

Caring Connections

An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling



Ethical Pathways, Moral Dilemmas

The Purpose of Caring Connections

Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling is written primarily by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable, solidly grounded in the practice of ministry, and theologically probing. *Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries and concerned congregational pastors and laity.

Caring Connections also provides news and information about activities, events and opportunities of interest to diverse constituencies in specialized ministries.

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Call for Articles

Caring Connections seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight within the wider Lutheran community. We want to invite any Lutherans interested in writing an article or any readers responding to one to please contact one of the co-editors, Diane Greve at dkgreve@gmail.com or Bruce Hartung at hartungb@csl.edu. Please consider writing an article for us. We sincerely want to hear from you!

And, as always, if you haven't already done so, we hope you will subscribe online to *Caring Connections*. Remember, a subscription is free! By subscribing, you are assured that you will receive prompt notification when each issue of the journal appears on the *Caring Connections* website. This also helps the editors and the editorial board to get a sense of how much interest is being generated by each issue. We are delighted that our numbers are increasing. Please visit lutheranservices.org/caring-connections-archive and click on "Subscribe to our newsletter" to receive automatic notification of new issues.

In 2022 we plan to focus on:

2022.4 Ethical Challenges and Joys in Our Work
More details on page 3!

Editorial

Diane Greve

MANY CHAPLAINS HAVE AT LEAST THREE OR FOUR “BOSSES” directing their ministry. There is the endorsing denomination, the certifying organization, the institution’s expectations, and then there is our own moral compass. At times, these entities and their ethical principles and practices may be in conflict with one another.

The articles in this issue will lift up personal stories and some of the ethical principles that govern the chaplain’s role and their own moral deliberations. Most chaplains are practioners. Many have had a class in ethics as part of their theological education. But the day-to-day issues may create some conflict. In the medical world, the four primary principles are *autonomy, beneficence, non-maleficence and justice*. These will vary with the context in which we serve. But when one person’s autonomy causes harm to another or limits their autonomy, we are left to sort out a third way.

Some of our readers serve on ethics boards or committees; some may even chair them. But all have had to make decision on how to proceed on some matters. What are our core values? Are they in conflict with that of our denomination or the institution in which we serve? Where is our loyalty and how do we navigate this terrain? Can we offer ourselves and others grace, God’s grace, in the process?

I am grateful to those colleagues among us who have ventured onto this turf to offer their thoughts and some of their personal struggles. I hope these accounts will stimulate your own thoughts and help you to clarify your own values. Do we “go along to get along?” Do we compromise our principles to keep our roster status or our livelihood? Do we find ways to justify our decisions? And how does our faith inform us?

Our writers, and the topics they have explored, create a mosaic of insights on ethical matters. The first three articles are more theoretical while the other five arise out of the ministry and personal experiences of the writers. Hopefully, their reflections will be thought provoking and help inform your own ministry.

What are our core values? Are they in conflict with that of our denomination or the institution in which we serve?

- **Dave McCurdy** offers the reader a practical reflection on the use of a chaplain in end-of-life care in the hospital setting. This piece and the following one by Peter Baulk are particularly useful together.
- **Peter Bauck** provides a portion of his doctoral thesis on empathy in ethics consultations and the role of the professional chaplain in that context.
- **Chris Conklin** tells the history of military chaplaincy and the ethical concerns that have emerged over the centuries.

- **Anna Rudberg Speiser** reflects on some of the challenges of serving as a chaplain in the rural setting where she grew up.
- **Don Knudson** and **Bruce Pederson** consider, from a personal perspective, the complexity of navigating the dignity and life meaning for those who are having trouble swallowing safely.
- **Mark Whitsett** and **John Hollack** have co-authored an article from different contexts in which their moral compasses conflicted with the policies and expectations of their workplaces.
- **Evan Evans** speaks of the stigma of mental health disorders and the impact of her misdiagnosis from a personal point of view.
- **Cory Wielert** wrestles with some decisions made in long term care settings that conflict with his faith, values and beliefs.

Also, for those readers who affiliate with the ELCA, you may want to read about a regular opportunity to interact with Christopher Otten, the ELCA endorser.

May your reading and reflection on these articles enhance your ministries.



Next Issue:

Ethical Challenges and Joys in Our Work

Our next issue will continue the discussion of ethical challenges, joys, issues and opportunities. The focus of this issue is on the clinical experience of those sometimes very personal ethical conundrums. All of us in clinical practice are likely to encounter these. *Caring Connections* invites you to write about it. Such sharing is part of the very DNA of the reason for *Caring Connections*' existence. Contact co-editor Bruce Hartung, hartungb@csl.edu.

Some Reflections on Chaplains and End-of-Life Decision-Making

David McCurdy

Introduction

What role can chaplains play in end-of-life decision making with or for hospitalized patients? A recent study finds that role can be considerable; nearly 40% of chaplains surveyed report playing an integral part in this decision-making process.¹ However, two other surveys report that ICU clinicians value hospital chaplains' role and input, yet seldom call on chaplains and don't often read their notes in the chart.² The seeming disparity between these studies may suggest that chaplains' experience and level of input vary considerably across hospitals and locations, even if chaplains are commonly called on when a patient is near death or has died.

The composite case below depicts a kind of end-of-life situation that critical care staff members and chaplains may readily recognize. The aim is to provide a springboard for fresh reflection on what chaplains can offer in such ethically charged situations. I hope that chaplains seeking a clearer sense of their role in supporting family members' decision-making will find these reflections helpful. Perhaps even some "old hands," who already work in strong interdisciplinary teams or are ethics committee members, will find a fresh perspective or two that augments their existing experience and understanding.

The Case

Mrs. G., 66, had been receiving long-term treatment for leukemia and appeared to be holding her own. But then she was hospitalized with abdominal pain, shortness of breath, and weight loss. She was found to have an aggressive, previously undiagnosed metastatic cancer. She had now been hospitalized for over two weeks and had become decisionally incapacitated. She continued to be treated aggressively.

Mrs. G. and her family were Black and were being cared for by a team whose members were White. Mrs. G. had six living children. The youngest, a son who lived with her, was the legally designated proxy decision maker or healthcare agent. The proxy frankly disbelieved the new cancer diagnosis ("How could this have come on so fast?"). He believed that improved nutrition ("She must be fed better") would lead to recovery. The other children largely agreed that aggressive treatment should be continued.

I hope that chaplains seeking a clearer sense of their role in supporting family members' decision-making will find these reflections helpful.

1 M. Jeanne Wirpsa et al., "Interprofessional Models for Shared Decision Making: The Role of the Health Care Chaplain," *Journal of Healthcare Chaplaincy* 25 (2019): 20–44.

2 "Clinicians Believe Chaplains Helpful--But Call on Them Infrequently," *Medical Ethics Advisor* 35, no. 3 (March 2019): 20.

The son resisted physician and care team efforts to explain more clearly the basis of the diagnosis and prognosis, and to advocate for palliative/hospice care, as “not trying hard enough to save our mother.” He was increasingly experienced as “belligerent.” This perception affected the willingness of some staff members, including the attending oncologist, to engage him about treatment alternatives. He did not consent to pain medications for Mrs. G. because he felt they would interfere with his mother’s communication with him.

Ethics committee assistance was finally sought by nursing staff who believed that treatment was inflicting pain and discomfort on the patient. Some expressed moral distress at “once again” having to provide a patient with care that was harmful, with no apparent recourse. It was also suggested that a Black staff chaplain visit the family to “address possible religious beliefs about healing.” Unfortunately these interventions did not affect the impasse, which was “resolved” only when the patient died, without pain medications, five weeks after admission.

In the composite case, the impact of racial difference is addressed only indirectly, as often happens in predominantly White institutions and in health care generally.

Initial Comment

Attentive readers will notice more ethical and clinical concerns than can be addressed adequately, if at all, in a short article. One such concern merits at least some discussion here. In the composite case, the impact of racial difference is addressed only indirectly, as often happens in predominantly White institutions and in health care generally. The late involvement of a Black chaplain when the impasse is entrenched is not a recipe for success at any level; from the proxy’s and family’s perspective, it may not signal genuine care. The chaplain may be identified primarily as a representative of an organization that has not treated their mother (or them?) equitably, however sensitively the chaplain may offer care.

A recent survey indicates that 55% of African Americans mistrust the healthcare system, and 70% feel it treats them unfairly.³ The pain and power of lived experience underlying these numbers should not be underestimated. It is possible that Mrs. G’s family had encounters and communications with clinicians early in her hospital stay that confirmed similar apprehensions.⁴

Caught Downstream: Navigating the Impasse

A recent article by Shahla Siddiqui highlights the role of unrecognized or unacknowledged “upstream” shortfalls in care and communication that lead to more

³ Shahla Siddiqui, “The Ethics of Distrust: The Balancing of Perspectives Is Crucial in Surrogate Decision Making and Mediation,” *Journal of Clinical Ethics* 33, no. 3 (Fall 2022): 247.

⁴ Cf. Siddiqui, p. 246. See also Keisha Shantal Ray, “It’s Time for a Black Bioethics,” *American Journal of Bioethics* 21, no. 2 (2021): 38–40, for a basic overview and helpful references.

serious “downstream” ethical problems, including distrust and intractable conflict.⁵ Typically, the healthcare professionals’ “side” of the conflict seems—from the inside—to have the weight of medical considerations and ethical principles behind it. The patient has no prospect of recovery with quality of life; is evidently suffering, with the treatment itself adding to the suffering; and may even have an advance directive that directs cessation of life-sustaining treatment in such circumstances. Standard ethical considerations—respect for patient autonomy, nonmaleficence, and beneficence—all support replacement of life-prolonging measures with optimal palliative care, and perhaps hospice care.

However, ethical analysis that ends with these “obvious” conclusions may be incomplete and inadequate. This is where the chaplain may have a contribution to make. Bioethicist Autumn Fiester contends that in such cases, a besetting sin of ethics consultation is a “failure to capture all of the ethical considerations or moral reasons that undergird an ethical conflict,” thereby placing “the least powerful stakeholders”—patients and families—at moral risk.⁶

These non-professionals are more likely to have their “moral reasons” unarticulated, unrecognized, and thereby discounted. This can lead to a perception that recalcitrant family surrogates are acting out of ignorance or, worse, self-interest, particularly if they also depend on the critically ill patient for housing or financial support. As Fiester notes, this perception is even a “trope” that one sometimes hears among staff in such cases.⁷ Such negative characterizations of a family member make real respect for the person almost impossible, and lessen the likelihood that an impasse can be satisfactorily resolved.

Such disadvantaging of “least powerful stakeholders” is where the chaplain can make a significant contribution. Chaplains are trained to hear—really hear—patients’ stories and to “unearth what really matters” to patients and families.⁸ In the process they help to surface the underlying values that constitute unspoken *moral* reasons people have for their medical choices. In turn, chaplains may help healthcare teams understand family desires and concerns, and perhaps see their possible moral as well as existential legitimacy.

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In a classic 1986 article, Don Browning proposed that the chaplain could play several key roles in the interaction between patients/families and healthcare teams. Here two of these roles seem especially germane. The chaplain, said Browning, is a “value-committed cultural anthropologist” and a “negotiator of worldviews.” For

5 Siddiqui, p. 246.

6 Autumn N. Fiester, “Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable,” *Bioethics* 29, no. 5 (2015): 309, cited in Siddiqui, p. 247.

7 Fiester, p. 315.

8 Wirpsa, p. 33. For an early, extended treatment of the significance of patients’ stories, see David B. McCurdy, “Respecting Autonomy by Respecting Persons: Taking the Patient’s Story Seriously,” *Humane Medicine* 6, no. 2 (Spring 1990): 107–112.

Browning the values and worldviews of special interest were those formed by the religious traditions in which the chaplain had expertise.⁹ These religious values continue to be important, and their relevance to patient and family decision making is too often unappreciated or misunderstood. Chaplains can certainly help by providing accurate information (and correcting misinformation) about traditions and their teachings or practices, and also by giving religiously grounded values a legitimating voice.

In the ethical conflicts described by Fiester, and illustrated in the case above, I think the chaplain has another opportunity as a “cultural anthropologist.” Chaplains are less likely to be enmeshed in what I call the culture of health care, or modern biomedicine, than other staff members. Chaplains’ dual grounding in religious traditions and in whole-person conversations with patients and families can give them an independent perspective amidst polarized ethical conflict. This dual grounding, together with inside knowledge of the culture of health care, can also help them see differences in worldview that underlie the cultural differences.

Chaplains’ dual grounding in religious traditions and in whole-person conversations with patients and families can give them an independent perspective amidst polarized ethical conflict.

In the case before us, critical care staff members are steeped daily in the culture and assumptions of health care and critical care. They are caring, empathic people drawn to their profession by a desire to help. They care about their patients and want what is best for them. At the same time, each patient is both a distinct person and one case in a series of cases. In their roles, for staff there is always an “on to the next” dynamic. The death of an individual patient is ultimately, and over time, the death of one case among others.

For families, the “death of the patient” is the unique death of *my* loved one, *my* father or sister, husband or mother. It is “personal” in a way it cannot be for the healthcare professional, the death a loss that will be *my* loss. The treatment decisions I or we as a family make are about an irreplaceable person in my life/our lives, and it is we who will live with the memory and the consequences of our decisions. Family members hope to avoid, or at least minimize, their own “moral distress” over the loss they are about to suffer.

Further, physicians and other staff members see care of patients through the lens of an established set of clinical values and goals, some formally stated and others implicit. In recent years, these values have evolved from a singular stress on preserving life at all costs to include awareness that life-extending treatments often impose harm without real benefit, and may be forgone. To use Browning’s term, the clinical “worldview” has shifted. Today the healthcare staff’s explicit or implicit driving concept in cases [*sic*] like Mrs. G’s is likely to be *quality of life*, not *life* at all costs.

9 Don S. Browning, “Hospital Chaplaincy as Public Ministry,” *Second Opinion* 1 (1986): 70–72.

In the worldview of families like Mrs. G's, it is often *life* that still matters most. Again, *my* loved one/father/mother is irreplaceable in a way that clinical staff members' "cases" simply cannot be. In the moment, families may lack the conceptual tools or language to articulate their worldview, or to state "ethical principles" and values supporting their stance on medical treatment. But their experience, emotion, and existential distress can tell their story and convey meaning to those with ears to hear.

Resourceful chaplains have the skill to hear, and then to find or create avenues to share the significance of what they hear: in the medical record, in strategic conversations with staff members, in team meetings or family conferences. Giving voice to family members' values and reasons may help to make a family's "irrational" or "uncaring" stance more intelligible and "balance" the moral scales, even in an impasse.¹⁰ This intervention does not mean the impasse or ethical conflict will dissipate, but it may contribute to greater openness and eventually to improved communication and understanding, perhaps even to a softening of entrenched positions.

A Brief Look Upstream

Upstream ethics intervention is always to be preferred. Ethically attuned chaplaincy begins upstream and can be part of "preventive ethics."¹¹ Chaplains can monitor patients' prognoses (and changes for the worse), patients' loss of decisional capacity, the appointment and identity of surrogate decision makers, any lack of clarity about goals of care and specific treatments, and apparent disagreements about the course of treatment. Ethical concerns can arise in any of the areas, or in more than one. When a concern seems to need attention, the chaplain can be a catalyst, or directly involved, in ethics follow-up.



David McCurdy, RBCC, is a retired healthcare ethicist and chaplain, and a retired ACPE supervisor. He was also a long-time adjunct faculty member in religious studies at Elmhurst College, Elmhurst, Illinois. McCurdy is an ordained minister in the United Church of Christ. He welcomes questions and comments about this article at dbm1946d@aol.com.

¹⁰ Siddiqui, p. 247.

¹¹ Lachlan Forrow, Robert M. Arnold, and Lisa S. Parker, "Preventive Ethics: Expanding the Horizons of Clinical Ethics," *Journal of Clinical Ethics* 4, no. 4 (Winter 1993): 287–294.

Interpersonal Skills and Clinical Ethics Consultation

Peter Bauck

Introduction

As clinical ethics consultation becomes professionalized, chaplains' relationship with the consultation process is shifting. Speaking from my knowledge and experience of clinical ethics in Minnesota, historically, chaplains have facilitated consults either on their own or as part of a team made up of ethics committee members. Currently, many of the major health systems have trained clinical ethicists on staff who provide ethics consultation, ethics education, and various types of organizational support to their respective institutions. The clinical ethicists have graduate school training in healthcare ethics and may have done a clinical ethics fellowship. There is also a healthcare ethics consultant certification process for clinical ethicists to become board certified (HEC-C) through the American Society of Bioethics and Humanities (<https://heccertification.org/about-hec-c>). Because of these shifts, chaplains are often on ethics committees and support the work of ethics in their institutions, but they may not be the ones involved in facilitating the ethics consultation process.

In light of these historical shifts, how can chaplains continue to support and engage with clinical ethics? A strength that chaplains bring to all patient and family encounters is the clinical skill of listening and supporting what I call the meaningful life: the values, beliefs, and practices that are meaningful for people, and are central for making decisions about their healthcare. The training and formation process for chaplains helps them to hear the story of the patient and family in such a way that centers the patient and family and de-centers the chaplain. This skill is at the heart of the BCCI competency PIC2: "Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice."

In the professionalization process for ethics, various organizations list similar skills and competencies related to interpersonal communication necessary for the consultation process. American Society for Bioethics and Humanities (ASBH) lists communication skills, identifying conflicting value frameworks through reflective and active listening, and emotional sensitivity in the consultation process in their *Core Competencies for Healthcare Ethics Consultation* (American Society for Bioethics and Humanities, 2011). Veterans' Health Administration's National Center for Ethics in Health Care published an ethics consultation guide (National Center for Ethics in Health Care, 2015) and lists

A strength that chaplains bring to all patient and family encounters is the clinical skill of listening and supporting what I call the meaningful life.

the following skills: communicate empathy, recognize and respond to suffering and strong emotions, and enable involved parties to be heard by other parties.

The interpersonal work of clinical ethics, like chaplaincy, will raise questions about the role of the ethicist's meaningful life and how it relates to the care they provide. Should their own meaningful life guide the conversation and frame the consult recommendations, and if not, in what way is it part of the ethics consult? As chaplains continue to be part of and support clinical ethics in their contexts, chaplains can provide interpersonal communication training and mentoring for those in ethics to help them provide care that centers the values, beliefs, and practices of the patient and family, and not those of the clinical ethicist.

Using religion as one example of the meaningful life, clinical ethicists have proposed different methodologies for the role of the ethicist's religion and values in the ethics of the consult process.

One example of this comes from three ethicists wrestling with the role of the ethicist's religion and values in the consultation process. Using religion as one example of the meaningful life, clinical ethicists have proposed different methodologies for the role of the ethicist's religion and values in the ethics of the consult process. The first proposal, from Janet Malek (2019), is that religion and values should play no role at all in the ethics consult process; the second, from Clint Parker (2019), proposes that in order to remain authentic in the consult process, the religious values and beliefs of the ethicist can be made explicit; the third, from Abram Brummett (2020), suggests that there are quasi-religious beliefs—acknowledging the moral worldviews are part of all of us—can be part of the consultation process. Looking at the differences in these proposals will help elucidate a way that chaplains can continue to engage and support the work of clinical ethics in their contexts.

Malek: Religious Absence

Janet Malek (2019) argues the religion of the ethicist has no place in the process of the ethics consultation—consultation methodology, expertise, consistency in recommendations, and interpersonal communication or connection:

I will defend the strong claim that a clinical ethics consultant's religious worldview has no place in developing ethical recommendations or communicating about them with patients, surrogates, and clinicians. Further, if used in other aspects of consultative work, the consultant should proceed with extreme caution and only under certain conditions. (pg. 92).

In general, if the clinical ethicist introduces their own religion, it would be imposing their beliefs on the process. When communicating with the family, these beliefs could be used to persuade the family to follow certain recommendations; in terms of expertise, ethicists are not trained in bioethics and religion, and even if they are religious themselves and share the same general religion with those under their

care, there is great variation in religious belief and practice; and if their religion is part of the consultation methodology, these beliefs would negatively influence the recommendations and process overall. Malek favors relying on bioethical consensus and institutional policy. She does not define the bioethical consensus, but it seems to be some combination of clinical standards of care and the four bioethical principles of autonomy, beneficence, non-maleficence, and justice.

For many chaplains and educators, Malek's argument correlates with the interpersonal and intrapersonal competencies of chaplaincy. Whether working with a patient-family on an ethics issue or in a standard patient visit, the focus of the care is the meaningful life of the patient and family, not the chaplain. However, Malek's approach can be too rigid and suggests that an ethicist can completely wall off their own meaningful life matrix. What is clear from the training and practice of spiritual care professionals is the matrix of the meaningful life is unconsciously and consciously present in moments of care. Chaplains can support ethicists by demonstrating that one does not need to suppress their meaningful life matrix, but to be aware of it and not let it influence the care the ethicist provides.

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Parker: Religious Presence

Clint Parker has the strongest stance of the three on the explicit role of religion beliefs in communication and recommendations throughout the consult process. Parker seems to think that any consult method that requires people keep their religious beliefs out of the process treats theism different than other ideologies. An ethicist who has religious beliefs should not be kept from expressing those in favor of the bioethical consensus. Because religious commitments are just one example of ethical commitments, there is no reason for the theistic ethicist to avoid making these beliefs explicit in a consult.

I think there is a time and a place for making bioethical arguments based in one's religious beliefs. The place for this is not at the bedside or the conference room performing an ethics consult with staff, patient, and families. There are conferences, publishing opportunities, and educational contexts for this purpose. Parker fails to recognize that the goal of an ethics consultation is not to give voice to the ethicist's view of the meaningful life. It is to offer recommendations about the range of ethical possibilities for a specific case and understand the meaningful life of the patient and family. For those in clinical ethics that struggle with the centering of themselves and their beliefs, chaplains can provide support and mentoring on how to provide care, focused on the view of the meaningful life of the patient and family.

Brummet: Religion as Sort of Present

Abram Brummet (2020) argues for a middle path between Parker and Malek. This is a view that neither walls off religious belief, nor makes it an explicit and direct component of communication and recommendations in the ethics consult. He refers to this as a quasi-religious approach:

“ a quasi-religious approach, rejects the idea that a clinical ethicist who makes recommendations about what is morally permissible, obligatory, or prohibited in medicine may do so by either invoking their deepest, religious beliefs, [per] Parker, or excluding religious belief entirely, [per]] Malek ... Focus on a quasi-religious approach moves away from distinguishing between religious and nonreligious and towards a more inclusive dialogue focused on the reasonability and not the religiosity [that comprises the bioethical consensus.]” (pg. 203, 208).

A quasi-religious approach, per Brummet, advocates for the bioethical consensus and holds that that such a consensus is not free of its own meta-ethical commitments and ideologies. These commitments are not synonymous with religious beliefs but are made up of meta-ethical frameworks. Malek’s reliance on the consensus is an effort to eschew religious and metaethical commitments; Parker’s insistence on invoking religious beliefs because we all have these background meta-ethical beliefs is not appropriate at the bedside. All ethical paradigms have their own lens and are not free of meta-ethical frameworks, just as the bioethical consensus on what is ethically permissible is not free from meta-ethical commitments.

I think Brummet’s position is a good one and one that resonates with chaplaincy’s understanding of the meaningful life in the provision of spiritual care. Patients or families do not always name their meaningful life as religious or spiritual and the supportive visit of the chaplain focuses on meaning making of a quasi-religious/spiritual nature.

The dialogue of the three authors focuses on religious belief and leaves out the concept of practices (Bauck 2022). Chaplains are trained to think in terms of theory and practice; clinical ethicists, especially those who have more academic training than bedside experience, can be supported to understand that the moral dilemmas families face are not moral struggles divorced from the lived and practiced meaningful life. A meaningful life is something that is embodied through behaviors and actions as well as beliefs. Such a connection is woven throughout clinical pastoral education and the board certification competencies for chaplains. Chaplains are very aware of this overlap as they prepare verbatims during clinical pastoral education, visit with patients and families, and write the essays for board certification. Again, chaplains can mentor

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and support ethicists as the latter sort through how their values, beliefs, and attitudes impact their clinical practice. Beliefs and practice are not separate entities; the meaningful life is woven together as people go about their lives every day.

Conclusion: The Meaningful Life and Interpersonal Skills

When considering the relationship between the interpretation of the meaningful life of the ethicist and the consultation they provide, chaplains are well positioned to provide support and guidance to clinical ethicists as the latter navigate the interpersonal and intrapersonal dynamics of providing ethics support. I provided examples of three ethicists' interpretation of one component of the meaningful life. Applied more broadly, there are ethicists like Malek who wall off their own meaningful life paradigm; there are others who might explicitly assert their view of the meaningful life like Parker; and there are others that may chart a middle way like Brummet's quasi-religious belief. Chaplains work on how their meaningful life affects their clinical practice. For example, the BCCI competencies and ACPE outcomes listed below are a few more examples of how the skills and competencies of board certified and CPE trained chaplains can support the work of clinical ethicists (BCCI Competency Essay Writing Guide, 2022).

There are ethicists like Malek who wall off their own meaningful life paradigm; there are others who might explicitly assert their view of the meaningful life like Parker; and there are others that may chart a middle way like Brummet's quasi-religious belief.

- **ITP1 AND L1.1, L2.1:** Articulate an approach to spiritual care, rooted in one's faith/spiritual tradition that is integrated with a theory of professional practice.
- **PIC1 AND L1.2, L1.9, L2.1, L2.6, L2.9:** Be self-reflective, including identifying one's professional strengths and limitations in the provision of care.
- **PIC2 AND L1.1 L1.2 L2.1 L2.6 L2.9:** Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice.
- **PPS8 AND L1.1 L1.2 L2.2 L2.3 L2.4:** Facilitate theological/spiritual reflection for those in one's care practice.

These competencies are focused on the meaningful life of the patients and families so that they can use their own meaningful life as a resource in their healing. Such training helps chaplains address their own meaningful life and how it impacts the care they provide. Like chaplains, clinical ethicists will have varying degrees of interpersonal and intrapersonal skill and need varying levels of support from chaplains. The training and support from chaplains could be verbatim-like exercises with ethicists; going over case studies and identifying their own attitudes, emotions, and values in response to the patient and family; or processing with a chaplain post-ethics consult. The ability of chaplains to hear the story of the meaningful life and

de-center the person of the chaplain and center the meaningful life of the patient or family is of value for clinical ethicists.

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The History, Role and Challenges of the US Military Chaplains

Christopher A. Conklin

THE CHAPLAINCY IN THE U.S. MILITARY dates back to July 29, 1775, when, at the behest of General Washington, the Continental Congress authorized one chaplain for each regiment, making the Chaplain Corps the oldest Corps in the U.S. military.¹ Washington, seeking to outfit his army with chaplains, was adopting and innovating on European practices. The chaplaincy was not something that Washington thought was only required for the Revolutionary War. As a commander during the French and Indian War, Washington appealed to Lieutenant Governor Dinwiddie that they were in such dire need of a chaplain that the officers were willing to pay the salary themselves.² The services of chaplains were essential to Washington. His utilization of chaplains and their performance in American history provides strategic lessons for the chaplaincy today.

George Washington employed chaplains to promote two lines of effort within the Continental Army: religious support and advisement to the command. Accomplishing both these missions has determined the successes and failures of the U.S. military chaplaincy and impacted U.S. security ever since. Religious support includes: Seeking Divine guidance and favor, Provision of worship, rites, and sacraments, Providing for the pluralistic needs of military members, and Ministering to the sick, dying, and imprisoned. Advisement to the command includes: Ethical and moral guidance and support, Instructing and modeling military professionalism, and Instilling a healthy patriotic culture. At the time of the Revolutionary War, there were no schools in chaplaincy. Fortunately, history has preserved Washington's directions for the army and its chaplains.

At the time of the Revolutionary War, there were no schools in chaplaincy. Fortunately, history has preserved Washington's directions for the army and its chaplains.

Religious Support: Seeking Divine Guidance and Favor

George Washington believed that the colonists were engaged in a holy endeavor, fighting to secure freedom. He determined that the soldiery ought to be led by chaplains in seeking divine favor for the cause, indicating so in the General Orders of March 22, 1783.³ In addition, in the General Orders of May 2, 1778, Washington directed chaplains to lead the army in worship for, "The signal Instances of

1 "U.S. Army Chaplain Corps – The Campaign for the National Museum of the United States Army," accessed March 14, 2022, <https://armyhistory.org/u-s-army-chaplain-corps/>.

2 Mitchell Lewis, "Colonel Washington Needs a Chaplain," *Mitchell Lewis* (blog), February 22, 2017, <https://milewis.wordpress.com/2017/02/22/colonel-washington-needs-a-chaplain/>.

3 Lewis.

providential Goodness which we have experienced and which have now almost crowned our labours with complete Success, demand from us in a peculiar manner the warmest returns of Gratitude & Piety to the Supreme Author of all Good.”⁴

Moreover, when the war ended, Washington expected his chaplains to lead the way in giving thanks. “The Chaplains with the several

Brigades will render thanks to almighty God for all His mercies, particularly for his overruling the wrath of man to his own glory, and causing the rage of war to cease amongst the nations.”⁵

Washington moored his faith in seeking divine guidance and favor that the Revolutionary War was in the service of a righteous cause. This practice has continued in the invocations of chaplains imploring the Divine for guidance and blessings. A notable example is Patton’s commissioning of a weather prayer during the Battle of the Bulge and awarding his chaplain the Bronze Star for the fair weather that followed the day after the prayer.⁶

Washington moored his faith in seeking divine guidance and favor that the Revolutionary War was in the service of a righteous cause.

Religious Support: Provision of Worship, Rites and Sacraments

On July 4, 1775, two days after taking command of the Continental Army, Washington issued orders that chaplains provide Divine services at 1100 every Sunday and that all military members were to attend. This order was given multiple times throughout the Revolutionary War, and Washington wrote that failure to attend Divine services would constitute disobedience of standing orders.⁷ For as much as Washington wrote about worship services on Sundays at 1100, it is clear that he placed great value in their necessity for his soldiers and officers. Keeping with Washington’s orders, at almost any military installation, one can still find worship services at 1100 on Sundays.

Religious Support: Providing for the Pluralistic Religious Needs of the Military

The provision, by Washington, of chaplains of different faith groups was an innovation on the European model of chaplaincy. All chaplains in the British military came from the Church of England. However, this was not the case in the Continental Army. Major General Muhlenberg was a Lutheran pastor who took a commission as commander of a Virginia Regiment and served as the unit’s chaplain upon the outbreak of the Revolutionary War. From the Reformed tradition came

4 Lewis.

5 Mitchell Lewis, “What General Washington Expected from His Chaplains,” *Mitchell Lewis* (blog), February 28, 2017, <https://milewis.wordpress.com/2017/02/28/what-general-washington-expected-from-his-chaplains/>.

6 “When Patton Enlisted the Entire Third Army to Pray for Fair Weather,” *History*, November 23, 2016, <https://www.historyonthenet.com/when-patton-enlisted-the-entire-third-army-to-pray-for-fair-weather>.

7 Mitchell Lewis, “General Washington and Chaplain Support of Sunday Services,” *Mitchell Lewis* (blog), February 26, 2017, <https://milewis.wordpress.com/2017/02/26/washington-sunday-services/>.

James Caldwell, who further blurred the lines between clergy and line officer by leading worship with his unit and bearing arms with them in battle. Perhaps even more telling of the concern for pluralism is Washington's appointment of John Murray as a chaplain, precisely because he ordered that Murray "is to be respected as such."⁸ Murray was a Universalist and may not have been accepted by the more orthodox clergy. Murray's appointment to the Rhode Island regiment is in response to their needs, and Murray needed to be afforded all the rights of a chaplain to fulfill those needs. The Continental Army chaplains thus reflected the makeup of the army, in service of the soldiery and not representative of a national religion. The chaplaincies still seek to achieve the capability to serve the plurality of faiths represented in the U.S. military, employing rabbis, imams, pastors, and priests eschewing the notion of a national religion.

The chaplaincies still seek to achieve the capability to serve the plurality of faiths represented in the U.S. military, employing rabbis, imams, pastors, and priests eschewing the notion of a national religion.

Religious Support: Ministering to the Sick, Dying and Imprisoned

Washington gave careful consideration to the provision of religious services to those in dire need. He ordered chaplains to visit the wounded, take care of the dead, and write letters home for illiterate soldiers.⁹ They were ordered to visit the sick "regularly and constantly attend the Hospitals," no small task given the severe infection rates and death in hospitals at the time.¹⁰ On one occasion, when too many chaplains were on furlough and not attending to those in need, Washington angrily reacted, ensuring future leave could only be granted by his staff.¹¹ Furthermore, Washington personally requested the support of chaplains for imprisoned enemy soldiers. Chaplains continue providing care for the sick, the dying, the imprisoned, including the condemned in the Nuremberg trials, and in present-day Guantanamo Bay.

Advisement to the Command: Ethical and Moral Guidance and Support

Washington viewed chaplains as a force for moral behavior by the army, noting with sarcasm to a commander, "I see no objection to your having (a chaplain) Unless you suppose yours (cavalry) will be too virtuous and Moral to require instruction. (The chaplain) will influence the manners of the Corps both by precept & example."¹² Washington included chaplains on command staffs to facilitate critical advice to leaders on ethics and morality. He instituted the necessity of a

8 Mitchell Lewis, "General Washington, Pluralism and Chaplain John Murray," *Mitchell Lewis* (blog), February 24, 2017, <https://milewis.wordpress.com/2017/02/24/washington-and-john-murray/>.

9 "Military Chaplains: A Historian's View from the American Revolution to Iraq," *Christian Science Monitor*, October 30, 2007, <https://www.csmonitor.com/2007/1030/p25s02-usmi.html>.

10 Lewis, "What General Washington Expected from His Chaplains."

11 Lewis.

12 Lewis, "What General Washington Expected from His Chaplains."

prophetic voice in a command staff to ensure that military decisions would not be devoid of a perspective that represents the altruistic and religious aspirations of the nation. Today U.S. military regulations acknowledge the advisory role chaplains play in command staffs.¹³ In addition, chaplaincies play a unique role in ethical and moral training.¹⁴

Advisement to the Command: Instructing and Modeling Military Professionalism

George Washington thought it critical for chaplains to assist in developing military professionalism within the Army, noting that chaplains taught “the necessity of courage and bravery and at the same time of perfect obedience and subordination to those in Command.”¹⁵ In addition, he tasked chaplains with reading the military law to soldiers each Monday, ensuring that the Army adhered to the discipline of the military profession. This task has transformed throughout the history of the U.S. military, yet chaplains staff military training commands where there is no shortage of recruits seeking the counsel of chaplains as they make the adjustments from civilian to military life.

Advisement to the Command: Instilling a Healthy Patriotic Culture

George Washington tasked chaplains to encourage soldiers to be “brave people who are fighting for their Liberties.”¹⁶ He even charged chaplains with announcing and interpreting important events to the army. Following the battle of Saratoga, when France recognized American independence, Washington charged chaplains with delivering the news to the army, offering prayer, and delivering a speech expounding on the importance of the occasion and ordered the same at the conclusion of the war.¹⁷ Chaplains today are rarely tasked with the duty to announce such vital events. However, as participants in unit training and activities, they are expected to uphold and model the professional ideals of the military culture.

While Washington saw success in shaping the character of the chaplain corps, perhaps his most significant fight was arguing for the requisite amount and disposition of chaplains.

Chaplain Corps Manning and Assignment

While Washington saw success in shaping the character of the chaplain corps, perhaps his most significant fight was arguing for the requisite amount and

13 “Ethics Smartbook” accessed March 12, 2022, <https://usachcstraining.army.mil/documents/71216/89620/Ethics+C4+Smartbook.pdf/30253a0b-bcdd-494a-a86d-acb9da616ab1>.

14 “Pam165-19.Pdf,” accessed March 12, 2022, <https://irp.fas.org/doddir/army/pam165-19.pdf>.

15 Lewis, “What General Washington Expected from His Chaplains.”

16 Lewis.

17 Mitchell Lewis, “General Washington and Chaplain Support of Military Ceremonies,” *Mitchell Lewis* (blog), February 26, 2017, <https://milewis.wordpress.com/2017/02/26/washington-chaplains-at-military-ceremonies/>.

disposition of chaplains. Congress initially provided a chaplain for each regiment, about six-hundred soldiers. As appropriations became scarce, the Continental Congress placed chaplains at the brigade level. This expanded span of responsibility made the chaplain's mission more difficult as they were now responsible for up to two thousand soldiers. However, even though each chaplain was paid equivalent to a colonel, Washington would regularly engage the Continental Congress asking for chaplains to be assigned to each regiment. Though, he did not sacrifice quantity for quality, noting that not having a chaplain was better than having an inadequate one.¹⁸ These issues would continue to haunt the U.S. military and its chaplaincies throughout the years.

From the Civil War through World War I, chaplains would return to the battlefield in their familiar roles, facilitated by unit members with their clergy being drawn from individual localities.

The Chaplain Corps Since the Revolutionary War

From the Civil War through World War I, chaplains would return to the battlefield in their familiar roles, facilitated by unit members with their clergy being drawn from individual localities. Chaplains retained their advisement role on command staffs.^{19 20} During World War II, U.S. military chaplaincies would expand rapidly, growing from 145 to 9,111 in the Army in one year.²¹ This rapid increase left most chaplains with little experience in the mission of advisement to command, and so they focused on spiritual duties and moral advocacy.²² Individual chaplains served with great distinction, including Francis Sampson, who was the inspiration behind the movie "Saving Private Ryan."²³ Nevertheless, the cycle of rapid decreases in the chaplaincies followed by a rapid rise with conflict would erode the chaplain's role in the future.

The Korean Conflict required the rapid expansion of the chaplaincies again, but recent World War II veterans were reluctant to leave post-war life and new ministry fields to return to war. Chaplain positions went unfilled. Those who served did so

18 Mitchell Lewis, "General Washington and Continental Congress Support for Chaplains," *Mitchell Lewis* (blog), February 23, 2017, <https://milewis.wordpress.com/2017/02/23/washington-continental-congress-chaplains/>.

19 "Military Chaplains." One famous story involves then Colonel U.S. Grant, who sought his chaplain's advice stating, "You need to advise me about whether what we're doing is what we should be doing ... I know what the law permits; what I want to hear from you is whether you think this is the right thing to do."

20 "Army Chaplain Credited With Inventing Basketball," U.S. Department of Defense, accessed March 14, 2022, <https://www.defense.gov/News-Stories/Article/Article/604354/army-chaplain-credited-with-inventing-basketball/>. In 1916 General Pershing led the Punitive Expedition into Mexico and U.S. forces in World War I. Chaplains expanded their roles to include health promotion activities. One, James Naismith, the inventor of basketball, included athletic activities and religious support to care for the soldier's body and soul.

21 "Military Chaplains."

22 "Military Chaplains." Concern rose about VD rates in the army occupying Germany. Staff officers wanted doctors to evaluate women in the brothels and then assign military police to regulate prostitution. Chaplains went to see the commander and threatened to resign their commissions causing the commander to go a different path. The houses of prostitution closed, and jobs for the young women expanded so they could earn an honest living, ultimately reducing the venereal disease rate.

23 Greg Timmons, "Saving Private Ryan: The Real-Life D-Day Back Story," *HISTORY*, accessed March 15, 2022, <https://www.history.com/news/saving-private-ryan-real-life-dday-back-story>.

with great distinction.^{24 25} However, the difficulty in filling chaplain positions in the Korean conflict led the U.S. to change manning in the Vietnam War, opting for “area coverage.”²⁶ Chaplains in the Vietnam War were responsible for larger populations and traveled vast distances to accomplish their missions. This led to two adverse outcomes. Chaplains were rarely seen by their units, and they no longer actively served on commanders’ staffs, thereby eroding their moral influence. The Army determined that a contributing factor to the massacre at My Lai was that a chaplain had not visited the unit that committed the atrocities in several months.²⁷

The Army determined that a contributing factor to the massacre at My Lai was that a chaplain had not visited the unit that committed the atrocities in several months.

Other chaplains, where they could be present, stopped atrocities through their advocacy with commanders.²⁸ However, this would not be the last war where a lack of trained chaplains contributed to the moral failures of military members.

During the first two decades of this millennium, the U.S. military engaged in the War on Terror and dealt with multiple ethical and moral failures. In Abu Ghraib, where military guards abused Iraqi prisoners, the chaplain assigned to the unit was young, inexperienced, and confined to an office away from leadership and personnel, effectively neutering any positive moral influence.²⁹ The Army response included increasing the experience level and number of chaplains at Abu Ghraib.³⁰ In 2014 a cheating conspiracy scandalized the Air Force missileer community. The Air Force responded by increasing the number of chaplains serving missile bases and mandating field visitation with missile crews. The Navy has faced significant ethical issues within its SEAL community.³¹ The response has included assigning a chaplain to every Naval Special Warfare squadron. The Air Force chaplaincy is growing by a third, and the Navy is putting a chaplain on every destroyer. In hopes of countering rising morale issues, suicide, and sexual assault, the military is increasing their numbers of chaplains and embedding them into even smaller

24 “Korean War Children’s Memorial,” accessed March 14, 2022, <http://koreanchildren.org/docs/AirForceChaplains-Q.htm>. Chaplain Russell Blaisdel was responsible for saving a thousand orphans.

25 “Father Kapaun,” Kapaun Mt. Carmel Catholic High School, accessed March 14, 2022, <https://www.kapaun.org/about-us/history/father-kapaun>. Chaplain Emil Kapaun may be the only chaplain to have an installation named after him, earn the Medal of Honor and become a saint in the Catholic Church.

26 “Faith Under Fire: Military Chaplains and the Morality of War,” Historynet, March 22, 2017, <https://www.historynet.com/faith-fire-military-chaplains-morality-war/>.

27 “Faith Under Fire.”

28 “Military Chaplains.” Father Angelo Liteky, who won the Medal of Honor, on his second tour, heard of a policy that if you brought in five [human] ears to show you had killed five Viet Cong, then you could get leave to Saigon or Cam Ranh Bay. Father Liteky said, “you have turned professional soldiers into barbaric mercenaries.” He went straight up the command until he got to General Creighton Abrams who put an end to the policy.

29 “‘Ministry by Presence’ and the Difference It Made at Abu Ghraib,” HuffPost, October 10, 2012, https://www.huffpost.com/entry/ministry-by-presence-and-_b_1912398.

30 “‘Ministry by Presence’ and the Difference It Made at Abu Ghraib.”

31 Stavros Atlamazoglou, “After the Eddie Gallagher Case and Other Scandals, Navy SEALs Say They Have to Rethink How They Pick Their Leaders,” Business Insider, accessed March 14, 2022, <https://www.businessinsider.com/after-scandals-navy-seals-rethink-how-they-pick-leaders-2021-8>.

units. The chaplain's span of responsibility is again at the forefront, just as it was in Washington's Day.

Conclusion

Chaplains enable the military member to effectively struggle with the morality of war and help to define a warrior ethos that respects the virtues, values and religious beliefs of the United States. George Washington emphasized the dual mission of chaplains, to provide religious support and advisement to the command, as essential for a professional, effective, and moral military. A prescient George Washington, in 1775, proclaimed chaplains, "As important as the cannon to the success of our endeavor."³² The modern Chaplain Corps encounters similar challenges as the one in Washington's day. Ethical and moral challenges confront our Corps every day in the profession of arms. Theorists remind us that war is inherently violent and preparing the soul to engage in the application of force is no easy task.

George Washington emphasized the dual mission of chaplains, to provide religious support and advisement to the command, as essential for a professional, effective, and moral military.

Chaplains must be well versed in the moral intricacies of Just War theory in order to advise and counsel service members. The advent of new technologies like artificial intelligence and remotely controlled weapons are the next step in the ethical dilemmas of how wars are waged. Theologians weighing in on the morality of the use of certain weapons is not anything new and hearkens back to the pope banning the use of crossbows in battle. The question is, will chaplains be in the room at the critical moment when the development and employment of weapons are discussed and decided? If history is a lesson, weapons are often wielded first and then the morality of them is debated in the public sphere. Examples include the use of the crossbow, chemical weapons, land mines, nuclear weapons and remotely piloted aircraft.

But perhaps the greatest impact of chaplains is seen on the humans bearing the battle. The stark differences in battlefield performance, professionalism and ethical conduct exhibited between Ukrainian and Russian forces are a reminder to modern military leaders of the moral character of war and the importance of the prophetic voice that chaplains hold in the command. A growing component of modern chaplaincies is advisement to other countries' religious leaders and chaplaincies. Such was the case with the Ukrainian chaplains and other nations to help partner nations develop a moral character in their militaries that makes a better peace possible. With the growing demand for chaplains and the services that chaplains provide, the Chaplain Corps faces a renewal of the same challenge that the Continental Army faced. Washington struggled with the Continental Congress to secure enough

32 "The Chaplain Historical Marker," accessed March 12, 2022, <https://www.hmdb.org/m.asp?m=141338>.

competent chaplains to provide the Army with consistent, sufficient support. The modern U.S. military is engaged in the same struggle over chaplain manpower and allocation to effectively accomplish its mission and serve with honor.



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Dual Relationships and Decision Making in Rural Hospitals

Anna Rudberg Speiser

RECENTLY, AS I WAS LEAVING A PATIENT'S ROOM, I met a nurse coming down the hall carrying a plate covered with tin foil. “He’s the husband of my mom’s best friend,” she said, nodding to the patient’s room, “so I’m bringing in some of the leftover apple crisp that my mom made for his wife last night.” It’s the sort of small moments that can make health care in a rural or small-town hospital feel especially personal and hospitable. On the other hand, rural hospitals offer unique ethical challenges for providers and staff, including chaplains. Although there is immense diversity between rural hospitals, they tend to be in isolated settings with more limited resources than their urban counterparts. This then intensifies a number of ethical challenges, including overlapping professional-patient relationships, boundary issues, difficulty maintaining confidentiality, limited opportunities for consultations or referrals, and allocation of resources.¹

In rural settings, it is not uncommon for people to hold many overlapping relationships with little buffer between their personal and professional lives. This means I might be providing pastoral care to a teacher at my children’s school, a neighbor, a business associate of my husband, even a personal friend—or, on occasion, a combination of all these relationships at once. Other times, I am operating as the chaplain or pastor with people who knew me as a child. While of course this can happen in large cities as well, it occurs more frequently in small towns. There is very limited anonymity.

On several occasions I have been involved with cases in the emergency room in which the patient or family are close friends, neighbors, or even family to one of the staff providing care. While an effort is made to arrange alternate staffing, in a hospital with limited employees this simply isn’t always possible. Things become even more difficult when the case is complicated or highly emotional.

A number of years ago we had a tragic, accidental death of a young person. The child’s family was close friends with the provider. Afterwards he spoke with me several times about his experience—not only his own personal grief for a friend’s child, but also questioning his own treatment decisions. Even though the staff all agreed that his care had been excellent, a sense of responsibility and “second guessing”

In rural settings, it is not uncommon for people to hold many overlapping relationships with little buffer between their personal and professional lives.

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2598268/>

weighed heavily on the provider, in a large part due to knowing the patient and family so well. This lack of anonymity created greater stress for everyone involved, particularly as the case was discussed widely and with great concern in the community at large. A similar sense of increased pressure can be true for chaplains as they care for those they know personally or through multiple layers of connection.

Maintaining good boundaries, particularly around patient's information and status is a central ethical challenge for healthcare workers, chaplains included. HIPAA² was established in 1996 as a way to protect the privacy of patients and their health information. Clear boundaries can certainly be a challenge anywhere, especially in rural areas and small towns where anonymity is not always possible. In rural areas like ours, where radio stations commonly announce local birthdays on air, where placards in front of businesses offer congratulations to area graduates and newlyweds, and where farmers will join together to help a neighbor in need, the idea of HIPAA can run against a common shared value of rural areas. For many the time when patients' names were listed in the local newspaper or read on the radio feels like a recent memory. While most community members are understanding, many miss how easy it was to learn who was admitted by simply making a phone call to the front desk at the hospital. Then they were able to offer support to families, loved ones, and patients themselves. Patients, too, remember when churches were automatically informed of hospitalizations of their members. Despite repeated reminders that their church will not be informed of their admission unless the patient gives permission, many patients and families continue to be disappointed when their clergy do not visit.

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In the healthcare setting, the lack of anonymity takes many forms. For example, because the fact that I'm a hospital chaplain is widely known, I am at times approached by concerned (or nosy) community members asking about the status of patients — a topic I've learned to deftly sidestep. Similarly, because it is widely known that I work for hospice, just seeing me stop at a home can cause assumptions from neighbors or passersby that my presence indicates a hospice admission. Clearly, small towns have their challenges; but, at their best, the sense of knowing and being known can be a great gift. What at its worst is gossip, at its best is concern.

Although people sometimes bemoan the increased bureaucratic opacity of HIPAA, these regulations allow the rights of the patient to keep their health information private. Two years ago, when our young son required some major

2 Health Insurance Portability and Accountability Act (HIPAA)

medical care, we were so grateful for HIPAA regulations that allowed us to decide when, how, and what information about our son was shared with others. Maintaining this degree of privacy is challenging and depends on a strong sense of discretion and good boundaries among the staff even when complete anonymity is rare, a distinct ethical challenge for rural hospitals.

Limited opportunities for consultation or referrals can also be a challenge. Certainly, rural hospitals are not alone in this sense of professional isolation.

Undoubtedly many solo pastors or chaplains feel the pressure of managing all aspects of pastoral care in their setting. In rural hospitals, this can be further complicated by fewer referral options. For example, in my rural hospital hospice program we had no local therapist or psychologist who specialized in youth or child counseling. Several such therapists were available in a neighboring larger city but we found our hospice families were often reluctant to take advantage of this more specialized care, sometimes because of financial or time restraints, other times because travel to a large city felt intimidating or less personal. As a result, the grief support group that the hospice social worker and I provided encompassed a larger grief profile than we might have had if we had more opportunities to make referrals or enlist consultations.

Undoubtedly many solo pastors or chaplains feel the pressure of managing all aspects of pastoral care in their setting. In rural hospitals, this can be further complicated by fewer referral options.

Finally, some ethical challenges relate to the limited resources of rural hospitals. This can result in needing to make decisions about allocation of services. Our hospice department had a limited number of alternating pressure mattresses; consequently, we had to constantly assess which patient was in greatest need and make changes in response. The pandemic brought these circumstances into greater relief. Although we had many fewer cases than bigger cities, we were quickly stretched by both limited staffing and equipment. The strain became most severe when larger area hospitals began to refuse requests for transfers, causing smaller hospitals like ours to have both a higher census and more critical patients than we were normally prepared to treat. This put an immense amount of stress on our staff physically and emotionally. Like many small hospitals, we had no formal ethics committee previously and as Covid increased, we considered convening one to help navigate potentially difficult or even tragic resource allocation questions. Thankfully, the surges never strained us to the point that we needed to face such difficult question around withholding care. Still, even the potential was a stress for everyone.

Living and serving in a small town or rural area can offer many blessings but also many challenges, particularly for smaller hospitals. Having worked in both cities and rural settings, I value the sense of comradery, community, and mutual

concern frequently shared in rural hospitals. That said, I see many of these ethical challenges in my own practice or in the work of others, and am grateful that the unique challenges of rural settings are beginning to garner more attention and concern.



Anna Rudberg Speiser served as a hospice and hospital chaplain at Providence Medical Center in Wayne, Nebraska. She lives on her family farm near Emerson, Nebraska, with her husband and two children. She holds an MDiv from Harvard and has studied one year at Luther Seminary. Anna is a rostered ELCA Minister of Word and Sacrament and is certified with BCCI. She currently serves on the Caring Connections Editorial Board.

Safety or Dignity in Aging Communities

Editor's Note: *The following two articles reflect the struggles around the risk of choking and swallowing as one's body declines. Both men have faced the ethics of allowing their loved ones the pleasure of eating food without the meal being puréed. Don and Bruce are friends and former colleagues in chaplaincy. Since these articles complement each other well, their articles are bundled together.*

"It is Hard to Swallow..." Ethics in Aging communities

Don Knudson

AMONG AGING ELDERS an issue that can present conflicting values occurs with a person is diagnosed as having a risk of choking. This condition usually results in a recommendation for puréed foods.

A resident in the nursing home I served was diagnosed as having a risk of choking. I will call her Martha. When Martha's family heard the recommendation for puréed foods, they reacted with dismay, "You can't serve her baby food! It's undignified!" This strong reaction from Martha's family resulted in postponing the recommendation. When this issue is identified among the elders, it can present conflicting values: safety vs dignity.

The resident continued eating regular food. Because this person was, indeed, at risk for choking, at many meals Martha would end up choking on some portion of food. The staff person had to use the Heimlich maneuver to clear food from her airways.

This situation was unacceptable to the nursing assistant who, in turn, appropriately reported this regular choking incidence to nursing staff. As a result, social services called a family meeting. The family was told of the choking episodes and consequent Heimlich maneuvers required at public meal time. "This cannot continue," they were told.

My role in this situation was as an observer and support in the process. The principal participants in the family meeting were the dietician, social services and family members.

It was difficult emotionally for Martha's family to accept that she had come to this stage in life.

It was difficult emotionally for Martha's family to accept that she had come to this stage in life. Staff explained that they also valued dignity for Martha; however, it was not dignified for their loved one to be choking during the dining hour. The result was to switch back to a form of food, usually puréed, that Martha could swallow.

The perception of puréed food as "baby food" and the episodes of choking both were expressed and perceived as undignified. Choking episodes risk aspiration and

serious peril to health, even death. It seemed dignity for the resident was at risk. What to do? No answer is easy.

Puréed food is often perceived as undesirable to the frail elder. I cannot remember anyone expressing pleasure when told they no longer could eat regular food. Often residents refused to eat or would eat very little.

As a Lutheran, when I approach such issues ethically, I hold to a contextual ethical principle. In my view, there is no absolute value in the mix of competing values that may be held by individuals. In this case, I identified the following values at play: dignity, safety of resident regarding choking hazards, resident's preference regarding food, compassionate support for resident's needs by both staff and family members. This latter value, caring for vulnerable elders, is the goal we wish to achieve.

In this case, I identified the following values at play: dignity, safety of resident regarding choking hazards, resident's preference regarding food, compassionate support for resident's needs by both staff and family members.

Hovering over this situation is the inevitable mortality of the resident or patient. What kind of death might the resident be facing? Choking and aspiration episodes, in my opinion, would be a traumatic and undesirable way to die. As spiritual care providers, the increased difficulty with eating may be a good time to listen to the concerns and thoughts of the family and the resident. The chaplain may engage the individual about their quality of life, awareness of their mortality, sense of meaning, religious and spiritual beliefs and purpose at this time of life, according to their ability. It is their life, after all.

Pizza Party drama!

Until her death just a few years ago, my sister suffered from MS for 24 years. During the last year of her life, she was cared for in a long-term care facility. I remember having a family reunion of sorts at the nursing home where she resided. She wanted a Pizza Party! So, we had a Pizza Party. She loved pizza, as many of us do.

By this time, her care plan required that she have only puréed foods. The care giver offered to purée the pizza. My sister would have nothing of this! "I want to eat pizza, not mush!" The conflict was clear. I confess, I was rooting for my sister's "right" to eat pizza in the way she wished. We were all informed by the caregiver that we should not, as family, try to feed her this pizza, as she could choke! What to do?

Her husband arrived shortly after "the talk." We told him what was said. He knew this was an issue. They had him sign an agreement that if he fed her anything other than puréed food, the risk of choking was on him. The nursing home wanted protection from liability if she would choke, experience aspiration and/or death. He willingly accepted the responsibility.

Knowing this, our Pizza Party spirit was restored. He fed my sister the delicious pizza which she wanted. She was able to swallow in small pieces. Because of that, she enjoyed the social experience with us. She did not choke. Because of her husband's support, she had the dignity of eating pizza with us, her family.

This issue touches many families and elders personally along the aging spectrum. How do we negotiate institutional requirements regarding responsibility for the safety of patients, while honoring their expressed personal preferences and their individual right to choose what is important to them, even when it presents some risks?

Without family support, how many times might the safety concerns of the professionals and the institutions dominate over other needs a person may have? It's a question to ponder in this time when Aging Services are struggling to find enough care providers for the growing number of elders needing such care.

It's a personal issue. Any day now I could be one of those people needing care too.



Don Knudson, MDiv, BCC retired, 78, grew up on a farm in South Dakota as a baptized member of an Augustana Lutheran congregation. Ordained in 1970 by the LCA, he served over 20 years as a pastor of congregations in Minnesota and North Dakota. Later, as a Board-Certified Chaplain, he served Ebenezer Care Center in Minneapolis as director of Spiritual Care for over 23 years. Now retired, he was the primary family caregiver for his wife until her passing 18 months ago.

Nutrition, Hydration and Life's Meaning

Bruce E. Pederson

I WILL BEGIN BY SAYING this is up close and personal for me. Over a decade ago, my wife Nancy was diagnosed with atypical Parkinson's. It was eight years ago that she was hospitalized with an infection that went into sepsis. She was very sick for over two weeks. When Nancy returned to health, she was discharged with orders for thickened liquids and puréed foods. The order was written by a hospitalist who had had minimal interaction with Nancy while she was in the hospital.

Before this hospitalization, she frequently had difficulty swallowing liquids that had not been thickened, but she experienced no difficulty with regular food. After a long journey trying all available thickeners, which she did not enjoy and often rejected, we had an appointment with an occupational therapist who had just returned from their national conference. A company exhibiting there had promoted a new formulation of their product. She said that everyone at the conference was very excited about this new product. It was the first time they had experienced a thickener

that they themselves could stand to drink! Nancy began using this product and from that time on has been able to enjoy thickened drinks without coughing or risking aspiration.

Eating puréed food was another matter.

Nancy had never had difficulty eating most food except for the time she was hospitalized as noted above. When the puréed food came to the table, she was unable or unwilling to eat at that meal. I called her nurse practitioner and asked that she discontinue the order for puréed food, which she did. For these past eight years Nancy has continued eating regular food from the daily menu without difficulty. Considering the many ways this disease has limited her functioning for more than ten years, I am pleased that regular food and mealtimes have remained an enjoyable and enriching experience for her.

Considering the many ways this disease has limited her functioning for more than ten years, I am pleased that regular food and mealtimes have remained an enjoyable and enriching experience for her.

I frequently reflect on how much has been taken away from Nancy due to her Parkinson's. Eight years ago, she was having frequent falls due to balance issues (30 falls in three months). We moved to assisted living. Communication has become increasingly difficult for her as she often speaks so softly that others are not able to understand her. She has lost her ability to write with clarity. I am so grateful when I see how much she continues to enjoy meals and share this time with others. I also think about how important it is for health care professionals to listen to care givers and family members before they make radical changes in what people are able to do independently at meals.

Another situation relates to my mother. She had reached the ripe old age of 94 and had been living in a nursing home facility for several years. At this time, she was confined to her bed and was ready to die. She suffered from pain due to contractures in her feet and legs. It finally reached the point where she would no longer eat and would drink very little. The physician recommended hospice and said that due to her inability to eat and drink, she would die within two weeks.

Once hospice entered the picture there was an immediate change. She began eating and drinking again. She was eventually taken off hospice care. She lived for an additional seven months!

What happened? When I spoke to the Director of Hospice after her death, I asked that very question. Two factors were suggested. First, the hospice program immediately increased her pain medication. This greatly reduced her pain which helped her relax and get some enjoyment from life again! She immediately returned to her regular eating and drinking. Second, staff mentioned a total change in her affect when the music therapist from the hospice program came with his guitar to share music and sing with her each week. He had asked me about her favorite music

and hymns and, in turn, shared this music with her during his visits. It clearly added an additional dimension of well-being and meaning to her life.

What can we learn from these first-hand stories?

For many people, eating and drinking are at the very center of life's meaning. Therefore, it is important for medical professionals to tread carefully in the areas of nutrition and hydration. They need to listen to patients and caregivers about how they understand the risks and rewards. Also, there is the need to balance clinical judgments made when a person is hospitalized, and may be at a much higher risk, compared to when they have returned to health and to their home environment. Curiously Nancy and I both recall several conversations with physicians and nurse practitioners who have questioned whether they would be able to accept such dietary orders if they were given by their personal physician. The maxim which states, "First, do no harm," seems particularly appropriate here.

My mother's experience with hospice mirrors many other stories that I have experienced both as a hospital and as a long-term care chaplain. I have heard of other instances where individuals experienced radical improvement in their health after being enrolled in hospice. The wholistic approach of hospice programs can be followed by a positive change in health status. My mother's experience, along with others, begs the question about why we cannot bring this wholistic approach more fully into our whole approach to health care.



The Rev. Bruce E. Pederson, MDiv., BCC, served as Corporate Director of Chaplaincy Services and Church Relations for Ebenezer Society in Minneapolis beginning in the fall of 1988. He retired from the ELCA Word and Sacrament roster in the fall of 1999 on his 66th birthday but continued in his role at Ebenezer. The following year he was offered and accepted a new half-time position with Fairview Health Services as Manager of Church Relations in the department of corporate community health where he has continued to serve for the past twenty-two years, most recently on a casual basis.

Bruce participated on the Steering Committee of the LSA Chaplains' Network for six years. He edited and published its newsletter for ten years. The first meeting to consider the possibility of creating Caring Connections took place at his home in South Minneapolis with Craig Carlson of Duluth, Dick Tetzloff (LCMS) and Don Stiger (ELCA) participating. Bruce also served for twelve years as Director of Chaplaincy at Mercy Medical Center and for fifteen years as pastor in both rural and suburban congregations.

In 2010 he was a recipient of the Christus in Mundo and is pictured here wearing the medallion.

Ethical Challenges of Pastoral-Chaplaincy Care in the Mix of Church, State, Legal Mandates, Policies and Procedures

John Hallock and Mark Whitsett

THE THEME OF ETHICAL CHALLENGES FOR CHAPLAINS hit home for both of us (John and Mark) in our different ministry settings. Each of us have had to work through circumstances as pastor-chaplains which seemed to represent an ethical clash between the matrix of callings that our individual ministries required of us. Vocationally, we are pastors/chaplains in the larger church, Mark in the Lutheran Church—Missouri Synod (LCMS) and John in the American Association of Lutheran Churches (AALC). We are committed by promise in faith and practice to scripture and our stated Lutheran Confessional framework. But we also function as agents of the state in terms of compliance and enforcement of state and federal regulations (more on this later). Additionally, we have served or are serving as employees of our respective institutions in supervisory and management roles that necessitated following organization policies and procedures.

While we are both sensitive to the commitments made as rostered members to our respective church bodies, we are stretched to be “good neighbors,” to relate the life and grace of God in Christ in our non-traditional, ministry contexts. These contexts are microcosms of the world, which, by definition, can be a messy place. To help our readers gain a sense of this complexity, using our own personal voices, we will first share a bit about each of our settings. Then each will describe circumstances that required him to respond in a way that might appear to bring into conflict personal convictions, commitments to church, to civil requirements and/or to that of the institutions we serve. Finally, we will reflect on personal and observed impacts these ethical moments have had on us, our sense of growth or insight, on-going questions or struggles that might continue.

Ultimately, the situations described are not about specific individuals/people or the institutions involved. As John notes below, any opinions expressed are our own and not that of the organizations we have been or are a part of. Our intent is to protect the integrity of individuals and organizations while still getting at the gritty, the thing that must be dealt with pastorally, theologically, perhaps legally, maybe with enforcement, or as faithful and godly employees.

Our intent is to protect the integrity of individuals and organizations while still getting at the gritty, the thing that must be dealt with pastorally, theologically, perhaps legally, maybe with enforcement, or as faithful and godly employees.

Pastoral Contexts from John's Perspective:

I currently serve as a Chaplaincy Services Coordinator for the Federal Bureau of Prisons (BOP) in the Mid-Atlantic and Northeast Regions.¹ Previously, I served for over twenty years with BOP, beginning as a Correctional Officer and working through the ranks to my current role. I have worked every security level including special population units such as medical and incarcerated women units. I also work alongside the finest of professional chaplains. I have thoroughly enjoyed my vocation and consider myself to be part of the premier correctional agency in the world. The Bureau of Prisons Chaplaincy Branch is committed to quality pastoral care and the inmates' free exercise of religion.

Ethical Moments for John

There are few ministry contexts that could present as many possible ethical dilemmas as federal prison chaplaincy. Federal prison chaplains are both sworn federal law enforcement officers and ordained clergy. The chaplain must simultaneously navigate both roles on a daily basis. Added to this tension, the chaplain ministers in a highly diverse and pluralistic setting that contributes to the fluidity and possible challenges to their ethics. The final challenge is the fact they are employed by the Federal Government and not the church. The theological tradition of Lutheranism positions the church well to help her chaplains face potential moral complications when they arise.

The Bureau of Prisons recognizes the chaplain's unique role and therefore protects their pastoral identity. This is evidenced by mandatory ecclesiastical endorsements, pastoral responsibilities, written policies, and identifying roles not appropriate for chaplains to serve in, such as mass shakedowns and inmate pat searches. The BOP expects their chaplains to be pastors. We must lead services, conduct counseling, and coordinate reentry programming. At the same time, there are law enforcement functions all staff members are tasked with, for example inmate counts, responding to institutional emergencies, general security, and order of chapel operations.

While Lutheran theology has much to say about the distinctions between the two realms of God, also known as the two hands of God, this doctrine is not fully realized among Lutheran and non-Lutheran chaplains. From my tenure with the Federal Bureau of Prisons, I will share an example that posed a significant challenge to my conscience and how the struggle enhanced my understanding of my identity as a prison chaplain. It also increased my effectiveness as a servant in a

The BOP expects their chaplains to be pastors. We must lead services, conduct counseling, and coordinate reentry programming.

¹ "Opinions expressed in this article are those of the author and do not necessarily represent the opinion of the Federal Bureau of Prisons, Department of Justice."

specialized ministry and further strengthened my already deep appreciation for the agency I serve.

Toward the end of the previous presidential administration, the Attorney General ordered the BOP to fulfill the execution of four inmates ordered by a federal judge. The inmates were convicted many years ago. The Bureau of Prisons Chaplaincy Administrator asked for volunteers to be part of a pastoral team to help the institution through this difficult time. Though I do believe the government has an obligation to punish violators of the law, I am not a proponent of the death penalty. However, to join this team challenged the notion that I might be complicit in something I didn't and still don't support. On the other hand, if I did not volunteer, would I be negligent in my pastoral role of assisting those who would be potentially traumatized by the events? Wasn't this a time for God's care to be present?

To join this team challenged the notion that I might be complicit in something I didn't and still don't support.

It posed a significant dilemma. I had to wrestle with my ethics regarding the death penalty and my role within government service as a chaplain.

I am grateful for the conversations I had with the BOP Chief Chaplaincy Administrator. She gave me space to process my quandary. She affirmed my distress and desire and provided timely wisdom. In the end, I decided to be part of the team. Though I was not called upon, the experience expanded my understanding and was invaluable in my growth as a chaplain.

The government (left hand of God) bear, what Luther calls, the sword. The government rules by reason and natural law. In other words, the government's authority is to enact laws and determine reasonable consequences for violations. My role as chaplain did require my involvement but not the planning and carrying out of the executions nor my agreement with them. My involvement was being a pastor (spiritual realm — right hand of God). I had a responsibility to provide a presence for God. In the spiritual realm, the Kingdom of God, the church, does not enact or enforce laws, and we do not execute the consequences for violations. I was to speak truth of both His justice and mercy. While the judge says "guilty," the chaplain declares "forgiven."

These two hands of God don't contradict each other; they are related but distinct. It articulates the fairness of God, a God concerned about justice for the victims of crimes. At the same time God offers mercy and forgiveness for the violators even though consequences remain. In short, I praised God that if called upon I could affirm God is simultaneously concerned about justice and forgiveness, yet His last word is always one of forgiveness and it is this last word that must be proclaimed.

My conscience was eased; my ethical dilemma resolved. Though I disagree with capital punishment, I had to leave the matter in His hands. I can only proclaim what He has revealed — For all who call upon His name, He is merciful, He is compassionate and kind. I am grateful that God called me to federal prison chaplaincy.

Pastoral Contexts from Mark's Perspective:

I have recently retired from my ministry with a Recognized Service Organization (RSO) of the LCMS that is located in Kentucky and supports individuals with intellectual and developmental disabilities (IDD). I was Director of Pastoral Care for just shy of 15 years. The organization serves over 250 people with IDD and has a staff of about 430 in 32 locations. My primary duty was to be the pastor offering Word-based ministry (and some sacrament)

to the individuals supported there, along with their staff. But I had other responsibilities too.

I was the legal advocate for the daily care of 7 individuals as their Qualified Developmental

Disability Professional. I was the Human Rights

Chairperson for the organization's long-term care facility and responsible for assuring compliance with state and federal rights regulations. I was also a member of the facility Interdisciplinary Team (IDT) which has legal responsibility to state and federal regulators for all aspects of facility governance and compliance. For a number of years, I worked alongside medical staff in relating to families to advise them about and to secure Advance Directives and Do Not Resuscitate orders for their loved ones. I also supervised the organization's employee assistance program for staff who were in crisis. Finally, I was the supervisor to other chaplains on staff and part of the organization's senior management. While I wore a number of "hats," I was always expected to be "Pastor Mark" representing the presence and purposes of God's love in Christ.

While I wore a number of "hats," I was always expected to be "Pastor Mark" representing the presence and purposes of God's love in Christ.

Ethical Moments for Mark

I have always understood my primary calling as Pastoral, whether serving in the parish, as a professor in a Christian university or a Director of Pastoral Care at an RSO. As such, I have worked to maintain theological integrity with a Gospel center, confidentiality, availability to those in distress, to advocate for life, to respect authority as God-given and to be a good neighbor without showing favorites. All easier said than done!

Here are just a few examples where ethical challenges have occurred for me:

Confidentiality is a code of trust in the pastoral relationship but, in a setting of individuals with IDD, procedures of protections from negligence, abuse or

potential harm must be enforced. This would include reporting immediately any suspected, witnessed or reported abuse to the facility administrator for the purpose of further investigation. I had a staff person report to me conversations of potential negligence that they had treated as confidential. Unfortunately, they did not report this possible negligence/abuse immediately as required. Pastorally I was sympathetic, but I also had to protect the people supported by the RSO. I therefore had to inform the employee that I was required to report this to the facility administrator. Staff confidentiality does not protect against self-harm or the harm of others. The immediate necessity to break this confidence was not just a legal or procedural requirement; it ultimately protects the people I was responsible for as pastor, senior manager, legal advocate and ultimately as good citizen.

Keeping theological integrity with one's church body is necessary from the point of view of confessional subscription and promises made.

In this case the LCMS has clear statements about same gender marriage relationships. Nevertheless, in an organization which is an equal opportunity employer and is not permitted to discriminate based on sexual orientation, I had an obligation to equitably administer our organization's Employee Assistance Programs to staff who were in crisis. If the context were that of a same gendered household, it made no difference in terms of evaluating the needs and providing the resources to meet those needs. Help was provided without exception to personal circumstances or choices. Ultimately, for me, giving care has been about being present as Christ did who sought out people in all circumstances.

In the media, support for life often focuses upon when life begins. However, it is also an end-of-life concern. For families with loved ones with IDD it is often an anguished consideration. These are beloved sons, daughters, brothers, sisters who would NOT say these are "lives not worth living." Nevertheless, to help families have a clear understanding of what treatment and non-treatment choices they may have and what the consequences may or may not be has been perhaps most difficult, for them, and also for me. Some in the medical professions may counsel that there are no right or wrong choices, just the choice that you make based on the best information you have at the moment. This sounds plausible, but the lines don't seem so clear when it's you and your loved one, or when you are the pastoral person in the room and you are not so sure the best motives are in play. I will tell you there are times I felt that families did get more clarifying information because I was there. And, they did implement life supporting measures that may eventually have included a Do Not Resuscitate where it was best. But there were other times I am not so sure.

The immediate necessity to break this confidence was not just a legal or procedural requirement; it ultimately protects the people I was responsible for as pastor, senior manager, legal advocate and ultimately as good citizen.

Evaluating the Impact

As we (John and Mark) have compared our experiences as chaplains with each other, there are a number of common threads. Foremost, with Luther we appreciate the guidance that a doctrine of Christian vocations gives. Note the plural here! In point of fact, all followers of Christ do not really wear one hat vocationally, and the potential for vocational ethical clashes seems inevitable. Second, living as a follower of Christ is key to living with vocational ethical clashes. Being as Christ, being a neighbor in Christly garb, suggests that uncomfortable realities are not an excuse for ceding the field to those who are weak or resistant to living a godly life, but reason for engagement. This usually requires more listening, less talking, being present with the character of Christ. Looking to be available in the places and circumstances where God is working in the lives of people has risks. Those places and circumstances can sometimes look counterintuitive (at least superficially) to the doctrine and practice that we are dedicated to in our visible church association, but to BE “neighbor” in its truest biblical sense also means being in the highways and byways of human life.² Finally, when we are in the moment and there is a sense of responsibility to act, hopefully in a way that is good, right and true, there is also the likelihood that our uncomfortableness will NOT BE RESOLVED. We can try to justify the ethical position on very sound reasons, and even what we believe to be sound biblical reasons; still, we may be at odds with colleagues, even ourselves, and perhaps other possible biblical or reasonable positions. This means that we too must receive what God would freely give to all, namely grace, forgiveness for Christ’s sake, even if others are not so generous.

When institutions or organizations give chaplains a place for pastoral care, there is an opportunity to carry forward a pastoral vocation while living in the mix with other vocations. At times these can appear to ethically compete with one another. Under the Cross there is a unity of purpose and a Lordship that remains even when we as chaplains do not experience it that way.



The Rev. Mark D. Whitsett, Ph.D., over the course of 43 years, has served in parish ministry as a bi-lingual-multicultural pastor in New York City, Long Island, NY and in the Midwest. He served on the adjunct faculty (theology and religious studies) of Concordia University Wisconsin and was Director of Pastoral Care at Cedar Lake. He currently serves on the editorial board for Caring Connections. Mark rejoices to share in ministry with Deaconess/Chaplain Margy Whitsett, his wife of over 47 years, along

² The parables of the Good Samaritan, who proves to be neighbor in the godly merciful love that is exhibited (Luke 10:30ff), and the Master who would have his Banqueting Hall filled and therefore sends his servants to compel even the outcasts of society to come (Luke 14:12-24) are especially motivating to us here.

with their 6 children and 9 grandchildren. Mark and John have come to know each other through John's ministry at Resurrection Lutheran Church where Mark has often participated and assisted.



Chaplain/Pastor, Rev. John G. Hallock is married and has four children. He is a veteran of the US Air Force. He has served the Federal Bureau of Prisons for twenty-one years and worked at all security levels within the BOP as a Supervisory Chaplain, including female and medical units. Chaplain Hallock is currently assigned to the BOP's Central Office, Chaplaincy Services Branch, providing chaplaincy guidance and leadership for over 100 full-time staff and approximately 60,000 inmates for two (Mid-Atlantic & Northeast) Regions of the BOP's six regions. John is also the Pastor of Resurrection Lutheran (LCMS), Louisville, KY, where he serves as a part-time worker priest.

Living with Stigma: They, Them...We, Us—Me

Evan Evans

STIGMA SURROUNDING MENTAL HEALTH MATTERS continues to be alive and thriving. It rears its ugly head in the least expected situations, or at least when we have our guard down. From the stranger in the grocery store to the collar in the pulpit, stigma is all around us; fluid like, it has its own dark shadow.

For 10 years, I lived with the diagnosis of Major Depressive Disorder (MDD). Having changed my insurance in January 2022, I was required to see a new doctor. During our initial examination, she asked very succinct questions and carefully dissected the last 10 years of my medical records since my accident, just as other doctors have done. But her conclusion shocked me. I had been mis-diagnosed with Major Depressive Disorder (MDD) when I am actually battling a neurological disorder: Pseudobulbar affect (PBA).¹

PBA affects the brain in a way that sometimes makes it very difficult for a person to process emotions. I found out it's not that I just have depressive symptoms, but I have a neurological disorder that affects less than 200,000 people per year. PBA is treatable but cannot be cured. The mis-diagnosis put me in a maze where I struggled with a label that was carelessly given; and, the stigma associated with it has left me dumbfounded. Come to find out I have a neurological condition resulting from a car accident about 10 years ago and I had been treated by my doctor for something completely different.

Oddly enough at that moment, a huge burden was lifted off my shoulders. That burden was stigma. The stigma I had lived with for the past 10 years would never be changed, but from that moment forward, I no longer carried the same label. The label was no longer the truth, worse yet, it never was accurate in the first place.

Oddly enough at that moment, a huge burden was lifted off my shoulders. That burden was stigma.

Living with an incorrect label and receiving treatment for symptoms related to that label was crazy making. Told I had MDD, I had made many major decisions throughout those 10 years that changed the trajectory of my life. Once I got the right treatment for my Traumatic Brain Injury (TBI), Pseudo Bulbar Affect, I replaced the old label. And after reading about PBA, through my doctor, I became an active ambassador for the condition. That day changed my life, but the stigma has prevailed.

¹ *Mayoclinic.org* defines PBA in this way: Pseudobulbar affect (PBA) is a condition that is characterized by episodes of sudden uncontrollable and inappropriate laughing or crying. Pseudobulbar affect typically occurs in people with certain neurological conditions or injuries, which might affect the way the brain controls emotion.

If you have pseudobulbar affect, you'll experience emotions normally, but you'll sometimes express them in an exaggerated or inappropriate way. As a result, the condition can be embarrassing and disruptive to your daily life.

Pseudobulbar affect often goes undiagnosed or is mistaken for mood disorders. Once diagnosed, however, pseudobulbar affect can be managed with medication.

What exactly is this concept of stigma that surrounds mental health disorders? How do we quantify an abstract concept such as stigma? It is the glare I saw when standing at the pharmacy while a mother with more than two children in the cart picked up a handful of prescriptions to treat her postpartum depression. It is the highly respected leader of a church who referred a person to counseling because he is concerned about their mental wellbeing while he's confessing his malice involving a mis-diagnosis. It is the inferences of "they, them, and those people" that we hear during mental health presentations about barriers and mental illness from the elitists that profess no mental health issues of their own.

Wake up good people! ALL have mental health challenges; no one is exempt.

Wake up good people! ALL have mental health challenges; no one is exempt. Our very own loving Creator equipped us to experience emotions such as sadness when mourning a loss or the anxiety we felt preparing our first thesis defense. God gave us the gift of emotions. Yet, society portrays emotions by assigning a "one size fits all" label to them. We all have experienced mental health barriers or challenges and they can be situational or chronic. When these symptoms become patterned — such as evidenced by duration (2 weeks or more) and depth of effect on ADL's (Activities of Daily Life), we can get a doctor's advice just as we do for our bodies.

Our individual mental health extends into mental wellness. Mental wellness assumes an array of self-care and self-compassion that we need on a daily basis, i.e., exercise, praying, music, journaling, etc. It is the actions we take by setting boundaries, investing in personal growth, and taking time getting closer to God through open conversation. He is Yahweh, the God that loves us and wants to guide us to be the person He genuinely wants us to be mentally, physically, and spiritually.

Along with many others who have experienced deep losses during the pandemic, our family was impacted as well when my nephew died last year of Covid-19. My nephew was also the Godfather to my oldest daughter, Jessica. Saddened by the loss, I talked casually to a leader in my church and again I experienced stigma. So, saddened, I found myself writing laments to my Father, God.

While I was learning the art of continuous prayer, God revealed to me He always listens and answers, but not in my human definition of time. I learned that those conversations I have with God are the same concept as the embodiment of the Book of Lamentations on a much simpler level. I found that writing the laments of my heart-wounds to be a beautiful process of communicating with God on a whole different level, and extremely helpful in healing my heart.

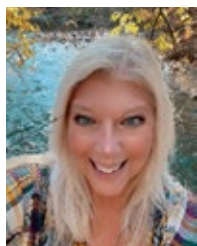
Realizing I was not alone in the journey, I identified a plethora of different examples throughout the Bible that normalize emotions of depression, anxiety and other emotions, especially in the Psalms. For example, David in Psalms 6:6-7 said "I am worn out from my groaning. All night long I flood my bed with weeping and

drench my couch with tears. My eyes grow weak with sorrow; they fail because of all my foes.” The Book of Psalms includes community-oriented and individual/personal laments.² Reading these laments in the Psalms and visualizing what David was going through helped me to find connection in my life, bringing it full circle.

The psalms are now part of my everyday self-care. A couple years ago, after I started participating in Trauma Healing Groups, a man there gave me a separate book of Psalms that I keep next to my desk. There I can write my own laments using some of the language of the Psalms to help me identify, express and process differing degrees of my emotions. That book of Psalms has opened my mind and will always be instrumental to my lamenting.

I then realized, looking back, that there was a message God wanted me to learn from this travesty. What I learned is that stigma is wrong, it is like a sticky web. Stigma is imposing your own thoughts and stereotypical ideas about a person’s (mental) condition that may or may not be true and doing it in a *shameful* manner. It is unethical. We are human beings; we all have mental health limitations! Let us talk in terms of what God commanded us to do. He wants to hear our lament during our trials and suffering, to talk to Him when were happy and as well sad or angry. He wants to hear from us, He wants us to communicate with Him and to rely on Him in every situation and on His guidance always. Let us not shallow ourselves and talk in terms of “They, Those, or Them,” but in terms of “We, Us and Me!”

My doctor has started titrating the MDD medications I was using before the new diagnosis. Because these medicines and the synergistic changes that dramatically affect brain chemistry and neural connections, it will take years to get off all of them, if ever at all, because they are so powerful. I pray to my Lord and Savior daily for strength and courage to face this, with Him leading me.



Evan Evans is currently working on a PhD in psychology. She has a passion for her faith and enjoys contributing to the choir as a flautist. Despite losing 90% of her vision in a car accident, Evan is an avid reader and researcher. A devout Catholic for 30 years, Evan raised her three daughters in the Catholic Faith and put them through Catholic Schools without a waiver of her own faith.

Following an exciting change to the Lutheran faith in 2019, Evan has found a new depth and richness to her faith and family life. Often, Evan can be found communing with nature, hiking and camping, soaking up a sunrise/sunset, and aspiring to become a goat farmer someday due to her love of animals and to teach goat yoga (goga) from her home in Indiana.

² A lament has a distinct structure and flow to it, always beginning with describing the specific suffering of a community or individual person. Many more of David’s laments are expressed throughout the Psalms and are written like songs: Psalm 3, 4, 5, 7, 9-10, 13, 14, 17, 22, 25, 26, 27, 28, 31, 36, 39, 40: 12-17, 41, 42-43, 52, 53, 54, 55, 56, 57, 59, 61, 64, 70, 71, 77, 86, 89, 120, 139, 141 and 142, just to name a few.

Definitions Matter

Cory A. Wielert

DURING A COURSE I TOOK in Classical Rhetoric over 20 years ago, the professor said, “He who controls the definitions controls the argument.” This has stayed with me since then. While it has always seemingly been true, it seems no truer words have ever been spoken to describe our current climate in the world. As some have suggested, especially in the public square, “goal posts keep shifting.” In essence, more things are being allowed, which can at times translate to definitions being controlled. In some cases, definitions of what we thought we knew something to be are no longer that, according to today’s defining capabilities.

This notion, which I would dare to contend to be a simple watering down of solids, has permeated many ethical foundations as well. What once was considered solidly wrong according to ethical standards has shifted, or through a redefining of terms, has become permissible, allowable, or at least probable. Most of these changes have occurred incrementally over a period of time. Therefore, it has become easier to make similar changes in more specific areas of ethics, beyond the political climate, into schools, businesses and the medical field. Of course, there are other places, like the Church and day-to-day relationships, that see or deal with ethics as well, which tells you how important the changing of definitions can be, let alone who has the control to make the changes in the first place.

This is why pastors in general and chaplains in particular are vital, because we, through faith, believe we hold the Truth. There is some caution, however, as St. Paul writes to Timothy in the second epistle, “For the time is coming when people will not endure sound teaching, but having itching ears, they will accumulate for themselves teachers to suit their own passions, and will turn away from listening to the truth and wander off into myths” (2 Timothy 4: 3-4). We are absolutely and unequivocally in this time—that is to say, the time is now—as we see an immeasurable number of individuals who have “itching ears” and who have clearly wandered off into “myths.”

This is a dangerous time when it comes to ethics, especially in an area like the medical field. Why? Because all you need to do is find the right person to narrate your myth—that is, a doctor to sign off on whatever it is you are concocting to fit your own selfish desires. Throughout my sixteen plus years I have encountered the “signing off” aspect on countless occasions from doctors to hospice agencies to simple day to day nursing aspects—simply to appease a family. Often it is to quiet a potential family member, more out of a desire to avoid having a

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complaint registered against the facility than to fight a potential harm to the patient or resident.

The advocacy of and for the resident has been shuffled aside to save face or, to in the end, mitigate the risk against the brand or the business providing the service. Appeasement is another downfall of ethics, because when a family member wishes to have a procedure done for a resident who is already facing a failure to thrive situation, there ought to be some questions asked.

One would be, “Why?” If the resident or patient is already approaching their end of life, then what is the impetus behind the desire to prolong life?

While a chaplain is often present to advocate for life over death, there are still some instances where a chaplain should be wise enough to recognize

when death is near. Some procedures in such instances are unethical, especially when the impetus is grounded in financial gain or a family member’s simple desire to have mom alive longer out of an inability to let go.

In fact, for me, when I parse out what families are potentially thinking when making tough decisions, I often in my own mind question whether or not the decision is being made around monetary issues. “We need to do all we can for our 99-year-old mother.” “Why?” I ask in my head, but say, “So by ‘doing all’ you mean to say having all life-saving measures in place, including CPR?” “Yes,” they typically respond. “While I understand your love for your mother and your desire to keep her in your lives for as long as you possibly can, you must know if CPR is performed on her that she could possibly end up with cracked ribs or other complications?” “Yes, but we want her to stay alive for as long as she can,” they continue. “Even at the risk of her being absolutely miserable due to CPR complications or other life-saving measures?” “Yes,” they often say, “Absolutely.”

Then you dig deeper and discover who is living in Mom’s house, who is getting some of the pension monies or social security and you see why Mom “needs to stay alive.” Money. Greed. At times entitlement and more. But it is okay, because definitions of care keep changing, definitions of “need” keep changing and what we who bear the truth see as pride and entitlement, others see as deserving and completely warranted.

These examples are two I see often, but when you think about money as being the “love” behind the curtain, it helps you to understand certain aspects of people and their decision making in regards to medical intervention or the withholding of medical intervention. I also see money playing a part in taking the human factor out of the decision making for insurance companies, the government, businesses and some families. What happens when the human factor is reduced? A person becomes a number and nothing more. One person who cannot work due to dementia could

Some procedures in such instances are unethical, especially when the impetus is grounded in financial gain or a family member’s simple desire to have mom alive longer out of an inability to let go.

potentially be one less person contributing to society in some people's money driven eyes, and therefore when the person is reduced to a number, it becomes easier to erase said number through varying means. Some of those means include withholding certain medications, withholding certain life-saving measures or changing the definition of mercy to allow for euthanasia.

Definitions matter. They really do, and if money is at the heart of the changing of the definitions, those who hold the responsibility to bear light to the Truth, ought to be the ones speaking up. As Dietrich Bonhoeffer once said, "To not act is to act. To not speak is to speak." As pastors, chaplains, ministers and priests we ought to be bold in our actions and be a part of the conversation. Be a barometer for the Truth, because silence is getting the Church-at-large nowhere, and each day we are seeing the foundations of our society being overtaken by relative thought, coupled with erroneous entitlement.

In the name of what? Most often, in the name of money or personal gain. Perhaps this is why St. Paul bookends the thought quoted above with these two imperative thoughts... "I charge you in the presence of God and of Christ Jesus, who is to judge the living and the dead, and by his appearing and his kingdom: preach the word; be ready in season and out of season; reprove, rebuke, and exhort, with complete patience and teaching... As for you, always be sober-minded, endure suffering, do the work of an evangelist, fulfill your ministry" (2 Timothy 4:2,5).

Our ministry is fulfilled in speaking the Truth, bringing the Truth to light and bearing witness to the Truth in this world of ever-changing ethics based upon rapidly changing definitions. In short, as the band *Rage Against the Machine* once said, "You got to take the power back." If we can take the power back and reset the definitions based upon the Truth, then maybe the ethical landscape will once again change for the betterment, not of self, but of those we serve.



Rev. Cory A. Wielert is a 2006 graduate of Concordia Seminary St. Louis and currently serves as the Corporate Director of Spiritual Care for Lutheran Life Communities, where he oversees pastoral care for five communities. He has written for Hope-Full Living and been published in other various publications such as the American Geriatrics Society annual. Rev. Wielert resides in Crown Point, Indiana with his wife Kristin and four boys, Liam, Silas, Tobias and Atticus, where they all enjoy a variety of sports the boys play.

ELCA Chaplaincy Connections

Interested in connecting with other ELCA Lutheran chaplains around the country and with the ELCA leadership?

Rev. Christopher Otten, the ELCA Ecclesiastical Endorser, holds monthly Zoom calls on **the 15th of each month at 2 PM Eastern Time** to check in with the chaplains throughout the ELCA. He provides updates from his work and allows time for the chaplains to respond or ask questions.

To receive reminders that contain the Zoom link, you are encouraged to sign up to receive the email newsletter from his office by contacting Michael Sonnenberg at michael.sonnenberg@elca.org.

Contact information for the ELCA Chaplaincy office is:

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