduction and Chapters 1, 2, 5, and the Conclusion for further discussion of spiritual care during COVID-19). Many Jewish families sought out the rabbis in the various hospitals. One type of request was particularly fraught, as rabbis needed to negotiate complex dynamics between families and staff. The following composite case study illustrates power struggles when organizational policies make it challenging for members of minority religious groups to practice their religion.

A Jewish son contacted the chaplain with this urgent request: “Help! My mother is dying, and the hospital said we cannot come for an end-of-life visit. But we know that end of life visits are allowed by the Department of Health. We have a legal right! The doctor called this morning and told me she is dying. I must be able to come and say *vidui* (the final confession) for my mother.[[29]](#endnote-29) Can you please help!”

The hospital-based rabbi, like all chaplains, lives between the world of the hospital and the world of communal religious practice. The family member who calls, in this case, a son, trusts that the rabbi is an insider in the hospital and also has shared faith-based values that will propel the rabbi to advocate on the patient’s and/or family’s behalf. Despite never having met in person, family members hope and expect that the rabbi will do everything possible to enable practices of faith—in this instance, an end-of-life visit. The family may be prevented from entering the hospital, but the reality that the rabbi has the power of institutional position and proximity may allay their fears, and may help families feel that they will be heard and understood both in the caregiving relationship and in the wider institution. Being heard and understood builds spiritual trust, as this and previous chapters illustrate.

While people from many backgrounds feel a deep need to be heard and understood, people from minority populations may have a particularly acute need, especially if their practices and approaches to care differ from the institutional norm. Research has shown that minority populations are significantly less likely to engage in advance care planning and consent to a “Do Not Resuscitate” (DNR) request, based on issues that include “distrust of the health care system, health care disparities, cultural perspectives on death and suffering, and family dynamics such as parent-child relationships.”[[30]](#endnote-30) In this case study the son is a Hasidic Jew, someone who lives in an insular religious world that intentionally keeps its distance from mainstream American society. But in a time of great physical vulnerability, he has brought his mother to the hospital to save her life, in keeping with his religious teachings and practices. Yet, he searches for a way to influence the hospital in order to practice faith traditions and follow commandments that accord with his and his mother’s deepest values. The rabbi is a bridge. It is likely that the rabbi is not a Hasid from the son’s community, so this initial encounter is already a negotiation of difference. While Jewish communities can remain siloed in much of ordinary life, the hospital is one place where rabbis who would not be considered authoritative in a patient’s communal context are suddenly key allies.

In this case study, the rabbi is a woman, whose rabbinic status is not recognized in most of the Orthodox Jewish world, and certainly not in the Hasidic world. In order to navigate the complex intersections of patriarchy and religious minority status, the rabbi needs to draw upon her capacities for spiritual empathy and self-reflexivity (described in chapter 3), which will help her identify and reflect upon any ambivalence she may feel about holding insider-outsider status in relation to the care receiver so that she can lean into her power most appropriately. Without such self-reflexivity, she could unintentionally neglect this patient and her family, or wield her power in a less-than-conscious effort to assert her religious authority. The rabbi hears the son in his distress, responds with empathy and agrees to help in whatever ways are possible, aware of the strict restrictions on visiting. The rabbi holds the identity of the patient as she’s been described by her son: a nurturing mother of nine, a *tzadekes* (righteous woman) who is quick to perform *mitzvos* (commandments), has always welcomed strangers to her Shabbos table, an *Eshes Chayil* (a woman of valor). The rabbi goes to talk to the nursing administrator, who is the gatekeeper on the patient unit, the one who decides whether a visitor is allowed. As the rabbi opens the conversation with the nursing administrator, the rabbi will once again be aware of dynamics of difference. Is the nursing administrator Jewish? Secular? Religious and of a different faith? What kind of experiences might this nursing administrator have had with Orthodox Jews, especially in end-of-life care? As ethicists Gabbay and Fins have explored, Orthodox Jews have a reputation for religious struggles in hospitals at the end of life.[[31]](#endnote-31)

In talking to the nursing administrator, the rabbi discovers that the nursing administrator has several objections to allowing the son to pay an imminent death visit. One of them is that if this son comes then others will know about it and will also advocate to be able to come, which will be disruptive on the unit. The nursing administrator wants to be fair, to keep order, to treat everyone the same. The nursing administrator may well feel a profound obligation to minimize harm in a devastating pandemic by keeping out visitors who can spread the virus and are themselves vulnerable to contracting a life-threatening disease. But what about the obligation to accommodate an imminent death visit, in accordance with the New York State Department of Health “Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation”? That document states: “To prevent the introduction of COVID-19 into hospitals: Effective immediately, suspend all visitation except when medically necessary (i.e., visitor is essential to the care of the patient) or for family members or legal representatives of patients in imminent end-of-life situations.”[[32]](#endnote-32) Here the nursing administrator could argue that the patient is not in a category of imminent end-of-life, because she has the status of a full code, which means that she will receive all possible medical interventions to revive her if her heart stops. And would the patient ever qualify for an imminent end-of-life visit when her medical team is ethically required to revive her? The nursing administrator could say no; there is no such thing as imminent death when patients have not completed advanced directives that include ‘do not resuscitate’ instructions when death is imminent. But this Hasidic woman will receive all possible medical interventions when her death is imminent because of her religious conviction that life is precious and cannot be given up on, even if it’s the tiniest drop of life that remains at the end. And so, the culture of the hospital and the belief system of this woman are in an irreconcilable conflict. What is a rabbi to do?

The rabbi, trained in translation and rabbinic logic, can draw on multiple cultures to arrive at a compromise.[[33]](#endnote-33) She asks the nursing administrator how long the patient is expected to live, even with the team’s resuscitation efforts. The nursing administrator assesses 24 hours, perhaps 48. The updated Health Advisories specify that “the Department defines imminent end-of-life situations as a patient who is actively dying, where death is anticipated within less than 24 hours.”[[34]](#endnote-34) Using rabbinic logic, the rabbi finds some wiggle room for satisfying both the family’s and the hospital staff’s needs. She postulates that 24 to 48 hours are not so different from 24 hours. What if the son has his imminent death visit now, with the understanding that the family will not get another visit later, should the mother live beyond 24 hours? It is crucial for the family that this visit happens while the patient is alive, so that she can have the proper prayers to escort her to her death. If they are not allowed to come until the patient has died it will be too late. In this composite case study, the nurse is willing to allow one family member, the son, to stay for 15 minutes, outside the room. Both the nurse and rabbi need to anticipate that the son may refuse to leave. They agree that the unit will call security if that happens. The son comes for an imminent end-of-life visit, escorted by the rabbi. He prays outside the room. He is profoundly grateful that he can accompany his mother with the proper prayers at this moment that he prays will not be end-of-life. And he leaves peacefully at the end of his 15 minutes.

In this case study, the staff members are upset when they witness this family visit. They are aware that this son is part of a community where COVID-19 has hit the hardest. Perhaps they are further exposed to COVID-19 risk by his presence. To them, this exposure is unnecessary. They are already upset that the patient has a full code status, because this means that she will need to have aerosolizing procedures, which are the ones that put the staff most at risk for becoming sick from COVID-19. Staff members have already become sick. Some have become hospitalized and put on ventilators. Some have even died. They question whether it is right to perform “futile” treatments on patients—treatments that will not prevent a patient from dying, even if those treatments might prolong the dying process for a little while—when they put staff at risk. How much risk is it okay to expose staff members to for the sake of care that fulfills religious obligations when someone is dying?[[35]](#endnote-35) Imagine the added complexities if a staff member is African American, and is living with heightened fears of vulnerability to COVID-19.[[36]](#endnote-36) Imagine if frontline healthcare workers live in extended family households with vulnerable family members. Here, the differences of race and ethnicity come into play in particularly painful ways. As a chaplain who works in the hospital, the rabbi cares for patients, families, and staff. While needing to advocate for the patient, the rabbi must also offer care to staff members who are wrestling with moral stress about core values in conflict. They want to provide the best possible healthcare they can, while not harming themselves or their family and community members. The rabbi needs to hear the anguish of staff members who are afraid for their lives and offer spiritual support to them.

The hospital’s ethics committee might be wrestling with the same questions about the limits of treatment at end-of-life. As a member of the ethics committee, the rabbi has a voice in helping to shape the conversation about futile treatment, maintaining safeguards for different religious beliefs, and the need to pursue treatment at the end of life. It is possible that the rabbi might hold that Jewish wisdom allows people at the end of life, “to peacefully and comfortably pass rather than employ disproportionate aggressive medical interventions with little or no prospects of meaningful benefit.”[[37]](#endnote-37) But as a rabbi for Jews of all backgrounds, within the context of the hospital, the chaplain needs to extend her religious imagination to the spiritual commitments to others who do not share her views. And while there are many voices for the staff, there are far fewer voices for the minority religious groups whose views and practices trouble the waters.

What if the patient does not die within 24 hours? Perhaps she lingers for another day or two, or even three. The family may now feel more at peace with her imminent death and regulations that they cannot visit again. They may also place their spiritual trust in the rabbi, who regularly returns to the patient and stands outside her room, praying. They are comforted when she lets them know that she has seen their mother, who is comfortable and being well cared for. The rabbi’s spiritual care may prompt conversations with this patient’s medical care team, who confer with her about how to involve the family in end-of-life interventions. The rabbi and the doctor initiate a call to the family, in which the doctor explains that the mother is in a full medical code, receiving the maximum amount of medication, which is still not preventing their mother from dying, so she does not have much time left. The doctor suggests that it might be in keeping with their beliefs to allow for the full medical code to be sufficient intervention, without the chest compressions that are a violent way to come to the end of life and will cause her considerable pain. Will the son agree that the doctor can make that determination when the time comes and not request that the team perform chest compressions if they will be futile at that point? In this instance, the son says yes, and the team breathes more easily. If the son were to say no because he believes he must say no, then the team would have to be resigned to initiate chest compressions.[[38]](#endnote-38) Either way, the patient dies. Questions about how her wishes have been honored, and her life has been held as sacred can give rise to moral distress when the team disagrees with family decisions in which spiritual and religious values do not align with team member’s beliefs about what makes a death ‘good’. On the other hand, when patients and their families are fully involved in facing together the ‘void of death’ they may be able to negotiate profoundly meaningful and comforting end of life care that honors the mystery of life and death.

As this case study illustrates, a chaplain must have knowledge of the pathways, gatekeepers, and boundaries of the hospital system, as well as wider systemic issues such as differing needs and outcomes of patients, family members, and care team professionals based on varying, intersectional social locations. But even beyond this base knowledge, the chaplain must first and foremost have a listening ear for the differing, often conflicting needs of the various human beings involved, in this case, a Hasidic family with certain boundaries on end-of-life healthcare designations and religious practices on the one hand, and on the other hand, a care team seeking the safest possible protocols in the midst of the COVID-19 pandemic.

These then are the competencies of socially just spiritual care: the ability to contextualize individual care situations within wider trends and dynamics that create differing institutional outcomes based on social location; the humility to watch for and learn from difference rather than assume similarity across difference; and finally, the willingness to employ one’s own institutional power to empower one’s colleagues, care seekers, and the system itself to be more empathic, more just, and more willing to learn from and grow with one another. This chapter serves as a basic introduction to these competencies, but, as the case studies of this chapter illustrate, socially just care requires ongoing practice and improvisation. The institutions in which chaplains operate can always be *more just and thus more caring.* It is within chaplains’ scope of practice that their care strives toward this ever-expanding goal.

**Reflection Questions**

1. What does the chapter’s opening sentence mean when it states that chaplains do not meet their care receivers in a vacuum without context or power dynamics?
2. What power does a chaplain hold? What is proper use of that power and how can it be abused?
3. What does it mean to contextualize isolated events in caregiving within wider trends and power dynamics? How might this contextualization aid your own caregiving?
4. How does the history of the progression from the therapeutic to the communal contextual paradigm of spiritual care impact your understanding of chaplaincy?
5. How do you see the core terms defined in the chapter (power, social location, patriarchy, systemic racism) at work the second case study presented in the chapter?

**Recommended Readings**

Bishop, Jeffrey. *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying.* Notre Dame: University of Notre Dame Press, 2011.

Coble, Richard. *The Chaplain’s Presence and Medical Power.* Lanham: Lexington Books, 2018.

Kujawa-Holbrook, Sheryl A. and Karen Brown Montagno, eds. *Injustice and the Care of Souls: Taking Oppression Seriously in Pastoral Care.* Minneapolis: Fortress Press, 2011.

Stevenson-Moessner, Jeanne and Teresa Snorton, *Women Out of Order: Risking Change and Creating Care in a Multicultural World.* Minneapolis: Fortress Press, 2010.

Sullivan, Winnifred Fallers. *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law.* Chicago: University of Chicago Press, 2014.

1. ACPE, “Objectives and Outcomes for Level I/Level II CPE,” 2020, https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/objectives-and-outcomes-for-level-i-level-ii-cpe [↑](#endnote-ref-1)
2. ACPE, “Objectives and Outcomes for Level I/Level II CPE” [↑](#endnote-ref-2)
3. See Association of Professional Chaplains, “Common Qualifications and Competencies,” https://www.professionalchaplains.org/content.asp?pl=198&sl=254&contentid=254 [↑](#endnote-ref-3)
4. Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*, Revised and Expanded Edition (Louisville: Westminster John Knox Press, 2015), 44-45. [↑](#endnote-ref-4)
5. “Kimberlé Crenshaw on Intersectionality, More than Two Decades Later,” Columbia Law Review, June 8, 2017. https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later [↑](#endnote-ref-5)
6. In fact, as queer theorists such as Judith Butler and Anne Fausto-Sterling have pointed out, the very binary of only two genders, man and woman, understood as being rooted in biological sex characteristics, is a patriarchal construct that obscures identities such as those who identify as transgender, gender-queer, and intersex, among others. For an overview of the social construction of the gender binary and its use by patriarchal systems, see Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990) and Anne Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York: Basic Books, 2000). [↑](#endnote-ref-6)
7. Nikki Graf, Anna Brown, and Eileen Patten, “The Narrowing, but Persistent, Gender Gap in Pay,” Pew Research Center, March 22, 2019. https://www.pewresearch.org/fact-tank/2019/03/22/gender-pay-gap-facts/ [↑](#endnote-ref-7)
8. Taken from a longer list by Judith Warner, Nora Ellmann, and Diana Boesch, “The Women’s Leadership Gap,” Center for American Progress, last modified November 20, 2018. https://www.americanprogress.org/issues/women/reports/2018/11/20/461273/womens-leadership-gap-2/. [↑](#endnote-ref-8)
9. See Pamela Braboy Jackson and David R. Williams, “The Intersection of Race, Gender, and SES: Health Paradoxes,” in *Gender, Race, Class and Health: Intersectional Approaches*, eds. Amy J. Schulz and Leith Mullings (San Francisco: Jossey-Bass, 2006), 136. [↑](#endnote-ref-9)
10. bell hooks, *Feminist Theory: From Margin to Center* (Cambridge: Beacon Press, 2000), 37. [↑](#endnote-ref-10)
11. Some critical race theorists such as Layla F. Saad and Tema Okun term widespread systemic racism “white supremacy” or “white supremacy culture” in order to denote the systemic and cultural advantage of white identifying people. In Saad’s words, “White supremacy is far from fringe. In white-centered societies and communities, it is the dominant paradigm that forms the foundation from which norms, rules, and laws are created…White supremacy is an ideology, a paradigm, an institutional system, and a worldview…I am talking about the historic and modern legislating, societal conditioning, and systemic institutionalizing of the construction of whiteness as inherently superior to people of other races.” Layla F. Saad, *Me and White Supremacy: Combat Racism, Change the World, and Become a Good Ancestor* (Naperville: Sourcebooks, 2020), 13. See also Tema Okun, “White Supremacy Culture,” Dismantling Racism. https://www.dismantlingracism.org/uploads/4/3/5/7/43579015/okun\_-\_white\_sup\_culture.pdf. However, we have chosen to employ the term “systemic racism” because it better describes the institutionalization of racist trends and bias as they are systematized in the institutions where chaplains work. [↑](#endnote-ref-11)
12. As Ibram X. Kendi traces exhaustively in his work *Stamped from the Beginning: The Definitive History of Racist Ideas in America* (New York: Nation Books, 2016), current iterations of systemic racism have historical roots in western colonialism and the slave trade. Kendi further points out that the structural oppression of western colonialism preceded racist understands and ideas. The latter serve as an ideological basis to substantiate the violence of colonialism. As pointed out above, this continues in the institutions in which chaplains operate today. Racist ideas serve as a rationale for systemic oppression and inequality. For a thorough overview of how religious leaders can bring a post/decolonial lens to their leadership in faith communities, see Kristina I. Lizardy-Hajbi, “Frameworks Toward Post/Decolonial Pastoral Leaderships,” *Journal of Religious Leadership* (2020): 98-218. [↑](#endnote-ref-12)
13. Linda Villarosa, Myths about Physical Racial Differences were used to Justify Slavery — and Are Still Believed by Doctors Today, *The New York Times Magazine,* August 14, 2019, https://nyti.ms/38RE95Y. [↑](#endnote-ref-13)
14. Donald A. Barr, *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health.* 2nd Edition. (Baltimore: Johns Hopkins University Press, 2014), 39-44. [↑](#endnote-ref-14)
15. See Nancy J. Ramsay, “A Time of Ferment and Redefinition,” in *Pastoral Care and Counseling: Redefining the Paradigms*, ed. by Nancy J. Ramsay (Nashville: Abingdon Press, 2004). [↑](#endnote-ref-15)
16. Anton Boisen, *Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience* (New York: Harper, 1960), 187. [↑](#endnote-ref-16)
17. Rodney Hunter and James Patton, “The Therapeutic Tradition in Pastoral Care and Counseling,” in *Pastoral Care and Social Conflict: Essays in Honor of Charles V. Gerkin*, eds. Rodney Hunter and Pamela Couture (Nashville: Abingdon Press, 1999), 36-38. Note: these are direct quotes from Hunter and Patton. [↑](#endnote-ref-17)
18. See Richard Coble, *The Chaplain’s Presence and Medical Power: Rethinking Loss in the Hospital System* (Lanham: Lexington Books, 2018), 23-30. [↑](#endnote-ref-18)
19. Chaplaincy itself is often referred to as a ministry of presence, a definition that emphases the empathic and relational rather than functional work of the chaplain. Recently, scholar Winnifred Fallers Sullivan has noted that presence itself, however, by emphasizing relationship, is resistant to instrumentalist or systemic dehumanizing of care receivers: “Presence also works as a place of resistance to instrumentalist approaches to religion and spirituality. The ministry of presence refuses interpretation and explanation…Presence can refuse to be made part of a system – to be measured and quantified and offered as a means to an end. It is the end.” *Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014), 177. [↑](#endnote-ref-19)
20. Bonnie J. Miller-McLemore “The Human Web: Reflections on the State of Pastoral Theology,” *The Christian Century* 110:11 (1993). Expanded in “The Living Human Web: Pastoral Theology at the Turn of the Century,” in *Through the Eyes of Women: Insights for Pastoral Care*, ed. J. Stevenson Moessner (Minneapolis: Fortress Press, 1996). [↑](#endnote-ref-20)
21. Richard Coble, “From Web to Cyborg: Tracing Power in Care.” *Journal of Pastoral Theology* 26:1 (2016), 6. Coble quotes Bonnie Miller-McLemore, “Feminist Theory in Pastoral Theology.” In Feminist and Womanist Pastoral Theology, ed. Bonnie J. Miller-McLemore and Brita L. Gill-Austern (Nashville, TN: Abingdon Press, 1999): 90. [↑](#endnote-ref-21)
22. Miller-McLemore, “The Living Human Web” 20. [↑](#endnote-ref-22)
23. Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling.* 2nd Edition (Philadelphia: Jessica Kingsley Press, 2003), 34). [↑](#endnote-ref-23)
24. Edward P. Wimberly, *African American Pastoral Care: Revised Edition*. Nashville: Abingdon Press, 2008. [↑](#endnote-ref-24)
25. Evelyn L. Parker, “Womanist Theory” in *The Wiley-Blackwell Companion to Practical Theology*, ed. Bonnie J. Miller-McLemore (Malden: Blackwell Publishing, 2012), 206.  [↑](#endnote-ref-25)
26. Carroll A. Watkins Ali, *Survival and Liberation: Pastoral Theology in African American Context* (St. Louis: Chalice Press, 1999), 123. [↑](#endnote-ref-26)
27. Teresa E. Snorton, “What About All Those Angry Black Women?” in *Women Out of Order: Risking Change and Creating Care in a Multicultural World*, eds. Jeanne Stevenson-Moessner and Teresa Snorton (Minneapolis: Fortress Press, 2010), 217. [↑](#endnote-ref-27)
28. Jacqueline Kelley, “Womanist Pastoral Care Using Narrative Therapy,” in *Women Out of Order: Risking Change and Creating Care in a Multicultural World*, eds. Jeanne Stevenson-Moessner and Teresa Snorton (Minneapolis: Fortress Press, 2010), 141. [↑](#endnote-ref-28)
29. For an introduction and outline of this form of prayer, see Anita Diamant, “Viddui: The Final Confession-Traditional and Liberal Possibilities for this Little Known Practice,” My Jewish Learning. https://www.myjewishlearning.com/article/viddui-the-deathbed-confession/ [↑](#endnote-ref-29)
30. H. Russell Searight and Jennifer Gafford, “Cultural Diversity at the End of Life: Issues and Guidelines for Family Physicians,” *American Family Physician* 71:3 (2005), 519. [↑](#endnote-ref-30)
31. Ezra Gabbay and Joseph Fins, “Go in Peace: Brain Death, Reasonable Accommodation and Jewish Mourning Rituals,” *Journal of Religion and Health* (2019) 58:5, 1675. While this article explores brain death specifically, the contentiousness over brain death also extends to full codes for patients who decline to sign DNRs. Full codes include medication such as pressors, chest compressions, electrical shock, and mechanical ventilation for patients when their hearts stop. [↑](#endnote-ref-31)
32. Andrew M. Cuomo, Howard A. Zucker, and Sally Dreslin, “Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation,” New York State Department of Health, March 18, 2020. https://coronavirus.health.ny.gov/system/files/documents/2020/03/covid19-hospital-visitation-guidance-3.18.20.pdf. These guidelines were updated March 27, 2020, April 10, 2020 and May 20, 2020 and following. [↑](#endnote-ref-32)
33. Andrew Schumann, “Logical Cornerstones of Judaic Argumentation Theory,” *Argumentation* 27:1 (2013). [↑](#endnote-ref-33)
34. Andrew M. Cuomo, Howard A. Zucker, and Sally Dreslin, “Health Advisory: COVID-19 Updated Guidance for Hospital Operators Regarding Visitation,” New York State Department of Health, April 10, 2020. https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh\_covid19\_ hospitalvisitation\_041020-002.pdf. [↑](#endnote-ref-34)
35. See Ersilia M. DeFilippis, Lauren S. Ranard, and David D. Berg, “Cardiopulmonary Resuscitation During the COVID-19 Pandemic: A View from Trainees on the Front Line,” *Circulation* 141:23 (2020) and Lina Ya’Qoub, “CardioPulmonary Resuscitation (CPR) in the Time of COVID-19,” American Heart Association, July 17, 2020. https://earlycareervoice.professional.heart.org/cardiopulmonary-resuscitation-cpr-in-the-time-of-covid-19/. [↑](#endnote-ref-35)
36. See Ravina Kullar, Jasmine R. Marcelin, Talia H. Swartz, Damani A. Piggott, Raul Macias Gil, Trini A. Mathew, and Tina Tan, “Racial Disparity of Coronavirus Disease 2019 in African American Communities,” *The Journal of Infectious Diseases* 222:6 (2020). [↑](#endnote-ref-36)
37. Gabbay and Fins, “Go in Peace,” 1682. [↑](#endnote-ref-37)
38. Katherine Fischkoff, Gerald Neuberg, Joyeeta Dastidar, Erin P. Williams, Kenneth Prager, and Lydia Dugdale, “Clinical Ethics Consultations during the COVID-19 Pandemic Surge at a New York City Medical Center,” *The Journal of Clinical Ethics* 31:3 (Fall 2020): 212-8.

 [↑](#endnote-ref-38)