

**Chaplaincy in the Modern Health Care System:  
Presence, Dying, and Community in the Advance and Subversion of Biopolitics**

By

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# CHAPTER 1

## INTRODUCTION

Let us walk together, for a moment, in my memory of entering a large, university hospital, a medical center connected to one of the top research universities in one of the major cities in the United States. First, before entering, we cross the bridge over the river that divides this city. Regard for a moment those sleeping under the bridge, the series of sleeping bags, a few tents. The bridge is quite high, so we can only see the spot from far away, populated with bodies long neglected in our city. But they are there nonetheless, and we will need to think about the connection between such indigent lives and the medical center later in the dissertation. Now we walk through the university to which this hospital is connected. Feel the awkwardness of its colonial brick sidewalks; see the ornate, castle-like structures that serve as classroom and administrative space, so different from the skyscrapers we can still see if we just glance behind our shoulders. The campus is also a contrast from the scene under the bridge just a few blocks away – so many boundaries that we erect to separate ourselves from each other.

On to the entrance of the hospital! It is morning, right at shift change, so we are a part of this large flock of people, all compressing more closely together as we shift to fit through the large revolving doors of the main entrance. Some have coffee in their hands, determined looks on their faces. Others seem to be on autopilot, not quite ready to start yet another day here, but the clock moves us along. Many are in uniform scrubs – navy blue for the registered nurses, sky blue for the nursing assistants, grey for the unit clerks. A few physicians are in the crowd as well, already wearing their decorous white coats. These are marks of the medical hierarchy; everyone



dresses for her or his station. As we enter, nod briefly at the uniformed security officer standing with arms crossed, eyeing everyone just a bit suspiciously. She will need to check my badge, but I will let her know you are with me. So many networks of structure and power flow through this place, creating a sense of order and calm. People and organization flow through these doors at the same time.

Now, stop for just a minute here at the entrance, opening to this expansive room. To the far left is the hallway to the emergency department (ED). Two large, white swinging doors block off the main entrance from the ED waiting room. You would need to scan your badge and have the correct permissions to enter. Emergency patients enter from a separate door outside. To the far right is a long corridor with doctor offices. There are bathrooms down there and a few classrooms, but it is not space where I travel often. Then, in front of us, two escalators climb to a second floor. The ceiling of our entrance rises to the top of this second floor, so you can see both floors at once from where we are standing. Off to the sides both floors split into various hallways and elevator corridors, leading on to various patient floors, surgery centers, research labs, department offices, all the various destinations that cumulatively make up this hospital, this maze of healing and work. Look at everyone, going off to their designated place, their designated tasks. Feel the routine, the fast pace, *the institution* that we are a part of here. What an incomprehensible grid of activity, life, and power, this system! Sometimes I just stop here at the entrance and look in awe at this vast confluence of human industry.

The French philosopher Michel Foucault in the conclusion to his work *The Birth of the Clinic* writes of the beginning of modern medicine as an answer to death once mortality was understood as located within the flesh of the human body rather than controlled by more metaphysical conceptions of the gods or fate – a key development towards what he would later

call *biopolitics*. Once death became a part of the human body, the body in its inevitable decline, then a new science could be born, a new way to counter that toward which the body ultimately moves: “Medicine offers modern man the obstinate, yet reassuring face of his finitude; in it, death is endlessly repeated, but it is also exorcized; and although it ceaselessly reminds man of the limit that he bears within him, it also speaks to him of that technical world that is the armed, positive, full form of his finitude.”<sup>1</sup> Medicine reminds us of our impending death but only so as to counter it, to arm us against it.

Moreover, the technical world of medicine built around the fight against death *grows*, “unfolds endlessly,”<sup>2</sup> now that death is “open without remainder to the sovereign dissection of language and of the [medical] gaze.”<sup>3</sup> The language, knowledge, and technology of medicine dissect death, peering into it in order to master it, to gain power over it. In this mission, medicine proliferates; it keeps growing, as health care professionals find new ways to delay death, to stifle off decline. This unfolding task has built this huge center of healing, just a small corner of the vast network of healing institutions that cumulatively make up American health care. Think of this system before you, then, as an expanding instrument of mastery. It is like the high castle walls, all built up to surround and contain a common enemy, death. Look around you. As death has spoken, we have answered.

Yet, regard that older gentleman in the sharp black suit running off to the left hallway on the second floor, likely up to one of the hospital’s many intensive care units, or maybe to an inter-departmental meeting. He carries few markers, no scrubs, no white coat. In fact, other than his hospital badge, it would be hard to know that he belongs here in the hospital. This is one of

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<sup>1</sup> Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage Books, 1973), 198.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid., 196.

the hospital's chaplains; in fact he is my clinical pastoral education (CPE) supervisor Ralph, an understated man, small and quiet yet powerful when he speaks, always so steady and assured. He is thus a religious figure, but he carries no religious symbolism, no cross, crescent, or star on his lapel, no stole over his shoulders, no hat on his head. He blends into the crowd, just another human face in the hospital. This man has spent the better part of a career building up the pastoral and spiritual care office in this hospital, overseeing so many changes, so many caregivers, so much care.

My wife Lindsey is a master of nursing student at the university. She tells me one day Ralph gave a lecture to her class and related a story about his care with a dying child. Approaching the child's bed once when the patient was alone, when his understandably anxious and desperate parents had left for just a moment, the child suddenly brought up to Ralph his realization that he would soon die:

"I'm sick," the young patient said. "I'm going to die."

"Well," said Ralph, calmly, like this was a discussion he had all the time with children, "What do you think that will be like?"

I wonder if at that time Ralph was thinking about his own boys, grown and healthy but nonetheless fragile, just as close to death as all the rest of us. Or was Ralph thinking of his own death, a reality never too far from one's mind? What fears did Ralph have to set aside to ask that question, to look death square in the eye with that child, to peer into its void? In such ways, chaplains attend to death, sick and injured people thrown towards their mortality, as well as grieving families, friends, and lovers touched by loss in this hospital. When many in this place, in fact all of us at one time or another, need to fight off death as it approaches, the chaplain also

sits beside death, watches it, and feels it come. “What do you think that will be like?” asked Ralph to a dying child.

How do we fit these two realities together, on the one hand, the hospital as the grand human answer to death and decline and on the other, the chaplain, very much an extension of the hospital, sitting with and just staring into the void of death with a dying child? Certainly, the chaplain is a member of the hospital’s staff, a part of its general care of patients, but what exactly is the chaplain’s role in medicine’s pursuit of knowledge and power over death? How does the chaplain serve, or fail to serve, the trajectories of healing and cure in the hospital? And what are the implications of such service to chaplaincy’s own mission to be present to sick, hurting, and dying people?

When I work as a chaplain, I function through innumerable connections and vast networks. The chaplain is connected to her department, her patients, the hospital’s staff and administration. She is a part of the hospital, therefore a part of American health care, linked all the way through its local, state, and national levels. Because of the very size and intricacy of the setting and nature of my work, the meanings and the implications of my care as a chaplain always evade me, eluding my grasp and understanding. What interests and trends does my care serve or subvert? My work as a chaplain, set in such vast networks, always surpasses me, serving trajectories I can never fully know.

These questions and my memories of walking into that hospital, working with its staff, and caring for its patients continue to fill me with contrasting feelings of awe, confusion, appreciation, and sadness. I worked for this hospital in a CPE residency immediately after graduating from a mainline Protestant seminary. It was a nine-month, sixty-hour per week on-

site training program where I worked and trained as a full time chaplain.<sup>4</sup> Before that, I had worked a summer while in seminary doing similar work on an intern basis at another hospital, and now today, I continue to practice as a chaplain on a *pro re nata* (PRN) or “as needed” basis for a series of local Catholic hospitals in and around the city where I am finishing my PhD in Religion, Psychology, and Culture. This history means that at various times in my life, I have been steeped in the practices and questions of hospital chaplaincy, though I have not taken it as a career. I therefore make no claim of expertise in the practices and care of chaplaincy. Rather, I am both a researcher and a practitioner, coming to my practice with a series of questions and a lingering feeling of division and confusion. I then bring these experiences, feelings, and questions to this dissertation.

## I. Focus and Problem of the Project

This dissertation analyzes the relationships between hospital chaplaincy and the hospital in particular and American health care or biomedicine more generally on a political level, by which I mean on the level that examines the exercise and operation of power, not necessarily in the form of domination, but more subtly in the forms of influence, knowledge, and organization. More specifically, I explore the impact of the hospital’s systemic work to cure and heal its patients on the lives and deaths of those patients as well as chaplaincy’s advancement and subversion of this work. How does the hospital organize, separate, and systematize its patient population towards bodily healing? Who does this healing work benefit and what experiences

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<sup>4</sup> Clinical Pastoral Education is an educational program designed and accredited through the Association of Clinical Pastoral Education (ACPE). The training is divided into units, each consisting of 400 or more hours of on-site work and reflection on chaplaincy practice. ACPE requires four units of CPE to be certified as a professional chaplain. Though this dissertation focuses primarily on professional chaplaincy practice, CPE nonetheless remains the locus of my own experience with chaplaincy. For more information on CPE, see Association of Clinical Pastoral Education, “Frequently Asked Questions,” accessed July 9, 2015, <http://s531162813.onlinehome.us/faq/>.

and people are silenced, obscured, or coerced by this mission? Further, how is chaplaincy implicated in this healing as well as the organization, exclusion, and omissions of the hospital?

In order to understand the political trajectories of health care and chaplaincy, I situate both in the theory of biopolitics. Biopolitics is the operation – as well as the contestation – of what Foucault terms “biopower,” the power of life itself, or the power “to make live and to let die.”<sup>5</sup> Biopower is the power to manage, produce, and sustain life, as well as to order peoples and populations toward life and flourishing. As religious scholar Ellen Armour points out, biopower is distinct from, but also employs two older forms of power: sovereign power, the power of a sovereign ruler or government to take life by sheer force, and disciplinary power, the ordering of bodies and minds toward institutional and productive regularity.<sup>6</sup> As Armour puts it, “Exercising sovereignty now in the name of the people rather than the king, biopower works on and through the individual (aided and abetted by disciplinary power). Its ultimate targets are populations, its aim the survival and flourishing of the (human) race.”<sup>7</sup> I analyze the theorists and intricacies of biopolitics in detail in the body of this dissertation; however, for the purposes of this introduction, I characterize biopolitics by three distinctive trends:

1. **The promotion of life:** Biopolitics is the organization of a population at varying levels – the city, the state, the country – into a political body for the purpose of that population’s survival and health. Towards the promotion of its life, the political body structures itself through institutions such as hospitals, schools, prisons, military branches, and the market in order to ward off various internal and external threats as well as to organize, reproduce, and advance itself. In this way, the trajectory of biopolitics exceeds any one

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<sup>5</sup> Michel Foucault, “*Society Must be Defended*”: *Lectures at the Collège de France 1975-1976*, trans. David Macey (New York: Picador, 2003), 241.

<sup>6</sup> See Ellen Armour, *Signs and Wonders: Theology after Modernity* (New York: Columbia University Press, 2016), 26.

<sup>7</sup> *Ibid.*, 29.

particular body or life, but the preservation and placement of such lives in mass are its general aim. Thus, the hospital, as a center of healing and the fight against death, is central to biopolitics.

2. **The production of knowledge:** Towards the promotion of life, the political body constructs fields of knowledge that substantiate the power that its institutions hold over its individual members. I have already alluded to one such field in medicine, the knowledge of death when decline is located within the human body. Once death was located within the body's fleshy material, then a science of the human body could proliferate, examining all the intricacies of the body, unraveling its many secrets, and creating a series of practices that exercise control over the body and its decline. This medical knowledge then functions to legitimize the power that the medical institution holds to name the realities of health and decline in individual bodies. Similar realms of knowledge have been created around human sexuality, spirituality, psychology, and delinquency. Each of these fields substantiates the power of various institutions to name the reality and shape the lives of individual people, all for the purposes of protecting and promoting the general life of the social body.
3. **The division of people:** The knowledge promoted by the social body and operating within its institutions filters people through various systems. In the hospital, people are divided between sick and healthy. Some are designated as patients, others visitors, others as staff. Then, each of these divisions is divided further. Patients are moved to certain halls based on the nature and severity of their illness. They are also divided on an economic level, between insured and uninsured patients, as well as those on Medicare, Medicaid, charity care, or paying out of pocket. These divisions then hold implications

for what services, technologies, and therapies are available to each patient. The staff is also divided neatly, not just from the patients, but from one another by the division of tasks and a hierarchy of orders, having wide implications on the economic security and the level of authority of individual employees. Substantiating such divisions, health and knowledge are not passive and objective aims and fields, always already present and waiting to be discovered. Rather, they work actively to arrange people, with very real consequences on individual lives.

I know many health care professionals who work long careers dedicated to the health and flourishing of their patients, who sit with them through the ups and downs of their lives, and stand beside them in love and compassion in their deaths. On my better days, I try to be such a health care professional. This dissertation does not contradict or deny this reality; however, it is an analysis of the practices of health care, specifically of chaplains, *on a biopolitical level*. From this level, it is clear that while systems and professionals caught in the trajectories of biopolitics work to aid the individual members of a social body, this pattern can also tend to extremes that hurt not only individuals but also the social body itself. In this dissertation, I argue that such an extreme and damaging course is apparent in current practices surrounding death in American health care. This is a systemic political pattern in which professionals, patients, and families are caught. It is a trajectory in which we each participate when we interact with American health care.

For the purposes of this dissertation, I examine death on a phenomenological level, by which I mean on the level of direct and immediate experience. On this level, death is known and felt as the end of experience, the loss of the self, or the loss of the other. At this level, I refuse to see death as gain or fulfillment; I do not look to promises of a hereafter. Death may in fact be all



or none of these things, but whatever death is, it is immediately the end of life; it is loss. I remain at this phenomenological level precisely because I argue that health care today is unable to articulate, envision, or deal with death at this level, as loss. Rather, in health care we seek to master death, to cast power over it and control it. In the trajectory of biopolitics, health care today functions to sustain its patient population and control the demise of the body, employing languages of treatment, therapy, and choice that obscure the experience of loss inherent within dying and death. Even when health care examines death directly, as in the palliative care and hospice movements of today, we transform death into a moral idea of acceptance and self-realization that again obscures loss. Medicine has produced knowledge of death in order to treat it, to ward it off or to manage it. In doing so, patients, families, and loved ones are separated from their own experiences of decline and mortality. Death, this pervasive reality within the hospital, is thus rarely expected and strangely silent.

What then of the chaplain, the one who sits at the bedsides of dying people? I argue that the hospital chaplain is caught up with the biopolitics of life in the hospital. This is in fact a necessity due to the precarious place of the chaplain within the secular hospital where the dictates of medicine determine not only the allocation of limited power and scarce resources, but also the focus, agenda, and limits of knowledge and practice within this setting. Centered in the hospital, chaplaincy must work within and expand the biopolitical trajectory of health care.

I argue chaplains do this in two ways. First chaplaincy brings a new realm of experience into the knowledge and assessment of biomedicine, that of spirituality, providing another avenue for the hospital to know and manage the experience of dying. Second, chaplains articulate their work as being a caring presence to the patient, approaching the patient without agenda, simply accepting the patient and her approach towards her illness and eventual death. I hear in this

approach an unspoken resistance to the biopolitics of life and treatment prevalent in the hospital, one that sets chaplains at odds with the task-driven operations of the hospital. Nonetheless, I argue that ultimately this weak resistance works to further biopolitics rather than subvert it, because such work fails to offer an alternative to medical power's ability to name and manage the reality of the patient. Through the chaplain's presence, the patient simply learns to accept her experience as medicine determines it, a reality that again obscures the experiences of death or transforms death as loss into a moral imperative of self-realization. In these ways, chaplains further rather than subvert the excesses of a medicine that cannot reckon with the loss of death.

Questions remain, however, of chaplaincy's agency within this system. Is chaplaincy simply an instrument of these wider health care trends, or does it also move health care, however subtly, towards something different? Remember the figure of Ralph, sitting with that child, staring with him into the void of death. How exactly does this image of the chaplain function to subvert the biopolitics of life? This is the central question of this dissertation.

## II. Two Powerful and Inadequate Solutions

Before answering this question, I need briefly to examine two prominent solutions within chaplaincy, religious studies, and the spirituality and health literature in order to set up a contrast with the approach I am taking. These answers move in separate directions, differing in their response to the question of biopolitics and chaplaincy care. In one direction, scholars and practitioners note the precarious place of chaplaincy within the modern hospital, given the tightening budgets of hospitals today as well as the contrast between the task and outcome orientation of the hospital and chaplaincy's reliance on more vague terms like spirituality and presence. These scholars push chaplains towards medicalization, conforming their practices more

overtly to the hospital in order to maintain chaplaincy care as a humanizing position within medicine. Conversely, moving in a different direction are chaplains and theologians who push the profession towards a more overtly confessional stance. These scholars ask chaplains to ground themselves in historical traditions and communities in order to offer a more substantial, prophetic contrast between the trajectories of medicine and care.

Sociologist Wendy Cadge exemplifies the first trend in her study *Paging God*. Cadge interviewed chaplains and department directors of seventeen secular hospitals and then spent a year following staff chaplains and intensive care staff at two hospitals,<sup>8</sup> seeking to answer the question of what “public and not so public forms of religion and spirituality take in medical settings.”<sup>9</sup> This question brings her into issues of the connection between chaplains and the wider hospital, where she sees a disconnect between the “looseness and variation in the identity and tasks of chaplains”<sup>10</sup> and their “broad talk of spirituality”<sup>11</sup> in terms of presence and care in contrast to the specified tasks and measurable outcomes of other professionals in the hospital. In order for chaplains to remain “the religious and spiritual experts in health-care organizations,” she recommends that chaplains adapt to the hospital.<sup>12</sup> She offers several proposals towards this end. Cadge would have chaplains (1) develop evidence based literature showing the effectiveness of chaplaincy care, (2) address chaplaincy care outcomes to the specified needs of the hospital, (3) move from humanities based educational requirements to more overt training in science and research, and (4) create standardized, professional licensing.<sup>13</sup> These are the

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<sup>8</sup> Cadge outlines her method in *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 214-226.

<sup>9</sup> *Ibid.*, 3.

<sup>10</sup> *Ibid.*, 127.

<sup>11</sup> *Ibid.*, 128.

<sup>12</sup> *Ibid.*, 203.

<sup>13</sup> *Ibid.*, 203-207.

necessary adaptations, Cadge argues, in order for chaplains to remain a caring presence with those who are sick and dying.

Cadge is echoing a wide range of literature in chaplaincy and the spirituality and health movement that argues that chaplaincy care both supports the wider aims of the hospital while at the same time transforming the institution with its care and presence. For example, a white paper from several chaplaincy organizations notes the necessity of spiritual care for the well-being of the hospital's patients: "A growing body of research demonstrates the health-related benefits of religious and spiritual beliefs and practices."<sup>14</sup> At the same time, it argues, "Spiritual care [also] contributes to a healthy organizational culture...Chaplains not only help staff members cope, but empower them to recognize the meaning and value of their work in new ways."<sup>15</sup> These organizations argue, in other words, that chaplaincy adapts to the wider aims of the hospital while at the same time contributing to institutional change. The first move is an immediate necessity, moreover, because of the precarious place of chaplains in biomedicine. Physician Harold Koenig, director of the Center for Spirituality, Theology and Health at Duke University, is a leader of the spirituality and health movement both in carrying out studies and compiling the movement's literature. He points to the increasingly numerous studies that link chaplaincy care to better health outcomes as well as higher patient satisfaction and compliance while in the hospital.<sup>16</sup> At the same time, Koenig laments, "Unfortunately, there are not enough chaplains

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<sup>14</sup> Larry VandeCreek and Laurel Burton, eds., "A White Paper: Professional Chaplaincy: Its Role and Importance in Health Care," *The Journal of Pastoral Care* 55, no. 1 (2001): 88.

<sup>15</sup> *Ibid.*, 84.

<sup>16</sup> As Koenig reports, "I did a MEDLINE search using the keywords 'religion' or 'religiousness' or 'religiosity' or 'spirituality' and 'health,' 'medicine,' and 'patient care' for six-year periods beginning in 1982, compared to all published articles during the eighty years between 1902 and 1981. Here are the results: 1902-1981: 3,369 articles; 1982-1987: 1,367 articles; 1988-1993: 1,976 articles; 1994-1999: 2,782 articles; 2000-2005: 4,108 articles; and 2006-2011: 5,155 articles. This means that in *each of* the last six-year periods since the year 2000, more peer-reviewed journal articles on religion, spirituality, and health have appeared than during the entire eighty-year period from 1902 to 1981." Harold G. Koenig, *Spirituality in Patient Care: Why, How, When and What*, 3<sup>rd</sup> ed.

employed by hospital organizations to screen all patients or address the spiritual needs that are present...In the current environment of intense competition among hospitals to survive financially, chaplain services are often the first to be downsized or eliminated.”<sup>17</sup> If chaplains do not adapt to the hospital, then whatever change they can offer will soon be rendered moot by their absence.

I am sympathetic to such arguments and recommendations. I echo similar concerns in the first chapter of this project when I argue that chaplains are in an increasingly precarious place in the hospital due to their differing methods and assumptions from biomedicine. I also agree that current care practices by chaplains advance the health and well-being of patients in substantial, measurable ways. The more that chaplains can articulate these benefits to safeguard their place in the hospital, the better. Further, I agree that whatever change chaplains make to the biopolitical trajectory of the hospital will by definition be an internal subversion. Chaplains *are already implicated* in and a part of the biopolitical trajectory of health care. Any attempt to separate care from this trajectory will fail to take into account the close relationship between the setting and practice of chaplaincy care. As a part of the hospital, any subversion that chaplaincy leads is therefore a change that health care does to and within itself.

However, I also argue that the push towards adaptation by Cadge and others is premature. Before adapting any further to medicine, chaplains must first assess the current political trajectory of their setting and their place within it. Chaplains have yet to explore the political ramifications of health care and biopolitics in any prolonged or substantial way, particularly as they impact the experience of death and decline within the hospital. Cadge herself does not focus

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(West Conshohocken, PA: Templeton Press, 2013), 4. I review the impact of this literature as well as its contribution to buttressing chaplaincy in the hospital below. See Section II.A in chapter 1.

<sup>17</sup> Harold G. Koenig, *Medicine, Religion and Health: Where Science and Spirituality Meet* (West Conshohocken, PA: Templeton Press, 2008), 25.

on political questions about health care trends.<sup>18</sup> Rather, her research addresses how religion reveals itself in discourse and practice throughout the hospital. However, as a chaplain myself, I wonder if we can easily separate care from politics. If trends within the hospital are directly impacting the lives and deaths of our patients, how can chaplains fail to inquire into and critique such trends and remain spiritual caregivers to their patients? Before chaplains further medicalize their work, they must first understand where medicine is going and how these trends are impacting patient experience before they unknowingly further these trends more directly. The current study is a start to such an analysis.

Conversely, the second group of scholars focuses more directly on the detrimental impact of health care practices and politics, which they contrast with the tenants of historical, confessional traditions and communities, most prominently those of Christianity. One of the leading advocates of this trend is the theological ethicist Stanley Hauerwas. He critiques the medical imperative of life as an ultimate end in itself, producing medical practices that have no internal limitations, drastically expelling resources without taking into account larger questions of the quality or purpose of life. Without a more comprehensive narrative, Hauerwas contends that, “cure, not care, has become medicine’s primary purpose,” and “physicians have become warriors engaged in combat with the ultimate adversary – death.”<sup>19</sup> In contrast, he calls for the Christian faith narrative overtly to structure medical practices in a confessional community. “In short,” argues Hauerwas, “I think that Christians may well find that they will need to develop a

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<sup>18</sup> Cadge does offer a chapter on chaplaincy care around death and notes that, “In their work with the dying, chaplains first call death by name. They describe this naming as challenging medical silences around death.” However, the chapter is more focused on chaplaincy’s management of death for the hospital rather than squarely addressing biopolitical health care trends. *Paging God*, 177.

<sup>19</sup> Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1990), 101.

medicine that reflects the Christian difference.”<sup>20</sup> By this, he envisions a Christian medicine that prioritizes the belief that the patient belongs to God first and foremost over the imperative to cure the individual. Whether or not that person can be cured, the patient is therefore to be cared for and kept close to the community.

Following in this line of thinking but more directly pertaining to chaplains, practical theologian Steven Pattison critiques the idea of generic spirituality, a term that I explore in depth in the following chapter referring to a generalized human capacity to make meaning out of a situation. Chaplains have pursued spirituality as the basis of their care rather than rely on the authority of a historical religious tradition in order to care for patients across various traditions. Pattison argues that this spiritual care, in contrast to religious care identified more overtly with a historical tradition, contributes to the individualism and commodification of current health care practices.<sup>21</sup> In contrast, “For Christians, finding personal meaning and individual acceptance is not enough. The Christian life is about praise, worship and work in community with an active loving God.” Therefore, he argues, “Perhaps it is time that chaplains were more willing to remind themselves and others of this as their distinctive contribution to the Babel surrounding ‘spirituality’ in health care and elsewhere.”<sup>22</sup> The writer Greg Garrett, in a work analyzing the grief he witnessed during a summer CPE internship, echoes this recommendation. Garrett

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<sup>20</sup> Stanley Hauerwas, “Suffering Presence: Twenty-Five Years Later,” in *Healing to All their Flesh: Jewish and Christian Perspectives on Spirituality, Theology, and Health*, eds. Jeff Levin and Keith G. Meador (West Conshohocken, PA: Templeton Press, 2012), 252. Hauerwas develops his ethics more systematically in his early work *The Peaceable Kingdom: A Primer In Christian Ethics* (Notre Dame, IN: University of Notre Dame Press, 1983) where he argues that character, formed within the narrative of a living community, creates a certain way of being, which precedes and determines our actions and choices. In this way, agency comes from our ability to claim our lives within the narrative of the community that forms us. For Christians, this narrative is God’s story as revealed in the person and life of Jesus. Knowledge of God is given in revelation, but, Hauerwas contends, all knowledge of God is only intelligible as it exists in a continuing narrative held by the community that it forms.

<sup>21</sup> Stephen Pattison, “Dumbing Down the Spirit,” in *Spirituality in Health care Contexts*, ed. Julia Neuberger (Philadelphia: Jessica Kingsley Publications, 2001), 38. Pattison rejected his own critique of spirituality and spiritual care almost a decade later in his article “Spirituality and Spiritual Care Made Simple: A Suggestive, Normative and Essentialist Approach,” *Practical Theology* 3, no. 3 (2010).

<sup>22</sup> Pattison, “Dumbing Down the Spirit,” 44.

critiques narratives that he saw on display in the hospital, such as narratives of progress and absolute faith in medicine to heal or the idea that God forms contracts with creation and does not allow bad things to happen to faithful people. “Review your stories for false premises and faulty plots,” he charges, “seek a story that incorporates suffering but encourages hope; stand alongside those who suffer, who grieve, whose stories have fallen apart.”<sup>23</sup> Garrett finds such a satisfying story in the theology of grief by Henri Nouwen as well as process theology that envisions God as working alongside creation towards human flourishing. Such historic traditions and the communities that they form thus present a prophetic critique to inadequate or damaging narratives, including those that underlie current trends in health care.

As with the first, more adaptive approach, I am also sympathetic to the intentions of this trend. Much more than the former, it is willing to make the necessary critique of health care and biopolitical excess, especially as it leads to the emotional and physical suffering of patients. However, as I argue in the next chapter, chaplains have strategically moved away from more overtly confessional identities in order to survive within the secular hospital. The push to generic spirituality has been a necessity for care to operate within the increasingly secular and pluralistic domain of the hospital. The push for critique via historical traditions and communities thus fails to take into account the precarious place in which chaplaincy currently finds itself as well as the good that chaplains currently do in their strategically interfaith role.

Scholars of this trend make too clean a separation between chaplaincy and health care, failing to see how each is infiltrated by the other. They therefore also fail to appreciate the subversive experience of chaplains as a part of the hospital. Like these scholars, I too argue for chaplains to critique current health care excesses, though I believe that the core of this critique

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<sup>23</sup> Greg Garrett, *Stories from the Edge: A Theology of Grief* (Louisville, KY: Westminster John Knox Press, 2008), 116.



can only come from what chaplains already experience within and as a part of the hospital itself. Chaplains continually witness death and loss in the hospital, an experience directly at odds with the omissions and obscurity of death prevalent in the primary discourses and practices of the hospital. It is the experience of death and loss that can best speak against the excesses that would deny these realities. I believe that experience is a chaplain's best guide to critique, and to the extent that a prophetic tradition would speak instead of or dictate the direct experience of loss for a chaplain, then it may detract from the chaplain's best and most immediate tool to subvert the excesses of her setting.

Further, I argue that scholars of this trend hold a reductionist view of the spiritual care that chaplains offer. In my own experience of care with patients of a variety of faiths, I have found meaning in spiritual terms. Not only does spiritual support offer comfort in the midst of loss, but I also believe that inherent within spiritual terms, widely understood, is also a language of loss itself. For example, the name of "God," even when it is spoken between people of a variety of traditions with various understandings of that term, is a way of reaching into that which we do not know, that which is outside of our mastery and thus that which withdraws from us. I argue in the final chapter of this dissertation that speaking this name in the midst of death is a way of acknowledging death and loss as beyond management, therapy, or mastery. It is a way of acknowledging death and loss as realities in the midst of our experience, a way of saying that the void of the unknown is before us. Far from empty terms, therefore, I argue that the spirituality that a chaplain supports and carries is also experienced as a way of articulating and acknowledging the significance of loss itself. Thus, it subverts the biopolitical trajectory of health care.

### III. Argument and Chapter Outline

In sum, I argue in this dissertation that chaplains are caught in the biopolitical trajectory of modern health care that relies on narratives of progress, commodification, and treatment to the omission of the experience of loss and death. Chaplains advance this trajectory in their shift towards spirituality, understood as a dimension of health that can be assessed and charted, as well as their description of their work as an accepting presence, as described above. However, I also argue that chaplains simultaneously subvert this trajectory through their constant exposure to loss and death within the hospital. Chaplains experience this loss more immediately than other health care professionals precisely because they are present in the room without any other task or agenda other than simply to be with families and patients in the midst of loss. In order to further change current biopolitical trends within health care, chaplains must articulate their experiences of loss within the hospital more overtly in their literature rather than simply describing their tasks to substantiate their place within the hospital. However, even prior to this change, chaplains are already subversive of the biopolitical trajectory of their setting today through their use of spiritual terms, particularly the name of God, which I argue is also the name of loss and withdrawal. The chaplain thus casts an ambiguous figure, very much caught in the trajectory of biopolitics in its current extreme forms, yet also pulling the hospital towards an acknowledgement of loss and death, experiences tied intimately to life itself.

In the next chapter, I examine the history and on-going negotiations between chaplaincy and its hospital setting. Since the early decades of the 20<sup>th</sup> century, chaplains have lost professional standing through the decline of traditional religious authority. In order to maintain their practices of care within the hospital, therefore, chaplains have recast their professional identity in the terms and aims of biomedicine. This includes the profession's move from

identifying with religious traditions to a focus on spirituality. Specializing in spirituality, a generalized term denoting an essential characteristic in the patient, chaplains have argued that their work supports the health of all patients no matter their religious affiliation. Moreover, as a general human capacity, spirituality can be assessed, recorded, and incorporated in the overall care team's work. However, chaplaincy's negotiations with biomedicine remain incomplete. Working in amorphous terms like presence and spirituality, chaplains also find themselves at the margins of the task and evidence based orientation of biomedicine.

The third chapter moves to critical theories in order to assess the practices and negotiations of the first chapter on a social and political level. I first examine prominent theories that trace the modern discursive turn from religion to spirituality as a product either of American individualism or the commodification of neoliberalism. While I find both theories insightful in locating the political trends in which chaplaincy practice participates, I find them both overly reductive when applied to spiritual care in the hospital because they fail specifically to understand how spiritual care is a part of wider trends of biomedicine. I thus turn to theories of biopolitics by Foucault and Roberto Esposito because these theories illuminate how the "spirit" fostered and cared for in the hospital is a part of the general political trajectory of life and knowledge, as I have described these trends above. Moreover, theories of biopolitics illuminate the tensions within chaplaincy care, the ways it advances the control of death by medical power while at the same time acknowledging moments of loss between people.

In order to fill out and concretize the insights and claims of biopolitical theory, chapter four examines current trends in American health care. I analyze medical assumptions, ideals, and practices to illuminate medicine's push towards treatment and control of the human body, a one-sided pursuit that omits death as loss. This analysis shows the connection between medical

progress and consumerism, which leads to unequal distribution of medical services, on the one hand causing patterns of early and unnecessary death for underserved populations and on the other coercion and denial of the experience of dying for over-served populations when hospitals pursue futile treatment all the way to the end of life.

This analysis continues in the fifth chapter where I examine current trends in chaplaincy, palliative care, and the hospice movement. While these various movements cumulatively turn medicine more directly to the experience of dying, I argue they obscure death as loss by envisioning the experience of dying as a process that ends in acceptance and self-realization. The pursuit then conceals the experience of death as loss by recasting it as gain. I also note that many chaplains refuse the pursuit of acceptance of death, articulating their work as presence with dying patients, accepting their approaches to death without coercion. However, I argue that in practice, the acceptance the chaplain offers functions to bring the patient to self-acceptance, but fails to provide any other means to envision or articulate her reality, which is strongly dictated by biomedicine. Thus, the patient will then only move to her “truth” as determined by medical power. In this way, even when chaplains seek to resist medical coercion, they also support it.

I then turn in the final two chapters to a sustained examination of the subversive potential of current chaplaincy practices. My argument, as I note above, is that the experiences of chaplains in the hospital holds great subversive potential for the excesses of biopolitics, even while the work of chaplains nonetheless contributes to such excess. In the sixth chapter, I examine my own experiences of death as a chaplain through psychological and phenomenological theories of loss by Julia Kristeva and Jean-Luc Nancy. I propose that the chaplain participates in loss while in the midst of death. She is not just an observer or a professional, but she also experiences loss herself on various levels in her care. While chaplains

tend to focus, understandably, on explanations of their role and work in the hospital, they nonetheless experience loss, and if, as a part of the hospital, chaplains would focus on such experiences in their literature, it would counter the obscurity of loss itself in their setting.

Moreover, in the final chapter of the dissertation, I argue that even prior to such a shift in the literature, chaplains already articulate this experience of loss, though it is done today in the hospital indirectly through the language of spirituality. Employing the philosophy of religion by Jean-Luc Nancy, supplemented by the work of Jacques Derrida and John Caputo, I argue that within the name of God today, widely understood, is also a reaching out towards that which withdraws from us. Chaplains, patients, and family members hold many different meanings around the name of God. This plurality is made possible through the interfaith nature of chaplaincy care. Chaplains use that name while praying with people from many different traditions, and use similar terms to denote love and transcendence when speaking to those who do not believe in God. However, inside this name, I argue, is also the articulation of the experience of loss; we pray to a foundation or a presence that withdraws from us, that escapes us. With the name of God, we thus reach out towards loss itself; we reach out toward and acknowledge the significance of that which escapes us. In this way, we also underline the finality of death, its void and end. Thus, chaplains are already speaking loss through the name of God today. I end with concrete proposals of how to further this subversion.

#### IV. Method

The dissertation takes a practice – theory – practice shape reminiscent to the method of *Fundamental Practical Theology* articulated by Don Browning in early 1990s. The project begins with current chaplaincy and hospital practices, employs political, psychological,

philosophical, and theological theories to understand both what is going on in the practices and how they can be improved, and then returns to chaplaincy practice with a more nuanced understanding of its political implications and steps for change. Unlike Browning, however, the current project does not follow a critical correlational method as he defined it. According to Browning, practical theology is “a critical reflection on the church’s dialogue with Christian sources and other communities of experience and interpretation with the aim of guiding its action toward social and individual transformation.”<sup>24</sup> This dissertation does not focus on a church, narrowly or broadly defined, but rather on an interfaith profession,<sup>25</sup> and does not look specifically to Christian or other confessional sources,<sup>26</sup> precisely for the reasons given above in my critique of Hauerwas and others proposing a similar solution. Though my own background, like Browning’s, is rooted in liberal Protestantism, my emphasis here lies on religious experience un-grounded from any one tradition.

This project follows methodologically more closely to what political theologian Mark Lewis Taylor names “cultural-political theology,” because my focus on personal experience and political context mirrors Taylor’s own emphases, though I also deviate from this method as well.<sup>27</sup> Taylor outlines his method in three steps. First, cultural-political theology begins in *reflective analysis* of the author’s experience, memory, and social location. Beginning with the memories of a relationship that prompt his own theological explorations and questions, Taylor writes, “In a sense, the whole project is an outworking of those memories, without being

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<sup>24</sup> Don S. Browning, *A Fundamental Practical Theology: Descriptive and Strategic Proposals* (Minneapolis: Augsburg Fortress, 1991), 36.

<sup>25</sup> Though this profession does have historical roots within Christianity, it has intentionally dis-identified with this foundation through the turn to spirituality.

<sup>26</sup> In contrast, confessional sources are key to Browning’s method: “It is a practical process of putting the theory-laden questions that emerge from contemporary praxis to the great religious monuments of the religious tradition.” *A Fundamental Practical Theology*, 139.

<sup>27</sup> Mark Lewis Taylor, *Remembering Esperanza: A Cultural-Political Theology for North American Praxis* (Minneapolis, MN: Fortress Press, 1990), 24.

reducible to them.”<sup>28</sup> The same can be said of this dissertation. Memory and self-reflectivity, as I demonstrate here in the introduction, are central to this project. I begin each chapter with a memory of my work as a chaplain, though I have omitted names and changed specific circumstances to hide the identities of the patients I describe. I then use the lingering questions about my practices and experiences as the starting point for broader theoretical and theological exploration. In this way, the project also follows closely to practical theologian Heather Walton’s definition of autoethnography: “*Autoethnography is a way of using personal experience to investigate a particular issue or concern that has wider cultural or religious significance.* The experience here acts as a lens that allows us to see and interrogate aspects of the concern in question that might be missed in a more abstract discussion of ethics or values.”<sup>29</sup> Both Taylor and Walton thus point to an epistemology of personal experience, not as a detached, objective observer, but rather as “relational, provisional, embodied, and local.”<sup>30</sup> As a participant of wider social and religious forces and symbols, my experience becomes the lens and starting point for this dissertation on health care politics and spiritual care.

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<sup>28</sup> Ibid., 27.

<sup>29</sup> Heather Walton, *Writing Methods in Theological Reflection* (London: SCM Press, 2014), xxxi-xxxii. Italics are original.

<sup>30</sup> Ibid., xvi. Taylor also points out that his emphasis on self-reflectivity is meant as a corrective of correlational theology’s emphasis on distanced reason: “[Rebecca] Chopp especially has commented on tendencies among practitioners of correlational method to neglect focus on ‘the who’ of correlational theology. Rarely has there been much ‘hermeneutical self-implicature’ in strategies of correlation. Typically, ‘experience’ and ‘tradition’ are discussed in generalizable terms, without attending to the location of the theologians as phenomenologists of experience or as appropriators of tradition.” *Remembering Esperanza*, 26. See Rebecca S. Chopp, “Practical Theology and Liberation,” in *Formation and Reflection: The Promise of Practical Theology*, eds. Lewis S. Mudge and James N. Poling (Philadelphia: Fortress Press, 1987). Cited in Mark Lewis Taylor, *Remembering Esperanza*, 250, n. 10. Taylor and Chopp are writing prior to Browning’s employment of the correlational method in practical theology; however, Browning also holds high regard for distanced, though not objective, reason in his method: “Reason in the form of philosophical reflection must in the end be given a central role.” Don S. Browning and Terry D. Cooper, *Religious Thought and the Modern Psychologies*. 2<sup>nd</sup> Edition (Minneapolis, MN: Fortress Press, 2004), 19.

The project also follows Taylor's understanding of self-reflectivity as "explicit attention to...location."<sup>31</sup> By this, Taylor means a critical analysis of one's own social location, including the ways a person's identity situates her in networks of power relations. Parts of this project read as particularly critical of chaplaincy practice. However, though I do make statements of chaplaincy in general, such critique begins in the form of self-analysis, examining the ways in which my own practice is reflective of wider trends in hospital chaplaincy. Especially in the third chapter, moreover, I also analyze the ways identity markers of class, race, and gender lead to specific levels of positionality within health care. Though I do not analyze my own identity beyond my professional role and practice, I am also certain that my identity as a white, cisgendered male coming from a liberal Protestant background also influences my experience and therefore also my analysis of chaplaincy and biopolitics. The fact that my identity is wrapped in these dominant categories surely leads to bias in terms of the ways I feel implicated in the power networks in which I am situated.<sup>32</sup>

The second step of Taylor's methodology is *portraiture*, offering "a portrait not just of ecclesial tradition, but also of the forces of cultural diversity and political power that are never separable from that tradition."<sup>33</sup> This means for Taylor examining the differences within a tradition, the unspoken incongruences or points of tension housed within it: "The 'understanding' of the cultural-political hermeneutics presented in this book is one that relates tradition, difference, and critical resistance in an overall vision."<sup>34</sup> I too am offering a portrait in

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<sup>31</sup> Taylor, *Remembering Esperanza*, 26.

<sup>32</sup> In contrast, Teresa Snorton writes of the need for students of chaplaincy coming from minority populations to be able to voice anger with colleagues in order to give voice to unspoken and unheard pain. Though Snorton does not explore the implications of chaplaincy practice in health care politics, this article points to the differing ways power is felt and shared among chaplains of differing identity categories. See "What about All Those Angry Black Women?" in *Women Out of Order: Risking Change and Creating Care in a Multicultural World*, eds. Jeanne Stevenson-Moessner and Teresa Snorton (Minneapolis: Fortress Press, 2010).

<sup>33</sup> Taylor, *Remembering Esperanza*, 27.

<sup>34</sup> *Ibid.*, 73.



this dissertation, one that seeks to account for networks of power as well as inner points of tension. I do not investigate a religious tradition like Taylor but rather a professional practice with religious roots and values. As such, I am trying to draw an outline of chaplaincy's many unspoken connections to the powers, narratives, and practices that chaplaincy supports as it carries out its care in the hospital. However, throughout I have also sought to represent the complexities and tensions within these relationships and within chaplaincy's own practices, avoiding reductionism wherever possible.

Much of the portraiture of the dissertation comes in the form of deconstruction. The contemporary French philosopher Jean-Luc Nancy defines deconstruction as “always a penetration; it is neither a destruction, nor a return to the archaic, nor, again, a suspension of adherence: a deconstruction is an intentionality of the to-come [*l'á-venir*], enclosed in the space through which the con-struction is articulated part by part.”<sup>35</sup> Here, Nancy relates deconstruction closely to what Taylor means by portraiture. It penetrates, examining the construction as well as the tensions and resistances (that which is “to-come”) of something that from the surface looks complete and simple, like the caring practices of chaplains as health care professionals. Moreover, deconstruction, especially as it was practiced by Foucault, examines the historical nature of sciences and knowledge that appear objective.<sup>36</sup> As Foucaultian scholar Jeremy Carrette puts it, deconstruction seeks “to know the material conditions by which we know and

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<sup>35</sup> Jean-Luc Nancy, *Dis-Enclosure: The Deconstruction of Christianity*, trans. Bettina Bergo, et al (New York: Fordham University Press, 2008), 44.

<sup>36</sup> Michel Foucault, “Nietzsche, Genealogy, History,” in Michel Foucault, *Aesthetics, Method, and Epistemology*, ed. James D. Foubion, trans. Donald F. Bouchard and Sherry Simon (New York: The New Press, 1998), 371: “If the genealogist refuses to extend his faith in metaphysics, if he listens to history, he finds that there is ‘something altogether different’ behind things: not a timeless and essential secret but the secret that they have no essence, or that their essence was fabricated in a piecemeal fashion from alien forms.” Here Foucault is laying out his method of deconstruction as taking apart fields of knowledge by placing them within historical frameworks that illuminate their construction.

understand ourselves and the world at any one point of time.”<sup>37</sup> The portraiture of chaplaincy and health care that I articulate here is a sustained critique of knowledge and practices that appear unified and free of vested interest. For example, the agenda-free presence of the chaplain, the assessment and charting of spirituality, the therapy of acceptance at the point of death, and the prognosis given by a doctor all appear on the surface to be simple and natural procedures drawn from the realities of bodies and medicine. However, behind and within such practices, I trace biopolitical trajectories, vested interests, and exclusionary practices, not because chaplains and medical professionals are underhanded or pernicious, but because the practices we assume to be objective and therapeutic serve wider political aims, which we rarely see or understand completely.

The final step of Taylor’s cultural-political theology is *address*. Cultural-political theology never approaches tradition “in the singular,” nor does it “separate traditions from their cultural and political matrices.”<sup>38</sup> It always accounts for the heterogeneity, connections to power, and resistance present within a tradition. Nonetheless, it “marshal[s] senses of tradition (involving communal practices and texts)” in order to address the “cultural and political matrix with a new word.”<sup>39</sup> Such address must also take into account the networks of power revealed in portraiture in which the tradition already participates. For example, working with the Christian tradition, Taylor writes, “Christology also needs deliverance from itself, from major elements and pervasive orientations in its traditions that have reinforced and even intensified the corporate and personal pain worked by these systemic oppressions.”<sup>40</sup> In other words, the deconstruction of

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<sup>37</sup> Jeremy Carrette, *Religion and Critical Psychology: Religious Experience in the Knowledge Economy* (New York: Routledge, 2007), 27.

<sup>38</sup> Taylor, *Remembering Esperanza*, 28.

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.*

the tradition also impacts, and perhaps limits, the ways the tradition can also address the political situation in which we now find ourselves.

In the final two chapters of this dissertation, I too seek address, not from a specific religious tradition, but rather from experience that may be called “religious,” both because it spans from the plurality of religious values that chaplains hold and because it happens in the midst of spiritual care. This emphasis on experience is in keeping with the discipline of pastoral theology, the discipline of the theological academy that reflects critically on care practices. In pastoral theologian Bonnie Miller-McLemore’s words, “One studies religion at the point where human suffering evokes or calls for a religious response.”<sup>41</sup> This religious response is informed by religious traditions, yet experience also speaks back, informs, and shapes our understanding of that which may be called “religious” or “spiritual.”<sup>42</sup> In this work, such religious experience and address come in the form of loss. This address is also informed by my critique of the politics of life, the pursuit of cure, progress, and treatment that render opaque the experiences of death and loss. In such a setting, the experience of loss itself becomes religious experience, reaching out into that which transcends us and withdraws from us. In the last chapter, I equate the name of God with the experience of loss itself. Articulating loss and feeling its significance and finality, in a setting where such loss is all but invisible, is itself a transcendent experience, an address or a new word in a place so singularly focused on life.

Thus, the arch of the dissertation moves from self-reflective analysis, to portraiture, to address, following in the method of cultural-political theology outlined by Taylor though

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<sup>41</sup> Bonnie J. Miller-McLemore, “The Subject and Practice of Pastoral Theology as a Practical Theological Discipline: Pushing Past the Nagging Identity Crisis to the Poetics of Resistance,” in *Liberating Faith Practices: Feminist Practical Theologies in Context*, eds. Denise M. Ackermann and Riet Bons-Storm (Leuven: Peeters, 1998), 179.

<sup>42</sup> Thus, Miller-McLemore also names pastoral theologians as “those preoccupied with everyday concerns that evade and disrupt traditional categories, doctrines, and loci in theological and religious study.” “Also a Pastoral Theologian: In Pursuit of Dynamic Theology (Or: Meditations from a Recalcitrant Heart),” *Pastoral Psychology* 59 (2010): 823.

modified and expanded by my emphasis on autoethnography, deconstruction, and religious experience. The chapters divide somewhat evenly through the three steps of this methodology. The first two chapters focus primarily on the state of chaplaincy today; the middle chapters portray the political trends and practices of health care and chaplaincy; and the final chapters look to the experience of the chaplain as it counters the damaging trends in which it is implicated.

## V. Conclusion

Once I get onto patient floors and walk the hallways, peering through open doors to see who is awake and willing to talk, I sometimes hear the sounds of loss and grief. Occasionally family members and loved ones weep openly in the hallways and waiting rooms. Others just stare out into the space before them, clutching at their coats and bags with whitening knuckles. Oftentimes, from the hallway you can hear people who are sick in their rooms, moaning quietly. Every once in a while the sounds are much more noticeable, people throwing up, or yelling out as medications wear off. The sounds and sights of loss and faltering bodies are in fact heard and seen in the hospital. Mortality is starkly visible.

In contrast, in his first book Foucault writes a *History of Madness*, admitting that such a history is impossible, because the words of that which has been termed “madness” have lost the ability to speak for themselves. Rather, when madness speaks, its words or rumblings are known only through the language of reason, a language that condemns such speech to “madness,” the mad incoherent speech of the other, that which contains no sense, that which only speaks sick and condemned words. Therefore, writes Foucault, “To write the history of madness will therefore mean making a structural study of the historical ensemble – notions, institutions,

judicial and police measures, scientific concepts – which hold captive a madness whose wild state can never be reconstituted.”<sup>43</sup> Even today, if we hear speech or murmurings at odds with the conventions of “normal” or reasoned speech, we see it as a product of mental illness or deficiency.<sup>44</sup> Madness cannot speak without already being “mad.”

If we have lost “madness,” have we also lost death? Surely not, for we are all acquainted with loss, though some much more than others. We still see grief, death, and pain in the hospital. Yet, we are losing our language of death, or rather, our languages for death multiply endlessly, but in ways that elide death in its immediacy as loss. We have therapeutic, moral, and medical languages of death, which I trace in this dissertation, but in this proliferation, we are losing our ability to talk about sheer loss in the hospital. The omissions I trace in this dissertation are, therefore, less total than the dominance of madness. Death and decline are present in the hospital; we still meet these realities in the room. Nonetheless, they are becoming obscured, veiled, and unexpected.

An intricate network of medical power combats the decline and loss of death, and, admittedly, it has done much good in the process. It has healed our bodies and preserved our lives, both as individuals and as a population. Chaplains too, as a part of this network, have lent their support powerfully to those struggling with the realities of loss and illness. However, in medicine’s good work, the tracings of harm, omission, and exclusion are also present, the products of a system that cannot recognize loss without either turning away or prescribing a therapy. It is in an effort to reveal such omissions and to reclaim the experience of loss that I take the plunge that follows. Because death is becoming more and more controlled, obscured, and

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<sup>43</sup> Michel Foucault, *History of Madness*, trans. Jonathan Murphy (New York: Routledge, 2006), xxxiii.

<sup>44</sup> In Foucault’s words, “That pain and those words only exist, and are only apparent to themselves and to others in the act of division that already denounces and masters them.” *Ibid.*, xxxii. By “act of division,” Foucault is alluding to the division between reason and madness created by knowledge supporting historical structures of power.

excluded by medical power today, I embrace death – not to love it or redeem it, but to hold it close, so that this void and loss already tied so intimately to our lives can speak its name, and moreover, so that those of us who work in health care can be fully present beside dying and the grieving people, when death speaks.

## CHAPTER 2

### MODERN HOSPITAL CHAPLAINCY: NEGOTIATIONS

During my residency, I experienced my work as an on-call chaplain and a member of the trauma team at our university hospital as work in tension, exacerbated by the pressing nature of trauma itself, but continuous with the tensions I continue to feel in my work as a hospital chaplain as a whole. In my role as the on-call chaplain resident – a role designated to each of the residents once every week for a twenty-four hour period – I could receive the same page at any given moment day or night as the rest of the trauma team, including the surgeon, emergency department residents, nursing staff, registration, and security<sup>1</sup>:

“Trauma Alert. Multiple GSW [gun-shot wounds]. In route. 10 mins.”

“Trauma Response. Fall. In Bay.”

“Trauma Alert. MVC [motor vehicle crash]. UniversityStar 1 [the helicopter]. 30 mins.”

Knowing the general nature of the trauma, the destination of the patient, and the time before she would enter our hospital for care and treatment, I would gently take leave of whatever work I was engaged in and make my way down to the ground floor of the hospital, walking through the bustling emergency department (ED) halls and into the trauma room, an expansive area, with high ceilings, pale fluorescent lights, and a white vinyl floor. My supervisor once told us to

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<sup>1</sup> During my residency, the chaplain stayed in the hospital, or “in house,” throughout the twenty-four hours she was on call, which is itself a mark of the strong integration of pastoral care into the various care teams of that hospital. In my current position as a PRN chaplain, in contrast, I stay home and am called in to one of two hospitals when a chaplain is needed. However, unlike my residency, in my current position chaplains are not a part of the general trauma or code teams, so we are paged only when someone specifically asks to see a chaplain. I describe such a call in my current position at the beginning of chapter six.

check the impulse to run towards the trauma. In an ED that is already hurried, traumas, especially of the dire kind, can make staff move quickly, rushing to provide vital, life-saving care. The chaplain, in contrast, though a part of this team, is not there to save a life or to add to the rush, the commotion of the trauma. My role in the early stages of the call was simply to stand behind the desk, off to the side of the room, and watch as the patient was carted in, stripped of all clothing, examined thoroughly, and became subject to emergency measures. I was there as a presence, a body in the room, perhaps a witness, but not as one who moved in to perform a life-saving task.

Slowly, however, I did engage. I added my contribution to the team. My work, once the staff had finished their initial assessment, was to introduce myself to the patient – if she was lucid – and quickly offer whatever emotional or spiritual support I could. I tried to convey that I was with and for this patient, that my work was to be in relationship to her, to be a fellow traveler of this hospital system, far removed from the patient's experience of course, yet present and open nonetheless. But perhaps more officially, more immediately, my task on the team was also to get the names and numbers of whomever the patient would like to have contacted so that family, loved ones, or friends would know that the patient was in the hospital. I would bring to the patient paper and pen to write down the correct phone numbers. But even here in my official tasks, I did my work with stealth. I waited until the rest of the team had left the patient momentarily, when their attention was directed to phoning radiology or they were grouped together examining various test results. My work with the team, in other words, happened when the team was elsewhere, when my presence would not be an obstacle in the way of their medicine and treatment.



Gathering the numbers, I left to call the family. However, not being a medical professional, I was prohibited from giving any relevant information about the patient's condition or the reason the patient was in the hospital. I could only state the bare facts. Yet over time, I learned how to give cues. I would say, "Michael asked me to call you to let you know he is in the hospital," so the family could intuit that the patient was alive and awake. In contrast, if the patient was in critical condition or had died, when family information was pieced together from hospital records, a cell phone, or any identifying documents that the patient or paramedics brought into the hospital: "Michael is in our hospital. We need you to come as soon as possible."

After the call, I would enter phone numbers and brief information regarding my success or failure to reach the family into the trauma records. I would also make my own record in the patient's electronic chart, checking boxes to indicate if I had a "pastoral conversation" with the patient, if I offered "prayer," or "contacted family." I also noted the patient's "spiritual condition," checking off the appropriate box in the electronic form to indicate if the patient was, for example, "distressed," "angry," "coping well," or in "acceptance" of her condition. Having produced my documentation, if the patient was not in radiology or surgery or being subjected to any other medical interventions, I could see if she would like to talk, or had any more specific spiritual needs such as prayer, or would like me to call a member of her own clergy who shared her religious identity. If the patient was not available, I would ask staff to page me once the family reached the hospital, so that I could sit with them and offer the same presence, conversation, or prayer as they waited to see their loved one.

Such is the nature of the work of the chaplain as a member of the trauma team. But is "work" the appropriate term? At times it did not feel like an activity, especially when set beside the very active and specialized *work* of the rest of the team, with their hierarchy of orders and

tasks, their ever more sophisticated instruments, their unmediated access to the person and body of the patient. How does chaplaincy justify its place when standing off to the side of the fierce animation of the rest of the trauma team? How is chaplaincy a part of the same undertaking as this team when its “work” is so much that of *being* a presence rather than *doing* a task? As the London based palliative care chaplain Steve Nolan explains, “In general, healthcare chaplains seem not to see themselves as being there to *do* any particular thing with or for the people with whom they work, instead they speak of being with them.”<sup>2</sup> This “being with” means being a presence alongside the patient, an attempt to underline and convey the common humanity of chaplain and patient in a caring relationship. In the midst of jarring illness or injury, coupled with the disorientation that follows becoming subject to hospital procedures and interventions, the patient is to find in the person of the chaplain a caring, human presence. As chaplain Lawrence Holst puts it, “Broadly speaking, [the chaplain’s] task might be seen in this way: to help the patient retain his personhood apart from the devastation of his illness.”<sup>3</sup> However, precisely by their stress on presence, relationship, and personhood, chaplains are set apart from the defined, hierarchized, and highly technical interventions of the rest of the health care team. Chaplains’ amorphous work of presence stands in contrast to the team’s other, more precise interventions.

The Dutch pastoral theologian Heije Farber famously compared the work of hospital ministry to that of a circus clown, who is also an amateur among thrilling experts, the acrobats and artists of the circus. The clown belongs to the professional team of the show but is also isolated from it. She stands between the audience and the spectacular feats performed by other

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<sup>2</sup> Steve Nolan, *Spiritual Care at the End of Life: The Chaplain as ‘Hopeful Presence.’* (London: Jessica Kingsley Publishers, 2012), 60.

<sup>3</sup> Lawrence Holst, “The Chaplain Today,” in *Toward a Creative Chaplaincy*, eds. Lawrence Holst and Harold Kurtz (Springfield, IL: Charles C. Thomas, 1973), 6. Note: Holst uses the exclusive masculine pronoun throughout to designate all patients.

members, for instance, on the tightrope and the trapeze, yet she does not belong to either side. The clown is neither patron nor expert but stands as the link between the two, often playing the buffoon, the emotive, often silly human face of the production. For Farber, clown and chaplain both symbolize and therefore illuminate in their various settings the smallness of human existence, the common vulnerability of our situation amongst the great feats of modern medicine or the spectacle of the show.<sup>4</sup> However, the analogy of the clown, though edifying, also fails to grasp the on-going negotiations taking part in and through the experiences of the modern hospital chaplain. The clown is too static an image, too much a settled type or trope of an institution, while, as I argue in this chapter, the place and work of the chaplain today is unsettled, an uncertain and precarious position that must continue to negotiate for its place in the hospital, not only on the trauma team but also on the hospital floor.

In this chapter, I describe the continued professionalization of chaplaincy as a process of on-going negotiations for a position within the specialized and increasingly pluralistic hospital system. I analyze these negotiations in two sections. First, though the history of modern chaplaincy has been traced thoroughly elsewhere,<sup>5</sup> I briefly analyze the profession as formulated by two founding figures of modern American chaplaincy in the 1920s and 1930s, Anton Boisen (1876-1965) and Richard Cabot (1868-1939), precisely because these early formulations encapsulate the tensions found in chaplaincy today. Both figures conceived of chaplaincy as a

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<sup>4</sup> Heije Farber, *Pastoral Care in the Modern Hospital*, trans. Hugo de Waal (Philadelphia: Westminster Press, 1971), 81-94.

<sup>5</sup> For histories of clinical pastoral education, the educational movement that has sought to standardize chaplaincy training and expertise in the US, see Edward Thorton, *Professional Education for Ministry: A History of Clinical Pastoral Education* (Nashville: Abingdon Press, 1970); Charles Hall, *Head and Heart: The Story of the Clinical Pastoral Education Movement* (Decatur, GA: Journal of Pastoral Care Publications, 1992); and Stephen King, *Trust the Process: A History of Clinical Pastoral Education as Theological Education* (Lanham, MD: University Press of America, 2007). For a more general history of pastoral care in America, including the modern chaplaincy movement, see E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf and Stock Publishers, 1983). For an exhaustive history of chaplaincy in the UK, see Christopher Swift, *Hospital Chaplaincy in the Twenty-first Century: The Crisis of Spiritual Care on the NHS*, 2<sup>nd</sup> ed. (Burlington: Ashgate Publishing, 2014).

religious, pastoral presence with patients but at the same time also argued that such presence, though a form of religious care, fits the wider medical aims of the hospital. To do this, these figures retained the religious background of pastoral presence in chaplaincy but moved it into a medical frame, blurring the lines between the religious and medical character of chaplaincy.

The second section then moves to contemporary discourses around chaplaincy concerning the ways the profession has employed the term “spirituality” to separate itself from religion and substantiate its contribution to the medical system, including its place on the health care team, its own assessment and care plan, and the profession’s contribution to patient care records. Here, my argument is that contemporary deployments of spirituality have become a route for chaplains to base their professionalization within the wider aims of modern health care. Nonetheless, while spirituality has come to encompass and validate chaplaincy practice under a label associated with medical research and health needs, this practice also constantly escapes the medical context. This breakage continues to center around descriptions of pastoral presence that fail to fit neatly within the hospital context.

### I. Negotiating a Foundation: Boisen and Cabot on Modern Chaplaincy

The use of modern medicine derived from scientific testing and observation to treat isolated illness and injury is a relatively recent innovation in Western hospitals, dating back to the beginning of the 20<sup>th</sup> century. Prior to this biomedical movement, hospitals were often ecclesial charity organizations for both indigent and seriously ill people where moral instruction and worship accompanied long-term care.<sup>6</sup> As chaplain Christopher Swift records in his exhaustive history of chaplaincy in the United Kingdom, prior to the invention of modern biomedicine, chaplains were central to the operation of hospitals and infirmaries, ensuring

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<sup>6</sup> See Cadge, *Paging God*, 21-24.

regular worship and providing the sacraments.<sup>7</sup> Even after the Reformation, when the running of hospitals was frequently transferred from the church to city governments, chaplains often held high administrative positions where they exercised considerable power in overseeing the behavior of patients and inhabitants.<sup>8</sup> Ecclesial and clerical dominance in health organizations carried over from England to the United States, though eventually the early hegemony of American Protestant health organizations there and the Protestant clergy within them began to give way as Catholic and Jewish hospitals open to all faiths were established in the late 19<sup>th</sup> century to prevent unwanted proselytizing and the overbearing influence of religious authority.<sup>9</sup>

The place and authority of chaplains then began to diminish considerably during the biomedical innovations of the modern hospital at the turn of the 20<sup>th</sup> century. As church historian E. Brooks Holifield records, this diminished authority in the hospital coincided with the lowering of public esteem for religious ministry in America as a profession in general. While other professions were rising in status, particularly those in law and medicine, ministers in the early 20<sup>th</sup> century lost social standing as their educational standards and salary remained stagnant.<sup>10</sup> This loss of social capital meant that for chaplains to argue for their inclusion within the modern medical hospital, they needed do so on the basis of medicine itself rather than rely on their traditional or ecclesial authority.

At the same time, clergy and academics within theological schools were growing weary of the classical training for ministry, modeled on the European university system, which was concerned more with coherence in systems and doctrine than practical application or professional

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<sup>7</sup> Swift, *Hospital Chaplaincy in the Twenty-First Century*, 9-20.

<sup>8</sup> Ibid., 21. Swift also notes that directly prior to the biomedical turn in the hospital, institutions of the poor and sick in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries often became workhouses, where chaplains also exercised a great amount of authority in enforcing religious behavior and proper demeanor. See Ibid., 35-39.

<sup>9</sup> See Cadge, *Paging God*, 22.

<sup>10</sup> Holifield, *A History of Pastoral Care in America*, 216-217. Holifield attributes some of the enthusiasm around clinical pastoral education to the desire to increase status among ministers. See Ibid., 231-232.

training.<sup>11</sup> In the early decades of the century, the deans of major theological schools in America, including those of Harvard and the University of Chicago, called for more integration between theory and practice and sought to incorporate the new social sciences of sociology and psychology into the divinity curriculum, along with a new emphasis on a case study method of learning.<sup>12</sup> Thus, as trends stressing professionalization, scientific methodology, and practical application were gaining prominence within American society in general, and American medicine in particular, the role of clergy was diminishing. In order to keep their relevance, clergy sought to modernize their training.

Yet by the early 1920s, such professionalization had yet to catch up to chaplaincy while their influence within the hospital continued to wane and compartmentalize. Especially in secular hospitals, chaplains were made up largely of retired clergy and volunteers, without special training. These chaplains primarily visited patients of their own traditions.<sup>13</sup> It was not until the clinical pastoral education movement, beginning in the 1920s and becoming more widespread in the ensuing decades, that chaplaincy education began to standardize and move out of limited, denominational visitation. As I note in the introduction, CPE is an ordered, on-site professional training program for chaplains that continues today as the main educational route for professional chaplains during or after they have finished the required masters degree in theological education.

The beginning of CPE includes a range of founders, including William Keller, Russell Dicks, Philip Guiles, Seward Hiltner, Carol Wise, and Helen Flanders Dunbar.<sup>14</sup> However, in what follows, I focus on Anton Boisen and Richard Cabot, two of the most prominent early

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<sup>11</sup> See Hall, *Head and Heart*, 2.

<sup>12</sup> See Thornton, *Professional Education for Ministry*, 24-25.

<sup>13</sup> Cadge, *Paging God*, 23.

<sup>14</sup> See note 5 for histories that include these figures.

founders of the movement, because their writings illustrate the tensions present at the beginning of the professionalization of chaplaincy, tensions that continue to strain the profession today. Both writers made arguments for the inclusion of religious chaplains within the modern, biomedical hospital through their appeals to standardized chaplaincy training. However, to do this, they both variously sought to retain a religious emphasis on presence and growth within chaplaincy practice, casting these religious practices into a new biomedical mold. Moreover, in what follows, I take up both Boisen and Cabot together, though my emphasis will lie on the former, because they also represent two separate approaches toward professionalization, as Boisen sought to ground professional chaplaincy in psychological research of religious experience while Cabot, who rejected Boisen's psychological approach, sought to improve the application of pastoral skills in training chaplains. As illustrated in the second section of this chapter, both approaches, one emphasizing research and the other practical skills, continue as means chaplains employ to argue for their professional position within modern medicine.

#### A. Anton Boisen's Research Agenda

Boisen's formulation of chaplaincy is steeped in his own biography and his understanding of the religious aspects of mental illness and health. Prior to his work with CPE, Boisen was a Presbyterian minister who had struggled professionally, not only in his congregations that had failed to grow but also in his other attempted careers in the academy and forestry. In the midst of his professional struggles, Boisen was also plagued by recurrent psychotic episodes, which began in his early twenties and continued intermittently throughout his life. He was diagnosed with catatonic schizophrenia in his forties during his first hospitalization, which followed a psychotic episode that began while Boisen was writing out a

statement of faith.<sup>15</sup> This hospitalization would later serve as the basis for Boisen's formulation and justification of chaplaincy as religious care within a medical setting.

During this hospitalization, Boisen, as he would later recount after his release, was struck both by the absence of religious care and at the myopic physiological approach toward mental illness of the medical professionals within the mental hospital.<sup>16</sup> In contrast, during this hospitalization and then afterward while he pursued coursework in the psychology of religion at Andover Divinity School, then affiliated with Harvard University, Boisen concluded that mental illness, when not spanning from a physiological origin, could be understood as "the disorganization of the patient's world," which Boisen understood as a religious problem.<sup>17</sup> As in his own case, Boisen attributed such disorganization to a sense of personal failure and isolation when one failed to live up to the ideals internalized from "those whom we count most worthy of love and honor, those whose composite impress is represented by our idea of God."<sup>18</sup> In other words, religious values for Boisen represented communal values that the believer elevated into a sense of transcendence and divinity. The sense of failure of one's religious ideals was then a route to alienation from one's self and community, which in the case of mental illness could

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<sup>15</sup> Much has been written about Boisen's diagnosis, following his own deep interest in the religious roots of his illness. Carol North and William Clements, "The Psychiatric Diagnosis of Anton Boisen: From Schizophrenia to Bipolar Affective Disorder," *The Journal of Pastoral Care* 35, no. 4 (1981) gathered support for a biopolar diagnosis based on Boisen's intermittent, sudden onsets of affective psychosis. Donald Capps, *Fragile Connections: Memoirs of Mental Illness for Pastoral Care Professionals* (St. Louis: Chalice Press, 2005), on the other hand, leans toward a diagnosis of paranoid schizophrenia based on Boisen's biography. In the middle, Curtis Hart, "Notes on the Psychiatric Diagnosis of Anton Boisen," *Journal of Religion and Health* 40, no. 4 (2001) notes overlap in Boisen's symptoms between bipolar disorder and schizophrenia. This continued inquiry into Boisen's diagnosis, which began with Boisen himself in his autobiography, *Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience* (New York: Harper, 1960), displays the continued influence, interest, and mystery surrounding Boisen in the fields of religion and health, chaplaincy, and pastoral theology decades after his death.

<sup>16</sup> This is a focus in several of Boisen's publications. It is perhaps most prominent in his case for a clinical component to theological education in "The Challenge to our Seminaries," *Journal of Pastoral Care* 5, no. 1 (1951).

<sup>17</sup> Boisen, *Out of the Depths*, 97. In earlier research, I argued that Boisen's explanation of mental illness as religious experience was also a political move that allowed him to move out of the stigmatized position of "madness" to become a leader in theological education. See Richard Coble, "Maneuvers in the Depths: The Politics of Identity in Anton Boisen's Pastoral Care," *Pastoral Psychology* 63, no. 4 (2014).

<sup>18</sup> Anton Boisen, *The Exploration of the Inner World: A Study of Mental Disorder and Religious Experience* (Chicago: Willett, Clark, 1952), 285. Boisen summarizes his understanding of mental illness in his article "The Problem of Values in Light of Psychopathology," *The American Journal of Sociology* 38, no. 1 (1932).



culminate in total mental disruption. For Boisen then, mental illness itself was a religious issue; it was the result of a sense of religious failure and abandonment as well as a search for a new orientation.

With these conclusions, Boisen formulated hospital chaplaincy as care and pastoral accompaniment of those suffering such a disruption. For Boisen, pastoral presence in the mental hospital served to convey that “in the eyes of love any man is a good man if he is doing the best he can with the material he has to work with.”<sup>19</sup> Thus, the presence of the chaplain to the patient in the midst of mental illness was meant to disclose love, worth, and goodness to the patient. Moreover, these attributes were religious values to Boisen. For him, the church – and for Boisen, this meant mainline Protestantism – stands for values “held to be permanent and universal in human society.”<sup>20</sup> Thus, the presence of the chaplain is meant to convey that the mental patient is good and loved on both a personal and transcendent level, helping the patient through feelings of religious failure and isolation.

Boisen’s argument for religious components within the hospital context was buttressed by his attempt to root chaplaincy in empirical and practical research. From the start, research and care were interconnected for Boisen.<sup>21</sup> Following his studies at Andover, he gradually accumulated students at his first chaplaincy position at Worcester Hospital in Massachusetts with the help of Richard Cabot, then a professor at Harvard. Here, in a training program that

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<sup>19</sup> Boisen, *The Exploration of the Inner World*, 280. Boisen was particularly concerned that pastoral presence was not simply meant to convey religious permission for the patient’s self-indulgence, a trend Boisen critiqued among his contemporary pastoral care-givers, especially in the case of personal failures to control sexual desire. Pastoral care was meant to reestablish traditional religious values but to do so through care and love rather than condemnation. For a brief summary of Boisen’s understanding of sexuality, see James Poling, “Sexuality: A Crisis for the Church,” in *Pastoral Care and Social Conflict: Essays in Honor of Charles V. Gerkin*, eds. Pamela Couture and Rodney Hunter (Nashville: Abingdon, 1999).

<sup>20</sup> Boisen, “The Problem of Values,” 8.

<sup>21</sup> As Henri Nouwen relates it, “From the very beginning Boisen’s future plans show two sides: ministry to the mentally ill, and the study of the interrelationship between religion and certain forms of insanity. These two aspects of his future task have been closely related to each other and have remained connected all through his life.” “Anton T. Boisen and Theology through Living Human Documents,” *Pastoral Psychology* 19, no. 7 (1968): 52.

eventually evolved to become CPE, Boisen employed his students in what he saw as two interrelated tasks: service and study. The students split their time between working in three roles: as hospital attendants, chaplains, and scientific observers of the interrelationship between religion and mental illness.<sup>22</sup> However, his emphasis in the clinical program was on the last of these three components. Though he thought that the love and value conveyed by pastoral presence was the proper treatment for a disorganized personality, as historian Edward Thornton records, “The training program that Boisen conceived in the summer of 1925 was not designed to develop competence in pastoral ministries. It was a program of ‘cooperative inquiry’ into the psychology of religious experience.”<sup>23</sup> Such research was an answer to the growing disquiet in theological education mentioned above for more integration between theory and practice while it also answered the charge of medicine and the new professions to base chaplaincy in authority “grounded not in tradition but in experience,” meaning experience as observed and recorded in empirical studies.<sup>24</sup> Boisen admitted the need for this new basis of pastoral authority in his article “Challenge to Our Seminaries”: “It is, moreover, absolutely essential to have the co-operation of medical men, for here the provinces of religious and medical workers overlap, and the medical worker is now in possession of the field.”<sup>25</sup> Such cooperation meant following the lead of medical science to base the work of chaplaincy in empirical research, which would seek to ascertain the religious aspects of mental illness and to demonstrate the worth of pastoral presence empirically.

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<sup>22</sup> See King, *Trust the Process*, 27-30.

<sup>23</sup> Thornton, *Professional Education for Ministry*, 58.

<sup>24</sup> Boisen, “The Challenge to Our Seminaries,” 11.

<sup>25</sup> *Ibid.* Thornton notes that both Boisen and Cabot learned of the importance of such cooperation from their experiences with the Emmanuel movement, an early partnership between religious and medical workers in the early 20<sup>th</sup> century that ultimately collapsed as the doctors came to suspect and resent the religious workers who were seen as trespassing into medical issues without proper training or cooperation with the doctors. See *Professional Education for Ministry*, 35.

Nonetheless, while Boisen understood his research as a scientific endeavor on which to base the authority of both religious inquiry and chaplaincy practice, he continued to reiterate that the research nonetheless worked with traditional religious problems and issues. For Boisen, tradition and research sought the same answers with different methods: “We are trying to call attention back to the central task of the Church, that of ‘saving souls,’ and to the central problem of theology, that of sin and salvation. *What is new is the attempt to begin with the study of living human documents rather than with books.*”<sup>26</sup> Even in research employed to base chaplaincy in scientific investigation, Boisen reiterated that he was simply casting religious practice and inquiry into a new method of study, now examining people rather than texts to understand religious experience. He thus sought to tie scientific medicine and religious practice together via sustained empirical research.

Boisen thus aligned religious values with medical conditions in order to argue for religious care within the modern mental hospital. Throughout, Boisen stated that he was working with traditional religious issues and doctrine. Pastoral presence and love, and alternately isolation and personal failure, were religious elements that Boisen applied to medical problems, issues of psychosis, institutionalization, and mental health care. At the same time, he sought to validate this religious care by studying it empirically, arguing for chaplaincy’s religious practice on the basis of science. Thus, he sought to fit religious terms and practices into a healthcare context, casting each into the mold of the other and employing this argument to validate his training of chaplains to care for patients within the mental hospital.

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<sup>26</sup> This quote comes from a speech given by Boisen in Chicago in 1950 recorded in Charles Gerkin, *The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode* (Nashville: Abingdon Press, 1984), 200, note 2.1. Italics are Gerkin’s.

## B. Richard Cabot's Care of the Soul

In tracing the history of modern chaplaincy in America, it is necessary both to align and contrast Boisen's formulations with that of another key founder of the movement, Richard Cabot, a Unitarian layperson and a highly influential figure in medicine in New England at the turn of the century whose work was key to the foundation of both chaplaincy and social work. As noted above, Cabot was an early supporter of Boisen and his influence was key to Boisen's first placement at Worcester. However, a crucial disagreement arose between the two, which would eventually cause a rift in their relationship and would mark Boisen's waning influence over the CPE movement after Cabot withdrew his support. The break was over Cabot's disagreement with Boisen's understanding of the religious nature of mental illness.<sup>27</sup> As a clinically trained physician, Cabot followed the psychiatric consensus of his day that mental illness held only a physiological origin.<sup>28</sup> This difference meant that Cabot would need to base chaplaincy on a different foundation than research inquiring into the connection between religious experience and mental illness. In contrast to Boisen, Cabot found such a foundation in professional religious training for care of the soul.

Cabot, like Boisen, saw great value in the presence of chaplains as members of the health care team within the hospital; however, rather than aligning chaplaincy with medical research and cure as Boisen had done, Cabot emphasized the profession's own unique contribution to the aims of the health care team. As Cabot put it in his famous article, "A Plea for a Clinical Year in the Course of Theological Study," the training of chaplains within the hospital is, "Not a medical

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<sup>27</sup> It is debatable whether Cabot eventually broke with Boisen over their disagreement about the etiology of mental illness or over Cabot's distrust of Boisen's leadership following a relapse into psychosis. The break came immediately after Boisen's relapse in 1930, as Boisen explains in *Out of the Depths*, 170-171; however, King relates that the psychosis was an occasion for Cabot to settle the long-standing dispute over the causes of mental illness. See *Trust the Process*, 33.

<sup>28</sup> Boisen recalls this disagreement in "The Challenge to our Seminaries," 8.

year or a sociological year, but a year of practice in applying [chaplains'] religious beliefs in the attempt to encourage, to console, to steady human souls."<sup>29</sup> Thus, for Cabot chaplains are not to be involved in medical investigation or empirical research into the nature of disease. Rather, clinical training was meant to hone pastoral skills and application in order for chaplains to contribute their religious care and consolation as a unique part of the hospital's overall care.

Later, in a book co-authored with Russell Dicks, Cabot formulated the chaplain's role as contributing to the "*growth of souls*," meaning the growth of the spiritual and emotional life of the patient who grew weary in the bleak experience of illness.<sup>30</sup> For Cabot, this work contributed to the aims of the health care team but did not overlap with the work of the doctor or medical researcher. Rather, chaplains contributed a unique, religious dimension to the care of the hospital, not the cure of the body, which for Cabot was the origin of mental illness, but rather growth of the soul, a separate religious realm nonetheless related to the overall care of the patient. Thus, while Boisen sought to incorporate the work of religious care directly into medical treatment of disease via research into the religious origins of mental illness, Cabot sought more of a differentiated but compatible role between chaplains and doctors. He broadened the overall care of the hospital by adding a specified religious dimension in which chaplains could specialize via clinical pastoral training.

### C. Trajectories and Tensions

Despite their differences, both Boisen and Cabot have held lasting influence not only in CPE but also on contemporary chaplaincy practice. This is apparent in the impact of Boisen's

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<sup>29</sup> Richard Cabot, "Adventures on the Borderland of Ethics: A Plea for a Clinical Year in the Course of Theological Study," *The Survey Graphic* Number 40, no. 5 (1925): 276.

<sup>30</sup> Richard Cabot and Russell Dicks, *The Art of Ministering to the Sick* (New York: The Macmillan Company, 1936), 13. Italics are original.

research agenda, which argued for the adaption of what he saw as fundamentally religious issues and practices into medical testing and treatment via empirical study. This practice, as is demonstrated in the second section of this chapter, has become a trajectory within chaplaincy as a profession. Research both from within and around the profession has inquired into the effects of spiritual dynamics in the experience, treatment, and outcome of illness, and this research has been employed to validate the work of chaplains within health care.<sup>31</sup> Cabot also adapted religious values and practice into a biomedical frame, not by collapsing religion into medicine, but actually arguing to expand the scope of health care to include a religious dimension, what Cabot called the growth of the soul. This too has had a great impact on the practice and self-understanding of chaplaincy, as the profession has argued for the expansion of health care to include what today is known as the spiritual dimensions of life and patient care. At the same time, Cabot was influential in turning what became CPE into a training program for ministers, where students can hone their pastoral skills through practice and reflection on the hospital floor.

More pertinent for the focus of this chapter, however, are the negotiations undertaken by both figures in order to make a case for religious practice within the increasingly secular, biomedical hospital. Both Boisen and Cabot sought variously to retain religious practices and values within chaplaincy practice, though both made arguments reliant on the assumptions and aims of the hospital, rather than religion itself, in order to make a case for chaplaincy within this institution. Nonetheless, while they could not base chaplaincy on the authority of religion, they also variously retained traditionally religious values. Boisen maintained throughout his work that he was still concerned with questions of sin, salvation, goodness, and love, though he was

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<sup>31</sup> Boisen has held an even greater influence over the academic discipline of pastoral theology, with its study of the religious dimension of health and well-being, of which chaplaincy practice is a part of a much wider range of foci and practices. Boisen's foundational influence in this discipline is argued for strongly in Gerkin, *The Living Human Document*, 37-54 and Robert Dykstra, "Introduction," in *Images of Pastoral Care: Classic Readings*, ed. Robert Dykstra (St. Louis: Chalice Press, 2005).

interested in how these theological terms operated in a patient's experience and could lead to the disorganization and possible reunification of the mind. Likewise, Cabot held that religious concern for the state of the soul mattered much to one's experience and the outcome of medical treatment. As such, these two figures sought to bring religion into medicine in order to make a case for professional chaplaincy.

However, tensions remain within the practices and assumptions of chaplaincy as formulated by these early founders despite their efforts to mold religious practice within the aims of health care. Even as Boisen and Cabot sought to bring these spheres together, a number of questions remain regarding the compatibility of medicine and care originating from religious perspectives. For example, Boisen retained classic Christian theological terms in his understanding of mental illness. He not only spoke of love and presence, but he also retained terms such as sin and salvation, as noted above.<sup>32</sup> This orientation isolates Boisen's concerns to Christian patients, a barrier to the work of the increasingly secular and pluralistic setting of the hospital. Do questions of sin and alienation and values of love and presence, when originating from Boisen's Christian outlook, carry over to patients of other religions or to patients without a religion? If they could be translated to a different religious experience, how would the basic assumptions underlying Boisen's method and values need to be amended across these different populations? Assuming a predominately Protestant framework, Boisen failed to answer these questions. Further, are the practices of presence and accompaniment outlined by Boisen compatible with modern medical interventions? There was a disconnect with the medicine of his day because Boisen's recommendations did not deal primarily with a changes in body, but with a

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<sup>32</sup> Winnifred Fallers Sullivan traces the Christian, incarnational roots of the practice of chaplaincy presence in *Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014), 181-185.

holistic understanding of patients' own integration of their transcendent values. Boisen himself failed to reconcile these differences, and this discrepancy continues in chaplaincy practice today.

Finally, Cabot's attempt to widen medical concerns with issues of growth of the soul lays a traditional Christian practice, that of the care of the soul, onto the nonreligious setting of general medical care.<sup>33</sup> He does not answer how soul care can become a prominent value when it rests on a religious idea, the human soul, rather than a physical intervention within a setting in which religious narratives are ancillary to the concerns for health. Can the concern for soul growth, when it originates from a specific religious orientation, really exert any true influence or demand resources in the realms of health care?

These are the tensions and questions that Boisen's and Cabot's early formulations create and leave with modern chaplaincy at the beginning of its professionalization in the early decades of the 20<sup>th</sup> century. By molding religious values into a secular context, they elide the differences in how these two spheres conceive of care and treatment, leaving a fundamental tension within the work of professional chaplaincy. In the next section, I look at how contemporary chaplaincy has taken on the discourses of spirituality as a center of research and practice in order to substantiate its role within the hospital and unburden itself from the specific religious overtones of these early formulations.

## II. Spirituality and Contemporary Arguments for Professionalization

From these foundations in the early 20<sup>th</sup> century, chaplaincy has continued to professionalize. In North America the profession is structured within five major professional

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<sup>33</sup> Cabot's definition was later echoed in a widely used definition of Protestant pastoral care: "The ministry of the cure of souls, or pastoral care, consists of helping act, done by *representative Christian persons*, directed toward the *healing, sustaining, guiding, and reconciling* of *troubled persons* whose troubles arise *in the context of ultimate meanings and concerns.*" William A. Clebsch and Charles R. Jaekle, *Pastoral Care in Historical Perspective* (Lanham, MD: Rowman & Littlefield Publishers, 1975), 4.



organizations that have outlined credentials, standards of practice, and the core roles of chaplains within healthcare.<sup>34</sup> The Association of Professional Chaplains, the Association for Clinical Pastoral Education, the Canadian Association for Pastoral Practice and Education, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains represent today over 10,000 professional members practicing in North America.<sup>35</sup> Following the continuously growing and sophisticated infrastructure and literature of modern chaplaincy, in this section I argue that the questions inaugurated in the profession's foundation have been negotiated to a degree by the incorporation of spirituality, a new foundation that chaplaincy has employed to separate from its religious underpinnings and thus making room for it to be assimilated into the care teams of the hospital. However, because the care of chaplains today continues to rest on a relational concept of presence, such incorporation remains a negotiation, as chaplaincy amends its practice to suit the needs of the interdisciplinary team while seeking to retain the character of its care.

#### A. Spirituality as Professional Foundation

As an answer to the lingering tensions exemplified by Boisen's and Cabot's formulations, contemporary professional chaplaincy employs the discourse of spirituality as a foundation on which to tie its professional legitimacy. Today, spirituality is a contested domain of research and professional practice within health care, an amorphous term lacking an official definition, but one that also designates a sphere of growing concern and influence in contemporary American

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<sup>34</sup> These are summarized in VandeCreek and Burton, eds., "A White Paper: Professional Chaplaincy: Its Role and Importance in Health Care."

<sup>35</sup> For a brief summary of the historical development of CPE following Boisen and Cabot, along with the current educational standards and aims of the ACPE, see Teresa Snorton, "Setting Common Standards for Professional Chaplains in an Age of Diversity," *Southern Medical Journal* 99, no. 6 (2006).

hospitals. Chaplaincy literature tends to define spirituality as an inherent or essential capacity within human beings to create meaning out of their circumstances. The 2001 white paper named “Professional Chaplaincy: Its Role and Importance in Healthcare” is an official statement compiled by the five major chaplaincy organizations. Its first section begins by stating “Spirit is a natural dimension of every person. . . . The word *Spirituality* goes further and describes an awareness of relationships with all creation, an appreciation of presence and purpose that includes a sense of meaning.”<sup>36</sup> Definitions of spirituality seek to be wide enough to encompass all people, but also point to some transcendent dimension of meaning making, often with reference to interpersonal relationships. The contemporary psychologist and researcher Kenneth Pargament specifies spirituality further as the “search for the sacred,” where “the sacred” designates anything a person deems transcendent or divine, or any aspect of life that takes on transcendent significance, which Pargament further identifies with a sense of boundlessness and ultimacy.<sup>37</sup> This means that spirituality overlaps with religious concerns, but it also transcends any particular religious tradition or context, because it is something basic or essential rather than historical and cultural, like religious traditions. As contemporary psychologists of religion Ralph Hood, Peter Hill, and Bernard Spilka explain, “The connotations of ‘spirituality’ are more personal and psychological than institutional, whereas the connotations of ‘religion’ are more institutional and sociological. In this usage, the two terms are not synonymous, but distinct: Spirituality involves a person’s beliefs, values, and behavior, while religiousness denotes the

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<sup>36</sup> VandeCreek and Burton, eds., “A White Paper: Professional Chaplaincy: Its Role and Importance in Health Care,” 82. Similar essentialist definitions in the literature can be found in Mark Cobb, *The Hospital Chaplain’s Handbook: A Guide for Good Practice* (Norwich: Canterbury Press, 2005), 21; Mark Cobb, “Preface” in *Oxford Textbook of Spirituality in Healthcare*, ed. by Mark Cobb, Christiana Puchalski, and Bruce Rumbold (Oxford: Oxford University Press, 2012); Larry VandeCreek, “Defining and Advocating for Spiritual Care in the Hospital,” *Journal of Pastoral Care and Counseling* 64, no. 2 (2010): 2; and Stephen Pattison, “Spirituality and Spiritual Care Made Simple: A Suggestive, Normative and Essentialist Approach.” See also Cadge, *Paging God*, 97.

<sup>37</sup> Kenneth Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (New York: Guilford Press, 2007), 32, 39.

person's involvement with a religious tradition and institution."<sup>38</sup> Thus, chaplains employ spirituality to denote a certain capacity or search, often pointing to a person's pursuit of meaning, value, and purpose, while religion designates certain traditional, historical, and institutional routes in which communities have developed and filtered their spirituality.

This shift to spirituality, understood as an essential capacity, is a strategic move for chaplains within the hospital. While the separation between spirituality and religion is contested in the literature,<sup>39</sup> it substantiates the professional standings of chaplains in two dimensions. First, if spirituality is recognized as an essential element to human beings, then it can be seen as something independent from the historically situated nature of specific religious traditions such as Christianity. Spirituality thus becomes a generalized concern of human health and well-being and thus has significance as a dimension of health care. Whereas Boisen and Cabot kept religious ties to the work of chaplaincy, uneasily seeking to situate these within modern medical assumptions, today spirituality is understood as separate from any specific religion as a general dimension of being human. Separated from its religious moorings, spiritual well-being can become a generalized need crossing the boundaries of communities and contexts, and thus spiritual care can become a general service that hospitals can provide to all patients without fears of undue proselytizing or religious authority.

Proponents who advocate for spiritual care within the hospital then point to research that suggests that spiritual well-being is linked to greater bodily and emotional health as well as better experiences within the hospital. This includes research that links spiritual well-being to

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<sup>38</sup> Ralph Hood, Peter Hill, and Bernard Spilka, *The Psychology of Religion: An Empirical Approach*. 4<sup>th</sup> ed. (New York: Guilford Press, 2009), 9.

<sup>39</sup> See the discussion of commodification and spirituality in chapter 3 below.

lower levels of abuse of tobacco, alcohol, and drugs,<sup>40</sup> better overall mental health,<sup>41</sup> and greater community support.<sup>42</sup> Further, as Harold Koenig catalogues thoroughly in his work *Spirituality in Patient Care*, inquiring into and meeting spiritual needs within the hospital has been linked empirically with greater overall patient satisfaction, greater compliance with medical instructions, increasing patient trust in physicians, more effective coping with illness, and greater use of hospice services over heroic care measures at the end of life.<sup>43</sup> Through these studies, spirituality, without recourse to a particular tradition or community, becomes linked generally to the ends of the hospital, in both bringing about greater health and in improving the experience and compliance of patients within its system. By taking transcendent meaning making outside the particular traditions in which such meaning has historically been made, researchers have created or isolated a category of experience that purportedly crosses all populations of the hospital. Thus, by offering spiritual care, chaplains can argue that they are addressing a general need, demonstrated with the backing of empirical research, rather than appealing to a limited, communal tradition that those within the modern, pluralist hospital do not share universally.

The second way spirituality grounds chaplaincy care is through its utility across different religious orientations. Because spirituality has become a generalized concern connected to but also transcendent of particular religious traditions, chaplains can claim specialty in a type of care

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<sup>40</sup> Compilations and reviews of this literature can be found in Cynthia Geppert, Michael Bogenschutz, and William Miller, "Development of a Bibliography on Religion, Spirituality and Addictions," *Drug and Alcohol Review* 26, no. 4 (2007); Joan Kub and P. Ann Solari-Twadell, "Religiosity/Spirituality and Substance Use in Adolescence as Related to Positive Development: A Literature Review," *Journal of Addictions Nursing* 24, no. 4 (2013); João Castaldelli-Maia and Dinesh Bhugra, "Investigating the Interlinkages of Alcohol Use and Misuse, Spirituality and Culture – Insights from a Systematic Review," *International Review of Psychiatry* 26, no. 3 (2014); and Harold Koenig, *Medicine, Religion, and Health*, 68-76.

<sup>41</sup> Peter Gilbert, "Spirituality and Mental Health: A Very Preliminary Overview," *Current Opinion in Psychiatry* 20, no. 6 (2007).

<sup>42</sup> See Koenig, *Medicine, Religion, and Health*, 67-68.

<sup>43</sup> Koenig, *Spirituality in Patient Care*, 24-43.

that speaks to people across various religious systems.<sup>44</sup> As such, modern chaplains do not simply visit people who belong to their own particular tradition or denomination, but rather chaplains offer interfaith care. One chaplain can be assigned to an entire floor of the hospital, seeking to meet whatever spiritual needs she finds on the floor among its religiously heterogeneous patient population.<sup>45</sup> As chaplain and researcher Mark Cobb explains, speaking of his context in England with the National Health Service (NHS) but also reflecting similar concerns in American hospitals,

Spiritual care is the official term that the NHS uses when it refers to aspects of healthcare that involve religious, pastoral or spiritual dimensions. The term is a category of convenience whose breath is intended to avoid association with any particular faith community or practice, and therefore be acceptable to the widest number of people...The language of spiritual care is a practical solution to a dimension of life that many people can relate to in some way or other without being specific.<sup>46</sup>

Thus, the deployment of the category of spirituality allows for an area of practice and specialty for chaplains without narrowing such practice to any one particular community or tradition.

In practice, interfaith spiritual care becomes a balancing act between the chaplain's own theological beliefs and commitments and those of the patient. As researchers Wendy Cadge and Emily Sigalow describe, following the former's qualitative study of the interfaith care practices of a particular chaplaincy department, chaplains tend to negotiate interfaith care through two strategies: either they try to "*neutralize* religious difference" or "code-switch" to the language of the patient's tradition.<sup>47</sup> Chaplain Martha Jacobs illustrates the former strategy when she explains, "My theology has to be large enough to accept the theology of those whom I serve,

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<sup>44</sup> See Simon Craddock Lee, "In a Secular Spirit: Strategies of Clinical Pastoral Education," *Health Care Analysis* 10 (2002): 348.

<sup>45</sup> For example, during my CPE residency, I was assigned to two floors, a cardio intensive care unit and a general medical-surgical floor, with a total of approximately forty-five beds.

<sup>46</sup> Cobb, *The Hospital Chaplain's Handbook*, 40-41.

<sup>47</sup> Wendy Cadge and Emily Sigalow, "Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare," *Journal for the Scientific Study of Religion* 52, no. 1 (2013): 148.

whether they be Christian, Buddhist, Jewish, Muslim, Sikh, Catholic, Humanist, or Atheist...I have to be open to the other person's theology and help them through using their belief system, not my own."<sup>48</sup> Here, to neutralize difference, Jacobs employs a theology that allows her to appreciate the spiritual resources of a range of traditions, using whatever specific religious orientation is employed by a patient to care for the general human dimension of spirituality. Similarly, to "code-switch" means the chaplain moves between the terms, symbols, and rituals of different religions, translating her own practices into the faith language of the patient in order to care across different faiths.<sup>49</sup> Steve Nolan exemplifies this tactic in a case study when he writes,

So I measured my responses, consciously examining each sentence, almost each word, to gauge whether they might be acceptable to [another] and authentic to me. I've become quite proud of being theologically bi-lingual. Having lived and moved in and among a number of theological persuasions – Roman Catholic, charismatic, neo-Pentecostal, evangelical, Baptist, liberal, radical – I like to feel that I have more than a working understanding of a variety of Christian sub-traditions; that I can understand their various mindsets and linguistic nuances.<sup>50</sup>

In these ways, chaplains negotiate between their own commitments and religious worldviews and their care of patients from a variety of different backgrounds. Chaplains can do so because spirituality is understood both as a general human dimension and the core of their practice.

Thus, the separation of spirituality from religion enables chaplains to substantiate their care practices within the wider aims of health care while retaining both its secular and religiously plural character. By moving from religion to spirituality as it is understood within health care, modern chaplaincy has unburdened itself of some of the central tensions of Boisen's and Cabot's early formulations. Though Boisen and Cabot also sought to formulate chaplaincy under the assumptions of medicine rather than rely on traditional authority, as demonstrated in the prior

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<sup>48</sup> Martha Jacobs, "Creating a Personal Theology to Do Spiritual / Pastoral Care," in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 5.

<sup>49</sup> Cadge and Sigalow, "Negotiating Religious Differences," 153.

<sup>50</sup> Nolan, *Chaplain as Hopeful Presence*, 39.

section, modern chaplaincy has moved yet another step toward medicine by adapting spirituality, thereby loosening chaplaincy's connection with its early Christian formulations. Chaplaincy can now make the argument that its work aligns with the general aims of the hospital to improve patient health and hospital experience for all patients.

#### B. Spiritual Care on the Health Care Team: Integration, Assessment, and Charting

Further, employing spirituality as a means to validate their practices within the hospital also enables chaplains to make a case for their inclusion in the health care team itself, sharing in the interdisciplinary and multifaceted nature of patient care with a wide range of professionals, including doctors, nurses, physical therapists, and social workers.<sup>51</sup> Chaplaincy and advocates of the profession argue that chaplains should be incorporated into the team because they are the most well trained professionals to meet the spiritual needs empirically demonstrated in the hospital. Research shows that even though medical and nursing schools have increased the proportion of classes geared to train providers in meeting spiritual needs of patients,<sup>52</sup> doctors and nurses still often fail to inquire into or address such needs in their own assessments and care.<sup>53</sup> However, since 1998 the Joint Commission on Accreditation of Healthcare Organizations (JACHO), the organization that officially sets hospital quality care standards within the US, has stipulated that hospitals must respect and care for the spiritual needs of their patients, though the

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<sup>51</sup> Different chaplaincy departments are more or less integrated within various hospital systems. Some, like the department where I did my residency, are well integrated into the trauma and code teams. Wendy Cadge names these as “professional departments,” which often have well experienced directors and board certified staffs. Cadge contrasts these with “transitional” and “traditional” departments, which still resemble those prevalent at the beginning of the 20th century, made up largely of volunteers who primarily visit patients belonging to their own tradition. The focus in this section is primarily on professional departments. See *Paging God*, 114-118.

<sup>52</sup> Koenig, *Spirituality in Patient Care*, 10-12.

<sup>53</sup> Ibid. See also Barry Gallison, Yan Xu, and Suzanne Boyle, “Acute Care Nurses’ Spiritual Care Practices,” *Journal of Holistic Nursing* 31, no. 2 (2012); Luciana Banin et al., “Religious Beliefs or Physicians’ Behavior: What Makes a Patient More Prone to Accept a Physician to Address his/her Spiritual Issues?” *Journal of Religion and Health* 53, no. 3 (2014).

standards do not specify how this care is to be performed or who is qualified to do it.<sup>54</sup>

Employing the discourses of spirituality, chaplains have thus sought to be recognized as the experts and practitioners of spiritual care on the care team as stipulated by these standards.

The integration into the health care team also further pushes chaplaincy to adopt practices that mirror those of other professionals on the team. In order to demonstrate how it contributes to the overall care of the team, chaplaincy must articulate, assess, and record its interventions with patients. As chaplain Dagmar Grefe and physician Cheryl Lew explain together in a recent article, “The only way to have both a seat and voice at the table as other allied health professionals do is not to inhabit the same technical language as physicians and nurses, but to be visible and vocal from the perspective and expertise of spiritual care.”<sup>55</sup> Wendy Cadge makes a similar recommendation after following two chaplaincy departments for an extended ethnographic study: “To the extent that chaplains are and wish to remain the religious and spiritual experts in health-care organizations, they need to continue to articulate and clarify their professional roles and responsibilities with others in health care.”<sup>56</sup> Thus, chaplains are pushed not to mimic the medical expertise of other professionals, but to develop and articulate their own expertise. However, as noted above the work of the chaplain does not fall easily into the exact and active tasks of health care. How then do chaplains incorporate their open presence to a patient into the language of tasks and expertise that they can share with the health care team? Or, as chaplain D.W. Donovan puts it, “How do we move the conversation from language of ‘presence’ to ‘prove it?’”<sup>57</sup>

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<sup>54</sup> Cadge, *Paging God*, 37-39.

<sup>55</sup> Dagmar Grefe and Cheryl Lew, “Engaging Medical Culture: Suggestions for the Education of Healthcare Chaplains,” *Reflective Practice: Formation and Supervision in Ministry* 34 (2014): 173.

<sup>56</sup> Cadge, *Paging God*, 203.

<sup>57</sup> D.W. Donovan, “Assessments,” in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 57.



First, modern chaplains have moved towards an assessment model of care, in which the chaplain performs an inquiry into the spiritual needs, connections, and resources of the patient in order to understand his or her spiritual state and to develop a plan of care, which the chaplain can then share with the rest of the team. Psychologist Paul Pruyser was an early advocate for chaplains to develop their own specialized assessment models to contribute to interdisciplinary health care teams. In his influential 1976 book *The Minister as Diagnostician* Pruyser asked, “What special basic or applied science or art does the chaplain bring to bear on the diagnostic and therapeutic processes in [interdisciplinary] institutions?”<sup>58</sup> By asking this question, Pruyser was also critiquing contemporary trends of his time in chaplaincy care that mirrored the assessments of psychologists without contributing its own unique perspective.<sup>59</sup>

To answer this call while emphasizing their own unique mode of care, chaplains have often not adopted the diagnostic interview model of many medical professions. Chaplains rarely enter a patient’s room with an itemized list of symptoms to check off with the patient.<sup>60</sup> Rather, because the work of the chaplain consists of ongoing presence with the patient, chaplains have sought to integrate their assessments into their relationships with patients. As chaplain George Fitchett explains, “In this view, models of spiritual assessment do not consist of interview questions. They are interpretative frameworks that are applied based on listening to the patient’s

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<sup>58</sup> Paul Pruyser, *The Minister as Diagnostician: Personal Problems in Pastoral Perspective* (Philadelphia: The Westminster Press, 1976), 41.

<sup>59</sup> See *Ibid.*, 27: “These pastors all too often used ‘our’ psychological language, and frequently the worst selections from it... When urged to conceptualize their own language, using their own theological concepts and symbols, and to conduct interviews in full awareness of their pastoral office and church setting, they felt greatly at sea.”

<sup>60</sup> Conversely, chaplaincy departments are increasingly asking other health care professions to administer an initial spiritual history when the patient enters the hospital in order to gauge whether or not the patient should be referred to a chaplain. This history is generally an itemized series of yes or no questions. One of the most widely used is the Rush Protocol, outlined in George Fitchett and James L. Risk, “Screening for Spiritual Struggle,” *Journal of Pastoral Care and Counseling* 63, no. 1-2 (2009). Fitchett argues that such screening is necessary in the hospital precisely because proper spiritual care is correlated with improved hospital outcomes. See “Screening for Spiritual Risk,” *Chaplaincy Today* 15, no. 1 (1999).

story as it unfolds in the clinical relationship.”<sup>61</sup> Fitchett’s own 7x7 model, widely used and adapted by chaplains today, is an example of assessment in relationship. As Fitchett writes in his 1993 book *Assessing Spiritual Needs*, “Our preference was to have a model that wouldn’t require changing key elements in pastoral care as we understood it.”<sup>62</sup> Rather, *through* the pastoral relationship, the chaplain employing the 7x7 model fills out seven holistic and seven spiritual dimensions, the former assessing the medical, psychological, cultural, and social dimensions of the patient’s experience, needs, and resources, the latter assessing their spiritual and religious dimensions.<sup>63</sup> By understanding and recording these fourteen dimensions, the chaplain would gain a full picture of the patient’s state and experience from a holistic, spiritual perspective, which she can then share with the interdisciplinary team.

Thus, chaplaincy and medical practice form a dialogue within the practice of spiritual assessment. Moreover, beyond refashioning the typical diagnostic interview of medical experts, chaplaincy practice has also continued to modify the medical diagnostic model by moving from an inventory of the needs and resources of the patient as an isolated, individual case to taking what Mark Cobb calls an “ecological approach” to assessment. This holistic frame sets the individual patient within the context of wider interpersonal relationships, environmental contexts, and economic and political systems.<sup>64</sup> Thus taking an ecological approach, chaplains situate individual spiritual problems, needs, and resources in their wider social and political context. For example, in Fitchett’s 7x7 model, medical and psychological dimensions are set

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<sup>61</sup> George Fitchett, “Next Steps for Spiritual Assessment in Healthcare,” in *Oxford Textbook of Spirituality in Healthcare*, eds. Mark Cobb, Christiana Puchalski, and Bruce Rumbold (Oxford: Oxford University Press, 2012), 299.

<sup>62</sup> George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Minneapolis: Augsburg Fortress, 1993), 41.

<sup>63</sup> Fitchett’s seven holistic dimensions are: medical, psychological, psychosocial, family systems, ethnic and cultural, and societal and spiritual. The seven spiritual dimensions are: beliefs and meaning, vocation and consequences, experience and emotion, courage and growth, ritual and practice, community, and authority and guidance. *Ibid.*, 42.

<sup>64</sup> Cobb, *The Hospital Chaplain’s Handbook*, 50.

beside cultural and social experiences, producing what Fitchett calls a “whole person assessment.”<sup>65</sup> Such an approach is an attempt by chaplaincy to answer internal and external calls to move beyond a narrow, individualistic model of assessment, which would mirror the medical-disease model prevalent in diagnostic medicine.<sup>66</sup>

Nonetheless, despite such efforts spiritual assessments continue to be modeled towards individualized care of the singular patient, mirroring the practices of modern medicine. While the ecological view of spiritual assessment recognizes the wider social structures that contribute to the spiritual detriment or flourishing of the patient, such assessment nonetheless emphasizes intervention on the side of the patient. Chaplains are rarely able to change the social structure that they assess while caring for an individual patient. As chaplain and researcher James Woodward reports, “The chaplain seems reluctant to take on the role of saboteur, mole or whistleblower.”<sup>67</sup> As with Cobb, Woodward believes a holistic spiritual assessment *should* lead to change in the cultural structures that inhibit spiritual well-being. Such a call, however, goes unheard in the current practice of spiritual assessments. This is a reality of the medicalization of the chaplain’s role, turning presence and relationship into an interdisciplinary medical assessment of the individual patient to be shared with the care team.

Moreover, the spiritual assessment model also complicates the profession’s commitment to presence without judgment or agenda. Spiritual assessment itself includes the basic assumption of diagnosis that some spiritual beliefs and practices are unhealthy or unsupportive of the patient’s experience. Though Fitchett is opposed to “medical paternalism” that assumes

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<sup>65</sup> Fitchett, *Assessing Spiritual Needs*, 43.

<sup>66</sup> See Cobb, *The Hospital Chaplain’s Handbook*, 50-52; Bonnie Miller-McLemore, “Revisiting the Living Human Web: Theological Education and the Role of Clinical Pastoral Education,” *The Journal of Pastoral Care and Counseling* 62, no. 1-2 (2008).

<sup>67</sup> James Woodward, “Health Care Chaplaincy: A Reflection on Models,” *Modern Believing* 41, no. 2 (2000): 29.

professional knowledge and treatment should be imposed on an unknowing and passive patient,<sup>68</sup> he nonetheless admits that, “It is difficult to engage in spiritual assessment without eventually identifying some of the patient’s spiritual or religious beliefs or behaviors as unhelpful, if not limited or immature.”<sup>69</sup> Such judgment makes clear the imbalance of power in the care relationship between care provider and patient. Nancy Ramsay, writing about pastoral diagnosis from a congregational context, contends that this imbalance is necessary to all assessment: “Because diagnosis involves the power to name the reality of another through defining that person’s predicament, authority is a significant dimension of any diagnostic process.”<sup>70</sup> Thus, assessment introduces a task in which the chaplain’s power over the patient enters explicitly into the chaplain’s relationship with the patient.

Chaplains would argue that such imbalance works towards the empowerment of the patient, ensuring that her spiritual resources, community, and context are substantial and integrated enough to support the patient’s spiritual needs during the hospitalization. Nonetheless, this power over the patient in assessment also removes chaplaincy practice from its foundations as an open, nonjudgmental human presence. Introducing spiritual assessment into the pastoral

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<sup>68</sup> See George Fitchett, “The Medical Captivity of Religion and Health,” *The Journal of Pastoral Care* 45, no. 3 (1991).

<sup>69</sup> Fitchett, “Next Steps for Spiritual Assessment in Healthcare,” 302. This quote echoes the psycho-spiritual assessment model of Kenneth Pargament. For Pargament, psychology cannot determine the veracity of any particular spiritual belief. Truth is always contextual and perspectival, including the various truths held by psychology in general. Rather, spiritually integrated psychotherapy for Pargament can judge the level of integration of a client’s spirituality: “A well-integrated spirituality is defined not by a specific belief, practice, emotion, or relationship, but by the degree to which the individual’s spiritual pathways and destinations work together in synchrony with each other. At its best, spirituality is defined by pathways that are broad and deep, responsive to life’s situations, nurtured by the larger social context, capable of flexibility and continuity, and oriented toward a sacred destination that is large enough to encompass the full range of human potential and luminous enough to provide the individual with a powerful guiding vision.” *Spiritually Integrated Psychotherapy*, 136.

<sup>70</sup> Nancy Ramsay, *Pastoral Diagnosis: A Resource for Ministries of Care and Counseling* (Minneapolis: Augsburg Fortress, 1998), 109. Ramsay assumes this imbalance to be temporary, though I would argue that this is more the case in the congregational setting where pastoral relationships continue for a much longer time past acute crises than in the hospital, where such power imbalance remains set in the hospital’s hierarchy through the patient’s stay.

relationship as it contributes to the assessment and care of the overall team turns spiritual care into a medicalized instrument of the hospital, moving chaplaincy presence into a powerful medical frame. With assessment, one's spirituality can be labeled as problematic or unhealthy, put into a frame where it is assessed, either positively or negatively, rather than allowed simply to be. Assessment thus turns the deployment of spirituality in the realm of chaplaincy practice into a medical rather than a relational and meaning-making category.

Second, in addition to spiritual assessment chaplaincy care is further solidified into a medical frame by the professional practice that necessarily follows assessment: charting. Recording data of chaplain visits meets two related needs of the hospital. First, entering data into the patient chart is a necessary step to ensure that the chaplain's perspective is heard and incorporated into the overall care of the patient by the rest of the health care team. Second, entering documentation of chaplains' assessment, visitation, and interventions allows the department and administration to record and assess the adequacy of coverage by chaplains to meet the spiritual needs of each floor and the costs of chaplaincy intervention and care per patient and per visit.<sup>71</sup> Though chaplains do not work in terms of billable procedures or hours, involving chaplaincy in the records of the hospital is an attempt to trace the work of the profession through its statistical and economic records. Writing on administrative coding for chaplaincy interventions, chaplain Paul Derrickson writes, "The motives for this work are to incorporate pastoral care into the administrative and managerial structures and procedures of an institution or health care system. In short it is an administrative perspective for pastoral care."<sup>72</sup> Thus, on both care and administrative levels, charting produces legal records of chaplain

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<sup>71</sup> See Will Kinnaird and Elizabeth McSherry, "The Development and Use of Codes for Chaplain Interventions (Procedures and Products) in the Veterans Affairs Healthcare Service," *Chaplaincy Today* 14, no. 1 (1998).

<sup>72</sup> Paul Derrickson, "Computer Coding of Pastoral Ministry: Contributions and Challenges," *Chaplaincy Today* 14, no. 1 (1998), 24.

interventions, holding chaplains accountable both to the team and the administration for their contribution to the care of the patient and the work of the hospital.

However, charting and records also put chaplains in the awkward position of quantifying their presence and relationships with patients into discreet tasks, a mode that resembles the active and specialized interventions of the medical staff, which are often seen as at odds with the relational work of the chaplain. By participating in the charting and records of patient care, chaplains record and code pastoral conversations, the giving of sacraments, prayer, Scripture reading, and other traditional acts of care and worship as interventions that are now a part of the medical care team. These religious or spiritual acts are transformed into therapies meant to aid a now defined spiritual condition recognized during the assessment. “Presence” now becomes an intervention recorded into the chart alongside the medication given by a nurse or a procedure done by the surgeon. The following figure is a screen-shot from the charts at my current position quantifying the interventions and outcomes of a chaplaincy visit for the rest of the care team:

Figure I.<sup>73</sup>

**Chaplain Interventions**

<input type="checkbox"/> SPIRITUAL INTERVENTIONS	<input type="checkbox"/> Provided Ministry of Affirmation	<input type="checkbox"/> Explored Impact of Illness	<input type="checkbox"/> Encouraged Socialization
<input type="checkbox"/> Established Initial Rapport	<input type="checkbox"/> Scripture Reading	<input type="checkbox"/> Encouraged Involvement/Care Plan	<input type="checkbox"/> Explored Addictive Behavior
<input type="checkbox"/> Contacted Faith Community	<input type="checkbox"/> Provided Crisis Intervention	<input type="checkbox"/> Identified Ethical Issues	<input type="checkbox"/> Explored Cultural Traditions
<input type="checkbox"/> Explored Belief System	<input type="checkbox"/> Provided Grief Support	<input type="checkbox"/> Provided Comfort during Pain	<input type="checkbox"/> Explored Family Dynamics
<input type="checkbox"/> Explored Cultural Needs	<input type="checkbox"/> Provided Prayer/Rituals	<input type="checkbox"/> Provided Palliative Care Education	<input type="checkbox"/> Explored Impact of Changes/Appearance
<input type="checkbox"/> Explored Meaning/Purpose	<input type="checkbox"/> Provided Spiritual/Emotional Support	<input type="checkbox"/> Provided Palliative Care Information	<input type="checkbox"/> Facilitated Relaxation Techniques
<input type="checkbox"/> Explored Spiritual/Emotional Support	<input type="checkbox"/> Religious Handout(s) Given	<input type="checkbox"/> Provided Palliative Care Support	<input type="checkbox"/> Identified Coping Strategies
<input type="checkbox"/> Helped Articulate Feelings	<input type="checkbox"/> MEDICAL INTERVENTIONS	<input type="checkbox"/> Provided Post-surgical Care	<input type="checkbox"/> Identified Strengths/Potential
<input type="checkbox"/> Helped Reframe Hope	<input type="checkbox"/> Attended Palliative Care Conference	<input type="checkbox"/> Provided Pre-surgical Care	<input type="checkbox"/> Identified Support Systems
<input type="checkbox"/> Helped to Articulate Loss/Grief	<input type="checkbox"/> Attended Patient Care Conference	<input type="checkbox"/> PSYCHOSOCIAL INTERVENTIONS	<input type="checkbox"/> Provided NICU Support
<input type="checkbox"/> Listening	<input type="checkbox"/> Clarified Ethics/Values	<input type="checkbox"/> Addressed Abuse/Neglect	<input type="checkbox"/> Provided Perinatal Support
<input type="checkbox"/> Engaged in Life Review	<input type="checkbox"/> Clarified/Reviewed Information	<input type="checkbox"/> Addressed Conflicted Relationships	<input type="checkbox"/> Provided Positive Reinforcement
<input type="checkbox"/> Provided Affirmation	<input type="checkbox"/> Discussed Code Status	<input type="checkbox"/> Addressed/Reported Suicidal Ideation	<input type="checkbox"/> Stressed Uniqueness/Self Worth
<input type="checkbox"/> Provided Reassurance	<input type="checkbox"/> Discussed Diagnosis/Prognosis	<input type="checkbox"/> Affirmed Mature Outlook	<input type="checkbox"/> Suggested Creative Activities
<input type="checkbox"/> Provided Ministry of Presence	<input type="checkbox"/> Discussed Hospitalization	<input type="checkbox"/> Encouraged Open/Honest Communication	<input type="checkbox"/> Other:
<input type="checkbox"/> Provided Ministry of Music	<input type="checkbox"/> Discussed Treatment/Goals	<input type="checkbox"/> Encouraged Self-care	

**Chaplain Visit Outcomes**

<input type="checkbox"/> SPIRITUAL OUTCOMES	<input type="checkbox"/> Resilient	<input type="checkbox"/> Accepting of Body Image
<input type="checkbox"/> Able to Express Feelings	<input type="checkbox"/> Felt Supported	<input type="checkbox"/> Communicating Effectively
<input type="checkbox"/> Acknowledge Impact of Illness	<input type="checkbox"/> Sacramental Needs Met	<input type="checkbox"/> Entertains Potential/Possibility
<input type="checkbox"/> Connected to Sources of Support	<input type="checkbox"/> Strengthened by Spiritual Resources	<input type="checkbox"/> Felt Supported/New Family Baby
<input type="checkbox"/> Developed Trusting Relationships	<input type="checkbox"/> Ongoing Struggles	<input type="checkbox"/> Found Support/Intervention re: Abuse/Neglect
<input type="checkbox"/> Envision Future/Goals	<input type="checkbox"/> MEDICAL OUTCOMES	<input type="checkbox"/> Found Support/Intervention re: Suicidal Ideation
<input type="checkbox"/> Experiencing Spiritual Growth	<input type="checkbox"/> Adapting to Hospital Environment	<input type="checkbox"/> Greater Self-esteem
<input type="checkbox"/> Expressed Gratitude	<input type="checkbox"/> Choose Palliative Care	<input type="checkbox"/> Improved Social Interaction
<input type="checkbox"/> Expressed Sense of Well-being	<input type="checkbox"/> Code Status Choice Clear	<input type="checkbox"/> Increased Ability to Cope
<input type="checkbox"/> Feels Supported During Loss/Grief	<input type="checkbox"/> Completed Advance Directives	<input type="checkbox"/> Making Positive Changes/Addictive Behaviors
<input type="checkbox"/> Finding Greater Meaning/Purpose	<input type="checkbox"/> Felt Supported/CPR/Code Blue	<input type="checkbox"/> Need for Perinatal Support
<input type="checkbox"/> Grieving Appropriately	<input type="checkbox"/> Felt Supported/Trauma Crisis	<input type="checkbox"/> Reduced Anxiety/Stress
<input type="checkbox"/> Increased Hope	<input type="checkbox"/> Involved in Treatment/Care Plan	<input type="checkbox"/> Reported Abuse/Neglect to Appropriate Authorities
<input type="checkbox"/> Integrating Spiritual Experiences	<input type="checkbox"/> Making Informed Choices	<input type="checkbox"/> Resolving Family Issues
<input type="checkbox"/> Reaffirmed Positive Beliefs	<input type="checkbox"/> Reduced Pain Level	<input type="checkbox"/> Explored Options for Making Decision(s)
<input type="checkbox"/> Receptive to Spiritual/Emotional Care	<input type="checkbox"/> Resolved Ethical Issues	<input type="checkbox"/> Other:
<input type="checkbox"/> Reduced Spiritual/Emotional Suffering	<input type="checkbox"/> PSYCHOSOCIAL OUTCOMES	

The wide range of options displayed here show the attempt by the chart to capture a variety of interventions and responses. At the same time, both chaplain and patient are reduced to a set limit of choices. The visit has to fit within the parameters of the chart, so it can be understandable and quantifiable to the team and administration.<sup>74</sup>

However, because of the relational nature of spiritual work, chaplains often feel both under-qualified and uncomfortable with recording their observations and interventions, especially as their care is set beside that of other professionals in the chart. As one chaplain said to Wendy Cadge during her observations, “I don’t go into a lot of detail...it might come back

<sup>73</sup> I am thankful for the pastoral care department of St. Thomas Hospital in Nashville, TN for allowing me to use screenshots of their electronic charts for the purposes of this dissertation.

<sup>74</sup> Below these choices is a text box where chaplains can give a narrative account of the visit. This option helps mitigate some of the reduction inherent in checking the boxes above the text box.

and haunt you. Like if you dare write ‘Patient is depressed,’ as a chaplain, you can’t give a diagnosis, so you have to be really careful. I pretty much only write ‘I was here.’”<sup>75</sup> This chaplain’s description of her notes, or lack thereof, reflects the incongruence of quantifying care into discreet tasks like other professionals on the team. The awkwardness further bespeaks the tensions of incorporating the chaplain into the hospital.

Thus, by grounding its professionalization in spirituality, a realm of practice and research broadly identified with the supposedly essential capability to make meaning out of one’s experience, chaplaincy’s spiritual care takes a medical turn, incorporating itself into the overall care of the patient by the interdisciplinary health care team. However, this medical turn also takes the shape of a dialogue between chaplaincy practice and medical norms rather than simply the incorporation of the former into the modalities of the latter. The ecological, relational character of spiritual assessment is one product of this dialogue. The attempt simply to chart presence while chaplains voice hesitancy to record other interventions is another.

### C. Falling Out of the Frame

Yet, even as chaplains negotiate their practices as a part of the professional care team, at other points this negotiation breaks down. Though it has provided the foundation of their professionalization and practice within the modern hospital, the centrality of spirituality also concretizes chaplaincy’s difference with its setting. Spirituality within chaplaincy denotes the amorphous concepts of meaning-making, presence, and care, a realm of growing concern within

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<sup>75</sup> Cadge, *Paging God*, 124. Chaplain Rafael Goldstein reflects this hesitancy in his advice on charting to chaplains after noting that charts are legal documents: “Notes should keep patient information pertinent, clear, and informative, without violating patient privacy or clergy-community relations. Documentation should stay with facts and observations. The language we use should be grounded in our professional field and the work we do as chaplains.” “Chaplains and Charting,” in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 83.



health care yet also a place that continues to be set apart from the more specialized tasks and precise outcomes within current medical practices.<sup>76</sup> While also providing an avenue towards professionalization and legitimation, spirituality also grounds the chaplain's difference from the rest of the care team.

Because of the amorphous nature of spirituality, chaplains simply cannot describe their work in terms of expertise and localized tasks.<sup>77</sup> There remains an ongoing tension between chaplains' needs and desires to fit into the medical frame and their historical modes of care and self-understanding. For example, chaplain Kevin Massey argues that chaplain training in contemporary clinical pastoral education has often revolved around reflections on the student's pastoral identity formation rather than the acquisition of practicable techniques and skills: "What is missing is specific training on techniques and procedures in the delivery of healthcare chaplaincy and the exploration of how specific techniques and practice patterns can deliver improved patient outcomes."<sup>78</sup> In contrast to training on techniques and procedures, chaplaincy training and practice have rather emphasized pastoral formation and presence, which mirrors chaplaincy's unique holistic and relational grounding in spirituality rather than the technical skills that mark professionalization. Researchers Wendy Cadge, Katherine Calle, and Jennifer Dillinger interviewed thirty physicians and twenty-two chaplains at thirteen large academic research hospitals regarding the role of chaplains on the health care team. Here, they found a gap between how chaplains articulate their contribution in terms of holistic care and how physicians describe it in discrete tasks. Summarizing their findings, the researchers explain,

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<sup>76</sup> As former chaplain and professor of practical theology John Swinton notes, "The language of spirituality exposes gaps within current practices. If our practices were already meaningful, loving, and hopeful, then we would have no need to 'introduce' the idea of generic spirituality... Our systems would have these dimensions built into them." "Healthcare Spirituality: A Question of Knowledge," in *Oxford Textbook of Spirituality in Healthcare*, eds. Mark Cobb, Christiana Puchalski, and Bruce Rumbold (Oxford: Oxford University Press, 2012), 103.

<sup>77</sup> See Cadge, *Paging God*, 126-127.

<sup>78</sup> Kevin Massey, "Surfing through a Sea Change: The Coming Transformation of Chaplaincy Training," *Reflective Practice: Formation and Supervision in Ministry* 34 (2014): 148.

We find that physicians generally see chaplains as part of interdisciplinary medical teams and work with them around certain topics, most frequently related to death. Physicians expect chaplains to conduct rituals and to provide information and counseling for families...Chaplains see themselves doing all the things physicians describe, but frame their contributions less in terms of discrete tasks and more in terms of their distinct perspectives related to wholeness, presence and healing. Chaplains generally see themselves making broader contributions to patient care than do physicians, and explain their contributions in broader frames using a vocabulary distinct from that of physicians.<sup>79</sup>

This distinct vocabulary and perspective of chaplains can be traced to the nature of presence and spirituality within chaplaincy practice. Reflecting common assumptions of the profession, one chaplain explained to Cadge and Sigalow, “I think the most we can offer [patients] is just a listening ear, and a caring heart, and somebody who takes them the way they are, who has no expectations...There’s a challenge to put words to what we do...It is about presence, about being present for whatever happens.”<sup>80</sup> Given the nature of their work, it is not that chaplains have simply not *yet* articulated their work as discreet and specialized tasks as other professionals have. They are not just an inchoate profession moving towards better integration within the care team. Rather, spirituality as it is currently conceived within the profession sets chaplaincy at odds with further specialization.

This inability to formulate their work into specialized tasks then becomes a barrier between chaplaincy and the rest of the professionals on the health care team, pushing chaplains to the margins of the team’s overall work. As a result, chaplaincy practice, though seeking to become a part of the health care system, can become separated or untethered from this system.

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<sup>79</sup> Wendy Cadge, Katherine Calle, and Jennifer Dillinger, “What Do Chaplains Contribute to Large Academic Hospitals?: The Perspectives of Pediatric Physicians and Chaplains,” *The Journal of Religion and Health* 50 (2011): 302. A similar survey shows that medical directors rate the importance of chaplains’ roles in emotional support, consultation, and advocacy - roles that can be associated with pastoral relationships - lower than pastoral care directors. See Kevin Flannelly et al., “A National Survey of Hospital Directors’ Views about the Importance of Various Chaplain Roles: Differences among Disciplines and Types of Hospitals,” *The Journal of Pastoral Care and Counseling* 60, no. 3 (2006).

<sup>80</sup> Cadge and Sigalow, “Negotiating Religious Differences,” 152.

An example of this separation comes in the absence of physical space designated for chaplains to practice. Because chaplains have yet to articulate their own specialized work on the team in the same way as other professionals, the hospital itself has yet to make space for the chaplain to practice her care. For example, I mention in the introduction to this chapter that my work on the trauma team happened when the team was elsewhere, when my presence with the patient would *not be in the way* of the specialized work of the team. A similar dynamic is also at work outside of the trauma room. Francis Norwood, an anthropologist who observed early CPE students as they navigated patient floors at the beginning of their training, captures well the ambivalence that follows working without a defined task or space:

All chaplain interns had difficulty trying to find “place” on the floors of the hospital. The space is strictly divided between patient space and staff space, and that left little room for chaplains... With the busy and directed movements of the staff and the location of the staff room, circled, as it was, by the barrier of the front desk, chaplains felt uninvited into staff space... [Chaplains] circle the floors looking for a place to land, and, finding none, they often end up “re-grouping” in the visitor waiting room, getting up the nerve to “cold call” on a patient and re-strategizing about what to do next.<sup>81</sup>

The tensions in finding space that Norwood records are likely exacerbated by the unease of the chaplain interns she studied who were just beginning to navigate their role in the hospital.<sup>82</sup> Yet the exaggerated tension felt by the interns points to an unease underlying chaplaincy care in general. The work of the chaplain occurs in the interstices of the more specialized and discreet tasks of the care team. It occurs in relationships, not in tasks; thus, hospitals do not make space for spiritual care, which pushes chaplaincy to the system’s periphery. One result of such separation is that departments of pastoral care are often some of the first within the hospital to

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<sup>81</sup> Frances Norwood, “The Ambivalent Chaplain: Negotiating Structural and Ideological Difference on the Margins of Modern-Day Hospital Medicine,” *Medical Anthropology* 25 (2006): 16.

<sup>82</sup> This is the conclusion reached by Grefe and Lew in their review of Norwood’s article. “Engaging Medical Culture,” 167.

face budgetary cuts during times of financial struggle within healthcare.<sup>83</sup> Lacking defined space and tasks, chaplaincy becomes subject to a loss of resources as well.

Thus, chaplains have negotiated with the wider norms of medicine, first by regrounding their profession in the contemporary realm of spirituality aimed at promoting health and interfaith care and second by seeking to plan and articulate their interventions through assessment and charting while also retaining the relational nature of their work. At the same time, chaplaincy practice continues to slip out from the medical frame with which it negotiates. Because its practice relies on pastoral presence, chaplaincy continues to fail to articulate its role in the form of specialized and discrete tasks that characterize other medical professionals in the hospital. Emphasizing relationship and perspective, chaplaincy therefore finds itself outside of the very system with which it negotiates. Thus, the professionalization of chaplaincy is characterized by its tension, negotiating with a medical frame that it never quite fits.

### III. Conclusion

In this chapter, I have traced the historical and ongoing tensions within chaplaincy practice. In order to outline an adequate picture of these tensions themselves, I have focused exactly on what chaplains do and how they explain and justify their work, beginning first with my own experiences as a on-call chaplain resident, then moving to the early formulations and tensions of chaplaincy as religious care within medicine by Boisen and Cabot, and closing with the modern deployment of spirituality as the basis for contemporary chaplaincy, particularly in

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<sup>83</sup> Harold Koenig notes: “Under intense scrutiny to reduce the costs of care, hospitals have been reducing their pastoral care services or combining them with social services. In a study of 370 randomly selected pastoral care departments, now over thirteen years old, 27 percent of department directors reported budgetary cutbacks... Other hospitals during the past few years have completely removed paid chaplain services to contain costs... In fact, a survey of chaplain availability in U.S. hospitals between 1980 and 2003 found that 36 percent to 46 percent of all U.S. hospitals had no chaplains on their paid staff.” *Spirituality in Patient Care*, 14-15.

its relation to chaplaincy's place on the interdisciplinary care team of the hospital. However, in order to understand the implications of such negotiations, I need now to move out from this narrowed focus on practice to the political sphere in which these negotiations take place. The tensions within chaplaincy are not solely about differing methods – specialized tasks vs. presence – but also about differing aims, how medicine and chaplaincy align and separate in what they understand as the purposes of care and healing. In order to get at these larger conjunctions and separations, the next chapter moves to broader theories that seek to understand what exactly is going on with spiritual care politically and socially today.

Unfortunately, as the literature cited in this chapter illustrates, chaplains have yet to move to a larger, contextual and political level when assessing their work. They have been squarely focused on issues like those addressed in this chapter: What is it that chaplains do and how does it fit or contrast with other medical procedures and technologies? But larger questions need to be asked in order fully to understand chaplaincy practice within medicine. What exactly are the narratives that medicine is promoting? How does it envision the patient and the population it serves? Further, how does it shape patient experience and who or what experiences are left out or obscured by its vision? Further, how does chaplaincy perpetuate or modify such narratives and trajectories? These are all wider political questions that the ensuing chapters seek to address.

## CHAPTER 3

### THE BIOPOLITICAL SPHERE: THEORIES OF SPIRITUALITY AND CHAPLAINCY CARE

Memory is key not only to this dissertation but also to the practice of spiritual care itself. Yet the memory operative in care is not confined to the mind of the chaplain alone. As a chaplain, I find that my memories often fail me, that no matter how much I try to remember the faces and names of the patients and family members I visit, I often quickly forget them. Moving throughout the hospital, between floors and across units, I need to transition quickly, for example, from the acute crisis of one room to the boredom of another to even the triumph or relief of a third. In this process, I lose my bearings. Vague impressions of moods and affects linger in my mind while the details of a visit quickly escape. Routine visits, trauma calls, codes, and all of the other various events for which I am present leave their impressions on me, but in the need to keep moving, to see the next patient, to answer the next page, to write up the next chart, I leave behind the specifics as the days pass.

Yet as my own memory escapes me, I nonetheless retain memory, not in my mind so much as on my person, or rather in the memories that circulate around me as I walk through the hallways of the hospital. I begin to serve as a catalyst or a reminder for the memories of others. I am stopped in hallways by parents, partners, spouses, and friends of patients, those who remember me attending the traumas and bedsides of their loved ones. Other times it is not family, but doctors, those whom I have stood beside as they delivered dire news following

emergency surgeries, who recount a distant night or case after spotting me again in the emergency department or the elevator.

Yet it is not just the forgetfulness of the chaplain that makes spiritual care transcend or detach from her direct experience; it is also the ways in which memories of care and presence register differently across various perspectives, even experiences of the same visit. For example, the father of a teenager who had been thrown from her car during an accident once stopped me in the hospital hallway. The trauma had occurred several weeks prior to this hallway meeting, during one of my overnight on-call shifts, and follow-up care of the patient and family had been referred out the next day to the chaplain responsible for the daughter's intensive care unit, so I had not kept in contact with the family after their first night. Therefore, when this man stopped me in the hallway and thanked me for staying with him for a number of hours while his daughter underwent emergency surgery, I did even not recall who he was. Of course, I pretended to remember and asked some vague questions about the patient's progress and recovery, but I only placed the man who had stopped me in the hallway afterward when I looked up the patient's chart and reviewed the notes I had made weeks ago.

What makes this episode stand out is the striking fact that this man remembered my presence with him that night appreciatively. Personally, I had experienced my series of visits with that family as rather fumbling and uncomfortable. The accident occurred in the middle of the night and emergency staff had rushed the patient from the trauma room into surgery before this father and the rest of the family even arrived to the hospital, so they were left without any official assessment of her injuries or prognosis for several hours after they arrived. All they knew was that their loved one had stepped outside the house to run an errand in one moment and was in the hospital undergoing emergency surgery in the next. Besides admitting and registration, I

was the only staff person from the hospital that this man or the other family members who accompanied him saw in the hours of their initial visit. He had been informed that his daughter had been in an accident and was in surgery, but throughout my time with him, this man had no idea about the extent of his daughter's injuries, the nature of the accident, or the possible outcomes of the surgery.

I moved during these hours back and forth between this family, who had constantly expressed their fear and frustration of not knowing anything, and the beleaguered emergency department and ICU staff, apparently too busy to see the family. I remember feeling helpless in that series of visits, angry at the hospital staff for not taking time to see the family and increasingly irritated with the family as well, who in the course of the night had begun to take their frustrations out on me, the chaplain but also the only face of the hospital that they saw for this prolonged and intense episode. By the end, when doctors finally saw the family and explained the patient's critical but stable condition, I was exhausted, grumpy, and pleased to leave the situation behind.

Yet when this man stopped me, he did not remember a desperate, frustrated, and helpless chaplain. Rather, he spoke to me of a person who provided spiritual care to him and his family in the time of their need, a person whom I do not remember being that night. He held an image in his memory of my being a stable and caring presence, while I had experienced my work in those moments as increasingly awkward and exasperated. Here was a family member whom I did not remember, speaking of a night that I recalled as a failure, yet he had attached a radically different memory to me, one of care and presence.

This divergence in our memories illustrates how the movements of spiritual care cannot be simply consigned to a single narrative, or to a series of stable, objective events, or even to a



single person's memory, even the recollection of the one purportedly proving this care. Rather, spiritual care is more mobile and fluid. It floats among and between a series of memories, narratives, and experiences in the hospital, encircling the chaplain but never quite contained by her perspective, memory, or actions.

In this chapter, I navigate between various theories of spirituality and their application to spiritual care in order to place chaplaincy practice within its wider political and institutional context. Yet even as I situate spiritual care, its fluidity and elusive nature remain key, for it resists easy categorization or reduction. Spirituality and spiritual care push against simple theorization and abstraction, and thus this fluidity itself must be taken into account in exploring theories of the work of chaplains. In what follows, I therefore constantly push against reductionist theories prevalent in current discussions of spirituality because the experience and meanings of the spiritual cannot be easily discarded in a reductionist account of the political trajectory of care. Rather, we must take account of how spirituality operates within experience even as we contextualize these experiences in wider political trajectories.

## I. Introduction

In the preceding chapter, I situate the work of chaplaincy in the negotiations it makes with its medical context, pointing to its history as well as its contemporary moves towards spirituality, assessment, and charting as measures taken to relate its work to the aims and procedures of the care team while also noting the ways spiritual care also continually falls out of the medical frame. This chapter moves out from this narrowed focus on negotiations and practices in order to situate them broadly within wider theories of American religiosity and politics. My argument is that we can only understand the nature of chaplaincy care, including

both its negotiations and its failures to fit within the medical system, by situating it within the trends of American biopolitics. As noted in the introduction, by biopolitics I mean the management and governing of populations and groups, not necessarily in a top down or dominating way, but rather in the systemic and institutional pathways through which groups travel and organize for their division, survival, and flourishing.

In examining chaplaincy care and biopolitics, I am focusing on the ways in which care not only responds to but also creates and manages spirituality within the hospital as a means of knowledge and organization. By care, I mean *both* the measures that chaplaincy takes to incorporate itself within the medical team as well as the ways in which it falls out of the medical frame. The turn to spirituality as well as the increasing use of assessment and charting within chaplaincy allows spirituality to be utilized towards the care of patients within the hospital, categorizing and channeling religious needs into the systems of health care. But in fostering spirituality through care, chaplains not only produce a new means for knowledge and management of the patient population. They also create space for presence and experiences of loss that push against the biopolitical frame, thus modifying this trajectory even as they contribute to its maintenance. An adequate theorization of chaplaincy care must therefore account for this advance and subversion of the political trajectory of its setting.

By framing spiritual care in this way, I am both pushing against as well as maneuvering between two contemporary and persistent interpretations of American spirituality currently prevalent within religious studies. First, there is an interpretation of spirituality as the product of an individualistic turn in American religiosity, which prizes individual choice and access to spiritual resources over traditional and communal authority. This interpretation tends to locate spirituality broadly within individual choices, which become both more free and more plentiful

as traditional religious authorities and communities – mostly Christian in the West – lose their authority. An alternate interpretation locates the rise of American spirituality in the commoditization of neoliberalism, noting that the stress on individual choice in spirituality turns religion into a commodity to be sold and consumed. This interpretation locates the change not within a shifting emphasis of religiosity but rather with the takeover of religion by the market, capitalizing on needs originally met by religious traditions and communities through putatively less meaningful products like interfaith spiritual care.

In what follows, I examine the biopolitical institutionalization of American spirituality through three sections. First, I locate the chaplain's spiritual care within these broader interpretations of American spirituality, noting how it fits both of these accounts in part but showing how a broader discussion of chaplaincy's role as institutionalized spiritual practice and formation within biopolitics is necessary in order to avoid reduction of chaplaincy's many complexities and contradictions. I then turn directly to theories of biopolitics, specifically those of Michel Foucault and Roberto Esposito, noting how the latter's immunity paradigm, which I outline below, helps to situate both the negotiations and the tensions of spiritual care within the health care system as a biopolitical apparatus.

## II. Theories of Spirituality

As I note in the first chapter, chaplains have aligned their work with current discourses of spirituality, which the literature defines as an essential human capacity to find meaning and value in one's context, often though not necessarily through the lens of a patient's religious tradition. While this move has enabled chaplaincy to make an argument for its place within modern health care, it also opens its work to a central contradiction: chaplaincy care is the institutionalization of

de-institutionalized spirituality, a spirituality no longer necessarily attached to the authority of religious traditions or communities. In this section, I examine this contradiction and how it lends spiritual care to alternating interpretations of individualism and commodification.

#### A. Spirituality as American Individualism

Chaplains today seek to support the spiritual traditions or resources most valuable to the patient. Thus, the spirituality that the chaplain fosters and responds to within the hospital is, at least by intention, unfettered from any direct oversight or influence of ecclesial authority or tradition. A patient may or may not refer to a tradition during a chaplain's visit, but what is central from the chaplain's perspective is how that tradition or other spiritual resources support and comfort the patient. The chaplain ultimately values tradition only in so far as it allows the patient to find meaning in her situation. Martha Jacobs, a chaplain quoted in the first chapter, illustrates this point when describing her spiritual care during a time of crisis: "Being present to [the patient] was what was important and made the difference. Equally important was my being able to be open to *who their God was* and to help them access their God at a time of pain and anguish."<sup>1</sup> The central emphasis in spiritual care is not the tradition, whether it is ultimately true or is being followed according to its historical and communal norms. Rather, the emphasis is on the individual and how the spiritual support of the chaplain, working with whatever tradition (or lack thereof) the patient chooses, provides support and meaning to the patient.

By formulating their care in this way, chaplains are responding to an increasing individualistic trend within American religiosity. Robert Bellah and his fellow researchers' perennial work *Habits of the Heart*, a study now thirty years old, began to trace this shift in how

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<sup>1</sup> Jacobs, "Creating a Personal Theology to do Spiritual / Pastoral Care," 8. Italics added for emphasis.

Americans practice and view their religious involvement. According to Bellah and his associates, whereas the congregation was once held as the place where faith was formed through worship and discipleship, the believers that these researchers interviewed were increasingly characterizing the congregation as a voluntary association, where people who had already made up their own minds about religion met in order to be with like-minded others.<sup>2</sup> Bellah characterized this as a shift to “expressive individualism,” where self-expression and growth are given priority over communal attachment.<sup>3</sup>

More recently, sociologist Christian Smith along with his research partners followed the spiritual lives of over a hundred young Americans from their teenage years through early adulthood. In the early stages of the research, they found “the de facto dominant religion among contemporary U.S. teenagers” was a creed the researchers termed “Moralistic Therapeutic Deism” (MTD), the belief in an unspecified creator who desires goodness and happiness for God’s creation. However, the God of MTD is not particularly involved in anyone’s life, though it is generally believed that this God will also accept all good people into heaven.<sup>4</sup> Thus, American teenagers’ religious beliefs do not demand commitment to a particular system or community but nonetheless provide basic assurances. Smith and his team later found MTD to be less prevalent as these teenagers grew to be young adults. These subjects, as they grew older, began to express a wider range of more particular religious outlooks.<sup>5</sup> However, even while drawing from more

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<sup>2</sup> Robert Bellah et. al, *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985), 227-232.

<sup>3</sup> As Bellah summarized the shift, “Community and attachment come not from the demands of a tradition, but from the empathetic sharing of feelings among therapeutically attuned selves.” *Ibid.*, 232.

<sup>4</sup> Christian Smith and Melinda Lundquist Denton, *Soul Searching: The Religious and Spiritual Lives of American Teenagers* (New York: Oxford University Press, 2005), 162-163.

<sup>5</sup> Christian Smith and Patricia Snell explain: “As the teenage faith of MTD has had to confront and address life’s realities during the transition to emerging adulthood...MTD itself has been put to the test. For some, MTD seems to have sufficed for managing life. For others, it seems MTD has simply proved too thin or weak to deal with life’s challenges.” *Souls in Transition: The Religious and Spiritual Lives of Emerging Adults* (New York: Oxford University Press, 2009), 155.

traditional resources, individual choice still held precedence: “What or who gets to determine what is true or good or right in or about religion for most emerging adults is each person for himself or herself. Religion doesn’t have any authority per se...Each individual knows best for himself or herself what ideas or help he or she might need.”<sup>6</sup> These studies point to an individualistic trend within American religiosity. Thus, the individualistic spirituality supported and fostered by chaplains in the hospital is itself reflective of this broader trend. Today, religion and spirituality are understood to be chosen by and for individuals prior to and in preference of communal attachment or traditional formation.<sup>7</sup>

A few scholars argue that this trend is reflective of the failure of traditional religions in the wake of scientific reason, and that individualistic spirituality is simply filling a limited but remaining need for meaning left after this decline.<sup>8</sup> As sociologist Steve Bruce has recently outlined exhaustively, religious practice and belief in general have radically declined in the past fifty years in the West, far more than individualistic religious and spiritual practices and preferences have risen.<sup>9</sup> Nonetheless, the decline of religious and spiritual practice alone cannot account for the individualistic turn. The Canadian philosopher Charles Taylor vehemently argues

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<sup>6</sup> Ibid., 156.

<sup>7</sup> This move has also been catalogued by theological scholars tracing the influx of individualistic trends within traditionally communal religious contexts. For example, Dale Andrews, *Practical Theology for Black Churches: Bridging Black Theology and African American Folk Religion* (Louisville, KY: Westminster John Knox Press, 2002) traces the influx of individualistic assumptions within American black churches. Barbara McClure, *Moving Beyond Individualism in Pastoral Care and Counseling: Reflections on Theory, Theology, and Practice* (Eugene, OR: Cascade Books, 2010) traces the individualistic paradigm throughout the discipline of pastoral theology in general and pastoral counseling in particular.

<sup>8</sup> For example, neuroscientist Sam Harris has recently published a book on spirituality *Waking Up: A Guide to Spirituality without Religion* (New York: Simon and Schuster, 2014), a follow up to his controversial works such as *The End of Faith: Religion, Terror, and the Future of Reason* (New York: WW Norton, 2004), often categorized as part of the new atheist movement. Also, though he puts far less emphasis on scientific reason, Steve Bruce puts forward the thesis that spirituality, specifically its New Age iterations, is a limited and withdrawing fad filling the need for relative religious meaning among a small segment of the middle aged population. See Steve Bruce, *God is Dead: Secularization in the West* (Malden, MA: Blackwell Publishers, 2002), 75-105.

<sup>9</sup> Steve Bruce, *Secularization: In Defense of an Unfashionable Theory* (New York: Oxford University Press, 2011). Bruce himself has been critiqued for offering a single secularization thesis rather than pointing to the contextual specificity in the rise and fall of religious belief and practice. See David Martin, *On Secularization: Towards a Revised General Theory* (Burlington: Ashgate Publishing Company, 2005), 123-140.

against what he calls the “subtraction theory,” which assumes that religious decline is simply the unshackling of secular reason from the bias or moral frame of institutional religion.<sup>10</sup> Rather, Taylor sets both secularism and individualism within a wider moral framework, premised on what he calls the “buffered self” and the “immanent frame.” The former is a product of what sociologist Max Weber called “disenchantment,” the assumption that the self is no longer porous, i.e. under the control of divine, providential, or magical forces, and thus buffered against anything external to its own mind.<sup>11</sup> This buffered self is then set within the immanent frame in which the workings of society and nature are understood exhaustively on their own terms, like a self-sustaining machine or ecosystem.<sup>12</sup> For Taylor, this shift is the movement from one paradigm to another. It is not simply the clearing of religious illusion; rather, secularism and individualistic spiritual practices exist within a new moral frame that values personal experience, self-realization, and tolerance, replacing older moral values of enchantment and authority. This new moral frame also emphasizes plurality and choice. It puts forward the platform that there is no one official, transcendent authority, or rather, what is now unquestionably authoritative in the West is this presumption that beliefs are plural and that they cater first to each individual’s need.<sup>13</sup>

Emphasizing individualism as a shift in frame rather than the simple triumph of reason then allows room to explain the plurality of beliefs and practices remaining even in the collapse of traditional religious forms of authority.<sup>14</sup> Even as religious affiliation has fallen, Americans still overwhelmingly profess a belief in God, and spiritual practice continues to proliferate in a

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<sup>10</sup> Charles Taylor, *A Secular Age* (Cambridge: Harvard University Press), 423-437.

<sup>11</sup> *Ibid.*, 38.

<sup>12</sup> *Ibid.*, 539-544.

<sup>13</sup> See also Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Harvard University Press, 1989), 14-19.

<sup>14</sup> As Taylor puts it: “Now if we don’t accept the view that the human aspiration to religion will flag, and I do not, then where will the access lie to practice of and deeper engagement with religion? The answer is the various forms of spiritual practice to which each is drawn in his/her own spiritual life.” *A Secular Age*, 515.

plurality of forms.<sup>15</sup> Paul Heelas and Linda Woodhead argue that the decline in traditional religious institutions and the rise and plurality of various spiritual practices, respectively described as “secularization” and “sacralization,” can be explained together by the “subjective turn” in modern spirituality.<sup>16</sup> Through a qualitative study of religious and spiritual practitioners in the town of Kendal in the northwestern portion of England, Heelas and Woodhead contend that modern individualism forms a link between the decline of traditional religious participation and the growth of individual spiritual practices, such as yoga, Reiki, aromatherapy, homeopathy, etc.: “The subjectivization thesis states that ‘the massive subjective turn of modern culture’ favours and reinforces those (subjective-life) forms of spirituality which resource unique subjectivities and treat them as a primary source of significance, and undermines those...forms of religion which do not.”<sup>17</sup> Thus, individualism fosters an abundance of religious and spiritual forms. According to these researchers, as authority weakens, believers and practitioners do not simply leave their spiritual capacities behind. Rather, they seek out new and unique forms and pairings to meet their spiritual needs in place of the singular paths prescribed by authority.

Thus, the individualistic focus of a chaplain’s spiritual care is in part a response to the growing individualistic trend of religious practice in general. Spiritual individualism in chaplaincy care mirrors a larger movement in which belief and practice have moved towards the needs and desires of individuals, who choose their religion for themselves prior to and in precedence of communal belonging. This is part of a wider paradigm shift within the West, a new moral platform that prizes experience and choice over authority and community.

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<sup>15</sup> Sociologist Robert Wuthnow characterizes this as a shift from a “spirituality of dwelling,” with clear boundaries outlining and protecting sacred space to a much more prevalent “spirituality of seeking,” which draws fewer physical boundaries around the sacred, seeking the spiritual in time and experience rather than space. See *After Heaven: Spirituality in America since the 1950s* (Berkeley: University of California Press, 1998), 1-5.

<sup>16</sup> Paul Heelas and Linda Woodhead, *The Spiritual Revolution: Why Religion is Giving Way to Spirituality* (Malden, MA: Blackwell Publishing, 2005), 9-10.

<sup>17</sup> *Ibid.*, 78.



However, what qualitative studies of spiritual practice such as those by Bellah, Smith, Heelas and Woodhead as well as the moral philosophy of Taylor elide are precisely the institutional settings in which individualism is not only responded to but also fostered and created. For example, individualism does arrive in the hospital room with the patient, but concurrent with that arrival is the institutional framing of chaplaincy care itself and the forms of spirituality it elicits from patients. As I outline in the preceding chapter, the spiritual turn in chaplaincy is *not* primarily a response to the individualistic trends of American spirituality but rather a negotiation with the hospital system for chaplaincy to be a part of the overall care of the hospital's population. Chaplains have moved to interfaith spiritual care so that they, along with other health care professionals, can care for all the diverse patient needs on the floor, no matter their affiliation. Chaplaincy has thus moved to individualistic care not only to follow wider spiritual patterns but also to systematize its care between patients as a consequence of its place on the health care team. This means that individualistic spiritual care does not just follow what the patient brings into the room, but it is also a product of how the chaplain understands and shapes her work with the patient as a part of the hospital system.

In order to understand spirituality as it operates within the hospital, the individualistic turn in the culture cannot be an explanation in itself. Rather, we must look at the structures and systems within the hospital that also produce the individualistic shape of spirituality found there. Sociologist of religion Courtney Bender has recently critiqued her discipline for stopping with individualism as an explanation in itself while omitting the institutional settings of current spiritual trends. For Bender, the idea that spiritual individuals simply shop on the marketplace of religious and spiritual resources for what suits them ignores the ways in which the individualistic approach to spirituality is the product of historical and institutional forces: "We must approach

spirituality and ‘the spiritual’ in America as deeply entangled within various religious and secular histories, social structures, and cultural practices.”<sup>18</sup> One of the settings Bender cites is the growing area of holistic and alternative medicine, often embedded within secular health care institutions and legitimated by national and state laws and licensing procedures. The health care system, which Bender points out once sought to marginalize and prohibit alternative and spiritual explanations and treatments for illness and healing, has become an avenue to create and legitimize spirituality, and in turn, these spiritual practices have come to conform to the standards and practices of medicine.<sup>19</sup> Though Bender does not address hospital chaplaincy directly, she nonetheless points to the ways in which health care practices and institutions situate and foster spiritual practices. In the hospital, what appears to be simply a reflection of trends in American religiosity is also the creation by an institution and its systematic treatment of patients.

Thus, spirituality within patient care can be understood, paradoxically, as the secular institutionalization of de-institutionalized religiosity. Though freed from the authority or oversight of traditional religious communities or authorities, patient spirituality nonetheless is fostered by chaplains and shaped by the systems of the hospital. As noted in the preceding chapter, this spirituality is channeled through versions of assessment and record keeping, which allow it to become a part of the overall care of the patient by the hospital care team. In this way, spirituality becomes a measure within the hospital, an item it develops and records as a part of

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<sup>18</sup> Courtney Bender, *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: University of Chicago Press, 2010), 182. See also p. 23. Bender holds a similar evaluation of sociological notions of modern American pluralism, which she critiques for being taken in a positivistic sense that fails to take into account the norms of what is allowed to compete in the plurality of recognized religious forms. See Courtney Bender, “Pluralism and Secularism” in *Religion on the Edge: De-centering and Re-centering the Sociology of Religion*, eds. Courtney Bender, Wendy Cadge, Peggy Levitt, and David Smilde (New York: Oxford University Press, 2013).

<sup>19</sup> As Bender reflects from her own research into alternative medical practices in a qualitative study of spiritual practices in Cambridge, Massachusetts, “Few of the offices I visited were distinct from those of regular doctors...Many alternative practitioners keep regular office hours, hire office managers, and file patient records.” *The New Metaphysicals*, 29.

the systemic treatment of the patient population. Now free of its traditional authority, spirituality comes under the eye of *another* institution, the hospital. Thus, modern trends of individualism, while certainly a factor in chaplaincy care, cannot be its single explanation. Wider systemic norms and procedures are at work, not just responding to but also fostering and creating the spirituality of this setting.

## B. Commoditized Spirituality

What then are the implications of the institutional fostering and creation of spirituality within the hospital? If spiritual care is not simply a reflection or response to individualism, but in this context is rather an institutional establishment of individualistic spirituality, then we must situate it within the wider aims of this setting. But the temptation of situating spiritual care within an institutional setting is, of course, to reduce it to simply a function of its setting, to see it as *nothing but* a façade for the system, an ideological mask for the aims of the various interests and powers within this hospital. In fact, another growing interpretation of the spiritual turn in religiosity that seeks to move past the individualistic interpretation has situated spirituality as a commodity within neoliberalism, the current global economic order that commoditizes not only goods and services but all other facets of human life and history, including items of cultural heritage and tradition such as religious belief and practice. By placing spiritual care as a product of the hospital system, we must then ask if chaplaincy care too is simply a commercialized product of neoliberalism, which governs health care itself like a marketplace, where health is a product that is sold in the form of care and cure.<sup>20</sup> In this section, I briefly review examples from the literature that align spirituality with commoditization as it pertains to chaplaincy, pointing

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<sup>20</sup> I outline commoditization practices in the health care system below in chapter 3, section II.

appreciatively to the ways this literature aids us in recognizing how power is managed through the deployment of spirituality in a way that the individualism interpretation does not. However, I also critique the reductionist approach of the commoditization interpretation, because it tends to interpret spirituality narrowly as *only* a commodity, ignoring the multifaceted meanings that span from chaplaincy care and patient experience.

Drawing a strict dichotomy between the interpretations that align spirituality either with individualism or neoliberalism is actually too stark of a division. Rather than simply rejecting individualism as a cultural interpretation, the scholarship aligning spirituality with neoliberalism tends to examine the ways in which individualism lends itself to consumerism and commoditization. However, precisely because it is rooted in individualism and consumerism, those who locate spiritual care as a commodity point to its emptiness to provide real meaning to those in need. Critiquing the trend of chaplains identifying with spiritual care in general rather than through their own religious community, Stephen Pattison aligns the two directly by tracing three assumptions by health care spirituality's proponents: (1) spirituality is universal and good (2) spirituality is a specified commodity for a specified need and (3) spirituality is a matter of individual well-being.<sup>21</sup> Put simply, because spirituality is assumed to be individualistic, spiritual care, according to Pattison, is employed as a commodity created to meet individual needs. As I note in the introduction, Pattison opposes this general, commoditized approach to the communal and traditional nature of religion, which brings "real wisdom and integrity of character and belief" rather than what Pattison sees as a generic sense of well-being.<sup>22</sup>

Perhaps the fiercest critique to date of the neoliberal character of modern spirituality comes from a pair of English religious studies scholars Jeremy Carrette and Richard King in

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<sup>21</sup> Pattison, "Dumbing Down the Spirit," 38.

<sup>22</sup> Ibid., 41. A similar argument is made in the context of pastoral counseling in Bruce Rogers-Vaughn, "Best Practices in Pastoral Counseling: Is Theology Necessary?" *The Journal of Pastoral Theology* 23, no. 1 (2013).

their work *Selling Spirituality: The Silent Takeover of Religion*. Carrette and King do not focus directly on spirituality as it appears in health care and chaplaincy but rather on its proliferation in various practices and discourses both inside and outside of institutions such as the workplace and self-help literature. Casting this wide net, Carrette and King term the entire cultural turn from religion to spirituality as “a wholesale *commodification* of religion, that is the selling-off of religious buildings, ideas and claims to authenticity in service to individual/corporate profit and the promotion of a particular worldview and mode of life, namely corporate capitalism.”<sup>23</sup> Carrette and King place spirituality within this overarching framework because they understand it to be the commoditization of a need once channeled through communal belonging structured through religious traditions. Today, this need is realigned into notions of personal development. We now transcend ourselves by reaching deeper into ourselves, finding new avenues of authenticity, depth, and humanity through spirituality that is mediated and sold to us by corporations as commodities.<sup>24</sup> Further, our need to belong is transformed into workplace belonging and “corporate community”; we express ourselves by belonging to the team that produces the commodity or the recognized brand.<sup>25</sup> With such broad claims, Carrette and King exemplify a reductionist reading of spirituality, the idea that it is a translation directly of one thing into another. Feelings and desires once wrought in communal, committed religion have been commoditized by individualistic spirituality.

Situating the commoditization argument directly in health care, theologian Joel James Schumann and physician Keith Meador place spiritual care within the commoditization of health

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<sup>23</sup> Jeremy Carrette and Richard King, *Selling Spirituality: The Silent Takeover of Religion* (New York: Routledge, 2005), 15. Italics are original.

<sup>24</sup> Lucy Bregman echoed this critique at almost the same time as Carrette and King’s work in an article aligning spirituality with humanistic psychology. “Defining Spirituality: Multiple Uses and Murky Meanings of an Incredibly Popular Term,” *Journal of Pastoral Care and Counseling* 58, no. 3 (2004), 166.

<sup>25</sup> Carrette and King, *Selling Spirituality*, 134.

in current medical practices.<sup>26</sup> Schumann and Meador in fact trace the commoditization of religion and health together, noting the change from a traditional religious understanding of healing and belief as closely tied together in a life of service to the goodness of God to our present understanding where bodily health has become an end to itself to be bought on the market and religion has been coopted as yet another merchandisable means towards health. According to Schumann and Meador, not only have we lost our understanding of community and commitment, but in doing so, we have also lost the reason we once pursued health in the first place.

With this double loss, spirituality becomes simply another commodity with nothing but health itself as its end, the selling of more life without providing any concrete meaning for this extra time besides personal enjoyment. In contrast to Schumann and Meador, advocates of spiritual care such as Harold Koenig and Kenneth Pargament state that spirituality should not simply be equated with good health and care. Rather, these proponents argue that the benefits of good spiritual care to patient health and their accommodation to the health care setting are secondary to meeting patient's spiritual needs.<sup>27</sup> However, Schumann and Meador state that in practice, these secondary benefits are the primary concern for the market that supports and funds

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<sup>26</sup> While I am aligning various theorists in this section, it is important to note that these authors also disagree on the possibility to return from spirituality back to religious communities of practice and commitment. Pattison seems to be echoing the post-liberal call to return to religious narrative of Hauerwas, who outlines the possibility for such communities of narrative rooted in biblical revelation in *The Peaceable Kingdom*. In contrast, Carrette and King state that such a return is impossible in the diffusion of religious traditions in neoliberalism and pluralism. See *Selling Spirituality*, 179-182. Joel James Schuman and Keith Meador, *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity* (Oxford: Oxford University Press, 2003), described below, leans in the direction of Pattison and Hauerwas, as their subtitle suggests.

<sup>27</sup> Harold Koenig's concern as a researcher is that spirituality cannot be equated with its accidents in good mental health and pro-social activity, lest the studies that correlate spirituality and these behaviors become tautological. Thus, Koenig sees spirituality and the ends of spiritual care as separate but correlated. See *Medicine, Religion, and Health*, 18; *Spirituality in Patient Care*, 52-54. Koenig follows Pargament's understanding that spirituality expresses our connection to the sacred, widely understood, which can be utilized for better integration and health but should not be equated with it. See Pargament, *Spiritually Integrated Psychotherapy*, 21.

the hospital and thus the main reason for health care's concern for spirituality. The spirituality fostered within the health care setting is then simply a tool for the commoditization of health:

This is precisely what an increasing number of those advocating a more religious medicine seem – sometimes in spite of their own disavowals of anything resembling such medically motivated proselytism – to suggest...Because religious practices of various sorts are associated in various ways with better health, they reason, those practices ought to be understood by caregivers and patients alike as valuable healthcare resources.<sup>28</sup>

Thus, rather than an accident or secondary benefit of spirituality and spiritual care, Meador and Schumann see spirituality itself, created within the health care context, to be *nothing but* commoditization, the “particular religion of capitalist high modernity.”<sup>29</sup> The elements of meaning making and connection to the sacred are merely masks of a system in which health is the only goal, an end unto itself: “God comes to be a placeholder in the logic of exchange: the abstract, faceless producer of, among other things, that exchangeable, acquirable commodity called health.”<sup>30</sup> According to Meador and Schumann, the spirituality fostered and created within health care boils God down to the therapeutic ends that spirituality produces. God, health, and the market become symbols and masks for one another, each blending into the other. The benefits of spirituality become the sum of what the spirituality fostered in the hospital really is.

Scholars who proffer the critique of spirituality as a façade of neoliberalism and the exchange of health deepen the interpretation of spirituality as individualism by exploring the ways in which spirituality and thus spiritual care are produced by the health care context and the ways they operate within and for this system.<sup>31</sup> If spirituality does not simply appear on a free

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<sup>28</sup> Schuman and Meador, *Heal Thyself*, 26.

<sup>29</sup> *Ibid.*, 40.

<sup>30</sup> *Ibid.*, 88.

<sup>31</sup> Philip Selrake echoes this sentiment when he states, “What is understood by ‘spirituality’ tends to take on the priorities of the domain in which it finds itself. Contemporary ‘spirituality’ has thus become a chameleon – changing colour depending on the foliage within which it sits.” “Spirituality and Healthcare,” *Practical Theology* 3, no. 3 (2010), 367.

marketplace of beliefs and practices but is rather produced by the institutional settings and cultural frames in which it appears, then these scholars push the inquiry into the spirituality operative within the hospital further by aligning it with the neoliberal economy through which this setting operates. They show how spirituality is not simply a free floating, meaning-making capacity that each patient utilizes in her situation, nor is the spiritual care of the chaplain simply an open and agenda-free presence, but rather both are set within structures of power where profits are made as health care is sold.

The question, however, that chaplains and scholars of spirituality must bring to these arguments centers around their reductionist approach. Even as chaplaincy and spirituality inevitably are implicated within the neoliberal economy, does this situation mean that the spiritual care formed within the hospital is *nothing but* the empty façade of a commercialized product? Does chaplaincy simply offer an empty shell of traditions once founded in community and commitment now made into the fetishized commodity of health? The problem comes when these scholars trace the movement from communal religion to empty commoditized and individualistic spirituality as a single and smooth translation, as if either term on this dichotomy could ever completely capture such a complex phenomenon as a person's beliefs and practices, especially in such a multifarious system as the hospital, whose practices contain multiple narratives and shades of meaning.

To make the reductive argument is to discount the subjective experiences of spiritual care providers and care receivers when they attach meaning, transcendence, and care to their spirituality. If the spirituality fostered and created within the health care context is only a façade for consumerism, then these experiences can be explained away as illusion rather than taken into account. Paul Heelas, mentioned above for his involvement with the Kendal study, is one of the



leading academic proponents for spiritual practices associated with the New Age movement in the UK, where the emphasis lies on the spiritual resources developed within a person rather than those found through God or otherworldly transcendence. While Heelas agrees that New Age spirituality, what he calls “spiritualities of life,” is implicated within consumerism, he critiques totalizing interpretations that reduce spirituality simply to commoditization.<sup>32</sup> Such interpretations read consumerism from spirituality because the two bear similar marks, but the total alignment of spirituality with consumerism must ignore the meaning that practitioners attached to their activities. Heelas, in contrast, seeks to avoid reductionism by examining the multiple layers of meaning through which spirituality is mediated. As he puts it, “I argue that it is highly unlikely that any particular activity or provision is *either* an act of consumption *or* not. My answer to the question ‘When is an act of consumption?’ is that acts...are *never* simply a matter of consumption.”<sup>33</sup> For Heelas, simply because spirituality is implicated in neoliberalism does not mean that spirituality can simply be discounted as consumerism. Something that people attach meaning to can never simply be reduced to a product.<sup>34</sup>

As a meaningful and multifaceted phenomenon, spirituality is thus both implicated in and more than consumerism. Likewise, the reality that chaplaincy care certainly is a function of the hospital and therefore implicated in a culture in which health itself has become a commodity does not reduce spiritual care to commoditization. To unite these two without acknowledging the complexity and ambiguity of chaplaincy practice and its context would be to discount the

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<sup>32</sup> Heelas specifically names Carrette and King in a long list of scholarship employing “the reduction to ‘consumption’ strategy.” Paul Heelas, *Spiritualities of Life: New Age Romanticism and Consumptive Capitalism* (Hoboken, NJ: John Wiley and Sons, 2009), 83.

<sup>33</sup> *Ibid.*, 14. Italics are original.

<sup>34</sup> For example, Heelas asks if flowers bought to place on a grave can be explained away as neoliberal illusion. *Ibid.*

presence and support that chaplains offer through the harrowing moments of life and death experienced every day within the walls of our hospitals.

In order to avoid reductionism while still being careful to locate spirituality and spiritual care within their political context, theory must not simply name spirituality as a function of the hospital system but rather seek to understand how the system incorporates chaplaincy within itself. This difference is subtle but critical, for while spirituality is certainly something fostered and created within the hospital, its various functions and meanings evade simple categorization. Just as New Age spirituality is never just an act of consumption as Heelas states, so too is spiritual care within the hospital not *just* a tool of this setting, though it certainly *is* a tool of its setting. By this, I mean that the meanings, values, and functions attached to spirituality and spiritual care within the hospital proliferate even as they originate in and continue to advance the political and economic systems in which they are situated. Thus, the necessary move to understand the political context and function of chaplaincy is not simply to name it as a product or façade for a certain type of politics, but rather to understand how the political trajectories of the hospital produce, manage, *and are changed by* the spiritual care that they foster. In the next section of this chapter, I explore how theories of biopolitics allow room for such complexity while also illuminating the politics of spiritual care.

### III. Theories of Biopolitics

The trajectory of biopolitics – the exercise and contestation of biopower – is both wider and more amorphous than either economics or the health care industry. As Michel Foucault originally outlined it, biopolitics is the systemic governance of life itself: “It is, in a word, a matter of taking control of life and the biological processes of man-as-species and of ensuring

that they are not disciplined, but regularized.”<sup>35</sup> This governance is therefore the exercise of power, but this power does not come in the form of the dominance of one person or group ruling over another. Biopolitics rather forms a movement of power through a mobile network of relations, channeled through a series of institutions by which a population orders itself to survive.<sup>36</sup> Biopolitics therefore includes institutions that intervene in and regulate biological processes, but it is also present in interpersonal interactions, as these interactions reflect the power arrangements of social norms and recognition.<sup>37</sup> For Foucault, biopolitics also produces systems of knowledge. It creates “facts” about people and bodies, dictating, for example, what is normal, healthy, and sane. It is not that these “facts” are simply illusions, but rather they participate in ways of knowing and seeing that also determine how we live our lives or how we feel we should live our lives in order to be normal and good. Thus, systems that manage health care, education, punishment, and defense are key to biopolitics; they are what Foucault calls its “apparatuses.”<sup>38</sup>

The apparatus is where biopower and life meet, legally in the forms of rights and laws granted to or exercising power over the body of, for example, the patient or the prisoner, but also

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<sup>35</sup> Michel Foucault, “*Society Must be Defended*,” 246-247. Foucault is often understood as the foundational theorist of biopolitics, a theory that was actually underemphasized during Foucault’s life but was later revived by the work of Donna Haraway, Giorgio Agamben, Michael Hardt, Antonio Negri, and more recently by Roberto Esposito. However, Esposito actually traces a genealogy behind Foucault’s development of the theory through European and American theorists of the 19<sup>th</sup> and 20<sup>th</sup> centuries. See Roberto Esposito, *Bios: Biopolitics and Philosophy*, trans. Timothy Campbell (Minneapolis: University of Minnesota Press, 2008), 13-24.

<sup>36</sup> Foucault famously describes power as “the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect.” Thus, power is not something “that is acquired, seized, or shared, something that one holds on to or allows to slip away” but rather is it the chain of connections and disconnections between and among people and groups, forming a grid or a series of networks through which a population comes to be and survive. In this way, power is not dominance, but rather dominance is one of several effects of power as the chain that binds people and groups together. Michel Foucault, *The History of Sexuality, Volume 1: An Introduction*, trans. Robert Hurley (New York: Vintage Books, 1978), 92-94.

<sup>37</sup> In *The History of Sexuality, Volume 1*, Foucault cites examples of such processes: “the propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (p. 139).

<sup>38</sup> *Ibid.*, 144. See also Timothy Campbell and Adam Sitze, “Introduction. Biopolitics: An Encounter,” in *Biopolitics: A Reader*, eds. Timothy Campbell and Adam Sitze (Durham: Duke University Press, 2013), 11.

informally in patterns of norms, where life is regularized by social trends and cultural frames, such that only certain types of life and living appear or are recognized as “normal” or “healthy” by individuals and social institutions.<sup>39</sup> Through laws and norms, biopower exerts influence on individual bodies, shaping them in ways meant to bolster the population.<sup>40</sup> Yet this guidance can also be threatening to people who are not included within the norms governing the group, creating entire social spheres of the “abnormal,” “degenerate,” or the “ill,” those who are known by their distance or failure of social norms.<sup>41</sup>

As the contemporary Italian political philosopher Roberto Esposito puts it, if biopower is the meeting of life and power, it moves politics from the realm of law to that of biology; the body politic itself comes to be seen and maintained like a biological body. This body is then understood to have healthy and sick parts, and thus the degenerate are treated as parasites.<sup>42</sup> The biopolitical governance of life can therefore mean both the flourishing and the oppression of the population, based on its operative norms. As normalizing and systemic pathways, the hospital and the economy that undergirds it can be seen as apparatuses within biopolitics; however,

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<sup>39</sup> Foucault writes, “I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory. A normalizing society is the historical outcome of a technology of power centered on life.” *History of Sexuality, Volume I*, 144. Judith Butler outlines the ways norms create frames in which only certain lives are recognized as life at all in *Frames of War: When Is Life Grievable?* (Brooklyn, NY: Verso, 2009), 1-32.

<sup>40</sup> Foucault develops his understanding of discipline as the systemic shaping and creation of the individual subject in his well-known work *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage Books, 1977). Here, Foucault writes of the ways institutions such as the prison, school, and military shape “docile bodies” into their own extensions through such means as the timetable, the gradation of tasks, and the use of signals. Through these means, bodies become machines of their institutions, shaped and disciplined through extensive training. In his lectures, Foucault differentiates disciplinary power from biopolitics, explaining that they exist on different levels of power, one focusing on the shaping of the individual, the other on the regularizing of the population. However, these two levels meet in the norm: “The norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularize.” “*Society Must be Defended*,” 253.

<sup>41</sup> Michel Foucault, “The Subject and Power,” *Critical Inquiry* 8, no. 4 (1982), 777-78: “In the second part of my work, I have studied the objectivizing of the subject in what I shall call ‘dividing practices.’ The subject is either divided inside himself or divided from others. This process objectivizes him. Examples are the mad and the sane, the sick and the healthy, the criminals and the ‘good boys.’”

<sup>42</sup> See Esposito, *Bios: Biopolitics and Philosophy*, 110-119. My characterization of the ‘degenerate’ in the preceding sentence also comes from Esposito, *Ibid.*, 119.

neither health care nor the market exhaust or provide the foundation of biopolitics. Rather, they are key elements of the wider management and governance of life.

#### A. The Hospital and Spiritual Care as Pastoral Power

I devote the entirety of the next chapter to situating the systems and pathways of the hospital as a biopolitical apparatus. Here, I examine the theoretical foundations of placing spiritual care within biopolitics through Foucault's treatment of pastoral power. I then analyze religion and law scholar Winnifred Fallers Sullivan's recent work with Foucault in outlining the biopolitical nature of chaplaincy care. I argue, however, that these theories, though illuminative especially in pointing to the power dynamics and oppressions of biopolitics, fail to provide a complete picture of the necessity and delicate balance of biopolitics. For that reason, I move from Foucault to Esposito's immunity paradigm, which I explain in the next section.

##### i. Foucault's Pastoral Power

Biopolitics produces knowledge of political subjects, for example, of a person's mental and physical health, sexuality, and behavior. These spheres of knowledge are meant to uncover that which is hidden, for example, the neuroses or the perversions that a person hides within herself. Foucault actually traces these ways of knowing to practices originating from the Christian West that created a type of power that he names "pastoral." For Foucault, pastoral power originates first widely in Hebraic and Mesopotamian religions where various gods were known as *shepherds* over their people rather than merely rulers of their territories or city-states, like the gods of Greek and Roman religion.<sup>43</sup> However, Foucault states that the Christian church

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<sup>43</sup> Foucault spends the most part of one lecture in the 1977-1978 series on Plato's *The Statesman* as one of the closest examples of Roman literature considering the pastoral as an analogy of government only to show that

is unique from its predecessors for putting pastoral power in human hands through the ecclesial and pastoral government of religious subjects.<sup>44</sup> Reading texts of early church fathers like Gregory of Nazianzus, John Chrysostom, Cyprian, and Ambrose, Foucault outlines a type of governance based on submission to God's will, but exercised through individualized pastoral oversight of the daily lives of believers. This oversight is not only the direction by an abbot or priest of the believer's religious and social life, moving her towards salvation by right conduct; it is also an excavation of what is hidden within the believer's soul, often through sacramental acts of penance: "The Christian pastorate is also absolutely innovative in establishing a structure, a technique of, at once, power, investigation, self-examination, and the examination of others, by which a certain secret inner truth of the hidden soul, becomes the element through which the pastor's power is exercised."<sup>45</sup> Biopower thus begins in pastoral power as an innovation in the government of people, not just outwardly but also inwardly, in elevating the soul to the inspections of authority.

As Foucault makes clear in his studies of modern iterations of pastoral power and the mechanisms of confession, the excavation of the one's interiority, one's conscience or spirit – what Foucault calls the "soul" – is also the formation of one's interiority.<sup>46</sup> The self-examination and confession structured through pastoral power are the point of contact between the self and the norms through which the penitent understands and experiences her self and her soul.<sup>47</sup> The

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even here the analogy is rejected as only useful "in minor activities that are no doubt necessary for the city-state, but that are subordinate with respect to the political order." Michel Foucault, *Security, Territory, and Population: Lectures at the Collège de France 1977-78*, trans. Graham Burchell (New York: Palgrave Macmillan, 2007), 146.

<sup>44</sup> "The Church is a religion that thus lays claim to the daily government of men in their real life on the grounds of their salvation and on the scale of humanity, and we have no other example of this in the history of societies." *Ibid.*, 148.

<sup>45</sup> *Ibid.*, 183.

<sup>46</sup> See Foucault, *Discipline and Punish*, 29-30.

<sup>47</sup> In his later work, Foucault writes of two levels of technology of the soul, one a set of mechanisms of domination through which the confessor extracts the truth she introjects into the penitent, the other another set of mechanisms of self-formation through which a person creates herself through the norms available in her culture. The

field of knowledge creates the conditions where one looks inwardly and finds her spirit. This does not mean that the spirit is simply imaginary. The soul “exists, it has a reality, it is produced permanently around, on, within the body by the functioning of a power that is exercised on those punished – and, in a more general way, on those one supervises.”<sup>48</sup> Foucault traces a similar construction of the soul through modern institutions such as the prison, the school system, and therapy. These institutions create fields of knowledge where we look inward, creating but also unearthing knowledge about ourselves, “and in this context, the word ‘salvation’ takes on different meanings: health, well-being (that is, sufficient wealth, standard of living), security, protection against accidents.”<sup>49</sup> Pastoral power expands its scope in biopolitics, enumerating broader goals towards which one must look (and conform) inwardly.

Yet, as Foucault states in his later work, this formation is not simply domination, not simply the penitent repeating the words expected of her by her priest, warden, schoolmaster, or doctor. Rather, this formation is more of a structured dialogue between the self and the norms in which the self comes to be. As theorist Judith Butler explains in her work on Foucault:

In Foucault’s view, there is always a relation to this regime, a mode of self-crafting that takes place in the context of the norms at issue and, specifically, negotiates an answer to the question of who the “I” will be in relation to these norms. In this sense, we are not deterministically decided by norms, although they do provide the framework and the point of reference for any set of decisions we subsequently make.<sup>50</sup>

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two levels of domination and self-creation are in dialogue and tension as the subject and its soul comes to be. In Foucault’s words, “One has to take into account the points where the technologies of domination of individuals over one another have recourse to processes by which the individual acts upon himself. And conversely, one has to take into account the points where the techniques of the self are integrated into structures of coercion or domination.” Michel Foucault, “About the Beginning of the Hermeneutics of the Self (1980)” in *Religion and Culture: Michel Foucault*, ed. Jeremy Carrette (New York: Routledge, 1999), 162.

<sup>48</sup> Foucault, *Discipline and Punish*, 29.

<sup>49</sup> Foucault, “The Subject and Power,” 784.

<sup>50</sup> Judith Butler, *Giving an Account of Oneself* (New York: Fordham University Press, 2005), 22. Butler is tracing an evolution in Foucault’s thinking, moving away from strict internalization of domination, as in his evaluation of psychoanalysis in his doctoral thesis, stating that it only “doubled the absolute gaze of the watcher with the indefinite monologue of the surveyed.” In short, Foucault moves from a strict internalization of domination in his early work to the more dynamic and dialogical understanding of subject formation covered here in his later work. *History of Madness*, 488.

These dialogues between the self and social norms happen today across various modern systems in which our population continuously forms, maintains, and reproduces itself: school and university systems, systems of health care, the economy, the prison, etc. We are patterned and thus come to be through the systems that form us, and thus we internalize and then speak or confess the interiors formed always under the influence of cultural norms. In this way, pastoral power continues even in the decline of Western Christianity.

Pastoral power also continues to evolve today in modern biopolitics. In his lectures, Foucault traces the evolution of pastoral power in light of the deregulation of world markets of post-war Europe and America. Gradually, in the modern rise of neoliberalism, governmental order moves to a greater emphasis on the guarantee of freedoms as political discourse revolves around the self-limitation of government, capitulating itself to the putatively natural power and wisdom of the market.<sup>51</sup> Yet, for Foucault, this self-limitation is actually the creation of a new public sphere, “civil society,” which Foucault describes as “the medium of the economic bond,” a sphere where political citizens meet one another as economic subjects, where each person is assumed to hold an economic interest that can be expressed by one’s participation in the economy.<sup>52</sup> Thus, rather than a simple freeing of market forces, the creation of this sphere is the generation of a new interiorized social norm, that of economic interest and pursuit, which becomes “a principle of intelligibility and a principle of decipherment of social relationships and individual behavior.”<sup>53</sup> Pastoral power comes to necessitate not only the confessions of conscience and abnormality, but also the formation of the self as an economic subject, a

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<sup>51</sup> Michel Foucault, *The Birth of Biopolitics: Lectures at the Collège de France 1978-1979*, trans. Graham Burchell (New York: Picador, 2008), 1-22. See also Foucault, *Security, Territory, Population*, 333-358.

<sup>52</sup> *Ibid.*, 302.

<sup>53</sup> Foucault, *The Birth of Biopolitics*, 241.



consumer with a market interest. Human beings and human relationships are now known by their place within the market and judged by their ability to serve the market.

For Foucault, the transformation of pastoral power via neoliberalism does not, however, collapse biopolitics into the market. Rather, neoliberalism is an economic system and a frame of recognition made possible but also contained within biopolitics as the general management of life.<sup>54</sup> Biopolitics makes way for neoliberalism through the creation of normalized persons and populations, placed strategically throughout modern institutions. The general apparatuses of modernity must then adjust themselves to the market and its language, but their power remains in their participation in the overall maintenance and control of the population, of which neoliberalism is a part.

## ii. Winnifred Fallers Sullivan, Pastoral Power, and Normative Spirituality

Like the Foucaultian “soul,” shaped, internalized, and confessed within a number of biopolitical institutions, the modern notion of “spirituality” too can be understood as normatively produced via the exercise of pastoral power.<sup>55</sup> Winnifred Fallers Sullivan analyzes this production when she looks at chaplaincy as it is legitimated by the American legal system. Sullivan first situates modern chaplaincy in a contemporary rereading of the first amendment of the American Constitution. Whereas the free exercise clause was once read as creating a strict dividing line between religious practice and public institutions in order to free religion from state oversight, increasingly today American courts have read the free exercise clause as a mandate on

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<sup>54</sup> Michel Foucault, *History of Sexuality, Volume 1*, 140-141: “This bio-power was without question an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes. But this was not all it required; it also needed the growth of both these factors, their reinforcement as well as their availability and docility.”

<sup>55</sup> The relevance of Foucaultian biopolitics to modern chaplaincy is already being traced by a number of scholars. In addition to Sullivan discussed below, Foucault’s work provides part of the theoretical foundation for Swift, *Hospital Chaplaincy in the Twenty-First Century* and Lee, “In a Secular Spirit.”

the government to provide the means for practice within public institutions.<sup>56</sup> By way of this mandate, the court has assumed that US citizens are naturally religious. Thus, the court has endorsed the essentialist view of spirituality, which as noted in chapter 1 is also prevalent in the literature by chaplains.<sup>57</sup> Through state funding and legitimation, the chaplain, according to Sullivan, then becomes the interface between a secular institution, such as the hospital, prison, or military unit, and the religious person, providing for the assumed essential needs of the latter.

Yet by endorsing and funding chaplains through an essentialist view of spirituality, the court, through the spiritual care of chaplains, also exerts a *disciplining* power over spirituality in the public sphere, because chaplaincy care fosters only a specific type or character of spirituality. According to Sullivan, the legal support of an essential spirituality leads only to “the celebration and fostering of a universalist and irenic spirituality that mirrors American politics and upholds the rule of law while containing or excluding forms of religion that are perceived to threaten stability, sexual mores, or national security.”<sup>58</sup> To be universally shared and then cared for institutionally, this spirituality must necessarily marginalize exclusionary and dogmatic forms of religion, those that would disrupt the systemization of spirituality as a mode of care between people and religions in the hospital. As such, spiritual care is itself a form of pastoral power.<sup>59</sup> It imagines and therefore fosters a field of knowledge that can be internalized, while exercising norms that control its expression, cultivating a universal, non-exclusionary type of spirituality that can be incorporated within the hospital’s overall care of the individual. This spirituality then can be recognized as an important part of the person and a field of knowledge and health no

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<sup>56</sup> Sullivan, *Ministry of Presence*, 3.

<sup>57</sup> *Ibid.*, 49. Sullivan is specifically covering the standardization of spiritual care in the Veterans Administration following a failed court challenge to it in *FFRF v. Nicholson*.

<sup>58</sup> *Ibid.*, 140.

<sup>59</sup> See *Ibid.*, 22. Sullivan cites Foucault’s 1977-78 lecture series in outlining chaplaincy care as pastoral power. She does not specifically term its trajectory as neoliberal or biopolitical.

matter the specific religious traditions of various caretakers or patients. Thus, it is the fostering of the soul, in the Foucaultian sense. It is the promotion of a type of soul that can be known, assessed, and cared for within the hospital system.

Sullivan's characterization of chaplaincy therefore is in line with the biopolitical trajectory of the hospital because she recognizes how care shapes spirituality in a way conducive to the political governance of the population as a whole. Because peace and commerce are aided by a shared spirituality without exclusions or borders, the essentialist view of spirituality imagined by the court and fostered by the chaplain holds a disciplining trajectory in line with Foucault's characterization of pastoral power. Through the interface of the chaplain, the state can "effectively normalize religion as an aspect of human life," promoting a spirituality that can be shared, assessed, and promoted towards the overall care of the person and the patient population.<sup>60</sup>

Sullivan's analysis of the disciplining influence of spiritual care is key to understanding how hospital chaplaincy is incorporated into the biopolitical trajectory of modern health care. However, in the chapters that follow, my own analysis deviates from and critiques her characterization of spiritual care in two ways. First, Sullivan's focus on the connection between the judicial imagination and spiritual practice too drastically separates chaplains from their immediate setting, the hospital. Her analysis does not speak to the ways chaplaincy participates in the particular biopolitical trajectory of modern health care, but rather examines chaplaincy broadly through a number of secular institutions including the US prison system and the military. While this scope enables Sullivan to speak generally about the intersection of law and American spiritual care, her broad scope means that the actual political and disciplinary character of

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<sup>60</sup> Ibid., 17.

chaplaincy in any one setting, like the hospital, is lost. The hospital today, however, is an epicenter of contemporary biopolitics, the setting where the politics of life itself, heavily laden with norms and moral visions, is carried out in innumerable practices, including the practices of chaplaincy care. To understand how chaplaincy exercises pastoral power and participates in biopolitics, we must first directly examine the practices of health care and then chaplaincy's support or subversion of these practices. This is why health care practices and trends are the focus on the next chapter.

Second, because Sullivan does not address health care trends her analysis oversimplifies the political character of the spirituality fostered by hospital chaplaincy care. While I agree with her analysis of the disciplining influence of care in fostering a non-exclusionary form of spirituality that is then systematized as another measure of health of the patient, she does not then take the further step in showing how such spirituality both strengthens *and resists* specific trends within health care. When Sullivan finally notes resistance within the practices of chaplaincy to biopolitics in the last chapter of her book, she only examines pastoral presence. She repeats the descriptions by chaplains of the tension between the medical frame and the ministry of presence: "Presence also works as a place of resistance to instrumentalist approaches to religion and spirituality. The ministry of presence refuses interpretation and explanation...Presence can refuse to be made part of a system – to be measured and quantified and offered as a means to an end. It is the end."<sup>61</sup> Here, Sullivan is showing how the generalized form of spirituality also operates against the systematization of people in the practice of pastoral presence, what she also calls "a movement of insurrection,"<sup>62</sup> free of "disciplinary imposition."<sup>63</sup> Without comment on how presence is incorporated within biopolitical practices of the hospital,

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<sup>61</sup> Ibid., 177.

<sup>62</sup> Ibid., 176.

<sup>63</sup> Ibid., 191.

however, Sullivan's take on presence is overly optimistic. It fails to look at how this "resistance to instrumentalist approaches to religion and spirituality" nonetheless supports specific biopolitical trajectories within the hospital. At the same time, by relegating generic spirituality in the hospital solely as an aspect of pastoral power, Sullivan's project also oversimplifies spirituality itself. Whereas Sullivan starts with the law and interpretations of the constitution, my focus in the coming chapters is on health care trends. I characterize chaplaincy care as both aiding and subverting the biopolitics of modern health care, particularly its overarching narratives of progress and healing and its commoditization of health care on the market.

Foucault's theories of biopolitics lend themselves to oversimplified interpretations of resistance such as Sullivan's optimistic analysis of pastoral presence because, when he speaks of resistance, he is hesitant to name how it functions *within* the realm of biopolitics. This is a consequence of the fact that when Foucault writes of resistance *to* biopolitics, he is reaching towards a yet unknown political reality, one that he cannot describe in detail, lest he simply repeat or add to the discourse and knowledge bases of biopower. When describing the production of knowledge in pastoral power, for example, Foucault states "Maybe the target nowadays is not to discover what we are but to refuse what we are."<sup>64</sup> Likewise, when describing the appearance of sexuality as a developing field of psychological knowledge, Foucault famously writes, "The rallying point for the counterattack against the deployment of sexuality ought not to be sex-desire, but bodies and pleasures."<sup>65</sup> In both cases, he is reaching toward an alternative political experience, reaching out to the limits or horizon of biopolitics, yet in doing so, he remains in the position of a biopolitical subject himself. He is outlining resistance to biopolitics from within, or rather, he is sketching out a liminal place between biopolitics and a yet unknown political

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<sup>64</sup> Foucault, "The Subject and Power," 785.

<sup>65</sup> Foucault, *The History of Sexuality, Vol. 1*, 157.

paradigm. However, because his descriptions of resistance remain opaque, both of these references can also be read as equating resistance simply to a refusal of biopolitics altogether, as if it were possible to escape our current political era.<sup>66</sup> While Foucault is nodding towards a more liminal – and therefore responsible – place between political paradigms, rather than simple refusal, his work with resistance also lends itself to oversimplified notions of refusal. The notion of pastoral presence as a way of simply stepping out of biopolitical systematization is such an oversimplification of resistance.

In contrast, is a resistant stance *within* biopolitics possible, one that seeks to counter its excesses while realizing the difficulty of simply stepping out of biopower? Are there even benefits of living within the realm of biopolitics, even as those benefits are distributed unevenly? What readers of Foucault who equate resistance with refusal miss, of course, are the beneficial possibilities of biopolitical systematization. Do the order, knowledge, and promotion of life central to our politics today not produce a certain amount of human good, even human flourishing, that we cannot or should not simply refuse? The benefits of biopolitical trends and practices are especially clear in the hospital. Even as this biopolitical apparatus exerts such a great amount of power over patients, leading to many disturbing excesses, it also improves the life and health of countless people who enter its doors. Rather than refusal, then, we need a more robust conception of the necessity – perhaps even the good – of biopolitics, along with a more detailed theory of resistance to its dangers and oppressions. In order to understand such dynamics, and thus to develop a more nuanced understanding of the detriments and necessities of chaplaincy's participation in health care biopolitics today, I turn to Roberto Esposito.

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<sup>66</sup> For example, in an article on neoliberalism Jeremy Carrette interprets Foucault's quote about refusing "what we are," concluding it means "to refuse the machine of capitalism itself," as if one can simply step outside of our economic reality today. "Cyborg Politics and Economic Realities: reflections on Elaine Graham's *Representations of the Post/Human*," *Theology & Sexuality* 10, no. 2 (2004), 54.

## B. Esposito's Immunity Paradigm

When discussing health care trends and practices in the following chapters, it will be necessary to gauge the rigidity of the norms of the system. The systematization of patients, the production of knowledge of their bodies, illnesses, and injuries, the assessment of spirituality are not in themselves harmful. In fact, it is through the production of medical fields of knowledge that great advances in healing and health have been possible, especially in the last century. However, such systematization can also become overly rigid, producing exclusions and omissions. The critical question then is: are these trends so overbearing within this system that certain experiences cannot be spoken or known? I argue in the following chapters that they have in the case of death and loss. But the answer then is not that we can simply do away with biomedical fields of knowledge and the politics of life. Biopolitics is not easily dichotomized as oppression on the one hand and resistance on the other. Rather, there is a delicate balance going on, between rigidity and flexibility, institutionalization and community.

The dynamics of this balance are key to Esposito's theories of biopolitics, especially his work with the immunity paradigm. Esposito's analysis of immunity shows how community is postponed through a series of systems, such as health care, in which the population is managed and sustained. However, according to Esposito, the shape of these systems, meaning the rigidity of the norms and boundaries around which they are formed, will determine if some glimpses or degrees of community are still possible in our political age. Thus, it is not that spiritual care is either purely resistance to or in accord with the biopolitical trajectory of its setting. Rather, it is the way spiritual care negotiates with its setting as it transforms and is transformed by the biopolitical trajectory of the hospital itself that allows for glimpses of community through spiritual care, no matter how fragmentary.

Stated broadly, Esposito's concern is that community, the true being-with another, is impossible because community assumes holding our lives in common in a way that divests each person of her identity. Esposito traces community to the Latin *munus*, meaning gift giving in the form of loss or subtraction.<sup>67</sup> For Esposito, we must understand community, or *communitas* in its Latin form, as the loss of what is properly one's own to that which is common, the divestment of rights and property, in fact, *the loss of self*. Thus, community is inherently a risk to the individual. It opens the individual to an annihilating violence, the undoing of each person, abandoned to the brutality of nature itself<sup>68</sup>: "community isn't an entity, nor is it a collective subject, nor a totality of subjects, but rather is the relation that makes them no longer individual subjects because it closes them off from their identity."<sup>69</sup> Because being with another without rights or property is then the loss of the self as we know it, the loss of all that protects the self and gives it its identity, community is never possible in its pure form.

In contrast, the modern notion of individuality isolates and protects us from community. If *munus* is loss, *immunus*, the Latin term for office, means being in a condition of difference from others.<sup>70</sup> By difference, Esposito means all the ways in which we separate ourselves from one another and retain our identities. Through my identity, I am set apart from you, distanced so that we can then be in relationship, rather than each collapsing into the other. Thus, *immunitas* is

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<sup>67</sup> Roberto Esposito, *Communitas: The Origin and Destiny of Community*, trans. Timothy Campbell (Stanford: Stanford University Press, 2010), 5.

<sup>68</sup> In *Communitas: The Origin and Destiny of Community*, Esposito follows Bataille against Hobbes in stating that any true experience of the other is a threat to the individual, whereas he places the Hobbesian state of nature as a product of immunity that keeps individuals in perpetual separation due to their mutual fear of one another. Thus, Esposito says at the end of the *Communitas*, Bataille can be seen as "the most radical anti-Hobbesian" (124).

<sup>69</sup> *Ibid.*, 138. Esposito draws on Bataille's work with community to illuminate its impossibility. For Bataille, the experience of another is what draws us outside of ourselves, thus transgressing our own boundaries, our individual interests: "to let go of existence inside me and to look for it outside is to take a chance on ruining or annihilating precisely whatever it is without which the outer existence wouldn't have appeared in the first place – the *self* – which is the precondition for there being a 'mine.'" Georges Bataille, *On Nietzsche*, trans. Bruce Boone (New York: Paragon House, 1992), 24.

<sup>70</sup> Roberto Esposito, *Immunitas: The Protection and Negation of Life*, trans. Zakiya Hanafi (New York: Polity, 2011), 6.



the taking in to the community of that which negates community in its pure form, just as the immune system needs an antigen in order to create an antibody. In terms of community, immunity protects the life of the population by separating the political body from itself, by negating the pull to dissolution that is being with another. Individuality, as a political concept, compresses life into the stark boundaries of the body, such that the modern political notion of the individual,<sup>71</sup> with its own property and rights,<sup>72</sup> becomes our way of separating ourselves from others.<sup>73</sup> Through the modern notion of individuality, we are “unified by the principle of common separation.”<sup>74</sup> Thus, as the political management of life, biopolitics is not simply the systemization of life through a number of apparatuses, but also the *absolutely necessary* political separation of life from itself for the protection of individuals.

Biopolitics is then not simply our participation in or resistance to systems or institutions that utilize our lives and our bodies towards their own ends and perpetuation. Rather, in its simplest form, coinciding with the modern notion of the individual, biopolitics enfolds the body like a skin.<sup>75</sup> Biopolitics is also our protection from one another, from the possibility of each person collapsing into the other. Thus, thinking of the presence of spiritual care as an end to itself, free of politics or agenda, is already inherently impossible. The practice of pastoral presence always already presupposes a political notion of individuality that protects the person of

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<sup>71</sup> Esposito maintains that modernity coincides with the appearance of the individual as a political entity. *Bíos: Biopolitics and Philosophy*, 54.

<sup>72</sup> In immunitary logic, property becomes synonymous with life: “Life and property, being and having, person and thing are pressed up together in a mutual relation that makes of one both the content and the container of the other.” Once life is sealed within the single body via individualism, property becomes another protective layer, separating that which is one’s own from the common. *Ibid.*, 64

<sup>73</sup> Esposito, *Immunitas: The Protection and Negation of Life*, 97: “Contrary to the closeness of the ‘common life,’ all these strategies go in the direction of distancing, of a functional separation, which primarily involves the reciprocal relationship between individuals.”

<sup>74</sup> *Ibid.*, 25.

<sup>75</sup> Esposito describes the extreme version of this enfolding the “*double enclosure of the body*,” meaning the enclosure of the self into the body and the body enclosed into the political body. This double enclosure is extreme when it relegates life solely to biology, which is racialized by the production of a racial genetics that gages one’s ‘purity.’ *Bíos: Biopolitics and Philosophy*, 141.

the chaplain and the person of the patient, two individuals already separated by their unique political identities, ordered along the biomedical separation and hierarchy. There is an entire political apparatus surrounding each person, a designation and protection of each person via rights and property that exists and is enforced on a political level. With his immunity paradigm, Esposito thus expands upon the necessities of biopolitics, which are downplayed in Foucault's work. Nonetheless, like Foucault, Esposito too is concerned with the deadly excesses of biopolitics. The question however turns to the balance of the systematization of biopolitics, the rigidity or flexibility of the norms of its institutions, and whether these lead in varying trajectories of oppression and/or care.

The issue with the political protection of life by means of separation is that this protection can become so rigid that it is detrimental to individual lives, as the social body becomes increasingly systematized. When the population is seen as a living body, when politics becomes biology, according to Esposito, the state can become so regularized that it uses violence in order to maintain its rigid order in the name of health.<sup>76</sup> Esposito takes up the extreme example of the Third Reich as the limit of biopolitics, such that the politics of life becomes indistinguishable from thanatopolitics, the politics of death.<sup>77</sup> In the Nazi Regime, the protection of life and the production of death were indistinguishable through the apparatus of the concentration camp. In

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<sup>76</sup> For Esposito, violence is already inherent within the notion of community, as I have summarized above. The exercise of law for the purpose of order neither creates nor does away with violence, but rather the exercise of violence is transferred to the state: "What changes in this case is not the object but the subject of revenge, who is made abstract and general like an institutional mechanism rather than a concrete individual." *Immunitas: The Protection and Negation of Life*, 40. Such violence can then in the extremity of a normative society become racialized and exclusionary, as we see in thanatopolitics, described below.

<sup>77</sup> Esposito, *Bios: Biopolitics and Philosophy*, 10. Here, Esposito departs from Foucault's uneven distinction between totalitarian regimes and neoliberal Empire (p. 111). This contrasts starkly to the political theorist Michael Hardt's reading of Foucault's later work and is more in line with that of Giorgio Agamben, though Esposito disagrees with the latter in stating that biopolitics does not necessarily lead to the politics of death, as explained below. See Michael Hardt, "Militant Life," *New Left Review* 64 (2010), 154; Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans. Daniel Heller-Roazen (Stanford: Stanford University Press, 1998). See also Timothy Campbell, "'Bios,' Immunity, Life: The Thought of Roberto Esposito," *Diacritics* 36, no. 2 (2006), 12.

fact, it was in the name of medicine and public health that people within the German political body who were deemed parasitical were extinguished: “The thesis that emerges is that between this therapeutic attitude and the thanatological frame in which it is inscribed isn’t a simple contradiction, but rather a profound connection; to the degree the doctors were obsessively preoccupied with health of the German body, they made [*operare*] a deadly incision, in the specifically surgical sense of the expression, in its body.”<sup>78</sup> This is the enormity of immunity, taken to its limit: the production of death in the name of life, the political body killing itself to preserve itself. Though the Third Reich is an extreme example, Esposito relates the trajectory of Nazi propaganda and the German state’s actions to the logic of immunity. When the body politic itself is seen as a type of organism, it relegates death for its own survival in an extremely normative society.<sup>79</sup> Taken to the limit, biopolitics produces the “*Absolute normativization of life*,” where the body politic is relegated in the same way as the body, where lives deemed abject or parasitical are continually destroyed in the name of life itself.<sup>80</sup> The production of death is the outcome of an overly rigid biopolitics that casts out those who do not fit.

Do the hospital and spiritual care, necessarily included in the biopolitical trajectory of Western politics, then participate and further a rigid system that is then detrimental to life? Though American health care is, *of course*, a far way away from the genocidal actions of wartime Germany, we nonetheless must ask how the rigidity and pace of its systems produce exclusions and oppressions. Do our systems operate under norms so rigid that they obscure certain experiences? Do our ways of doing health care leave out certain persons because they fail the norms of the imagined health care consumer? And to what extent do such exclusions and

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<sup>78</sup> Esposito, *Bíos: Biopolitics and Philosophy*, 115.

<sup>79</sup> See Esposito, *Immunitas: The Protection and Negation of Life*, 136-137.

<sup>80</sup> “Maintaining that they were removing life from the biological sphere, [the Third Reich] placed all aspects of life under the command of the norm.” Esposito, *Bíos: Biopolitics and Philosophy*, 140. Italics are original.

omissions then produce death and other oppressions? In order to operate, the health care system and chaplaincy within it must abide by certain norms, trajectories, and systems. However, in dealing with the theory of biopolitics, the question shifts: do the hospital and its spiritual care necessarily participate in an exclusionary and ultimately deadly trajectory? Does the fact that the hospital and its chaplains are governed by norms that systematize its patient population mean that both are moving towards rigidity and exclusion?

Esposito is clear in stating that biopolitics need not necessarily lead to the deadly trajectory of thanatopolitics. Though he is clear about the impossibility of community as reviewed above, Esposito also seeks to theorize a type of biopolitics that leads to openness and life rather than rigidity and exclusion.<sup>81</sup> For this, he turns to the character of systemic norms: how exactly do they operate within the social body? Do they necessarily function like an immune system that must define difference as parasitical and exclude that which is foreign? In order to envision a less rigid system, Esposito turns to the function of the human body as an analogical key to envisioning a positive biopolitics. For too long, according to Esposito, biopolitics has mirrored and dictated an oversimplified version of the science of immunity, imagining that the political body must draw strict, exclusionary lines between the healthy and abnormal.<sup>82</sup> In contrast, when looking at the function of the human body's immune system, medical science is

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<sup>81</sup> Vanessa Lemm summarizes Esposito's project concisely: "He begins with an immunitary device that has turned out to be deadly and reverses it into a device that can take on again the function of being the custodian and protector of life." Introduction to *Terms of the Political: Community, Immunity, Biopolitics*, by Roberto Esposito, trans. Rhiannon Noel Welch (New York: Fordham University Press, 2012), 11.

<sup>82</sup> Esposito draws on Donna Haraway's essay "The Biopolitics of Postmodern Bodies: Constructions of Self in Immune System Discourse," in *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991). Haraway investigates the political nature of scientific writings, noting that scientific images of the immune system throughout the modern period buttressed colonial relations between hegemonic identities and their various others: "The immune system is in some sense a diagram of relationships and a guide for action in the face of questions about the boundaries of the self and about mortality. Immune system discourse is about constraint and possibility for engaging in a world of full of 'difference', replete with non-self" (p. 214). According to Haraway, science is never merely positive but reflects the political relations of its time. Thus, immune system discourse has only recently understood the networking nature of the immune system as cultural discourse has moved from static to fragmentary and hybrid ideas of identity.

finding that the line between bodily self and other is far from simple or rigid. Rather than drawing a line between organic antibody and viral antigen, the immune system is more incorporative.<sup>83</sup> The immune system is not simply a dividing line between body and other, but rather it oversees a network of compatible relations, made up of a constantly changing mixture of living and dead cells, energy, technology, bacteria, and waste, any of which may be harmful or beneficial to the overall system at different times depending on the overall functioning of the body. As an operative conglomerate, “[The body] is never original, complete, intact, ‘made’ once and for all; rather, it constantly makes itself from one minute to the next.”<sup>84</sup> The immune system does not just sort out what is foreign from what is natural to the body. Rather it is constantly remaking the body out of a diversity of materials, looking for compatible groupings rather than drawing strict lines.

In contrast to the rigid normativization of life, biopolitics can also be imagined in the way of the human body’s immune system, as a network of relations never determined beforehand but constantly remade through momentary groupings. Thought in this way, biopolitics does not draw a pre-established dividing line between self and other in the political body. Rather, the political body reflects the living body, working “to think the norm together with life” by incorporating difference as the body itself does.<sup>85</sup> In this way, the immune system can allow for degrees of community, moments of commonality that break the rigid distinctions of individuality, moments where divisions are allowed to abate. In this way, Esposito theorizes biopolitics as a necessary but delicate balance between two deadly extremes, the collapse of community and the violent divisions of immunity. Each protects us from the other, but moving too far to either one is

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<sup>83</sup> Esposito, *Immunitas: The Protection and Negation of Life*, 169.

<sup>84</sup> Ibid.

<sup>85</sup> Esposito, *Bíos: Biopolitics and Philosophy*, 186.

disastrous. With this theory, Esposito, much more than Foucault, outlines the benefits as well as the monstrosity of biopolitics.

Thinking of a biopolitics that is not only the regulation of a population but is *also* responsive to its changing dynamics further allows a place for a dynamic spiritual care within the hospital. Imagined in this way, spiritual care is not simply a function of a biopolitical and neoliberal dominance over a population. Though the authors reviewed above are correct in naming these dynamics as a part of spiritual care's role in the systems of power and management of its setting, chaplains also continually negotiate with their setting. As their spiritual care is integrated further into the hospital system, they can also work to change the system, perhaps even to relax its norms and boundaries, incorporating more levels of experience than those allowed by the dominant narratives of medicine today. The question then becomes: does spiritual care hold the possibility for the integration of difference, following an immunitary paradigm built on incorporation rather than exclusion? Does chaplaincy allow for moments of community where neat boundaries around personal identity relax?

While furthering the biopolitical trajectory of the hospital, spiritual care also has a place in determining exactly what the character and consequences of this political trajectory are. Seeking to be responsive to the lives and deaths that they meet, chaplains are both entrenched in the maintenance and control of life *and* also caring for and participating in the experiences they meet in the room. Through the lens of biopolitical theory, the question is not *if* spiritual care is political; the question is *how* it is political. Does its work produce a highly regularized, static, and exclusionary spirituality and practice of care or does it allow for diversity, fluidity, and response? These are questions better left to the following chapters. The point here is that

biopolitical theory allows room for both possibilities while still seeking to account for the political trajectory of chaplaincy care.<sup>86</sup>

#### IV. Conclusion: Embodiment and Theories of Political Change

I return here in the conclusion of the chapter to the opening vignette of the man who stopped me in the hospital hallway with a far different memory of my care than the one I remembered. This example is key, for while the character of the biopolitical trajectory of the hospital is in fact modified directly by the work and negotiations of chaplains, the work that spiritual care does within the hospital is not entirely the work of chaplains alone, or even necessarily the work that they intend to do. Naming the spiritual care of chaplains as political may lead to an oversimplification if it means shouldering chaplains alone with the work of political protest. Rather than stating that the political meaning of the chaplain's work is left entirely to her own agency, we must recognize that political change of systems comes in multifarious layers of meaning and memory that originate in caring actions but are ultimately never fully decided by those actions or the intentions behind them.

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<sup>86</sup> In "A Manifesto for Cyborgs: Science, Technology, and Socialist Feminism in the 1980s," *Socialist Review* 80 (1985), Donna Haraway utilizes the science fiction of the cyborg, a fusion of human and machine, as an analogy of political action in a time when second wave feminism was beginning to come to grips with its participation in the exclusionary tactics of capitalism and racism. [Note: A brief history of this movement in feminism as well as its relation to pastoral theology can be found in Bonnie Miller-McLemore, "Feminist Theory in Pastoral Theology," in *Feminist and Womanist Pastoral Theology*, eds. Bonnie Miller-McLemore and Brita Gill-Austern (Nashville: Abingdon Press, 1999).] Haraway writes that the search for innocence, for a single homogenous voice of resistance is itself a colonial fantasy, because it assumes that all differences can be collapsed into a single movement (p. 92). Rather, like the cyborg, political action is itself always done in fusion, across differences and already implicated in the networks of power it seeks to alter: "Far from signaling a walling off of people from other living beings, cyborgs signal disturbingly and pleasurably tight couplings" (p. 68), yet they are at the same time "oppositional, utopian, and completely without innocence" (p. 67). Might spiritual care today be seen in the line of cyborg political action: at once implicated in the structures of power and refusing an innocent oppositional voice, but also reaching across difference, towards people and relationships? Might spiritual care be at once dominating and freeing, not in two separate movements but in the same movement, as it negotiates for its place and care, with and within a biopolitical horizon? Again, these are questions that will linger over the coming chapters, as I look specifically at the hospital system and at moments of spiritual care within the sphere of biopolitics, moving in various ways towards rigidity and flourishing.

The literature is filled with chaplains speaking of their feelings of inadequacy and marginalization within the hospital.<sup>87</sup> Chaplains often relate feeling overwhelmed, inadequate to their task of caring for and being present to the suffering within the hospital. These feelings accompany the constant sense of not belonging to the highly specialized system of the hospital. If shouldered not only with the charge of care, but also with political advocacy as an implication of that care, chaplains may find their already precarious place within the hospital as increasingly overwhelming and vulnerable.

Yet systemic change is not often confined to the agency of a single set of persons. As illustrated in the opening of the chapter, with the man I could not remember recounting my presence in entirely different terms than I experienced it, the meanings and memories attached to the person of the chaplain are not anchored solely in her actions or intentions. Rather, memories and meanings of her work proliferate around her person. The presence of a chaplain that a family member may remember fondly may not match the chaplain I remember being during that same moment. Judith Butler writes extensively of the limitations of agency within political systems that frame the possibilities of action, not only by suppressing subversive actions, but also by generating only a set limit of possible actions imaginable within a political context.<sup>88</sup> Similarly,

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<sup>87</sup> Examples abound: Jaco Hamman writes, “Chaplains...often find themselves alienated from the setting they serve. By definition, chaplains find themselves in a position of not belonging, a resident alien, a guest in someone else’s home.” “Being a Chaplain: Call, Conversation, and Charity” *Reformed Review* 57, no. 3 (2004), 1; Robert Dykstra writes of his own experiences as a hospital chaplain working with families during trauma care, “As I faced more and more of these situations in my own chaplaincy work in a large medical center, I eventually came to notice within myself an escalating sense of utter helplessness and inadequacy.” “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss” *Journal of Pastoral Care* 44, no. 2 (1990), 139. Bonnie Miller-McLemore writes of feelings of marginalization as one of the reasons she left chaplaincy: “One day, walking out of the hospital, I suddenly realized I didn’t want to spend every day of my working life there. My reasons were tangibly elusive—the medicinal smell, the clean tile, the bright light, and, more subtly, the short-term nature of relationships, the marginalization of religion in all that went on there, and the looming cloud of struggle and mortality. But for all practical purposes, my chaplaincy career ended then. “Revisiting the Living Human Web,” 5.

<sup>88</sup> As Butler relates it, “If the rules governing signification not only restrict, but enable the assertion of alternative domains of cultural intelligibility . . . then it is only within the practices of repetitive signifying that a subversion of identity becomes possible.” *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990/2006), 199. Thus, in terms of agency, “If there is agency, it is to be found, paradoxically, in the



the spirituality fostered and created within the hospital system too is limited by perimeters set by the biopolitical trajectory of the hospital apparatus, as Winnifred Fallers Sullivan rightly points out. Yet while generated in a limiting context that only allows for certain recognizable forms, spirituality and care can also hold implications and consequences that exceed the intentions or even the actions of chaplains themselves, as memories and meaning proliferate, originating in and also detaching from specific acts of care.

This detachment of meaning is itself a function of the pastoral presence of the chaplain, for presence means first being with another in bodily form. One chaplain, during a series of interviews carried out by Steve Nolan for his book on chaplaincy care related the following illustration: “All chaplains have to offer is themselves, if you like. There’s a cartoon...where the doctor goes in with the stethoscope, and the nurse goes in with her drugs and the chaplain goes in stark naked because that’s all they have to offer.”<sup>89</sup> The cartoon illustrates the glaringly bodily nature of the chaplain’s work.<sup>90</sup> Though its embodied nature relates presence directly to the chaplain’s own person, in fact it also works to detach the meaning of the spiritual care from the chaplain, for embodiment also means that we are directly related to others in ways not entirely of our choosing.<sup>91</sup> Our bodies are ultimately exposed to the meanings that others attach to them. The presence of a chaplain to another, though starting from her person, is ultimately something for which she cannot fully account, because it also detaches from her in the values and meanings that all around her take from it.

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possibilities opened up in and by that constrained appropriation of the regulatory law.” *Bodies that Matter: On the Discursive Limits of ‘Sex’* (New York: Routledge, 1993/2011), xxi.

<sup>89</sup> Nolan, *Chaplain as Hopeful Presence*, 105. The ellipsis is original to the text.

<sup>90</sup> As Nolan puts it, “In thinking about a chaplain’s presence, perhaps the most obvious, predictable and banal thing to point out is that it is always an embodied presence: that is to say, a chaplain, like any other healthcareer, is first of all another body in the room.” *Ibid.*, 37.

<sup>91</sup> As Judith Butler explains, “The body has its invariably public dimension. Constituted as a social phenomenon in the public sphere, my body is and is not mine. Given over from the start to the world of others, it bears their imprint, is formed within the crucible of social life.” *Precarious Life: The Powers of Mourning and Violence* (Brooklyn, NY: Verso, 2004), 26.

This does not mean that the meanings of spirituality and spiritual care are completely free or relative. As noted above, Butler and Foucault agree that self-formation happens within limiting contexts that both create and limit the possible appearances, expressions, and meanings available at any given time.<sup>92</sup> We are only recognized as we fit ourselves into and are formed within the social norms that govern recognition.<sup>93</sup> Yet even as possibilities are consigned, their limitations are not forever set. Systems change over time and in doing so, the range of possible expressions within them also expand.

What subversive possibilities does the presence and the experience of the chaplain make possible within the hospital? Even as chaplains are governed by the political trajectories of the hospital, what experiences do they articulate or make possible in the hospital room? In the coming chapters, I argue that death is all but excluded from the systemic and political trajectories of the hospital. I also argue that chaplains participate in and further this exclusion, mirroring the stark and rigid boundaries of Esposito's immunity paradigm. However, meaning and possibilities proliferate. Might there also be experiences that acknowledge and articulate loss made possible by the chaplain's presence? Might the chaplain, despite her therapeutic agenda, actually create a moment where family and staff alike stare fully into grief, loss, and the void? Outlining and understanding such possibilities will be the work of the final chapters of this dissertation. But

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<sup>92</sup> In his late lectures, Foucault explores the function of 'truth' as a product of political change, dating back to Antiquity. The notion of Parrhesia, meaning honest speech without rhetorical veil that exposes one's life to potential risk before the assembly, is itself a common device of Athenian politics. Nonetheless, in its later Stoic iterations, Parrhesia, though governed by its political context, was also the expression of right living also at odds with one's context. Tracing his own critical tradition back to the idea of Parrhesia, Foucault reveals the political origins and limitations of his own work, even as he notes the possibilities held within these origins. See Michel Foucault, *Fearless Speech* (Los Angeles, CA: Semiotext, 2001).

<sup>93</sup> Butler goes further in stating that to expose oneself to the recognition of another is thus to consign oneself to the limiting possibilities of the context: "The self is dependent, not just on the existence of the other in its singularity...but also on the social dimension of normativity that governs the scene of recognition." *Giving an Account of Oneself*, 23.

first, let us look more specifically at the exclusions and rigidities of the health care system, and thus fill out the theories outlined here in concrete terms.

## CHAPTER 4

### MEDICINE AS BIOPOLITICAL APPARATUS: PROGRESS, COMMODIFICATION, AND THE OMISSION OF DEATH IN CURRENT HEALTH CARE SYSTEMS

The busiest night on-call during my residency was New Year's Eve 2010-2011. My time that night was split between an overflowing emergency department (ED), with a string of fifteen trauma calls – at least one of which was a response to a trauma that occurred in the hospital itself, as one of the many intoxicated ED patients that night suffered a fall and possible head injury while in the waiting room – and a death on the coronary care unit (CCU), an intensive care unit specializing in cardiac issues. By midnight, every single chair in the huge waiting room for the ED was filled. The room was also full of noise, mostly loud conversations as the incoming patients spoke to their neighbors about their pain and the increasingly long wait. This, coupled with the clamor of the metal detector and invasive searches at the entrance, the shuffle of patients moving through admissions and into and out of the ED, and the blaring television in the corner tuned to the local news all made the noise feel tangible, like a presence in itself, filling the already packed room and contributing to its overall stuffy, stifling disquiet.

In 2010, 16.3% of the American population did not have health insurance, some 49.9 million people.<sup>1</sup> That number has since decreased due to the Patient Protection and Affordable Care Act (ACA), passed that same year by a fully Democratic congress and President Barack Obama. The nonpartisan Congressional Budget Office (CBO) now projects the ACA will cut the number of uninsured Americans down to about 31 million people by 2024, far below the initial

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<sup>1</sup> United States Census Bureau, "Health Insurance Highlights 2010," accessed February 17, 2015, <https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/highlights.html>.

hopes of 94% coverage when the bill was passed, because almost half of the states have blocked the law's Medicaid expansion, following a 2012 Supreme Court ruling that made it optional.<sup>2</sup> These numbers translate into the reality that though many present in that waiting room years ago were there for acute injuries accompanying the evening's festivities, another large segment of that group was coming for its primary care. This trend has followed from the passage of the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the "Patient Anti-Dumping Act," which stipulates that hospitals must stabilize all patients who enter their EDs before transfer or discharge.<sup>3</sup> In practice, this law has meant that the ED has served in place of primary care both for the large portion of uninsured Americans as well as for many who have insurance but work by hourly wages that prohibit access to doctors' offices open only during working hours. A part of our population thus waits until their illness and injuries are exacerbated to such a degree to warrant an ED visit, with its long hours in crowded rooms. It also means that instead of adequate primary care, these people must seek care with hospital staff already overwhelmed by treating and stabilizing acute crises, without time to focus on long-term social, environmental, or chronic factors contributing to the slow decline of their patients. The ED waiting room that New Year's Eve was therefore packed not just with inebriated, at times vomiting local college students and adults – though these made up the majority that evening – but also with families, the elderly,<sup>4</sup> those with chronic illness, all seeking care for the latest flare-

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<sup>2</sup> The CBO estimates that without the ACA, the number of uninsured Americans would be up to 57 million by 2024. The 2012 Supreme Court case that made Medicare expansion in the ACA optional was "National Federation of Independent Business et al. v. Sebelius." "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," accessed Feb. 17, 2017, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA\\_Estimates.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf). See also Margot Sanger-Katz, "Has the Percentage of Uninsured People Been Reduced?" *The New York Times*, October 26, 2014, accessed July 27, 2015, <http://nyti.ms/1tubFIj>.

<sup>3</sup> Elizabeth Bradley and Lauren Taylor, *American Health Care Paradox: Why Spending More is Getting Us Less* (New York: Public Affairs, 2013), 60.

<sup>4</sup> Adults over the age of sixty-five are eligible for the government sponsored health coverage known as Medicare. However, 50% of elderly Americans nonetheless visit the ED in the last month of life, often to receive

up from ongoing or acute sickness and injury. During down times, I walked around that room, hearing complaints about the long waits and the unbearable conditions, offering water in styrofoam cups and a sympathetic but also relatively powerless ear.

However, I did not stay the entire evening in the trauma and emergency rooms. I was paged for only one death that night, on the 6<sup>th</sup> floor CCU where I found a newly made widow, a woman only in her early 40s beside the body of her husband, who had died from complications with open heart surgery. He had not died during or immediately after the surgery, but rather in the long weeks of recovery he had slowly deteriorated from infection and organ failure. I remember feeling pulled in various directions during the moments I talked to this woman beside the body of her deceased husband. As a part of the trauma care team, I was supposed to attend every trauma page in our hospital, two of which happened during my visit to the CCU, but in just a few moments of talking with this woman, I realized just how unexpected this death was to her. Clearly, this man's death could have been prognosticated by medical professionals in the waning weeks of his life, as one complication after another had meant a slow and steady decline following what was already a risky procedure, but as the woman said to me, death had never really seemed an option, much less a conclusion until the very end. Nor, with children still at home and an already strained budget, was this widow ready for the loss of her husband. I soon realized I had stumbled into a tragedy, not only because of the loss itself, but the circumstances surrounding it, the shock, loneliness, and desperation that ensued following this death. I remember again feeling helpless beside this woman, hearing her speak of her shock and

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ultimately futile emergency care. As the IOM (Institute of Medicine) states, "Many terminally ill patients return to the emergency department because they have not been informed and do not know that they are dying or that there are no effective treatments for their underlying disease...They may be unaware of care alternatives, such as physician house calls, community-based palliative care, or hospice." *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* (Washington, DC: The National Academies Press, 2015), 281-282. These issues are elaborated below.

desperation without anything to say, no solution or words of encouragement in the midst of such a grave loss. After some time, I said a prayer for the family and left to continue my work downstairs in the ED.

Though death so often happens in the hospital, it is rarely expected, even in the midst of lingering decline. Despite a recent push towards hospice and palliative care in American health care,<sup>5</sup> still some 715,000 deaths occurred in 2010 in acute care hospitals, roughly 29% of all deaths in America that year.<sup>6</sup> Even among all Medicare patients, those aged 65 or older who receive publicly funded healthcare coverage, 24.6% died in acute care hospitals in 2009. Moreover, even though the use of hospice care increased from 21.6% of dying Medicare patients in 2000 to 42.2% in 2009, almost a third of these hospice stays began only in the last three days of the patient's life.<sup>7</sup> From 2000 to 2009, the amount of hospitalizations, ICU visitations, and multiple transitions in the last 90 days of the lives of Medicare patients were actually *increasing*.<sup>8</sup> This means that even though more patients are dying in hospice, these dying patients are first receiving more, eventually futile and often burdensome acute care in the hospital directly prior to their deaths. Further, it means that deaths like the one I encountered in the CCU that night are widespread. Though death is ever present in the hospital, patients and families are – understandably – pushing towards treatment more and more, and thus not planning for or expecting death when it eventually comes.

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<sup>5</sup> I elaborate on this point in the next chapter in my analysis of the biopsychosociospiritual turn in health care.

<sup>6</sup> Margaret Jean Hall, Shaleah Levant, and Carol J. DeFrances, "Trends in Inpatient Hospital Deaths: National Hospital Discharge Survey, 2000–2010," Centers for Disease Control and Prevention, March 2013, accessed Feb. 17, 2015, <http://www.cdc.gov/nchs/data/databriefs/db118.htm>.

<sup>7</sup> This is despite the fact that Medicare patients are eligible for hospice when given a prognosis of six months or less to live.

<sup>8</sup> Joan M. Teno, et al., "Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009," *Journal of the American Medical Association* 309, no. 5 (2013).

The paths that I walked on that busy night in the hospital point towards what it means to call the hospital a biopolitical apparatus. In the preceding chapter, I argue that theories of biopolitics best encompass the political trajectory of the hospital and spiritual care's place within it. Further, I contend that the more prevalent theories of spirituality and thus spiritual care that situate these factors either as a product of American individualism or commoditization within neoliberalism also aid our understanding of the political trajectory of care, but that neither of these allow room for the complexities of spiritual care in the way that biopolitical theory does. This chapter and the next fill out these claims on a more concrete level. My aim in this chapter is to situate the current American health care system, with my primary focus on the hospital, as a biopolitical apparatus and to understand the consequences of this trajectory on the lives and deaths of its patient population. As I describe in the third chapter, Michel Foucault defines biopolitics as the management by a population of itself, towards its basic organization and survival through a mobile network of power relations. Further, Roberto Esposito describes biopolitics through the paradigm of immunity, the introjection into community of what it is *not* – meaning the separation of the community from itself – in order for community to survive. This spacing can be understood as a type of systematization, a separation of people, channeling them into various organizations in order to sustain the population as a group and avoid collapse. The health care system is such an organization. In general, it is our nation's answer to death and our finite bodies prone to illness and age.

In this chapter, I align current political and social trends within health care to this trajectory, noting that health care broadly can be understood as a way for the population to envision, articulate, and handle death by casting power over it. However, the understanding of death that follows from the current trajectory of health care is not a confrontation with death as



loss but rather a way to delay this confrontation through ideals and hopes in scientific progress, empowered individual responsibility, and the market economy. The trajectory of health care meets death by delaying this meeting, making the task of healing into the combat against death. Mirroring the general immunity paradigm of biopolitics, the health care system sustains the population by separating the population from itself, or more specifically, by separating members of the population from their inevitable end.<sup>9</sup> The patient does not incorporate her death into her life, but rather continually delays it and pursues healing. This, of course, is a necessary delay that allows for the population's survival, moving towards health rather than death. However, I argue that, as with biopolitics in general, health care has a tendency to go too far in this approach to death and decline, with consequences both for those wealthy enough to take part in the health care economy as well as for the precarious lives that fall outside of this market. For the former, the delay of death is often taken to the extreme, such that dying patients become locked in burdensome and dehumanizing paths within the system. The latter, in contrast, are simply locked out of the system, or like many people in the waiting room described above, kept away via the stress of an overwhelmed safety net and the long term strain of institutionalized discrimination. This is thus the character of health care as a biopolitical apparatus, truly a promising means of sustenance and healing but also prone to consequences that dehumanize and hurt those within its grasp.

## I. Death and the Clinical Gaze

Health care confronts death on two levels. On the one hand is the actual experience of meeting and seeing death, illustrated in the example above that took place in the CCU on New

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<sup>9</sup> In fact, as I argue in the next section, the health care system employs death itself, or rather the anatomical lessons learned from the dead body, towards healing. Thus, death is employed to separate the population from its death. Following Esposito's paradigm, the population immunizes itself from death with death.

Year's Eve. Death arrived quite by surprise that evening, as a man after a few weeks of decline following a risky surgery slowly died under the care of the hospital. The family, the nurses, technicians, and eventually the chaplain all surrounded and confronted this scene of death. We met and saw death, in a place where it often appears, the intensive care unit. On the other hand, however, the health care system's confrontation with death happens far less like a meeting and more like an opposition, a fight with death to dispel it as illness and decline in the body. This, of course, is a product of medicine's mission to heal, to support and mend the body so that it can live its best life. Yet in this quest for healing, medicine must also envision death and decline as things it has some control over. It must cast its power over death, and in this way oppose rather than reckon with it.<sup>10</sup>

The modern reach of medical power over death dates back to the invention of a mechanical type of medicine two centuries ago. By mechanical medicine, I mean an approach to healing that views the body as an enlivened machine, as what contemporary physician and philosopher Jeffrey Bishop calls "matter in motion."<sup>11</sup> In his history of the development of medicine in France through the 18<sup>th</sup> and 19<sup>th</sup> centuries, Foucault ends with the invention of this

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<sup>10</sup> Foucault and Esposito both note that historically, institutional power over the subject is often sanctioned through the presence of medical professionals, even when this control is not medical in nature. In *History of Madness*, Foucault traces the appearance of the doctor in asylums dating back to the innovations of Philippe Pinel and Samuel Tuke in the 19<sup>th</sup> century: "Since the end of the eighteenth century, a medical certificate had been more or less obligatory for the confinement of the mad...Despite that, and this was the key point, the intervention of the doctor was not done on the basis of some skill or medical power as such that he alone possessed, justified by a body of objective knowledge. It was not as a scientist that *homo medicus* gained authority in the asylum, but as a wise man" (p. 504). For Foucault, it is the authority attached to the doctor that allows the sanctioned confinement of the body and later the mind through the development of psychology. As explained below, Foucault then traces the empowered medical gaze as it shifts from the asylum to the clinic in his subsequent work. Esposito then follows Foucault in his history of thanatopolitics of the Third Reich. It was through the authority of German doctors that the German political body was understood as a living body in need of absolute normativization and the expulsion of the so-called degenerates: "The doctors who had enjoyed great authority and prestige in Wilhelminian and Weimar Germany became more powerful in areas that had to that point been reserved for other expertises. In particular, their presence was made felt in courtrooms, where they accompanied (and in some cases surpassed) the magistrates in the application of restrictive and repressive norms." *Bios: Biopolitics and Philosophy*, 138. Thus, both theorists agree that in casting power over life and death, power will enlist medicine for its authority, even when medical expertise is not necessarily needed. Such a trend is continued today in the rampant medicalization of death and dying.

<sup>11</sup> Jeffrey Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011), 60.

mechanical medicine, defined by its use of the anatomical lessons learned from autopsies as the foundation of medical knowledge and training.<sup>12</sup> In this approach to medicine, death comes to be understood as rooted in the body. The site of disease is hidden within the layers of the body, revealed only when the corpse is opened in autopsy and the lesion comes to sight. The problem for medicine then became the question of how one takes the lessons learned from autopsies into the practices of the clinic. How does the doctor see in life that which is only revealed in death? The answer comes in the form of the clinical gaze, which according to Foucault projects the dead body onto the living body; the gaze envisions the living body as inherently pathological, moving towards death as its inevitable end. Only the tools of clinical technology can unearth the internal signs of this natural progression: “That which hides and envelops, the curtain of night over truth, is, paradoxically, life; and death, on the contrary, opens up to the light of death the black coffer of the body: obscure life, limpid death.”<sup>13</sup> In this way, the dead body is mapped onto the living person.<sup>14</sup> The doctor must envision the lesions seen only in autopsy to be lying under living flesh, and thus the tools of the clinic are employed towards unearthing that which is hidden.

However, as Foucault makes clear, the death mapped onto the living body via the gaze is death in an ideal state, not the decaying and broken body left behind after life.<sup>15</sup> This ideal death

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<sup>12</sup> The appearance of the autopsy coincides for Foucault with the appearance of life itself as an object of human knowledge. As Foucault traces in *The Order of Things: An Archeology of the Human Sciences* (New York: Vintage Books, 1994), originally published in 1966, life itself became the object of the human sciences only with the innovations of 18<sup>th</sup> century naturalism and biology. Prior to that innovation, life in the classical period was divided in a taxonomy by type. Rather than life being a unifying force that groups all living things, the sciences of the classical period divided living things by form in a classification system. In other words, rather than unified by an innate, vitalizing force, life was divided and thus known on a series of classificatory tables. Likewise, in *The Birth of the Clinic*, Foucault documents the transmission from symptomology that arranged and classified disease by forms into a mechanical medicine that rooted disease within the living (and dying) body itself. In both cases, living things – as they are known and studied – stop being known through a series of classificatory tables, and life (as an invisible force) enters into bodies.

<sup>13</sup> Foucault, *The Birth of the Clinic*, 166.

<sup>14</sup> As Foucault puts it, the gaze is “that absolute eye that cadaverizes life.” Ibid.

<sup>15</sup> As Bishop remarks in his analysis of *Birth of the Clinic*, “Yet death as stasis is a very thin moment – a fleeting moment – in the history of the living body. Death is represented as an ideal-type, even for the physiologists who resisted the ideal-type of ‘the average man.’ ... It did not matter that this ideal-type of the dead body was a

is like a map, like the frozen pictures that appear in today's basic anatomy textbooks rather than the broken, clumsy flesh that appears on the autopsy table. This understanding of death is therefore the casting of medical power into the sphere of death, creating a picture of death on which to found medical knowledge.<sup>16</sup> It is not, then, a meeting or reckoning with the actual end of a life. Bishop, following Foucault's analysis, states that this obfuscation of death is still present in the current practices of medicine: "Death is thus shrouded in technology, hidden in discourse, and finally cloaked in palliative care. And in its return, medicine tries more exhaustively to name it, to shape it, to control its uncontrollable features...In this sense, death is medicine's other, an other at its very heart."<sup>17</sup> Incorporating it into its gaze, medicine turns death into a utility, a tool to be employed in the delay of death, in medical healing. Death is thus an idea in this realm, an object of knowledge employed to ward off the end of life.

Yet a medicine based on death as an ideal results in reductionism when it comes to the treatment of patients. Bishop employs Foucault's work to trace what he terms the unspoken philosophy of contemporary medicine, which he summarizes as the "metaphysics of efficient causation."<sup>18</sup> By this, Bishop means that when medicine employs a static concept of death as the basis of its knowledge, it then must treat the body as matter in motion, creating a Cartesian reduction of the person as simply a material body open to physical intervention and manipulation. In practice, the body is envisioned as a type of machine, alive and changing of course, but nonetheless capable of being fixed, because it is also fundamentally material. This

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figment of medicine's imagination or that death, as thus conceived, was not a static reality on which to build scientific knowledge." *The Anticipatory Corpse*, 96-97.

<sup>16</sup> Reflecting on the innovations of the French anatomist Marie François Xavier Bichat who pioneered the mechanical medicine that envisioned death in life this way, Foucault concludes, "He integrated that death into a technical and conceptual totality in which it assumed its specific characteristics and its fundamental value as experience." *The Birth of the Clinic*, 146.

<sup>17</sup> Bishop, *The Anticipatory Corpse*, 22-23. I examine medicine's expansion in the biopsychosocial turn as well as spiritual care's place within it in the next chapter.

<sup>18</sup> *Ibid.*, 60.

understanding of the body is then the basis of the great technological apparatus created by modern medicine to support the function of the body. In Bishop's words, "The metaphysics of efficient causation...has triumphed in medical science. This triumph has resulted in an unquestioning view in which the machines of life – bodies – and the machines and techniques designed to support physiological function – technology – operate on the same principle. Success is judged in terms of mechanical successes."<sup>19</sup> Medicine has created a set of technologies that can support the function of our bodies, even when our bodies cannot function by themselves. This view of the body is most apparent in the intensive care unit, where the patient is attached to a set of machines – the vent, the IV, the catheter, the monitor – that allow bodily and technological material to function together. For Bishop, in the extremities of the ICU, medicine's basic understanding of the human bodily is most clearly revealed.<sup>20</sup>

Yet the mechanical view of life based on this view of death then makes medicine unable to deal directly with decline and death. Rather, it creates a medicine that confronts death, that fixes the broken or ill parts of the body, in opposition to reckoning with our inevitable deterioration. As contemporary physician Atul Gawande writes, "We're good at addressing specific, individual problems: colon cancer, high blood pressure, arthritic knees. Give us a disease, and we can do something about it. But give us an elderly woman with high blood pressure, arthritic knees, and various other ailments besides...and we hardly know what to do and often only make matters worse."<sup>21</sup> With death as an epistemological ideal point rather than an inevitable end, medical healing has utilized the knowledge gained from death to repel it, to heal and fix the body and its function. Intent on fixing, medicine has thus been unable to deal

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<sup>19</sup> Ibid., 108.

<sup>20</sup> Ibid., 110-113.

<sup>21</sup> Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (New York: Metropolitan Books, 2014), 44.

with limits, both its own limitations to heal the body as well as the limitations of the body itself, its inevitable decline into brokenness and death. Gawande continues, “Medicine’s focus is narrow. Medical professionals concentrate on repair of health...It’s been an experiment in social engineering, putting our fates in the hands of people valued more for their technical prowess than their understanding of human needs.”<sup>22</sup> In this way, medicine has confronted death and thus separated us from our deaths.

This utilization and separation of life from death is at the center of the biopolitical trajectory of modern health care. In the health care context, biopolitics is the management of life itself in its combat against death. It is further the introjection of death in life via the medical gaze in order to ward death off, separating the body from its decline by employing knowledge gained from death towards medical healing. Mirroring the immunity paradigm analyzed by Esposito, medicine is thus the systematization of death itself, casting power over death in order to separate patients from their inevitable decline. In other words, we utilize death in order to separate ourselves from death, and in this way we delay death over and over again. This trajectory is, of course, one of healing, improving and lengthening lives for many people. However, at the same time, medicine prolongs life by excluding and marginalizing the experience of dying within its own sphere. Through the constant utilization and delay of death, the actual experience of dying is rendered invisible within medicine, both to those who work in the system as well as to those who die within it. In health care, we are increasingly separated from our own deaths.

The following sections will look at the biopolitical trajectory of health care from three angles. First, I examine the ideals underlying medicine’s fight against death, specifically those of progress, empowerment, and consumerism, which I argue have resulted in the reduction of patients into consumers and neglected the realities of lives in marginalized social spheres that

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<sup>22</sup> Ibid., 128.

cannot buy into this economy. Second, I look briefly at current debates and trends in health care policy around the Affordable Care Act, noting how recent changes have in part alleviated but at the same time furthered the dynamics examined in the first section. Finally, I examine contemporary issues around dying in modern health care, arguing that the continued emphasis on life and healing has created a fundamental blind spot towards the experience of dying. This means that patients can rarely see their death as it comes, compelling them into futile, burdensome, and costly treatments. Further, it means that a fundamental human experience, the experience of facing the inevitable loss of death, is absent from our system, creating a skewed version of human health and life.

## II. Current Narratives and Trends: Progress, Distribution, and Consumerism

In the preceding chapter, I note that theories linking spiritual care in the hospital to commoditization are correct in part for revealing the hidden interests at play in chaplaincy's participation in health care, but ultimately this approach is reductive. The same can be said looking at health itself as a commodity that is sold by our current health care system. The question that theories of commoditization leave out is: What is the overall end of putting health on the market? My argument here is that the health care market itself is a product of biopolitics, of the confrontation of life with death and thus the overall opposition to and denial of death. Medicine does not exist solely to make money. Though still a highly regarded and well-paid position, physician incomes and the overall earnings of hospitals and health insurance companies have nonetheless been stagnant in recent years while inflation has increased dramatically.<sup>23</sup>

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<sup>23</sup> This is especially true of doctors working in primary care and less so for specialists, though even the latter are becoming increasingly trapped financially by equipment and maintenance fees as well as the ever increasing premiums for malpractice insurance, which can run from \$30-300 thousand a year. See Sandeep Jauhar, *Doctored: The Disillusionment of an American Physician* (New York: Farrer, Staus and Giroux, 2014), 5-15, 137-

Rather, health care operates on ideals of progress and individual empowerment against the realities of death and illness. Money then flows through the patterns established through these ideals, but rather than making money, it is sending individual consumers and the health care industry itself into financial collapse. At the same time, these ideals of progress and empowerment have elided the experience of dying in our system, making the experience increasingly more marginalized, unbearable, and expensive.

#### A. Progress and Expense

The trajectory of health care in the past century has been one of quick and steady advance. Whereas the 20<sup>th</sup> century opened with infectious disease as the primary cause of death, revolutionary innovations in antibiotics, vaccines, and sanitation have almost erased these threats in America, leaving cancer and the chronic diseases associated with old age today as the leading causes of death.<sup>24</sup> Bioethicist Daniel Callahan wrote in the 1990s that these triumphs allowed faith in medical progress to escape other disillusionments associated with Western ideals of progress in the 20<sup>th</sup> century.<sup>25</sup> Not until the past few decades, when medicine has hit against the limits of aging and chronic conditions as well as the onslaught of cancer has progress slowed. In contrast to infection, the biological barriers as well as the causes and cures of these ailments are both elusive and diffuse, which means that progress has increasingly become more slow and costly.<sup>26</sup> As Callahan puts it, “There is no reasonable likelihood either that medical progress will usher in a dramatic new era of human health, or that there will be gains in the twenty-first

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143. See also Atul Gawande, *Better: A Surgeon's Notes on Performance* (New York: Picador, 2007) 87-92. On the other hand, pharmaceutical and medical device companies have seen rampant profits in recent years.

<sup>24</sup> Seven of the top ten killers in America today are chronic diseases. Heart disease and cancer make up 50% of all fatalities in the US. IOM, *Dying in America*, 36.

<sup>25</sup> Daniel Callahan, *False Hopes: Why America's Quest for Perfect Health is a Recipe for Failure* (New York: Simon and Schuster, 1998), 56.

<sup>26</sup> *Ibid.*, 67.



century comparable to those made in the twentieth. The gains that medicine will achieve will be incremental, expensive, and erratically distributed.<sup>27</sup> A system that was built and has delivered on the promises of progress is then set on a precarious path when its gains become more and more elusive.

Callahan's predictions almost two decades ago have come true, especially in American medicine. The United States spends more than any other nation on health care, 17.2% GDP in 2012, rising \$100 billion between 2011-2012.<sup>28</sup> It is expected to rise to 19% GDP by 2019.<sup>29</sup> However, these expenses have not bought proportional gains. In 2007, the US ranked 26<sup>th</sup> in life expectancy, 31<sup>st</sup> in infant mortality, 28<sup>th</sup> in low birth weight, and 25<sup>th</sup> in maternal mortality among developed nations.<sup>30</sup> Moreover, public health care expenses are set to increase exponentially in the next few decades. Right now, Medicare and Medicaid make up 36% of all health expenditures in the US,<sup>31</sup> but precisely because of health care innovations of the last century, the American population is rapidly aging. By 2050, 20% of the country's population will be over 65 years old<sup>32</sup>; by 2030, for every 100 people at working age in America, there will be 38 Americans 65 years of age or older.<sup>33</sup> Further, because Medicare patients withdraw far more than they put into the system during their years paying taxes, at a ratio of 6:1, with an increasingly smaller tax base the system itself is headed to bankruptcy, which will in turn lead to the collapse of the health care market that depends vitally on Medicare.<sup>34</sup> Just as Callahan

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<sup>27</sup> Ibid., 72.

<sup>28</sup> IOM, *Dying in America*, 267.

<sup>29</sup> Bradley and Taylor, *American Health Care Paradox*, 28.

<sup>30</sup> Ibid., 6.

<sup>31</sup> IOM, *Dying in America*, 268.

<sup>32</sup> Ibid., xii.

<sup>33</sup> Ibid., 269.

<sup>34</sup> Ibid. In fact, it was through Medicare and Medicaid spending that the modern health care industry was built after their passage in 1965 under the Johnson administration. Health care spending only increased by 42.5% in the three decades prior to 1965. It rose by 140.4% in the 30 years after. Bradley and Taylor, *American Health Care Paradox*, 37.

predicted, health care is becoming threateningly more expensive while revolutionary gains comparable to those a century ago are elusive.

## B. Consumerism and Disparities

Behind these trends and figures lie two intertwined realities: (1) health care is propelled by an ideal, the empowered consumer, the patient who fights off death with her doctors by buying into the health care marketplace and (2) the reality that a system based off of this ideal has neither a place nor an accurate comprehension of decline and death. With progress as its foundation, medicine seeks to provide the means necessary for health, to create a marketplace where the empowered consumer can delay illness and death. As ethicist Nikolas Rose characterizes the ideal consumer, “The citizen here was not merely a passive recipient of social rights, but was also obliged to tend to his or her own body and, for a woman, those of her spouse and offspring...Individuals themselves must exercise biological prudence, for their own sake, that of their families, that of their own lineage, and that of the nation as a whole.”<sup>35</sup> The ideal empowered consumer is responsible for her health. She pursues it for herself and her family by buying into the health care market. However, with such a general ideal, the question of who is the envisioned empowered consumer and what are the limits of her empowerment become central.

A consumer is one who is able to buy into the system, with a body able to benefit from participating in health care and the means to participate in the first place. Though all classes, races, and genders consume health care in this country, either through private insurance or public programs, wider socioeconomic structures and racial bias make it so that those most able to

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<sup>35</sup> Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007), 24.

access and benefit from the health care system are those of historically privileged identities.<sup>36</sup> Class is overwhelmingly determinative of health care access and general levels of health in America. In fact, higher levels of health are directly correlated with every incremental rise in income and wealth, and, further, race is correlated with class,<sup>37</sup> though the rising middle and upper classes of minority groups, especially African Americans and Asians, in our country complicate this correlation.<sup>38</sup> When looking at education, whites and Asians have substantially more bachelors, masters, and doctorate degrees than African Americans and Hispanics in America.<sup>39</sup> Even with the same level of education, whites will earn more than almost any other racial group in the country.<sup>40</sup> Moreover, even when in the same socio-economic class (SES), whites have better health outcomes than African Americans, though differences between classes are far more determinative of health than racial disparities within the same SES.<sup>41</sup> With these

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<sup>36</sup> Theorists Jessie Daniels and Amy J. Schulz note that research in health disparities overwhelmingly compares some racial or ethnic group with a white norm without noting the socially constructed nature of either category. Thus, structural privilege not only enables greater access to health care but also hides this advantage behind statistics that only name the higher levels of health and participation in the health care. Though the analysis below employs such statistics, I am seeking to locate them within wider structural trajectories in health care politics. “Constructing Whiteness in Health Disparities Research,” in *Gender, Race, Class and Health: Intersectional Approaches*, eds. Amy J. Schulz and Leith Mullings (San Francisco, CA: Jossey-Bass, 2006), 102.

<sup>37</sup> According to a recent article in *The New York Times* covering a study comparing census data from 2010 to 2013, “The poverty rate remained stable for black children [between 2010 and 2013], while it fell for Hispanic, white and Asian children, a sign of just how pervasive and stubborn poverty has been for African-Americans... About 38.3 percent of black children lived in poverty in 2013, nearly four times the rate for white children, at 10.7 percent. About 30.4 percent of Hispanic children and 10.1 percent of Asian children live in poverty. For the first time since the federal government started collecting the data, the number of black children in poverty appears to have overtaken the number of poor white children, even though white children far outnumber black children in the American population... About 4.2 million black children were living in poverty in 2013, compared with 4.1 million white children.” Sabrina Tavernise, “Black Children in U.S. Are Much More Likely to Live in Poverty, Study Finds,” *The New York Times*, July 14, 2015, accessed July 14, 2015. <http://nyti.ms/1K5yIie>. See also Donald A. Barr, *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health*. 2<sup>nd</sup> Edition (Baltimore: Johns Hopkins University Press, 2014), 8.

<sup>38</sup> Particularly, discriminatory trends against African Americans in terms of education and housing work to solidify the correlation between race and class as noted below. However, the alignment of class and race itself also reflects and reifies racial bias on the part of researchers by identifying blackness with poverty.

<sup>39</sup> Barr, *Health Disparities in the United States*, 119.

<sup>40</sup> The one exception is at the masters degree level, where Asians actually earn more than whites. Ibid.

<sup>41</sup> Pamela Braboy Jackson and David R. Williams note that people of underrepresented minority groups within settings that do not represent diversity of minorities have to contend with elevated pressure, boundaries, and role entrapment. “The Intersection of Race, Gender, and SES: Health Paradoxes,” in *Gender, Race, Class and*

differences, African American men have a 26% higher death rate than white men and African American women a 19% higher rate than white women.<sup>42</sup> It is thus clear that those able most to utilize the health care system come from privileged social positions. In this way, the system's implicit ideal empowered consumer is one of a privileged identity.

These disparities are the result of both the chronic stress associated with oppressed social positions in the United States as well as disparities in access to health care. Physician and public health expert Donald Barr notes that class and race discrimination are high determinants for chronic stress, which over time results in high levels of what is known as the allostatic load, the particular mixture of stress hormones secreted by the hypothalamic-pituitary-adrenal axis. Over time, these stress hormones have disastrous effects on the body, causing chronic cellular inflammation, which then causes tearing in the vessels of the vascular system, resulting in dangerous calcium deposits that cause cardiovascular disease. Moreover, low SES is also correlated with elevated body mass index, cholesterol, and blood pressure.<sup>43</sup>

In addition to the ill effects of chronic stress, class position is also determinative of health care access. The section below on health care policy covers the ongoing trends related to health care distribution. Here I only note that even Medicaid, the government subsidized health plan for those unable to afford private insurance, is unevenly distributed throughout the country because it is administered by the states. Though the ACA had originally included a federally mandated expansion of Medicaid, overwhelmingly paid for by the federal government, in 2012 the Supreme Court ruled that states can opt out of this expansion. As of early 2015, only 29 states as well as the District of Columbia had met the federal guidelines for the expansion, and

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*Health: Intersectional Approaches*, eds. Amy J. Schulz and Leith Mullings (San Francisco, CA: Jossey-Bass, 2006), 141.

<sup>42</sup> Barr, *Health Disparities in the United States*, 39-44.

<sup>43</sup> *Ibid.*, 59-65.

Republican majorities elected to Congress and in governor races across the country in 2014 currently weigh against greater expansion in the coming years.<sup>44</sup> State administration of the program means that differing levels of poverty across the country qualify for assistance. In many cases, this qualification is well below the federal poverty line.<sup>45</sup> Moreover, because Medicaid, unlike Medicare, does not have a dedicated payroll tax, its reimbursements are below the levels doctors receive for caring for seniors and those who are privately insured.<sup>46</sup> Thus, physicians can only take a limited number of Medicaid patients, and these patients also have difficulty in getting approval for treatments. Fewer options also means longer waiting lines as well the need to delay care until one is sick enough to qualify for benefits.<sup>47</sup> Womanist ethicist Emilie Townes' words in the late 1990s thus still ring true today, "When Medicaid was created in 1965 it carried the promise that it would help end a dual-class medical-health delivery system. Inadequate funding, low physician payment rates, and increasing costs of long-term care have thwarted the realization of its promise."<sup>48</sup> Combined with the ongoing high numbers of uninsured Americans today, health care continues to be an uneven system, participating in and furthering entrenched class and race inequalities in our country.

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<sup>44</sup> In addition, 5 other states have been granted waivers from the federal guidelines to implement alternative Medicaid expansion. Robin Rudowitz, Samantha Artiga, and MaryBeth Musumeci, "The ACA and Medicaid Expansion Waivers," *Kaiser Family Foundation*, Feb. 17, 2015, accessed Feb. 21, 2015, <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>. See also Editorial Board, "The Fate of Medicaid Expansion," *The New York Times*, Nov. 14, 2014, accessed Feb. 21, 2015, <http://nyti.ms/1uvn3CZ>.

<sup>45</sup> Emilie Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care* (New York: Continuum Publishing Company, 1998), 36.

<sup>46</sup> David M. Craig, *Health Care as a Social Good: Religious Values and American Democracy* (Washington, D.C.: Georgetown University Press, 2014), 110.

<sup>47</sup> See Otis Webb Brawley and Paul Goldberg, *How We Do Harm: A Doctor Breaks Ranks about Being Sick in America* (New York: St. Martin's Press, 2012), 12, 23.

<sup>48</sup> Townes, *Breaking the Fine Rain of Death*, 36.

### C. The Costs of Buying

Thus, the ideal health care consumer is not a universal subject. Rather, it is narrowed by socioeconomic structures towards those who can buy into the system, though as noted below, these market trends are also complicated and mitigated by federal law and collective plans. In addition to the class and racial dynamics noted above, the consumer is also gendered. Feminist critics note that on average, men have higher death rates than women, spend less time with their health care providers, receive less advice, and are asked less by their doctors to change their behavior.<sup>49</sup> These trends reflect patriarchal beliefs of masculine autonomy and dominance within our culture. In contrast, theorist Tasha Dubriwny highlights the cultural image of the “vulnerable, empowered woman,” as central to health care consumerism.<sup>50</sup> Dubriwny names this image as “postfeminist,” meaning that it incorporates the central message of women’s empowerment from second wave feminism as well as its critique of medicine’s historical neglect of women’s health issues outside of their reproductive capacity, but it funnels these messages through a consumerist model, with its stress on an individual’s right to participate in the market economy.<sup>51</sup> In both popular media as well as medical discourse, women’s bodies are seen as inherently risky, open to degeneracy, for example, by breast cancer carrying genes, post-partum depression, and cervical cancer, all of which are understood to be naturally rooted within the female body rather than reflective of wider social and environmental trends.<sup>52</sup> In these discourses, women are thus viewed as *inherently* at risk, yet empowered to become consumers of the health care market, to spend money to mitigate the risks they carry.

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<sup>49</sup> Jackson and Williams, “The Intersection of Race, Gender, and SES,” 136.

<sup>50</sup> Tasha Dubriwny, *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women’s Health* (New Brunswick, NJ: Rutgers University Press, 2013).

<sup>51</sup> *Ibid.*, 3.

<sup>52</sup> Dubriwny spends a chapter for each of these areas of women’s health.

For example, Dubriwny traces the discourses currently surrounding the BRACA genes that put women at risk for breast cancer and the prevalence of “previvor” stories in popular culture, meaning stories of women who took preventive measures, often prophylactic double mastectomies, to ward off the threat inherent in their own bodies, such as those by Christina Applegate, Jessica Queller, and – since Dubriwny’s writing – Angelina Jolie.<sup>53</sup> These stories tend both to turn the medical choice of mastectomy into a moral choice, highlighting a woman’s sacrifice for the good of her family,<sup>54</sup> as well as connecting the discussion of preventative mastectomy to reconstruction and the need for continued beauty, equated with femininity: “The promise of ‘good boobs’ through new technology and the promise of a ‘better self’ with better breasts. These themes center on the issue of beauty and reify the central place of breasts in defining femininity.”<sup>55</sup> Buttressed by these narratives, the health care system is envisioned as a marketplace that enables women to take the necessary means to protect their vulnerable bodies, a protection that is often rooted in stereotypes of women’s bodies as inherently dangerous yet also valuable based on their physical appeal. However, Dubriwny points out that such stories tend to elide the fact that preventive mastectomy is often reserved only for a consumer with means, because the procedure is not always covered by insurance, and reconstruction is almost never covered.<sup>56</sup> Thus, women are compelled into monitoring and adjusting their at-risk bodies, a compulsion propelled by gendered narratives of women’s sacrifice and beauty. At the same time, these compulsions assume one has the privilege and means to take such measures to mitigate inherent risk.

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<sup>53</sup> Ibid., 44-46; Angelina Jolie, “My Medical Choice,” *The New York Times*, May 14, 2013, accessed Feb. 21, 2015, <http://nyti.ms/10U9HwL>.

<sup>54</sup> Dubriwny, *The Vulnerable Empowered Woman*, 54.

<sup>55</sup> Ibid., 59.

<sup>56</sup> Ibid., 58.

Moreover, the compelled consumer model is not only consumerism for its own sake. Rather as an ideal, it plays into a larger trajectory of the on-going fight against and thus denial of death. Three decades prior to Dubriwny's writing, theorist and poet Audre Lorde named such dynamics in her *Cancer Journals* following her own single mastectomy after testing positive for breast cancer. Lorde's work chronicles the compulsion she felt to wear a prosthesis in place of her breast, being told again and again that she would never know the difference.<sup>57</sup> Lorde contends that the compulsion to hide one's scars is in service to making the world comfortable, with its citizens showing no signs of illness and death. Further, the compulsion to hide the effects of cancer roots cancer itself solely in the individual body, thus hiding the cancer-causing agents that circulate freely in our society: "By accepting the mask of prosthesis, one-breasted women proclaim ourselves as insufficients dependent upon pretense. We reinforce our own isolation and invisibility from each other, as well as the false complacency of a society which would rather not face the results of its own insanities."<sup>58</sup> Consumerism individualizes and isolates patients, particularly women told to hide their scars.

The compulsion to pretend that one can simply go back to a time before cancer via medical procedures and devices also blocks for Lorde the necessary reckoning with her own death. The prosthesis simply puts up a blinder to the actual death brought near by cancer. Women are compelled to purchase this blinder rather than come to terms with their mortality: "Even in the face of our own deaths and dignity, we are not to be allowed to define our needs nor our feelings nor our lives."<sup>59</sup> It is not that buying into the health care market or using a prosthesis is inherently wrong. Lorde herself found the care she needed to survive once she had discovered

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<sup>57</sup> Audre Lorde, *The Cancer Journals* (San Francisco, CA: Spinsters / Aunt Lute, 1980), 42.

<sup>58</sup> *Ibid.*, 61.

<sup>59</sup> *Ibid.*, 25.



a lump during self-examination. Nor does Lorde condemn women who choose the prosthesis out of their own desire. The problem is that the prosthesis is often not freely chosen, but rather compelled by a world that tells women to hide their scars, to ignore their deaths, and to pretend as if cancer is not a product of the ravages that humanity does to its environment and food supply.

Thus, the ideals of progress and empowerment create a system that compels a certain type of consumer to buy into the market in order to fight off and deny death. Following Dubriwny's and Lorde's analyses, it is clear that the market is shaped such that death cannot be read on certain bodies, that these bodies are compelled to show the signs of health to society, or rather, that society must continually show itself that death is not a reality, that death is conquered through our overdrawn investments in health technology. On the other hand, the burden of death itself concentrates in marginalized social spheres where the constant stress of oppression and barriers to access make early death quite prominent, mirroring the trends of thanatopolitics analyzed in the last chapter. The delay and obfuscation of death means the displacement of death onto spheres that bear that burden heavily. As I argue in the last part of this chapter, such obfuscation further means that those who are dying in the systems of health care also come to be marginalized within the system, making the burden of dying increasingly expensive, painful, and extended. However, before delving into the experience of death within the health care system and its continuing invisibility, I analyze briefly the debates surrounding and trends furthered by the 2010 Affordable Care Act. I do this in order to illustrate that though health care as an industry is currently undergoing dramatic and corrective change, its primary biopolitical trajectory remains for the most part unchallenged.

### III. The Affordable Care Act: Progress and Limitations

The focus of this chapter does not allow room to cover or analyze the debates leading up to the ACA nor its benefits and limitations in their full complexity. Here, I only mean to examine how the biopolitical trajectory in modern health care examined above is furthered through the central facets and omissions of the reform. On the one hand, the ACA vastly improves the accessibility of our system. It extends the affordability of private insurance through subsidies both to individuals as well as small businesses and expands Medicaid to those in poverty – though as stated above, this expansion has been rejected by a number of states following the Supreme Court ruling that made it voluntary. On the other hand, the act fails both to end the inequality inherent within our current system as well as to cut skyrocketing health care costs. In this way, it plays into the ideals of consumerism and progress central to the biopolitical trajectory outlined above.

The ACA does not, as sociologist and public policy analyst Paul Starr points out, make health care a right in either a judicial or de facto sense. The law neither universalizes health care nor does it grant insurance to everyone. Rather, in Starr's words, "it creates a series of individual rights in relation to private insurance," making it affordable.<sup>60</sup> As I note in the introduction, by 2010, the year that the ACA became law, almost 50 million Americans were uninsured. The ACA lessens this number substantially by granting subsidies<sup>61</sup> to those with incomes up to four

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<sup>60</sup> Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), 248. See also p. 241.

<sup>61</sup> Recently, these subsidies were challenged in the 2015 Supreme Court case "King v. Burwell," because, as opponents of the ACA argued, vague language in the bill made it unclear if the ACA allowed for federal subsidies in states that did not set up their own exchanges, which are marketplaces where insurance is sold. By 2015, 85% of those who bought insurance from the federal exchange qualified for subsidies. Though the court upheld the subsidies by a 6-3 majority, the case nonetheless illustrates the resistance within American politics against any steps towards making health care affordable. See Adam Liptak, "Supreme Court Allows Nationwide Health Care Subsidies." *The New York Times*, June 25, 2015, accessed June 25, 2015, <http://nyti.ms/1SNeAFq>. Soon after this ruling the editorial board of *The New York Times* gave a summary of all ongoing legislative attempts to repeal or gut the ACA. See

times the poverty level: \$92,000 for a family of four in 2012.<sup>62</sup> These subsidies lessen the cost of insurance to roughly 8.05-9.5% of an individual's income.<sup>63</sup> Also, small businesses of less than twenty-five employees with an average wage below \$50,000 will have 50% of their contributions to employee plans covered by the federal government.<sup>64</sup> The law also puts caps on insurance deductibles, bans insurance caps on the amount a plan will pay towards an individual's health care annually or for a lifetime, and prevents insurance companies from refusing to cover preexisting conditions or dropping customers once they fall ill. By these measures, insurance and thus access to health care now becomes available to a much larger segment of the American population.

However, these measures towards the affordability of health care can still be seen in line with the ideal of individual empowerment already prevalent in the system, as described above. The ACA sets up an online health care marketplace where plans are divided into bronze, silver, gold, and platinum levels based on their cost and the amount of insurance they provide. The subsidies are based on the silver plan, which has what is known as an actuarial value of 70%. This means that, in general, a person with a silver plan will have 70% of her health care expenses covered by insurance, which still leaves a great amount of responsibility for the individual.<sup>65</sup> As Starr puts it, "So while the law will reduce financial stress from illness, it will not eliminate it."<sup>66</sup> The ACA thus depends on the ideal of the empowered consumer, now empowered more to buy private insurance, but still largely responsible for the costs of health care. In Lawrence Jacobs and Theda Skocpol's words, "Affordable Care uses conservative means to pursue progressive

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"The Fight for Health Care Isn't Over" *The New York Times*, June 28, 2015, accessed June 28, 2015, <http://nyti.ms/1QW3rof>.

<sup>62</sup> Lawrence R. Jacobs and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs to Know*. Rev. Ed. (New York: Oxford University Press, 2012), 126.

<sup>63</sup> Starr, *Remedy and Reaction*, 241.

<sup>64</sup> Jacobs and Skocpol, *Health Care Reform and American Politics*, 127.

<sup>65</sup> Starr, *Remedy and Reaction*, 243.

<sup>66</sup> *Ibid.*, 244.

ends.”<sup>67</sup> Through the ACA, the market and the ideal of the empowered consumer are employed towards more widespread and affordable coverage.

At the same time, the ACA is not simply individualistic. Rather, it collects pools of private and public money towards a level of communal responsibility. The subsidies outlined above are paid in large part by taxes, both on employer based, so-called Cadillac plans, those that cost more than \$10,200 for an individual,<sup>68</sup> as well as higher Medicare and income taxes on individual incomes over \$200,000 (or \$250,000 for couples).<sup>69</sup> Moreover, the most striking and controversial aspect of the law is the individual mandate to purchase health insurance, accompanied by the threat of a tax penalty for those not covered. Like the Medicaid expansion, this mandate too was challenged in the same Supreme Court ruling of 2012, but was held up as constitutional by a 5-4 majority. The insurance industry has argued that the mandate is necessary if preexisting conditions are to be covered. Otherwise, without the possibility of being denied coverage based on preexisting conditions, customers would simply wait until they became sick to buy insurance, which when done in mass would either make premiums skyrocket or would bankrupt insurance companies.<sup>70</sup> Thus, through taxes, Medicaid expansion, and the individual mandate, the ACA pools money together under the ideal of collective responsibility. Because health care is funded in this way, religion scholar David Craig contends that health care in America is functioning more as a “social good” rather than either a simple market commodity or

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<sup>67</sup> Jacobs and Skocpol, *Health Care Reform and American Politics*, 131.

<sup>68</sup> Starr, *Remedy and Reaction*, 258. This is actually a fairly radical change from the longstanding history of employee health plans being tax exempt in the US, a benefit championed by unions since the 1940s. Steven Brill, *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix our Broken Healthcare System* (New York: Random House, 2015), 22.

<sup>69</sup> See Jacobs and Skocpol, *Health Care Reform and American Politics*, 134.

<sup>70</sup> Brill, *America's Bitter Pill*, 52. In fact, President Obama did not incorporate a mandate in his reform plan during the 2008 campaign, and his campaign actually criticized Hillary Clinton's plan during the Democratic primary because it included such a mandate. It was only after the President was confronted with the economic data regarding the costs of forgoing the mandate after election that he supported it in the ACA. *Ibid.*, 45-47, 116.

an individual right.<sup>71</sup> It is a commodity that the community buys for itself based on our common vulnerability and shares for the common good, even as access to it remains unequal.<sup>72</sup>

On the other hand, though conservative politicians and public figures have overwhelmingly opposed the ACA, often specifically citing the mandate as government encroachment on individual freedom, the idea itself also reinforces market principles. In fact, the law employs and expands the health care market to a greater extent than the status quo prior to the ACA. Following the passage of the EMTALA in 1986, which mandated that emergency departments stabilize all patients who enter their doors, public funding actually covered – and continues to cover – 80% of the costs for care of the uninsured. The rest, when not covered by the patient, is taken on by the hospital and thus paid for by raising prices on insured patients. In this way, the costs of health care have always been shared as a social good.<sup>73</sup> Via the mandate supported with government subsidies, the ACA simply shifts the burden of this care back to the insurance marketplace, broadening the resources of private insurance to pay for care as well as enriching public Medicaid for those who still cannot afford insurance with the subsidies.<sup>74</sup>

Though the ACA does the much needed work of extending health insurance and thus accessibility, it therefore does so by furthering the ideal of the individual, empowered consumer. With this act, the consumer is empowered to buy health insurance for herself. However, as the law is put together, the ideal of consumerism is not opposed by a complementary ideal of communal responsibility. Rather, each supports the other. Through the ACA, the individual is also empowered to buy into the community.

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<sup>71</sup> Craig, *Health Care as a Social Good*, 88.

<sup>72</sup> *Ibid.*, 89.

<sup>73</sup> *Ibid.*, 96.

<sup>74</sup> In fact, the conservative nonprofit Heritage Foundation first drafted the idea of a mandate in the late 1980s based on the principle of individual responsibility. Further, it was Republican President Richard Nixon who first supported a mandate on employers to provide insurance and providing subsidies to aid those who could not afford insurance. Brill, *America's Bitter Pill*, 30-32.

The ACA also furthers the progress narrative of modern health care by its failure to curtail the increasingly unmanageable costs within the health care industry. Though cost containment was originally central to many of the law's key early proponents,<sup>75</sup> political realities made such containment impossible. The Senate version of the bill, which eventually became the template of the final law,<sup>76</sup> negotiated with special interests to fund reform primarily via deals with the industry rather than taxes.<sup>77</sup> Central to these negotiations was a series of promises not to cut the costs of health care or scale back the industry. As investigative reporter Steven Brill recounts in his recent research on the ACA's development, in return for discounts, fees, and subsidies worth \$80 billion, the drafters of the Senate version promised the pharmaceutical industry that the bill would not allow Medicare to negotiate further on drug prices and would continue to prohibit the sale of drugs from Canada in the United States.<sup>78</sup> Likewise, nonprofit hospitals agreed to givebacks totaling \$155 billion – primarily via reductions in planned increases to Medicare and penalties for readmissions – in return both for the influx of new customers via the mandate as well as the bill leaving out any antitrust laws that would prohibit hospital mergers.<sup>79</sup> Finally, though there were no explicit negotiations with medical technology companies, and there is a medical device tax in the law, there are also no constraints on hospital

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<sup>75</sup> Brill points out that President Obama's advisors were split between differing concerns with health care costs. Policy advisors Valerie Jarrett and Jeanne Lambrew came to oppose the economic team made up of Larry Summers, Peter Orszag, Bob Kocher, and Zeke and Rahm Emanuel in drawing up the bill. The latter team's concerns for cost containment eventually went unheard in the final drafts of the ACA. *Ibid.*, 70-71.

<sup>76</sup> The Senate version of the bill, far more conservative than the House version, became the only version passable through Congress after Senate Democrats lost their 60<sup>th</sup> vote needed to by-pass the Republican filibuster after the death of Senator Ted Kennedy and the special election of Republican Scott Brown of Massachusetts. Because the Senate bill had already been passed prior to Kennedy's death in office, the House, then controlled by the Democratic party, could not amend it without forcing another Senate vote. This meant that a public run insurance program (i.e. the public option) as well as a federally run – rather than separate state run – exchange never made it into the final bill. The final bill also had fewer taxes and smaller penalties for breaking the mandate than either the original versions of in the House or Senate. *Ibid.*, 186-193.

<sup>77</sup> *Ibid.*, 96. This version was written primarily by Montana's Democratic Senator Max Baucus.

<sup>78</sup> *Ibid.*, 97. This prohibition on Medicare negotiation with drug prices dates back to the implementation of Medicare Part D under the second Bush administration.

<sup>79</sup> *Ibid.*, 103, 106.

investment in technology.<sup>80</sup> In fact, there is hardly any mechanism within the bill to curtail rising health care costs or to limit the industry. In the final version of the bill, an independent advisory board can make recommendations to cut Medicare expenditures that exceed the GDP. However, the board has little power, because Congress can override it,<sup>81</sup> and Congress historically has refused any measure that can be interpreted as rationing health care.<sup>82</sup> Rather than curtailing costs, the bill will actually raise health care expenditures beyond where they would have been without reform 1% by 2019.<sup>83</sup>

This means that the ACA furthers rather than hampers the biopolitical trajectory of modern health care while at the same time mitigating some of the negative consequences to this trajectory. Though the bill will not increase access to insurance or public plans to the early hopes of 94%, it nonetheless dramatically increases the availability of insurance and prohibits many of the business practices that were damaging to consumers. It thus makes for a more equitable biopolitics. However, the trajectory remains reinforced by a consumer base empowered by a set of laws making it easier to buy into the system while not restraining the system. Health care will continue its fight against death all the more, and the industry will continue to expand in the name of giving life, though this trajectory continues to threaten the long-term viability of this market.<sup>84</sup> Thus, consumers will continue to be separated from their deaths. The reform's failure to challenge health care's biopolitical trajectory substantially also means that the experience of

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<sup>80</sup> Ibid., 110.

<sup>81</sup> Starr, *Remedy and Reaction*, 265.

<sup>82</sup> For example, a 1997 law prohibits Medicare expenses from exceeding the increase in percentage of the GDP without approval from Congress as a way of limiting the growth of the industry. However, because these expenses have in fact outpaced GDP, every year after its passing Congress has approved the increases in Medicare, mostly so that physicians would keep treating Medicare patients. In other words, Congress cannot and will not follow the cost containment mechanisms that it has implemented for itself. Brill, *America's Bitter Pill*, 153-154. In 2015, congress repealed the measure.

<sup>83</sup> Starr, *Remedy and Reaction*, 265.

<sup>84</sup> Starr concludes, "In the long run, failing to rein in costs will imperil the effort to ensure coverage for all Americans." Ibid., 266.

dying and death itself will continue to be more remote from human experience as it is imagined and shaped by our health care industry. This marginalizing of a basic human experience then means a marginalization also of those who are dying, making the end of life all the more burdensome.

#### IV. Invisible Deaths

If the health care consumer is empowered to utilize the system towards the fight against and thus the denial of death, what then happens with the patient who is in fact dying? Following from the ideals of progress and empowerment, death is becoming an increasingly marginalized position within health care; in fact, it does not fit at all. This is the consequence both of a system built to fight death as well as the proliferation of technology that supports bodily function. With its priority to heal set in opposition to death, medicine renders the experience of dying both muddled and invisible. The moment of death is now muddled because the line between death and life has increasingly become a shade of grey rather than a strict boundary now that technology can continue to support life well after the hope of recovery fades. Moreover, even the probabilities of recovery for patients with serious conditions are increasingly opaque, as doctors become more reticent to give prognoses and medical technology continues to offer options in support of the body's function. Further, death, when it comes, is also rendered invisible by a system built on discreet treatments and discernable diagnoses, which do not give a place for death. As a result, the experience of dying has been reduced down into a type of choice. One is merely given the option between treatment and withdrawal of treatment. Shifting the conversation to one about choice again elides the actual experience of dying. Rather than incorporating loss into our understandings of life and health, we move the conversation to



decisions about how to employ our mechanical medicine. In this section, I examine these factors surrounding and rendering invisible the experience of dying in our health care system.

#### A. Making Death Opaque: Treatment, Prognosis, and Futile Care

The treatment of illness and decline in our health care system is precisely that, treatment. A profound ambivalence surrounds the experience of dying in hospitals. In a place meant to fight off death, the experience of dying is rendered invisible by the hopes of medicine. As Callahan notes, patients have now come to recognize and fear the “wild death” of technologized living, the futile treatment of the body, hooked up to machines that support breathing and other functions well after the possibility of recovery.<sup>85</sup> Yet even with this fear in our minds, the choice between healing treatment and futile harm remains blurred and ambiguous. We think that we will have clear options at the end of life, that we will recognize our end and accept it, but these choices are incredibly opaque. In reality, patients often do not recognize that they are dying until they are well into it. As Gawande notes, “We imagine that we can wait until the doctors tell us that there is nothing more they can do. But rarely is there nothing more that doctors can do. They can give toxic drugs of unknown efficacy, operate to try to remove part of the tumor, put in a feeding tube if the person can’t eat; there’s always something.”<sup>86</sup> Gawande’s words echo the ethnographic work in hospitals by anthropologist Sharon Kaufman. In examining the experience of dying in the hospital, Kaufman notes that futile treatment is offered and taken in the midst of profound ambiguity. The families and patients that Kaufman observed rarely knew exactly what they

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<sup>85</sup> Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (New York: Simon and Schuster, 1993), 26.

<sup>86</sup> Gawande, *Being Mortal*, 173-174. See also Gawande, *Better*, 159: “Many talk about the border between what we can do and what we can’t as if it were a bright line drawn across the hospital bed. Analysts often note how ridiculous it is that we spend more than a quarter of public health care dollars on the last six months of life. Perhaps we could spare this fruitless spending – if we knew when people’s last six months would be. In the absence of certainty, the truth is we want doctors who fight.”

wanted, nor could they foresee the consequences to their decisions. Is a given treatment futile or life giving? Their decisions could only be made among a barrage of statistics and hopes.<sup>87</sup> Thus, arguments against futile treatment assume a type of clarity that is not present in the midst of making treatment decisions. There is always something we can do, and with our system in general, we tend to side towards treatment and life when facing the possibilities of death.

Moreover, physicians often obscure the futility of treatment and the coming of death when they speak to patients and families. A retrospective examination of 70 hospital cases that ended in death illustrates that doctors, even when they anticipate death in advance, wait until the very last days of a patient's life to admit this reality to the patient. In fact, only 11.6% of doctors in the cases reviewed who were certain of death well in advance told the patient of the possibility of death weeks before it occurred.<sup>88</sup> This means that in the vast majority of cases, patients and families do not have time to ready themselves for death nor to adjust their treatments in order to avoid burdensome and futile treatment. In part, this unwillingness by doctors to give a negative prognosis is the result of the shape of dying today. When death happens by chronic condition rather than acute infection, decline is slow and unpredictable.<sup>89</sup> Moreover, doctors tend not to manage general decline directly. Rather, physicians have moved away from primary care and gerontology, the areas that look at the entire condition of the patient, and more towards specialties that treat only specific systems.<sup>90</sup> These specialty doctors are more inclined and optimistic towards isolated and individual treatments without looking at the entire condition of

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<sup>87</sup> Sharon Kaufman, *And a Time to Die: How American Hospitals Shape the End of Life* (Chicago: University of Chicago Press, 2005), 34-37.

<sup>88</sup> Amy M. Sullivan et al., "Diagnosing and Discussing Imminent Death in the Hospital: A Secondary Analysis of Physician Interviews," *Journal of Palliative Medicine* 10, no. 4 (2007).

<sup>89</sup> IOM, *Dying in America*, 88. Kaufman calls this the "revolving door" approach to death in the hospital. *And a Time to Die*, 98.

<sup>90</sup> Gawande notes that the numbers of geriatricians have fallen by 25% in the past fourteen years. Despite the fact that geriatric care can greatly reduce the cost of care for the elderly, income in this specialty is – along with primary care – at the lowest levels among physicians. *Being Mortal*, 36.

the patient.<sup>91</sup> Finally, with the high overhead costs of technology, these specialists are increasingly compelled to order more tests and procedures, even when these procedures are not proven to benefit patients directly in declining conditions. As cardiologist Sandeep Jauhar notes, “Overtesting and overconsultation have become facts of the medical profession. The culture today is to grab patients and generate volume.”<sup>92</sup> With such uncertainty and outside pressures facing physicians, it is little wonder that, as Kaufman reports, unfavorable prognoses tend to be given by doctors in stages, couched in the language of hope, optimism, and statistics, overestimating the likelihood of survival.<sup>93</sup>

This obscurity and unwillingness to name death’s approach are also the results of a biopolitical system built on the sustenance of life. The hospital is a place where treatment is the default and hope is the plan of action. Kaufman points out that life sustaining technologies are often given to patients prior to conversations about the burden of futile treatment. If a patient will die without it, the vent is automatically applied unless the patient has given explicit instructions against it.<sup>94</sup> The same is true for CPR.<sup>95</sup> This means that in most cases, families have to withdraw patients from treatment when they understand it to be futile rather than being given a clear opportunity to refuse it in the first place. As Kaufman explains, “These choices must also be made in the face of a trap that the mechanical ventilator has created: it confers upon the decider a perceived responsibility for either ‘unnaturally’ prolonging dying or proactively ‘causing’

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<sup>91</sup> Cardiologist Sandeep Jauhar notes, “Patients often have ‘overlap syndromes’ (we used to call it aging), which cannot be compartmentalized into individual problems and are probably best managed by a good general physician. When specialists are called in, they are apt to view each problem through the lens of their specific organ expertise. (Perhaps the hardest thing in medicine is to do nothing, especially when you’re called for help.) Patients generally end up worse-off. I have seen it over and over again.” *Doctored*, 94-95.

<sup>92</sup> *Ibid.*, 97.

<sup>93</sup> Kaufman, *And a Time to Die*, 47. See also IOM, *Dying in America*, 160.

<sup>94</sup> Kaufman, *And a Time to Die*, 57.

<sup>95</sup> *Ibid.*, 49. Bishop points out that in the central experiments where CPR and ventilation were developed, all research questions centered around effectiveness and efficiency of the techniques rather than quality of life: “Mechanical success trumps the question of what their survival might mean, for example, whether there were other effects including neurological damage.” *The Anticipatory Corpse*, 102-103.

death.”<sup>96</sup> Though the withdrawal of treatment only means that the patient’s body is no longer kept alive by machines, it feels like the family is in fact causing the death of the patient by ordering the withdrawal. This incredibly difficult decision is the product of a system where treatment is the default option.

The obscurity of futile treatment, the optimism of doctors or their hesitancy to speak of death, and the default mode of treatment are the reasons for the statistics quoted at the beginning of the chapter about why hospice, available to patients six months before their death, is generally only utilized in their last days, and patients continue to spend time in the ICU and acute care in the months leading up to their deaths. The health care system simply is not made to reckon with death. Rather, it is the place of treatment to ward death off. In discussing the decisions available to patients in the face of death, Gawande writes,

There is almost always a long tail of possibility, however thin. What’s wrong with looking for it? Nothing, it seems to me, unless it means we have failed to prepare for the outcome that’s vastly more probable. The trouble is that we’ve built our medical system and culture around the long tail. We’ve created a multitrillion-dollar edifice for dispensing the medical equivalent of lottery tickets – and have only the rudiments for a system to prepare patients for the near certainty that those tickets will not win. Hope is not a plan, but hope is our plan.<sup>97</sup>

The hospital is a place to fight death, to ward it off. In a place built on hope, the experience of dying has no place.

## B. Making Death Invisible: Coding, Advance Directives, and Changing the Conversation

In fact, on an economic level, the hospital has no recognition of death. Hospice nurse, researcher, and theorist Helen Stanton Chapple notes that Medicare’s diagnostically related groups (DRG), its classification system of patients by disease to determine payment schemes,

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<sup>96</sup> Kaufman, *And a Time to Die*, 57.

<sup>97</sup> Gawande, *Being Mortal*, 171-172.

and the hospital's ICD-9 code system, which matches each patient with a diagnosis, both specifically exclude dying and death from the health care market. There simply is no code for dying. Rather, clear ailments and their treatments are articulated by the system, privileging the tasks of care utilized toward the treatment of acute conditions, while the slow fading away of death is rendered invisible to the hospital billing system.<sup>98</sup> As Chapple argues, time is what the hospital sells and also what the hospital manages. From an economic perspective, the hospital sells time alive to patients via discreet procedures and medications, and thus it must carefully manage the time that patients spend within its walls, minimalizing unfunded and unproductive time and maximizing billable procedures.<sup>99</sup> As Chapple puts it, "Rescue efforts in the United States receive open, continuous support from technology, economics, cultural ideology, and the hope for salvation. By contrast, dying is poorly defined and happens in the shadows."<sup>100</sup> The experience of dying is thus outside of the economic and procedural system of the hospital; it blocks the system's constant need to move patients through discreet operations towards discharge.

I remember an ambiguous feeling surrounding patients who clogged up this system when I spoke to the doctors and nurses on the floor. Patients who eventually turned out to be in prolonged states of dying were in the system, yet out of it, often passing back and forth between ICUs and step-down units, having constant complications that impeded going home or to a long term care facility. Yet they were not ready or unwilling to leave the system via hospice. Health

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<sup>98</sup> Helen Stanton Chapple, *No Place for Dying: Hospitals and the Ideology of Rescue* (Walnut Creek, CA: Left Coast Press, 2010), 148-152.

<sup>99</sup> *Ibid.*, 155.

<sup>100</sup> *Ibid.*, 13.

care workers would simply shake their heads when they spoke of these patients, like they did not know what to do with them, feeling simply and profoundly sorry for them and their suffering.<sup>101</sup>

While the hospital does not have the capacity to recognize dying patients in its economic system, the cost of continued care for dying patients is making the health care system itself unmanageable. Over a quarter of all public health money, meaning Medicare and Medicaid, is spent on patients in the last month of life.<sup>102</sup> In 2009, Medicare covered 80% of all deaths in the United States and the vast majority of this money went to hospital care rather than hospice, home- or community based care for the last three months of life.<sup>103</sup> In part, this is because Medicare is still based primarily on a fee for service rather than a fee for outcome payment system. Though Medicare has worked out stringent controls over the cost of each service, it will not contain the amount of services ordered by providers, lest federal regulation be seen as rationing care.<sup>104</sup> Thus, dying patients are put through procedure after procedure, often resulting in burdensome and futile care. Though hospice and palliative care have been shown both to lessen costs as well as, paradoxically, extend the life of patients who no longer receive invasive, burdensome, and futile treatments,<sup>105</sup> these services are still substantially underused in our

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<sup>101</sup> At the same time, as nurse and President of the Institute for Staffing Excellence and Innovation Kathy S. Douglas explains, floor nurse staffing models are based on discreet shifts that do not give thought to the emotional toll care of the dying patients puts on nurses. Moreover, the current classification system does not allow floor managers to attend to the specific needs of the family and staff for dying patients. “Staffing for End of Life: Challenges and Opportunities,” *Nursing Economics* 30, no. 3 (2012).

<sup>102</sup> Gawande, *Better*, 159.

<sup>103</sup> IOM, *Dying in America*, 275. 82% of Medicare money spent in the last 3 months of life in 2006 was given to hospital care. *Ibid.*, 280.

<sup>104</sup> Further, federal law prohibits hospitals from coordinating the care and orders of its physicians as another means to avoid the rationing of health care. Thus, while the hospital – being paid a single overhead charge per diagnosis of each patient – has a financial incentive to move the patient through as quickly as possible, the doctor – being paid separate fees per service – has the incentive to prolong the stay of the patient and continually order tests and procedures. Doctors are not paid to coordinate their care with one another. This means that doctors will repeatedly reorder tests already done at another facility because the doctor does not have access to these records. These systemic factors make for repeated tests and invasive procedures done to terminal patients that in many cases ultimately prove futile. See Einer R. Elhauge, ed., *Fragmentation of U.S. Health Care: Causes and Solutions* (New York: Oxford University Press, 2010).

<sup>105</sup> IOM, *Dying in America*, 61, 72.

system today.<sup>106</sup> Thus, even as the hospital system does not have an official way to recognize the experience of dying, making this experience invisible under the tangible and billable options for treatment, dying itself is producing an unmanageable cost on top of the burden that it puts on the patients for whom treatment ultimately becomes futile.

Thus, in a system where the coming of death itself is rendered obscure by the promises of medical technology, where physicians are hesitant to give accurate prognoses, where treatment is the default, and where payment systems cannot recognize the experience of dying, producing untold costs, death has yet to be fully confronted. Rather, the system continually fights death back, pursuing healing to such an extent that medicine now cannot even recognize death when it is coming. In order to mitigate the harmful burdens that this push towards treatment has created in patient experiences of dying as well as its rampant costs, states have now adopted Advance Directive (AD) forms that help the patient articulate what would be an unacceptable quality of life as well as what procedures the patient would like to be withheld should she ever reach this point. In addition to the AD, patients are also offered the chance to determine a medical proxy, someone who will presumably follow the patient's wishes in coordinating or deciding to withdraw care, should the patient reach a point where she is unable to make or articulate these decisions on her own. The AD is meant to stop the push for treatment as the default, taking patients' wishes about how they live their lives and how they die into account.

However, as researchers and critics have pointed out, the AD has yet to mitigate the burdens of treatment fully nor to make the health care system reckon with its blindness towards the experience of dying. As noted above, what many patients assume is that there will be a moment when the doctor tells the patient that there is nothing further that can be done, and thus the decision to withdraw will be clear. However, with prognoses, the possibilities of treatment,

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<sup>106</sup> Callahan made the same observation more than twenty years ago. *The Troubled Dream of Life*, 38.

and the coming of death all incredibly unclear in our system today, the moment when the physician says there is nothing else to do rarely happens, and when it does, the patient or family is usually told only at the end of a great amount of futile treatment. ADs do not mitigate these realities.

There are also barriers to having the AD followed once the patient has met what she would consider an unacceptable quality of life: (1) In most cases, an AD that one has at home or in another facility will not follow the patient into the hospital on a new admission, so the patient will need to draw up a new one, but this may not be possible if she is already in decline.<sup>107</sup> (2) Even when an AD is present, it can be trumped either by a physician or the family. Sixty percent of doctors in a recent survey said they would perform resuscitation on a patient against the wishes articulated in the AD if they thought it would be successful.<sup>108</sup> (3) Physicians may not follow an AD if a family member is likely to sue. Such a possibility leads to what is known today as defensive medicine, the ordering of extra tests and treatments beyond what the doctor feels is appropriate in her clinical judgment in order to cover herself from the threat of a malpractice lawsuit.<sup>109</sup> This threat is the result of another factor that can play into whether an AD is followed: (4) divisions within a family. Often the person designated as the proxy will have trouble following the patient's wishes if there is disagreement within the family about withdrawal, a situation that happens often in the ambiguities of modern medicine at the end of life. Or, if the family as a whole disagrees with the patient's wishes, the medical team will often follow the family once the patient can no longer speak for herself, even if they are not designated as a proxy. (5) Finally, the circumstances around dying can vary to such an extent that the patient's

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<sup>107</sup> IOM, *Dying in America*, 134.

<sup>108</sup> Christopher M. Buckle, et al. "Physician Perspectives and Compliance with Patient Advance Directives: The Role External Factors Play on Physician Decision Making," *BMC Medical Ethics* 13 (2012). Cited by IOM, *Dying in America*, 133.

<sup>109</sup> Jauhar, *Doctored*, 96.



wishes are no longer feasible, such as a patient's desire to die at home, and the family must make decisions at odds with the AD.<sup>110</sup> With these complications, Advance Directives have not fully settled the problem of futile treatment. Today, patients continue to receive burdensome treatment at the end of life and utilize hospice and other alternatives far less often than they are available. We continue to side with treatment, as a system and as dying patients, to the detriment of both.

Moreover, to make death into a decision actually evades the problem of the exclusion of the experience of dying in our health system. We still do not talk about the experience of loss or incorporate it into our understanding of what it means to heal and treat patients. Rather through Advance Directives, the system changes the conversation, making death into a choice rather than an experience with which to be reckoned. As Bishop argues, "The response of handing over the power to the patient focuses merely on the issue of who should have efficient control over this technology and the body...we have merely addressed the question of who controls matter in motion."<sup>111</sup> In other words, the move towards the AD plays into the same logic of the mechanical medicine that employs death to fight it off, as described above. The shift has only put the decision to employ the technology of this medicine out of the hands of the medical team and into the hands of the patient and family, but the directions and assumptions of this medicine are never put into question. The AD has not meant an actual taking into account of death by the system, an actual reckoning with the human experience of dying, incorporating this into how we understand human healing. In Callahan's words, "Instead of being put forward for common thought and probing, [death] was put into the courtroom, turned into a matter of grand human rights. That was not altogether inappropriate, but is it enough? Can it even be fully meaningful if it fails to

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<sup>110</sup> IOM, *Dying in America*, 137.

<sup>111</sup> Bishop, *The Anticipatory Corpse*, 124-125.

engage the older and deeper questions about the human significance of death?”<sup>112</sup> With the AD, medicine’s reckoning with death is again delayed, shifting the conversation rather to one about decisions on how to apply medicine at the end of life.

## V. Conclusion

Thus, the health care system promotes the ideal of life in contrast to death to the extent that the inevitable experience of dying is rendered invisible, both to the system and to the patient herself, who does not even see death approach amidst all the options for treatment and the obscurity of prognosis. As noted above, the system is built with an empowered consumer in mind, the one who can buy into the market and utilize it to prolong one’s life. This ideal then marginalizes both those who cannot buy into the market – creating trends of early death – as well as those who are dying within the system itself. The intertwined trends analyzed in this chapter point to a biopolitical trajectory that has gone too far, to a population that has completely separated itself from its dying, creating a health system that does not know what to do with this inevitable part of life and as a consequence, marginalizes its members and inflates its costs. The biopolitics of life has created unseen spheres of dying and death. In the last chapter, I asked about the character and rigidity of the biopolitical trajectory of modern health care and chaplaincy’s participation within it. Does the biopolitics of modern health care allow for heterogeneous experiences and people or does it rest on set of rigid boundaries and norms that make only certain people or experiences visible? This section has clearly pointed to the latter. The system rests on a one-sided norm of life that renders the experiences of death and decline invisible in a biopolitical sphere where only life and treatment are visible.

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<sup>112</sup> Callahan, *The Troubled Dream of Life*, 35.

In closing, I want to underline the connection between the obscurity of death within the hospital and its consumer model that creates wide disparities in access to health care. These two realities are connected in a pattern that over-serves those with the means to buy into the system and under-serves those who cannot. Making this connection clear is vital to understanding my critique of chaplaincy care in the following chapter. There, I argue that chaplaincy furthers the obscurity of death in the hospital and thus the biopolitical trajectory of modern health care. This means that chaplaincy is also an aid to the entire system in which health is distributed unevenly, death is caused and delayed, and loss cannot speak its name. To understand chaplaincy's political position, we have to place it within this *entire* biopolitical apparatus. Anything less tells only a partial story.

However, I also cannot either simply collapse nor artificially separate chaplaincy care from the health care system itself. Rather the two form a complex relationship, expanding and infiltrating one another. Thus, the question for the coming chapters is how exactly does chaplaincy further and subvert and thus change the trajectory outlined above. I spend the next chapter examining the participation of chaplaincy within this trajectory towards the exclusion of the experience of dying. The final chapters of the project then examine chaplaincy's subversion within this participation.

## CHAPTER 5

### BIO-PSYCHO-SOCIO-SPIRITUAL MEDICINE: THE TURN TO PATIENT EXPERIENCE AND THE ADVANCE OF MEDICAL POWER

A few weeks prior to writing this chapter, I followed a nursing referral to a white, female patient in her early sixties. The referral simply requested a “routine visit” without any indication of why the chaplain was needed. The woman looked older than her age, with wispy, unkempt white hair and deep, tired eyes set in a well-lined face. She spoke with a thick, at times mumbling southern accent that I had some difficulty following; however, I soon learned that she was in a spiritual crisis, spanning from a conflict between her Christian faith and her experience in the hospital. Because of her cancer, the doctors were recommending a necessary but invasive surgery, which held the possibility that she would die on the table, and the patient had experienced the choice of whether or not to have the surgery as a crisis in faith:

“I feel like I should have faith before I go to surgery, but I have doubts,” she said.

I responded, “What does having faith mean to you?”

“That I shouldn’t worry, that I should trust God completely. Otherwise I’m not saved.”

“You have doubts about the surgery? And that tells you about your salvation?”

“If I were saved, I wouldn’t worry. I would trust God completely.”

I have had versions of this conversation with many patients. Starring at the possibilities of death, patients want someone to sit and talk with them, to accompany or guide their approach to the mysteries and tragedies of life and its end. Is it here, then, that death is finally spoken in the hospital? Such conversations are the place where chaplains and patients have the opportunity to name the realities in the room. Death is present here, in an anticipated but uncertain way. The

realities of a faltering body and a scared patient come to the fore, often through the words of religion and spirituality, and the chaplain, as a part of the staff, sits with the patient and helps her speak about the emotions, fears, and spiritual concerns surrounding this reality. If death is rarely expected in the hospital, rendered opaque and silent through the prognoses and therapies of biomedicine, is it not simply present then in chaplaincy care? Was this patient not speaking about her approach towards death and the fears that accompanied it through this spiritual crisis?

In this chapter, I argue that the loss within death is not as clearly present in chaplaincy care as it may seem. For example, in this case I doubt that naming the realities of death was the only or even the main reason for my sitting with that patient, for being referred to that room, because she was not *only* seeing the realities of her illness and decline through the lens of a crisis in faith. Rather, in addition to the trouble and pain it caused this woman, her crisis in faith was also disrupting her progress through the hospital. She had yet to accept the need for the surgery or the reality that she may die on the table, a risk that needed to be taken, according to her physicians. Thus, in the midst of this conversation, I began to suspect that the unstated, perhaps implied purpose behind the medical team calling the chaplain was not only for me to offer spiritual care, but also to help the patient *through* this crisis, and, ultimately to move her along towards the surgery.

Such a plan was never stated outright to me. These are only suspicions. I did not have any conversation with the team that called me other than my own documentation of the visit, but I nonetheless felt pulled in this direction. And, in retrospect, I am conflicted about feeling that pull. On the one hand, my training, my theological tradition, my experiences in spiritual care all signaled to me that the absolute assurance that this woman was seeking seldom appears in life. Moreover, I suspect that her theological language was substituting for – and perhaps covering

over – her fears about mortality and perhaps her resistance to the hospital system. As a chaplain, I felt like it was first my job to offer care for this woman, to help her articulate the roots of her anxiety as a supportive presence, which may over time help her through this spiritual crisis to a more direct examination of her understanding and fears of death. My task was not, then, to help her through the system or get her to choose the needed surgery. But can these two tasks be so easily separated? Was it, in fact, possible to offer support, love, and presence, listening carefully to the patient’s worries, without at the same time promoting the unspoken agenda for which I believe I was called to this room? If I helped her speak her anxiety, did I not also help her move through it, possibly towards the surgery?

This chapter examines such ambiguity within various movements to name death within the hospital, first with what I, following Jeffrey Bishop, term the “biopsychosociospiritual” movement within medicine, meaning the longstanding but still underappreciated movement away from the more mechanical approach to medicine that focuses primarily on the patient’s physical body, to a medicine that also considers the patient’s psychological, social, and spiritual health in its treatment.<sup>1</sup> This movement dates itself back to the death and dying movement of the mid-20<sup>th</sup> Century but nonetheless remains secondary to the more mainline approaches towards treatment and the denial of death critiqued above. I then turn directly to chaplaincy care, a specific part of the “biopsychosociospiritual” turn, focusing on the notion of pastoral presence first explored in the first chapter of this project. In both cases, I identify resistance to medicine’s omissions of death through a new emphasis on naming the realities of decline and death in patients. However, I argue that both biopsychosociospiritual medicine in general and chaplaincy presence in particular, despite such efforts, must also be understood as expansions rather than full critiques of biomedicine’s refusal of death. Though this movement speaks of death, I argue

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<sup>1</sup> Bishop, *The Anticipatory Corpse*, 18.

that it nonetheless also turns the realities of faltering bodies and loss into a medical and moral discourse that stresses acceptance as the correct therapeutic approach to death. Such an approach turns the loss that is death into a new therapeutic pursuit of fullness. Further, I argue that pastoral presence, even when it refuses coercive notions of acceptance, nonetheless exists within a medical sphere that *is* heavily coercive, to which presence offers no real resistance. Thus, the acceptance that the chaplain offers to the patient can easily be co-opted by the system in moving the patient along the paths already prescribed by medicine.

### I. Chaplaincy and the Biopsychosociospiritual Turn

Today, chaplaincy departments are a part of a growing movement within medicine to attend to the whole person, biologically, psychologically, socially, and spiritually. As noted in the first chapter, chaplaincy has gone through a series of changes, most notably the discursive turn from “religious” and “pastoral care” to spiritual care, a broadly defined term designating care and support of the meaning making capacities of the patient. This change has allowed chaplaincy to attach itself to the care team, arguing that spiritual care is relevant to human health in general across different faiths. Moreover, the care team itself has expanded in recent decades. Today, palliative medicine of dying patients is its own medical specialty focusing on “(1) providing support that enables patients to remain for as long as possible at home or in the least restrictive and least intensive setting of care and (2) ensuring that patients receive care consistent with their values, goals, and informed preferences.”<sup>2</sup> Further, palliative care “provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness and their families.”<sup>3</sup> There are two levels of palliative care. Basic palliative care

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<sup>2</sup> IOM, *Dying in America*, 63.

<sup>3</sup> *Ibid.*, 27.

is delivered by health care professions in general, including nurses, social workers, and chaplains, who care for the dying but not certified in palliative care. Specialty palliative care is work done by board certified specialists. A key part of palliative care is hospice, a specialty institution or home-based care focusing on the comfort and “biomedical, psychosocial, and spiritual support” of patients with a life expectancy of six months or less.<sup>4</sup> As a part of both palliative and hospice care, chaplaincy is thus a part of a growing movement of holistic care with specific attention to issues at the end of life.

#### A. Resistance and the Naming of Death in the Biopsychosociospiritual Movement

Within this movement in medicine is a critique of the type of medicine that looks only at the physical aspects of the patient, as if the patient were an object, or simply matter in motion, as Bishop puts it.<sup>5</sup> Outlining this critique, medical ethicist and Franciscan Friar Daniel Sulmasy writes, “Despite all this technological progress, contemporary medicine still stands justly accused of having failed to address itself to the needs of whole human persons and preferring to limit its attention to the finitude of human bodies.”<sup>6</sup> Seeking to address more patient needs, Sulmasy is pointing to the idea that biopsychosociospiritual medicine takes into account more of the patient’s experience in its treatment. It does not simply look at the physical body, but also the psychology and spirituality of the person, her subjective experience of the disease and the hospital system.

Chaplains are key players in this turn. Anton Boisen was a leader in moving treatment for mental illness away from the strictly physiological approach of his contemporaries to attention to

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<sup>4</sup> National Quality Forum (NQF). *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report* (Washington, DC: NQF, 2006), 3. Cited in IOM, *Dying in America*, 27.

<sup>5</sup> See the introduction to chapter 3, section I.

<sup>6</sup> Daniel P. Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, D.C.: Georgetown University Press, 2006), 121.



the patient's subjective experience.<sup>7</sup> After Boisen, as Bonnie Miller-McLemore recounts, "Early advocates for CPE proposed a more holistic model of healing, recognizing many factors – medical, social, psychological, and spiritual – and seeking cooperation with other health professionals."<sup>8</sup> However, the biopsychosociospiritual movement in medicine is more often traced back to the invention of modern hospice by physician, social worker, and nurse Dame Cicely Saunders in the mid-20<sup>th</sup> century and the popularity of the death and dying movement started by psychiatrist Elizabeth Kübler-Ross in the 1960s. Their death and dying movement has now evolved into modern day hospice, palliative medicine, and spiritual care, though the basic aims and discourses of this movement remain almost unchanged from Saunders and Kübler-Ross's work fifty years ago. However, even before Saunders and Kübler-Ross, chaplains were pushing for more attention to the patient's experience at least since the mid-1930s.<sup>9</sup> It is not that chaplains are then merely attaching themselves to a movement within medicine so much as they have been on the forefront of this turn to patient experience from its beginning.<sup>10</sup>

Thus, the biopsychosociospiritual movement is not a recent phenomenon. Its popularization dates back to more than half a century ago with the death and dying movement, which itself has neither peaked nor died out but simply transformed through the

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<sup>7</sup> Hence Boisen's emphasis on understanding patients as "living human documents." *Out of the Depths*, 187.

<sup>8</sup> Miller-McLemore, "Revisiting the Living Human Web," 9.

<sup>9</sup> See IOM, *Dying in America*, 60. Even prior to the modern chaplaincy movement, American Christian clergy attempted to integrate spirituality into modern medical treatment at the turn of the Twentieth Century in the Emmanuel Movement in Boston. Started in 1905, this movement brought doctors and clergy together for patient care with an emphasis on counseling and moral instruction. See E. Brooks Holifield, *A History of Pastoral Care in America*, 201-209.

<sup>10</sup> However, this influence is not always noted especially in palliative care literature. For example, an article by physician Christina Puchalski (a leading proponent of spirituality in health care) and others begins: "In the early 1990s, academic medical centers, medical and nursing schools, residency programs, and hospitals began to recognize the role of spiritual care as a dimension of palliative care." Framing spiritual care's contributions as something that only came to be recognized later in the palliative care movement omits the lasting influence chaplains have had on the biopsychosociospiritual turn from the beginning. Christina Puchalski, et al., "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference," *Journal of Palliative Medicine* 12, no. 10 (2009): 885.

professionalization of medical and spiritual end of life care. The death and dying movement began as a protest movement against medicine's inattention to the dying process and the dying patient's subjective experience. Kübler-Ross especially was revolutionary in performing extended interviews with dying patients in the 1960s – often with chaplains as research associates. Rather than simply fighting off or denying death, Kübler-Ross held a keen interest in how patients adjusted to their deaths, and how death could best be approached. As I illustrate below, this emphasis continues today in literature published in recent years. Thus, while citations to Saunders' and Kübler-Ross's research have lessened,<sup>11</sup> those of us working in biopsychosociospiritual medicine still feel their influence keenly. Doctors, chaplains, and researchers continue to challenge the omissions of death and the excesses of treatment, which nonetheless still make up the majority of modern medical practices. They continue the protest and the care of the death and dying movement.

In general, the turn to patients' subjective experience has meant paying closer attention to their suffering and the things that remain important to patients at the end of their lives. Physician Christina Puchalski and nurse and researcher Betty Ferrell, in their work *Making Health Care Whole*, summarize the goals of such care when they explain that “spiritual care calls us to bear witness to and accompany people in their suffering and provide support as patients find meaning in the midst of that suffering and eventually integrate the suffering into their lives and become transformed by it.”<sup>12</sup> Following the overall contrast of this turn from more mechanical approaches to medicine, Puchalski and Ferrell distinguish spiritual care from what they call the Cartesian model of contemporary medicine, which understands, “that the world [operates]

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<sup>11</sup> In a recent, six hundred page volume collecting a vast amount of relevant literature on the state of death in American health care today, the Institutes of Medicine mention both Saunders and Kübler-Ross on only one page. IOM, *Dying in America*, 60.

<sup>12</sup> Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care* (Radnor, PA: Templeton Press, 2010), 10.

according to mechanical laws without mention of meaning and purpose.”<sup>13</sup> This latter philosophy in medicine has then lead to an ideal of “fixing” rather than healing as making whole,<sup>14</sup> a trend that spiritual care seeks to correct by ideals of accompaniment and meaning making. This turn is thus a needed corrective within medicine, moving medicine out of the strict mechanical view that utilized the autopsy and cadaver as the primary epistemology of patient care and looking to the patient as a person rather than merely a body.

Turning to the person of the patient, the biopsychosociospiritual movement also focuses on the way the terminal patient approaches her death. In contrast to the totalizing push towards progress and cure outlined in the third chapter, chaplaincy, palliative care, and hospice – continuing in line with the death and dying movement – all name the realities of when a patient has reached a critical point where further treatment can only harm. Specifically, the movement focuses on how patients approach their death. Do they accept it or deny it, and if they can accept their dying, can they then learn or gain something in the process? As hospice nurses Maggie Callanan and Patricia Kelley put it, “Can this time remaining be used to share treasured moments of living, while coping with the many losses death brings?...Can this person be helped to live until he or she dies? Can this be a time of personal growth for all involved? Yes.”<sup>15</sup> Key to the approach to death in biopsychosociospiritual medicine then is the acceptance of death. Once one can accept that one is dying, one can face its reality by getting the most out of the time remaining.<sup>16</sup> Buddhist hospice chaplain and key figure in contemporary end of life care Joan Halifax writes that, “The sooner we can embrace death, the more time we have to live

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<sup>13</sup> Ibid., 12.

<sup>14</sup> Ibid.

<sup>15</sup> Maggie Callanan and Patricia Kelley, *Final Gifts: Understanding the Special Awareness, Needs, and Communications of the Dying* (New York: Simon and Schuster, 1992), 13.

<sup>16</sup> However, acceptance is generally not conceived as a definite task that one can finish in the midst of dying. As Karen Speerstra and Herbert Anderson write, “The dying person has a single agenda, when all is said and done. And that is to get ready to die. That readiness includes deciding and deciding again and again.” *The Divine Art of Dying: How to Live Well While Dying* (Saline, MI: McNaughton and Gunn, 2014), 33.

completely, and to live in reality. Our acceptance of our death influences not only the experience of dying but also the experience of living.”<sup>17</sup> The focus is then living into one’s death, and thus learning and growing from it.

With its stress on experience, this end of life medicine tends to focus on agency in the patient’s life and death. The literature stresses that one can live fully into one’s dying through acceptance. Halifax writes that, “When you avoid death, you also avoid life. And I don’t know about you, but I want to be there through it all.”<sup>18</sup> Echoing this sentiment, Karen Speerstra – who in fact was a dying hospice patient at the time she wrote her last book with co-author, pastoral theologian Herbert Anderson – writes poignantly about her acceptance of her own death: “*I want to be conscious of this passage – this birth of my own into a new realm. I’m sick of ‘do not go gentle into that good night...’ I want to go gentle. Unfearful. And at peace...I want to die as I have lived – a full participant in all life has to offer.*”<sup>19</sup> Such acceptance contrasts with the denial and opacity of death so prevalent in the practices of the hospital. Rather than rendering death invisible behind a relentless and unlikely pursuit of a cure at the end of life – again, what Gawande terms “a multitrillion-dollar edifice for dispensing the medical equivalent of lottery tickets”<sup>20</sup> – this turn in medicine seeks an approach to death that embraces mortality.<sup>21</sup>

How does one turn towards such acceptance in the midst of dying? Further, how do caregivers in biopsychosociospiritual medicine guide such a turn? Palliative care physician David Kuhl explains that “For many people, learning that they have a terminal illness is akin to the bottom falling out, of being in deep water, uncertain as to how you will get to shore, a shore

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<sup>17</sup> Joan Halifax, *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death* (Boston: Shambhala Publications, 2008), xvi.

<sup>18</sup> *Ibid.*, xvi.

<sup>19</sup> Speerstra and Anderson, *The Divine Art of Dying*, 31. Italics are original.

<sup>20</sup> Gawande, *Being Mortal*, 171-172.

<sup>21</sup> Speerstra and Anderson, *The Divine Art of Dying*, 47: “Change in medical care is not likely to occur until there is a shared acceptance of finitude by patients, their families, and physicians.”

that is not visible.”<sup>22</sup> If death threatens one with the end of experience, with the void itself, how can health professionals then speak of acceptance, of growth in the midst of death? In the midst of such fallout, Kuhl recommends a course that is also key to chaplaincy care: life review. Life review is taking stock of a life, cherishing one’s memories and also attending to unfinished business. Kuhl warns, “Too many people wait too long to begin the inward journey of learning who they are, what the meaning of life might be for them, the value of relationships and spirituality.”<sup>23</sup> Moreover, as Speerstra and Anderson write, “Everyone and everything one has loved passes in review. We review life in order to let it go.”<sup>24</sup> Life review is a means of recounting past relationships, looking for unfinished business, and saying goodbye in the acceptance of death. Speerstra and Anderson write that in the process of letting go, the world becomes smaller, but also deeper, more grace-filled: “The nearness of death heightens our awareness of ordinary moments as bearers of grace.”<sup>25</sup> The turn towards experience in medicine is then towards a better approach towards death, more open and accepting of the end.

From these brief excerpts in the literature, it is clear that this movement continues to confront the realities of death rather than simply denying them in systemic opacity. This movement, now decades old but nonetheless still growing, also remains incomplete today. Time, efficiency, and tangible tasks and goals remain the central focus of the hospital, and the accompaniment and support that chaplains and other end of life caregivers provide are still marginalized by these ideals.<sup>26</sup> Patients rarely enter hospice until their last few days and patient

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<sup>22</sup> David Kuhl, *What Dying People Want: Practical Wisdom for the End of Life* (New York: PublicAffairs, 2002), 13.

<sup>23</sup> *Ibid.*, 28.

<sup>24</sup> Speerstra and Anderson, *The Divine Art of Dying*, 169.

<sup>25</sup> *Ibid.*, 139.

<sup>26</sup> See David Sulmasy, *The Rebirth of the Clinic*, 21.

referrals in the hospital to palliative care specialists remain slow.<sup>27</sup> Only rarely do patients experience the attention to spiritual matters that chaplains offer. Harold Koenig notes that while 75-90% of patients report that they have spiritual needs during their hospitalization, 70% of these patients report that these needs are not met, and only 20% of all hospital patients actually see a chaplain during their stay.<sup>28</sup> This trend continues despite the fact that, as noted in chapter 1, addressing such needs has been shown in research studies to lead to greater overall patient satisfaction, greater compliance with medical instructions, increased trust in physicians, more effective coping with illness, and greater use of hospice services over heroic care measures at the end of life.<sup>29</sup> Thus, while the movement for holistic care shows great promise within medicine, the biopsychosociospiritual turn has been longstanding yet incomplete. End of life care continues to be a needed voice at the periphery of the medical world.

## B. Acceptance as the Ideal State of Dying

While I believe that the biopsychosociospiritual movement is a needed change within medicine's approach to death, for the remainder of this chapter, I analyze this movement as also a continuance rather than a full subversion of medicine's more dominant refusal of death. Specifically, I question if chaplains and palliative care fully incorporate the experience of a patient's dying as loss when they push towards the acceptance of dying. Is dying itself, as loss, the end of experience, the same as the acceptance of death? Further, can the push towards acceptance and the idea of closure and growth in death actually work to obscure the experience

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<sup>27</sup> For example, only half of responding cardiologists in a national survey said they would review palliative care options in case studies involving elderly patients with advance heart failure. Dan D. Matlock, et al. "Regional Variations in Palliative Care: Do Cardiologists Follow Guidelines?" *Journal of Palliative Medicine* 13, no. 11 (2010). Cited in IOM, *Dying in America*, 64.

<sup>28</sup> Koenig, *Spirituality in Patient Care*, 13, 15. See also Puchalski and Ferrell, *Making Health Care Whole*, 5.

<sup>29</sup> See Chapter I, Section IIA above.

of death as loss, as end? I separate death from the acceptance of death here, aligning the latter with a moral vision of self-fulfillment, in contrast to death as loss.

I am not the first to make this argument. Both Bonnie Miller-McLemore and Jeffrey Bishop draw similar conclusions in their critical readings of Kübler-Ross's work, and thus I follow their arguments closely in this section. However, I also expand on these authors' contributions in the second half of this chapter because neither directly examines the practice of chaplaincy presence as a protest against the coercions of death acceptance as well as, paradoxically, their continuance. Further, whereas my focus throughout this dissertation is on the obscurity of death as loss in patient and chaplain experience, Bishop and Miller-McLemore in contrast utilize their critiques of acceptance to argue for more overtly confessional or Christian understandings of death.<sup>30</sup> In fact, neither chaplaincy nor the experience of loss in death is the primary subject matter of either author. Miller-McLemore's focus is the competing cultural interpretations of death in the 1980s while Bishop's focus is on contemporary iterations of medical power. Thus, while the work of both authors remains key to my assessment of the widespread discourse of death acceptance in medicine today, I nonetheless focus and expand their critiques directly as they pertain to chaplaincy practice and the experience of loss.

The issue of pursuing acceptance as a goal in the care of the dying is that it places the ends of this care under ideals created primarily by psychology and the death and dying movement, wrapping up the experience of dying into what Bishop calls the "discursive mastery"

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<sup>30</sup> Miller-McLemore turns to intersections between Neo-orthodox theologian Paul Tillich and theological ethicist Paul Ramsey as a more adequate moral vision of death than those provided by psychology, medicine, and the death and dying movement in *Death, Sin and the Moral Life: Contemporary Cultural Interpretations of Death* (Atlanta: Scholars Press, 1988). Bishop's work is less overly theological, though he concludes his work arguing for a turn to religion as a guide to medical practice: "It might be that we can learn once again not from history – a static past – but from living traditions. It just might be that the practices of religious communities marginalized in modernity and laughed at as unscientific are the source of a humane medicine." *The Anticipatory Corpse*, 313.

of “psychologists and social scientists.”<sup>31</sup> In stressing acceptance, chaplains and the biopsychosociospiritual movement in general are still primarily influenced by the model developed in Elizabeth Kübler-Ross’s *On Death and Dying*, published in 1969.<sup>32</sup> In this perennial work, Kübler-Ross ushers in the death and dying movement with a stage theory of dying, contending that dying persons tend to go through phases of denial, anger, bargaining, depression, and acceptance. Kübler-Ross envisions these stages as sequential, with clear preference for acceptance as the end goal of the dying process,<sup>33</sup> though she also maintains that in reality, the stages “last for different periods of time and will replace each other or exist at times side by side.”<sup>34</sup> The ideal of acceptance as the end of the dying process clearly remains in end of life care, as illustrated in the literature reviewed above, though Kübler-Ross is often no longer cited as its progenitor. Rather, acceptance is simply assumed as the expected end goal of care, as if acceptance itself were natural and belonged essentially to the experience of dying. In other words, Kübler-Ross’s work has been so integrated into death care that medicine has forgotten that her points once needed to be argued. Her stage theory is no longer understood as a theory of the dying process, but rather as the dying process itself.

This assumption is embedded into chaplaincy practices today at the end of life, including chaplaincy’s ongoing assimilation of biomedical procedures like assessment and charting. For example, in my current position, the pastoral care office is alerted every time a patient is placed in palliative care, and our department has set a goal to perform a spiritual assessment on each

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<sup>31</sup> Ibid., 228.

<sup>32</sup> Elizabeth Kübler-Ross, *On Death and Dying*, (London: Collier-Macmillan Ltd., 1969). For a discussion of chaplaincy’s continued use of Kübler-Ross as well as the profession’s overall medicalization, see Lucy Bregman, *Beyond Silence and Denial: Death and Dying Reconsidered* (Louisville KY: Westminster John Knox Press, 1999), 82-87.

<sup>33</sup> Callanan and Kelley, following Kübler-Ross’s stage theory, note, “Acceptance can be more comfortable than the other stages – especially for onlookers – but there is nothing right or wrong or well or poorly adjusted about any of the stages of dying. They’re normal, predicable responses to a process.” *Final Gifts*, 59.

<sup>34</sup> Ibid., 122.



patient within twenty-four hours of that placement. In our charting of that assessment, we are asked to assess the emotional state of the patient. As illustrated in the excerpt below from our charts, all five phrases are named among a number of possibilities for the chaplain to check off when filling out the patient’s chart, though bargaining has merged with denial or coded as “control issues” and depression is labeled simply as “sadness” to avoid a clinical label or diagnosis:

Figure II.<sup>35</sup>

**Chaplain Assessment**

<input type="checkbox"/> No Current Needs	<input type="checkbox"/> Crying	<input type="checkbox"/> Incomplete Information
<input type="checkbox"/> SPIRITUAL ASSESSMENT ISSUES	<input type="checkbox"/> Emotional/Spiritual Suffering	<input type="checkbox"/> Need for Palliative Care
<input type="checkbox"/> Hope	<input type="checkbox"/> Functional Changes (Physical, Mental)	<input type="checkbox"/> Pain
<input type="checkbox"/> Ability to Recognize Strengths/Potentials	<input type="checkbox"/> Grief	<input type="checkbox"/> Post-surgical
<input type="checkbox"/> Trust	<input type="checkbox"/> Guilt/Shame	<input type="checkbox"/> Pre-surgical
<input type="checkbox"/> Belief System	<input type="checkbox"/> Frustrated/Disappointment	<input type="checkbox"/> Prognosis
<input type="checkbox"/> Coping Well	<input type="checkbox"/> Isolated	<input type="checkbox"/> Understanding of Treatment/Goals
<input type="checkbox"/> Prayer Needs	<input type="checkbox"/> Inability to Recognize Strengths/Potential	<input type="checkbox"/> PSYCHOSOCIAL ASSESSMENT ISSUES
<input type="checkbox"/> Peaceful	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Conflicted Relationship(s)
<input type="checkbox"/> Relieved	<input type="checkbox"/> Overwhelmed	<input type="checkbox"/> Coping Strategies
<input type="checkbox"/> Acceptance	<input type="checkbox"/> Purpose	<input type="checkbox"/> Cultural Considerations
<input type="checkbox"/> Faith	<input type="checkbox"/> Self-blame	<input type="checkbox"/> Communication Concerns
<input type="checkbox"/> Family Support	<input type="checkbox"/> Relationship Changes	<input type="checkbox"/> Feelings Regarding Self-worth
<input type="checkbox"/> Faith Community Support	<input type="checkbox"/> Sadness	<input type="checkbox"/> Inability to Socialize
<input type="checkbox"/> Searching for Meaning	<input type="checkbox"/> Unresolved Spiritual Issues	<input type="checkbox"/> Need for NICU Support
<input type="checkbox"/> Loss of Hope	<input type="checkbox"/> Vocational Loss	<input type="checkbox"/> Need for Perinatal Support
<input type="checkbox"/> Loss of Trust	<input type="checkbox"/> MEDICAL ASSESSMENT ISSUES	<input type="checkbox"/> Neglect of Self-care
<input type="checkbox"/> Control Issues	<input type="checkbox"/> Awaiting Test Results	<input type="checkbox"/> Patient/Family Issues
<input type="checkbox"/> Denial	<input type="checkbox"/> Change in Condition	<input type="checkbox"/> Reported Abuse/Neglect
<input type="checkbox"/> Abandonment	<input type="checkbox"/> Code Status	<input type="checkbox"/> Reported Suicidal Ideation
<input type="checkbox"/> Anger	<input type="checkbox"/> CPR/Code blue	<input type="checkbox"/> Support Systems
<input type="checkbox"/> Anxiety/Fear	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Other:
<input type="checkbox"/> Apathy	<input type="checkbox"/> Ethical Issues	
<input type="checkbox"/> Crisis	<input type="checkbox"/> Hospitalization	

Chaplains can thus actually name the stage their patients are in during their assessments, which thus assumes that the stages are a part of a natural progression without examination of the theoretical basis of these stages. Further, when describing the work of the visit, options exist in

<sup>35</sup> I am thankful to the pastoral care office of St. Thomas Medical system for allowing me to use their charting system in this project. Figure II represents a cropped image from a blank patient chart. The circles are changes that I have made to the chart to indicate where the assessment follows Kübler-Ross’s stage theory.

our charts to name how care is working to help the patient progress toward acceptance. There are options to list “Spiritual outcomes” of the visit, including if the patient is “able to articulate feelings,” “acknowledged the impact of illness,” and “expressed sense of well-being.” There are also “medical outcomes” such as “adapting to hospital environment,” “choose palliative care,” and “completed advance directives.” All of these possibilities clearly indicate outcomes that move the patient along to an end goal of acceptance.

Figure III<sup>36</sup>:

Chaplain Visit Outcomes		
<input type="checkbox"/> SPIRITUAL OUTCOMES	<input type="checkbox"/> Resilient	<input type="checkbox"/> Accepting of Body Image
<input type="checkbox"/> Able to Express Feelings	<input type="checkbox"/> Felt Supported	<input type="checkbox"/> Communicating Effectively
<input type="checkbox"/> Acknowledge Impact of Illness	<input type="checkbox"/> Sacramental Needs Met	<input type="checkbox"/> Entertains Potential/Possibility
<input type="checkbox"/> Connected to Sources of Support	<input type="checkbox"/> Strengthened by Spiritual Resources	<input type="checkbox"/> Felt Supported/New Family Baby
<input type="checkbox"/> Developed Trusting Relationships	<input type="checkbox"/> Ongoing Struggles	<input type="checkbox"/> Found Support/Intervention re: Abuse/Neglect
<input type="checkbox"/> Envision Future/Goals	<input type="checkbox"/> MEDICAL OUTCOMES	<input type="checkbox"/> Found Support/Intervention re: Suicidal Ideation
<input type="checkbox"/> Experiencing Spiritual Growth	<input type="checkbox"/> Adapting to Hospital Environment	<input type="checkbox"/> Greater Self-esteem
<input type="checkbox"/> Expressed Gratitude	<input type="checkbox"/> Choose Palliative Care	<input type="checkbox"/> Improved Social Interaction
<input type="checkbox"/> Expressed Sense of Well-being	<input type="checkbox"/> Code Status Choice Clear	<input type="checkbox"/> Increased Ability to Cope
<input type="checkbox"/> Feels Supported During Loss/Grief	<input type="checkbox"/> Completed Advance Directives	<input type="checkbox"/> Making Positive Changes/Addictive Behaviors
<input type="checkbox"/> Finding Greater Meaning/Purpose	<input type="checkbox"/> Felt Supported/CPR/Code Blue	<input type="checkbox"/> Need for Perinatal Support
<input type="checkbox"/> Grieving Appropriately	<input type="checkbox"/> Felt Supported/Trauma Crisis	<input type="checkbox"/> Reduced Anxiety/Stress
<input type="checkbox"/> Increased Hope	<input type="checkbox"/> Involved in Treatment/Care Plan	<input type="checkbox"/> Reported Abuse/Neglect to Appropriate Authorities
<input type="checkbox"/> Integrating Spiritual Experiences	<input type="checkbox"/> Making Informed Choices	<input type="checkbox"/> Resolving Family Issues
<input type="checkbox"/> Reaffirmed Positive Beliefs	<input type="checkbox"/> Reduced Pain Level	<input type="checkbox"/> Explored Options for Making Decision(s)
<input type="checkbox"/> Receptive to Spiritual/Emotional Care	<input type="checkbox"/> Resolved Ethical Issues	<input type="checkbox"/> Other:
<input type="checkbox"/> Reduced Spiritual/Emotional Suffering	<input type="checkbox"/> PSYCHOSOCIAL OUTCOMES	

However, acceptance as the ideal of the dying process is not simply natural to dying itself. Rather, as an ideal pursued in end of life care, it assumes a moral status, naming what dying *ought* to be or ideally how the process should finish, as the literature cited above clearly indicates. In discerning the moral vision cast by the death and dying movement, Miller-McLemore places Kübler-Ross’s model as a “culture of joy” aligned with humanistic psychology.<sup>37</sup> Here Miller-McLemore is drawing on pastoral theologian Don Browning’s

<sup>36</sup> Again, I have annotated the chart with the circles to indicate the outcomes mentioned in the text above.

<sup>37</sup> Miller-McLemore, *Death, Sin and the Moral Life*, 85. More recently, Lucy Bregman has aligned the entire discursive turn to spirituality in general to the work of Kübler-Ross. “Defining Spirituality: Multiple Uses and Murky Meanings of an Incredibly Popular Term.”

critique of humanistic psychology.<sup>38</sup> Browning contends that though psychology generally purports to describe human behavior and health from an objective point of view, in fact, each branch of psychology holds symbols and norms that make up an unspoken worldview, complete with its own distinct moral vision.<sup>39</sup> Psychologies spell out how patients should act and thus how society can reorganize around therapeutic goals, casting a moral vision of the good life and the good society. Analyzing the humanistic psychology of Carl Rogers, Abraham Maslow, and Fritz Perls, Browning calls the implicit moral landscape envisioned by these authors a culture of joy because they rest on an ideal of personal fulfillment and self-actualization. These psychologies envision human beings as innately driven to self-actualization, though they contend that people are inevitably fragmented by the outside pressures of modern society, which tell people to repress certain unacceptable parts of themselves. Further, these psychologies articulate this innate self-actualization on a global level, envisioning that each person's fulfillment will harmonize with everyone else's. Thus, Browning contends that the moral vision of these psychologies is implicitly religious in nature, because they imagine a type of monism where each person's fulfillment complements another's.<sup>40</sup> Again, this vision is moral rather than scientific according to Browning, normative rather than objective. Humanistic psychologies do not simply name human behavior as it is, but rather as how it *should be*. In aligning Kübler-Ross with Browning's assessment of humanistic psychology, Miller-McLemore is thus arguing that her stage theory, which Kübler-Ross describes as objectively observed via a series of qualitative

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<sup>38</sup> This point is also reviewed in Bregman, *Beyond Silence and Denial*, 71-74.

<sup>39</sup> Don S. Browning and Terry D. Cooper, *Religious Thought and the Modern Psychologies*. Originally published in 1987.

<sup>40</sup> *Ibid.*, 69-76.

studies of dying patients, is actually a moral vision of what dying should be, not simply what it is.<sup>41</sup>

Specifically, Miller-McLemore analyzes the implicit connections between humanistic psychology and the ideal of acceptance envisioned by Kübler-Ross. Like the humanistic psychologies, “Kübler-Ross places the blame” for our current denials and bargaining with death “almost wholly on the ‘fall’ of modern society,” which Kübler-Ross claims is far different from the general acceptance of death prior to modern medicine.<sup>42</sup> Miller-McLemore casts this dichotomy between nature and human society as a nostalgic turn to “a romanticized past when good folk enjoyed the simple life of farm living,” where death was simply accepted as a part of life.<sup>43</sup> In other words, Kübler-Ross’s work rests on a presupposed past and a distinct worldview rather than a historical survey or a genealogy of past attitudes and social conditions surrounding death. She then injects a romantic vision of death acceptance from this vision into a putatively scientific picture of the natural course of dying. The goal of acceptance and personal fulfillment in death becomes seen as inherent to the dying experience. Kübler-Ross supposes that once we are freed from the entanglements and denials of modern society, we will somehow complete our lives through our deaths, or in other words, self-actualize in our dying. As Miller-McLemore points it, in Kübler-Ross’s work and the death and dying literature that followed it, “*Each individual ought to achieve for herself or himself a more personally satisfying, ‘appropriate death,’ and be helped to do so.*”<sup>44</sup> However, like self-actualization, the ideal of acceptance is

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<sup>41</sup> Both Miller-McLemore and Bishop critique Kübler-Ross’s qualitative studies, noting that her data does not actually align with her conclusions. In Bishop’s words: “What is amazing, given its influence, is the lack of scientific rigor of Kübler-Ross’s study, even though, throughout her life, she persisted in claiming the mantle of science. . . . These famous five stages of grief, however, are not supported by the case examples that accompany the descriptions of each stage.” *The Anticipatory Corpse*, 235. See also Bonnie Miller-McLemore, *Death, Sin and the Moral Life*, 93.

<sup>42</sup> Miller-McLemore, *Death, Sin and the Moral Life*, 90.

<sup>43</sup> *Ibid.*, 89.

<sup>44</sup> *Ibid.*, 94. Italics are original.

couched in objective and essential language in Kübler-Ross. Miller-McLemore notes that in her explanations and narratives of dying, the descriptive and the normative elements of the case study blend into one another, such as in statements like the following: “If we can accept our patients’ needs and do not project our own...the dying person will then reach the final stage of true acceptance.”<sup>45</sup> In the ideal of acceptance, the moral vision of what dying should be subtly overshadows what it is, or rather, simply takes its place. Rather than the reality of dying, Kübler-Ross presents a moral vision of what death can be, something to be learned from, a means to personal fulfillment.

Though Miller-McLemore was writing in the 1980s and thus looking squarely at Kübler-Ross and her immediate successors, the push towards self-fulfillment in death acceptance continues basically unchanged today in the current literature. Acceptance of death is laden with language that makes it seem to be the natural approach to death: “Each individual comes to the moment when it is right to take this turn [towards death] in his or her own way,” write Speerstra and Anderson.<sup>46</sup> A recent report on death care by the Institutes of Medicine quotes physicians lamenting patients’ failure “to face death and accept it as a part of life.”<sup>47</sup> Further, as I review above, the literature continues to speak of accepting death as the way to live into it, to have a complete and gratifying end. Callanan and Kelley note that, “Though it can be grief- and stress-laden, death can occur in a context of completion and closure. After going through a death this way, many people say, ‘This may have been the hardest things I’ve ever done, but I’m so glad I did it.’”<sup>48</sup> Halifax echoes this sentiment writing a decade and a half after Callanan and Kelley,

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<sup>45</sup> Elizabeth Kübler-Ross, “Dying as a Human-Psychological Event,” in *The Experience of Dying*, eds. Norbert Greinacher and Alois Müller (New York: Herder and Herder, 1974), 51-52. Quoted in Miller-McLemore, *Death, Sin and the Moral Life*, 94.

<sup>46</sup> Speerstra and Anderson, *The Divine Art of Dying*, 5.

<sup>47</sup> The quote actually comes from only one physician, but many other doctors and caregivers are quoted in this section lamenting the political and institutional hurdles to death acceptance. IOM, *Dying in America*, 446.

<sup>48</sup> Callanan and Kelley, *Final Gifts*, 30.

naming “dying as an experience rich in meaning and value, a developmental phase in our maturation process.”<sup>49</sup> With leaders in end of life care continuing a naturalized idea of death acceptance and completion, Kübler-Ross’s influence reaches far into biopsychosociospiritual medicine today.

While the goal of acceptance and fulfillment is a worthy end of the dying process, employing it as the sole function of death care casts this moral vision over death, making care pursue an ideal rather than naming death squarely as loss. Though practitioners of biopsychosociospiritual medicine speak of accompaniment and integration when outlining their care of the dying, as noted above, implicit in this discourse is a humanistic moral vision, an idea of where the dying process should lead. Thus, in this turn, medicine again obscures the experience of dying, even when it is looking directly at it. Medicine rolls the dying process up into a series of discourses that replace the loss of death, thus reshaping the actual experience and obscuring the realities of its loss. In fact, in place of loss, death is envisioned as a setting for something to be gained. As scholar of religion Lucy Bergman, following Miller-McLemore’s work, explains, the “aim is for the person to live as fully as possible, even when the medical prognosis is terminal.”<sup>50</sup> Whereas Miller-McLemore goes on to contrast Christian understandings of death with Kübler-Ross rather than examine the experience of loss directly, her critique is nonetheless relevant for my focus, because when medicine’s emphasis is on the fullness of life at the end, loss is again rendered silent. Further, even this replacement of loss with gain is concealed. The discourse of acceptance says that this is how the dying process *is*, when in fact it is covering over dying with a moral vision of what it should be. Thus, the

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<sup>49</sup> Halifax, *Being with Dying*, 105.

<sup>50</sup> Bregman, *Beyond Silence and Denial*, 88. Following Miller-McLemore, Bregman is outlining the moral vision of the death and dying movement in the segment from which this quote is taken.

biopsychosociospiritual turn is more a continuance of medicine's longstanding elision of death as loss rather than a full turn towards the experience of dying.

Bishop, writing twenty years after Miller-McLemore's work, holds a similar critique of the death and dying movement, but as a physician deeply influenced by Foucault's history of medical perception and power in *Birth of the Clinic*, he writes of the death and dying movement more as an expansion of medicine's control over the experience of dying. He then takes her critique a step further by arguing that the goal of acceptance does not only envision a moral way to die, but in addition, it describes an attitude conducive both to the function of the hospital as well as to the patient within the medical system: "The five stages appear to be primarily concerned with the functioning of the hospital, especially when something gets in the way of the processes for moving the patient through the system."<sup>51</sup> Labels of denial, anger, bargaining, or depression can be employed to name a patient who is disruptive, uncooperative, or simply not moving aside after treatment has become futile. Acceptance, on the other hand, "allows for better treatment plans, and...does not result in excessive treatments."<sup>52</sup> As noted above, patients who receive proper spiritual care tend to fair better in the hospital system, reporting greater overall satisfaction, requesting less futile treatment, and moving towards hospice, where dying patients tend to live longer and better lives. This ease in movement is, at least in part, a beneficial product of spiritual care and the biopsychosociospiritual movement in general guiding patients towards a naturalized ideal of acceptance of one's death. As Florence Gelo puts it, "In our medical culture, where the priority is often to preserve physical life at the expense of the patient's quality of life, the chaplain assists patients and families to accept the time when all measures to preserve life

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<sup>51</sup> Bishop, *The Anticipatory Corpse*, 236.

<sup>52</sup> *Ibid.*, 237.

have become futile and to ‘let go.’”<sup>53</sup> Thus, the goal of acceptance can aid those who are dying to make the proper care choices in their final days. Acceptance within spiritual care aids the dying in navigating, and also being navigated by the system.

However, helping one function within the system and acknowledging the loss inherent within death are two very different things. Though Bishop also does not address loss itself, he nonetheless illustrates how the ideal of acceptance continues medicine’s pursuit of power and control over death, asking for the dying process to meet certain ends and influencing the patient to make certain choices. Biomedicine has thus yet to reckon with or incorporate the loss of self that the experience of dying truly is. If medicine simply applies power over the experience of dying, asking for it to fit the ideals and the functioning of the hospital, then the experience of loss that is death is again rendered mute.

Further, if the goal of acceptance in dying promotes the function of the system, and chaplaincy is the key agent in guiding the patient towards this goal, then that also means that all of the negotiations noted in the first chapter must be contextualized in relation of this exercise of power. In the first chapter, I note that spiritual assessments necessarily involve a relationship of unequal power between the one who is assessed and the one doing the assessment. It places the chaplain in the place of an expert making judgments on the spirituality of her patient. Now, if the goals of death care can be aligned with the overall goals of the system, which also render power over the patient, asking the patient to accept her dying so as to move through the system, then the judgments made on one’s spirituality are also judgments about the patient’s degrees of acceptance. Though he does not tie assessment directly to acceptance, Bishop comes to a similar conclusion regarding chaplaincy work: “By creating themselves as [spiritual care] experts,

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<sup>53</sup> Florence Gelo, “The Role of the Professional Hospital Chaplain,” in *Religion, Death, and Dying, Volume I: Perspectives on Dying and Death*, ed. Lucy Bregman (Santa Barbara, CA: Praeger, 2010), 19.



chaplains are able to show that they promote the social functioning of the healthcare system, and the tools of assessment are part of promoting that professional identity.”<sup>54</sup> Further, in the first chapter I note the uneasy fit between the chaplain’s work and the charting that she must complete as a part of the care team. When the goal of acceptance is aligned with the wider functioning of the hospital, however, the reasons for charting become clear. If the chaplain is the part of the care team specializing in spiritual assessment and thus judging the degree of the dying patient’s acceptance, then a record of the chaplain’s judgments become paramount to the team. When the chaplain records her spiritual assessment and the progress made during a visit, she is communicating to the team how the patient is functioning within the hospital system, and what must be done to further the patient’s conformity with the overall goals of the hospital. In these ways, the professionalization and medicalization of chaplaincy are also the adaptation of the profession to the power relations of the hospital. Through spiritual assessment and charting, the chaplain participates in the power that the system exerts over the patient and the dying process.

A key part of biopolitics is the creation of fields of knowledge that make assessments and create divisions within the population. Such a measurement is apparent, then, in the care team’s assessment of a patient’s acceptance of her death. Through the creation of an accessible sphere known as spirituality, medicine has gained power over the attitude and the amount of closure one finds in one’s own death. Bishop contends that assessment is the key to the biopsychosociospiritual turn in medicine, because it “addresses all features of human thriving. It sets out to nominally define, to operationally assess, and to statistically measure the wholeness of human living...Biopsychosociospiritual medicine measures all things and is the measure of all things.”<sup>55</sup> However, again this measurement is also a creation.<sup>56</sup> We have created an approach to

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<sup>54</sup> Bishop, *The Anticipatory Corpse*, 246.

<sup>55</sup> *Ibid.*, 228.

death, made it appear natural, and then set out a measure of how closely a patient aligns her approach to death with this conception. Thus, medicine has cloaked death with its idea of the good death, a death that is accepted and lived out fully to completion.<sup>57</sup> With this measure and ideal, medicine has thus again cast its power over death. We are thus still selling health, just now a healthy way to die. Even when medicine accepts death, it nonetheless casts its power over it, obscuring it as loss.

### C. A Mixed Assessment

*I am not making a one-sided critique of such power.* I note above that the biopsychosociospiritual turn is itself a response to the biomedical arch that sides primarily with treatment, to the burden of those who are dying but cannot see or accept it, as outlined in the last chapter. In a place where dying has been and continues to be rendered invisible by a biopolitical trajectory that unquestionably values more time alive, without examining the consequences of this one-sided drive on the people within its system who are actually dying, the move towards acceptance ushered in by the death and dying movement and continued today by end of life caregivers, including chaplains, is a needed corrective. However, this corrective is not as revolutionary as it may first appear. Even at death's most visible point, where medical power is exerted to influence the patient to accept her dying and to find it as a fulfilling end to life, the experience of dying as loss also continues to be rendered obscure. Loss remains silent because

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<sup>56</sup> In his analysis of Foucault's notion of disciplinary power, theologian Mark Jordan writes, "The power of disciplinarity overwrites bodily peculiarity as measurable and controllable instantiation. It recognizes as usefully individual only what it can normalize. To accomplish this, it posits just the individual subject that it needs." *Convulsing Bodies: Religion and Resistance in Foucault* (Stanford, CA: Stanford University Press, 2015), 55. Disciplinary power thus measures and normalizes in the same motion. The same can be said of notions of the good death and death acceptance.

<sup>57</sup> Bishop, *The Anticipatory Corpse*, 277: "These discourses of expert care create the very thing that they purport only to promote, namely, a 'good death.'"

everything said about dying seeks to make the experience conform to the operations and expectations of the medical apparatus.

Medicine as a whole continues to talk about what dying should be, rather than what it is, an attempt “to control the uncertainty of dying,” confronting it rather than being confronted by it.<sup>58</sup> This attempt then feeds back into the biopolitical trajectory of progress, treatment, and cure dominant in the hospital. The system continues to be one that cannot accept loss. In place of loss, we continue to *treat*, now via a treatment plan of acceptance and gain. This persistence in treatment then continues to feed a medical model in which healing is commoditized and sold, populations are divided between sick and healthy (or “in denial” vs. those “in acceptance”), and treatment is the only default option. The biopolitics of life continues on in our death care.

## II. Chaplains’ Work in Death Care

I now turn specifically to the notion of pastoral presence in the midst of death care. Again, neither Miller-McLemore nor Bishop examines presence because chaplaincy is not their primary focus. Miller-McLemore does not address chaplaincy directly and the profession is only a periphery concern for Bishop. When he does address chaplains, he tends to oversimplify the relationship between medical and spiritual care by regarding chaplaincy simply as a pawn of medical power. For example, at the end of his critique of spiritual assessment quoted above, he states, “The great high priest who promotes social function within biopsychosociospiritual medicine is the doctor, and his chief altar boy is the generic chaplain, who has taken on the values of the institutions of health care within the larger sociopolitics of Western society.”<sup>59</sup> This blanket conclusion omits the on-going negotiations that chaplains make with their medical

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<sup>58</sup> Ibid., 228.

<sup>59</sup> Ibid., 246.

setting directly regarding assessment and charting. Moreover, it elides the literature on pastoral presence. Any discussion of chaplaincy's implication in or subversion of medicine's power and control over death must examine pastoral presence directly, because it is *the* dominant practice in chaplaincy death care. Moreover, chaplains tend to contrast pastoral presence with more coercive ideals of the good death, including death acceptance.

In fact, while some chaplains will agree with the above assessment of the biopsychosociospiritual movement, they may balk at my insistence that chaplains too are caught up in the push for death acceptance. Does the idea of pastoral presence, simply being with and beside the patient, not also oppose or even resist any effort by the care team to push the patient towards acceptance and through the system? In an excerpt from his qualitative interview material, palliative care chaplain and researcher Steve Nolan captures one chaplain's resistance and ambivalence toward being enlisted by the care team in prompting the patient toward acceptance:

Take a simple example, I mean, there might be an issue about, let's say, very, very common situation in a hospice where somebody's gonna be discharged to a nursing home and doesn't wanna go, okay. Now maybe, it could be that every other professional is there to actually try and make going to a nursing home much more acceptable for that person, okay. Now I, as a chaplain, wouldn't be attempting to do that – *I might sometimes be enlisted to do that* by other professionals, 'Would you go and have a talk with them (Name)?' Right? But *nevertheless*, what I'm there for is to hear how awful it feels for that patient to be going into a nursing home.<sup>60</sup>

This refusal echoes the non-coercive notion of presence that chaplains take to be the locus of their work. I felt similar resistance when I suspected that I had been enlisted towards influencing my patient to go into surgery in the opening vignette to the chapter. My job was not to weigh in

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<sup>60</sup> Nolan, *Spiritual Care at the End of Life*, 60. Emphasis added.

on that decision, but to be a human presence with her in the midst of her uncertainty, offering whatever spiritual support I could.

However, these neat divisions that we draw become murky in practice. The chaplain's work of presence and being enlisted in prompting a patient towards acceptance are actually more difficult to separate when chaplaincy practice is examined on a systemic level. We have to take into account all the other messages that the patient is navigating when we think about the work that pastoral presence performs in the hospital. Looking back at Nolan's material, would not having a chaplain sit and hear a hospice patient complain about the nursing home also lessen her anxiety and perhaps resistance towards that move? Especially when the rest of the team is telling the patient that this is the right thing to do, does the chaplain's accepting presence with the patient not provide room for her to accept the "truth" of her condition, as told to her by the medical team? When chaplains refuse the coercion and obfuscation prevalent in the discourse of acceptance, nonetheless, their descriptions of their work also leave them open to being co-opted toward the systemic coercion of their setting. In this section, I thus detail chaplaincy's refusal of coercion via presence and then critique it as resistance, arguing that presence nonetheless functions as a tool of the medical power's pursuit of patient acceptance.

#### A. Presence as Being With and Refusal

Presence continues to be the predominant way that chaplains explain their work, and this emphasis on being with a patient is in tension with the discreet and technical tasks prevalent for the care team. Moreover, chaplains, especially when describing the care of the dying, stress the non-coercive nature of their presence, one directly opposed to ideals of acceptance and the good death. Nolan himself writes cogently of presence as a stark contrast to the more task-driven work

of other medical professionals. He writes, “Chaplains intuitively understand the concept of dwelling or being-*with* another...being-*with* them in a way that allows that person to be the being they are rather than the being that the chaplain, or anyone else, may wish or need them to be.”<sup>61</sup> Presence allows the person to be who they are. Thus, according to Nolan, “Such accompanying extends to accepting the person’s right to die the death they need to die...rather than the ‘good death’ prescribed by palliative care.”<sup>62</sup> Nolan’s words echo Joan Halifax, who despite her prizing of the ideal of acceptance, nonetheless rejects coerciveness in death care, especially around notions of the “good death”: “The concept of a good death can put unbearable pressure on dying people and caregivers, and can take us away from death’s mystery and the richness of not knowing. Our expectations of how someone should die can give rise to subtle or direct coerciveness.”<sup>63</sup> These protests speak against the perceived pressures that have accompanied the discourse of acceptance in the biopsychosociospiritual movement. Presence, in contrast, seeks to be free of an agenda, even the therapeutic agenda of palliative care, accepting the patient’s right to die “on their feet if necessary; or with quiet acceptance; or with raging ‘against the dying of the light.’”<sup>64</sup> In this way, when outlining pastoral presence chaplains have increasingly resisted notions of the good death and death acceptance.<sup>65</sup>

The resistant non-coerciveness embedded in the notion of presence is the reason why religious scholar Winnifred Fallers Sullivan aligns pastoral presence with political resistance.

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<sup>61</sup> Ibid., 73. Italics are original.

<sup>62</sup> Ibid.

<sup>63</sup> Halifax, *Being with Dying*, 65. In contrast to Nolan’s (and my own) liberal Protestant background, Halifax is a Buddhist practitioner and aligns the tenants of non-attachment with her descriptions of caregiving presence. See p. 82-87.

<sup>64</sup> Nolan, *Spiritual Care at the End of Life*, 73.

<sup>65</sup> However, Nolan and Halifax’s direct resistance of the notion of the ‘good death’ is not universal within chaplaincy. For an example of a chaplain incorporating the term but retaining presence as a non-coercive practice, see W. Wilson Will III, “Hospice Chaplains, Spirituality, and the Idea of a Good Death,” in *Spirituality in Hospice Palliative Care*, ed. Paul Bramadat et al. (Albany, NY: State University of New York Press, 2013). Will simply assumes that patients universally desire the good death promoted by palliative care. See p. 138.

Even more than Nolan and Halifax, Sullivan explicitly names pastoral presence as resistance to medical power: “Presence also works as a place of resistance to instrumentalist approaches to religion and spirituality. The ministry of presence refuses interpretation and explanation... Presence can refuse to be made part of a system – to be measured and quantified and offered as a means to an end.”<sup>66</sup> Sullivan is detailing the ways generalized, “universalist and irenic” spirituality functions as resistance to the systematization of individuals in institutions like the hospital and the military.<sup>67</sup> According to Sullivan, presence “might be read as a form of resistance... The chaplain, whether in a hospital or prison or military setting, is not a doctor or a guard or a soldier or a government agent. He or she is not a priest or a rabbi. He is not trying to improve or constrain your life, but rather simply to be there, to listen, if asked to, to witness, to be with... you, whoever and wherever you are.”<sup>68</sup> Sullivan’s reading of presence as resistance also speaks to chaplains’ blatant refusal via notions of presence to coerce or pressure people at the end of life. A chaplain’s presence at the end of life refuses any ideal for death, but rather accepts one’s dying as it is.<sup>69</sup>

## B. Humanistic Psychology in Chaplaincy Presence

Yet a closer examination of the roots of presence complicates the finality of this refusal, for both the presence of spiritual care and the ideal of acceptance in the death and dying movement have a common origin in humanistic psychology. In the last section, I followed

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<sup>66</sup> Winnifred Fallers Sullivan, *Ministry of Presence*, 177.

<sup>67</sup> *Ibid.*, 140.

<sup>68</sup> *Ibid.*, 176-177. The second ellipsis is original to the text.

<sup>69</sup> For Nolan, the refusal to pressure the dying other is built into the limitations of chaplains’ role on the healthcare team: “Of all healthcare professionals, palliative care chaplains are the least best placed to effect material change, and perhaps because they understand there is *nothing* they can *do* to change a dying person’s situation, they understand that it is their being-*with* that matters... The point is not that being-*with* is the sole prerogative of chaplains; but that being-*with* is *all* that a chaplain has to offer.” *Spiritual Care at the End of Life*, 105. Italics are original.

Bonnie Miller-McLemore’s alignment of the death and dying movement with the culture of joy and moral horizon of humanistic psychology. Like this movement, chaplains today continue to employ the terms of humanistic psychology, most directly those related to Carl Rogers, in their descriptions of presence and being with another.<sup>70</sup> When describing their presence, chaplains speak of “unconditional positive regard,”<sup>71</sup> listening in a “reflective and non-judgmental way,”<sup>72</sup> and accepting the other “as a whole person,”<sup>73</sup> all terms that align closely with Rogerian therapy. Nolan, when he is developing his notion of being with as a non-directional mode in contrast to the agenda driven practices of the rest of the care team, directly cites Rogers: “[chaplains] speak of being with [dying people] in a way that is genuinely what Rogers terms ‘person centered.’”<sup>74</sup> These references speak to the continued influence of Rogerian techniques in chaplaincy practice and what pastoral theologian Barbara McClure terms “the institutionalization of Rogerian commitments in Clinical Pastoral Education.”<sup>75</sup> Chaplains’ stress on the non-coercive nature of pastoral presence then reflects Rogers’ own commitments in therapeutic practice.

Rogers himself stressed unconditional acceptance of the other in his therapeutic practice, allowing the patient to experience herself completely, without any coercion or censorship. In Rogers’s words, the purpose of unconditional acceptance is so that “[The client] can be aware of

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<sup>70</sup> The influence of Rogerian therapy and its moral worldview on pastoral care and clinical pastoral education has been catalogued thoroughly by pastoral theologians and historians. See Holifield, *A History of Pastoral Care in America*; Rodney Hunter, “The Therapeutic Tradition in Pastoral Care and Counseling,” in *Pastoral Care and Social Conflict: Essays in Honor of Charles V. Gerkin*, eds. Rodney Hunter and Pamela Couture (Nashville: Abingdon Press, 1999); Elaine L. Graham, *Transforming Practice: Pastoral Theology in an Age of Uncertainty* (Eugene, OR: Wipf & Stock Publishers, 2005), 67-76; McClure, *Moving Beyond Individualism in Pastoral Care and Counseling*, 80-106.

<sup>71</sup> Will III, “Hospice Chaplains, Spirituality, and the Idea of a Good Death,” 132.

<sup>72</sup> Jim Huth and Wes Roberts, “‘I Need to Do the Right Thing for Him’: Andrew, a Canadian Veteran at the End of his Life, and his Daughter Lee,” in *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy*, eds. George Fitchett and Steve Nolan (Philadelphia: Jessica Kingsley Publishers, 2015), 206.

<sup>73</sup> Nina Redl, “‘What Can You Do for Me?’: David, a Mid-Sixties Jewish Man with Stage IV Pancreatic Cancer,” in *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy*, eds. George Fitchett and Steve Nolan (Philadelphia: Jessica Kingsley Publishers, 2015), 239.

<sup>74</sup> Nolan, *Spiritual Care at the End of Life*, 60.

<sup>75</sup> Barbara McClure, “The Social Construction of Emotions: A New Direction in the Pastoral Work of Healing.” *Pastoral Psychology* 59, no. 6 (2010): 801.



what he is actually experiencing, not simply what he can permit himself to experience after a thorough screening through a conceptual filter.”<sup>76</sup> Whereas outside pressures push towards conformity, the presence of the caregiver is simply there to be with the client, accepting her. As a result, “The person becomes for the first time the full potential of the human organism... The person comes to *be what he is*.”<sup>77</sup> For Rogers, therapy is the process of emerging out of our defenses into our true, authentic reality: “Now in a safe relationship of the sort I have described, this defensiveness or rigidity, tends to be replaced by an increasing openness to experience.”<sup>78</sup> Chaplains then mirror Rogers’ practice when they speak of the non-coercion in death care. Just as Rogers sought the emergence of the authentic person, chaplains seek the emergence of the patient’s authentic death rather than coercing the patient into acceptance.

This alignment with Rogers, however, complicates chaplains’ use of presence as resistance to the coercion and obfuscation of death acceptance prevalent in the biopsychosociospiritual turn, because the acceptance that chaplains offer stands within the same fulfillment model as the death and dying movement. By referring to unconditional positive regard, chaplains echo Rogers’ own understanding that the therapist’s acceptance will allow the patient to accept herself and move towards self-realization.<sup>79</sup> The death and dying movement simply makes a further move in assuming that the patient will then accept the fact that she is dying and will find meaning within it. Though chaplains are not adverse to such acceptance, they refuse this extra step when outlining pastoral presence because they find notions of the good

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<sup>76</sup> Carl R. Rogers, *On Becoming a Person: A Therapist’s View of Psychotherapy* (Boston: Houghton Mifflin Company, 1961), 104.

<sup>77</sup> *Ibid.* Italics are original.

<sup>78</sup> *Ibid.*, 115.

<sup>79</sup> Rogers aligns unconditional positive regard with total acceptance of the client: “Standal... terms this attitude ‘unconditional positive regard’... I have often used the term ‘acceptance’ to describe this aspect of the therapeutic climate... It involves an acceptance of and a caring for the client as a *separate* person, with permission for him to have his own feelings and experiences, and to find his own meanings in them.” *Ibid.*, 283. Italics are original.

death or death acceptance to be coercive. It is thus at odds with their commitments to reject any treatment agenda for the sake of simply being with a dying person.<sup>80</sup>

However, in practice this delineation becomes murky. If the therapeutic agenda of palliative care is towards a good death, which includes the acceptance of death, then a chaplain in that setting, following a model of unconditional positive regard, can easily become a part of this agenda. The acceptance that the chaplain offers of the patient as she is, within a setting that stresses that the patient *should* accept her own death, can be co-opted in this agenda that is not the chaplain's own. In the example that I used to open this chapter, I had no preference or stake in regards to whether or not that woman should or should not choose the dangerous surgery that the team was recommending, but perhaps the acceptance that I offered worked to ease her own anxiety towards the surgery, and ultimately towards her death. To the extent that a chaplain can help someone accept who they are, and the palliative care team is telling the patient that she is a person who is dying and in need of their referrals, then the acceptance that the chaplain offers can make way towards the final goal of death acceptance.

### C. Empathy and the "Truth" of the Patient

In order to understand how pastoral presence contributes to the coercions of medical power, we have to complicate our understanding of power. Power is not simply domination, but rather a complex operation of relations through institutions and norms. More specifically, Foucault explains, "What defines a relationship of power is that it is a mode of action which does not act directly and immediately on others. Instead, it acts upon their actions."<sup>81</sup> By this, he means that power operates more by shaping actions than forcing them, providing only a limited

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<sup>80</sup> Though such refusal is not as universal as some chaplains articulate it. See Florence Gelo's quote above at the end of section I.

<sup>81</sup> Foucault, "The Subject and Power," 789.

amount of possible responses in a given field,<sup>82</sup> and then “it incites, it induces, it seduces, it makes easier or more difficult.”<sup>83</sup> This means that even actions that seem the most authentic and liberating are nonetheless performed within a given field of limited options. Even when a person speaks her “truth,” this truth too is heavily shaped and fostered by the power relations in which she exists.<sup>84</sup> Power “is so deeply ingrained in us, that we no longer perceive it as the effect of a power that constrains us; on the contrary, it seems to us that truth, lodged in our most secret nature, ‘demands’ only to surface.”<sup>85</sup> Speaking the very truth that power relations influence and coerce then can feel like resistance. “The irony,” says Foucault, “of this deployment [of power] is in having us believe that our ‘liberation’ is in the balance.”<sup>86</sup> The liberatory act of speaking one’s truth is itself shaped, even produced by the power relations around us.

The idea that the patient is depressed, conflicted, in denial, or finally in acceptance are all assessments predicated on the judgments of medicine. As labels attached to patients, they are exertions of medical power over an individual. When the chaplain then accepts the patient – “whoever and wherever you are” as Sullivan states, or as “the being they are” in Nolan’s words – this patient is never free of the influence and determination of medical power. Chaplains assume they are strengthening the self of the patient so that she can then accept or reject the judgments of

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<sup>82</sup> Perhaps the most well known analysis of performativity within a given field of options is Judith Butler’s use of Foucault to outline gender performativity in *Gender Trouble*. According to Butler, there is no universal or pre-existing gender behind the performance of gender: “In this sense, *gender* is not a noun, but neither is it a set of free-floating attributes, for we have seen that the substantive effect of gender is performatively produced and compelled by the regulatory practices of gender coherence” (p. 34). Butler’s analysis of gender can be further generalized: There is no pre-existing actor behind the action. Rather, the performance of the action within a limited field creates the illusion of a preexisting actor. As I analyze below, such a limited field is also present in the hospital as medical power circumscribes possible patient responses.

<sup>83</sup> Foucault, “The Subject and Power,” 789.

<sup>84</sup> *Ibid.*, 781: “This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects.”

<sup>85</sup> Foucault, *The History of Sexuality, Vol. 1*, 60. Foucault is here speaking of the reversal of pastoral power. Whereas one was once constrained to speak in confession, now confession feels like liberation, speaking one’s truth.

<sup>86</sup> *Ibid.*, 159.

medicine from a place of authenticity, but authenticity is grounded and known only in the fields of knowledge circumscribed in the hospital by medicine. In Foucault's words:

We should abandon a whole tradition that allows us to imagine that knowledge can exist only where power relations are suspended... We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge.<sup>87</sup>

There are no possible patient responses within the medical system that are not in some way shaped, produced, and labeled by the fields of knowledge that is modern medicine. The notion of the chaplain's acceptance of the patient without agenda denies medicine's power to determine the field of possible responses of a patient within its system and to name the truth of the patient's response, whether the patient is facing reality or in denial, or responding with "hope," "acceptance," "faith," "anger," or "sadness" – all possible labels assigned in the chaplain's spiritual assessment.<sup>88</sup> What the chaplain then accepts, and enables the patient to accept in herself, is a response already circumscribed and named by medicine.<sup>89</sup> And this identified response will then go into the patient's chart under the chaplain's spiritual assessment. The

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<sup>87</sup> Foucault, *Discipline and Punish*, 27. [Note: I am thankful to my colleague Ekaputra Tupamahu for drawing my attention to this section.] In his earlier work, Foucault describes the conditions of knowledge as historically constituted fields, what he calls the "episteme." *The Order of Things*, xxii. Via the episteme, a field of knowledge grounds itself rather than being grounded in an *a priori*, universal rationality. Foucault thus describes changes in the *episteme* of the sciences over time as "radical" "discontinuity" (p. 217), not evolving naturally as the progression of universal reason but disruptions in the historical conditions in which knowledge is produced. Then, in his later work, such as *Discipline and Punish* and *History of Sexuality*, Foucault grounds the establishment of knowledge more concretely in specific power relations, such as prison reform's science of delinquency based in class struggles and bourgeoisie morality of 19<sup>th</sup> century France.

<sup>88</sup> These are a few of the many options available in the spiritual assessment chart in figure II.

<sup>89</sup> My critique here echoes one by Bonnie Miller-McLemore against indiscriminant empathy in the pastoral care movement when it fails to take into account the power relations implied in gender: "This claim suggests limits to empathy that people in Carl Rogers's time never suspected. When those involved in pastoral care do not know how to recognize the realities of violence toward women, they foster further damage and violence. Particularly in situations of sexual abuse, for example, the problem in pastoral response is not too little empathy but too much indiscriminate empathy by an uninformed pastoral caregiver." "The Living Web and the State of Pastoral Theology," in Bonnie Miller-McLemore, ed. *Christian Theology in Practice: Discovering a Discipline* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2012), 41. Originally published in Jeanne Stevenson Moessner, ed. *Through the Eyes of Women: Insights for Pastoral Care* (Minneapolis, MN: Fortress Press, 1996). Just as indiscriminant empathy fails to recognize gender inequality, so too can it miss the patient caught up in the power relations of medicine.

responses of the patient and the labels of medical power coincide. Because medicine is in a place to name such “truth,” through its technical and putatively objective instruments, then the agenda of medicine and the patient’s experience of her true, authentic self begin to merge into one.<sup>90</sup>

So, when the chaplain offers unconditional positive regard, and the patient moves towards self-acceptance, does she accept herself as she truly is, or does this acceptance simply make room for the patient to accept the judgments of her doctors? Medicine will tell the patient that the two are the same, that its judgments in fact reflect the patient’s true and authentic reality. Under the prevailing influence of medical power today, there is no way for chaplaincy to differentiate between the true self of the patient and the self who is diagnosed by medicine. Even the resistance that the patient may bring to the system is already labeled and treated by the hospital. Under the mode of unconditional regard, chaplains fail to offer an alternative to the truth of medicine. Thus, even when chaplains reject pressures that coerce a patient into death acceptance or the good death, their agenda-less acceptance of the patient is co-opted by a larger system that names the truth of the patient. Presence, as an assuring being-with that enables the patient to accept who she is, may then move the patient to accept her self as it is determined by medical power. And medical power – if not the chaplain – pushes the patient eagerly to acceptance.

#### D. On Doing More

Can chaplains *do* any more? Yes and no. Yes, in the sense that chaplaincy as a profession has for too long now relied on descriptions of presence as a claim to innocence or even resistance to the disciplining powers of the medical system. By relying on presence as a way to free

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<sup>90</sup> Mark D. Jordan, *Convulsing Bodies*, 82: “Structures of power-knowledge conceal themselves in many ways...They erase their origin by pretending not to have had an origin.”

themselves from being enlisted into the coercions of biomedicine, chaplains have failed to make a wider, self-critical understanding of the political positioning of presence within the hospital system. Further, relying on presence has meant that chaplains have not looked more deeply into the *actual* ways they subvert biomedicine in their experiences with loss and self-loss. Such omissions have then left chaplaincy open to the one-sided, reductive critiques that simply name spirituality and spiritual care as pawns of neoliberalism or power. By aligning their resistance to the coercions of the system with practices of presence, chaplains have left themselves open to critiques of presence as critiques of chaplaincy in general. If presence is all chaplains have to offer in resistance to the excesses and omissions of biomedicine, then such resistance is futile indeed.

However, I also say “no” to the question of “doing more” for two reasons. On the one hand, chaplains must explain the work that they *do* for the hospital; they must make a case for their existence within this system and on the care team. The place of chaplaincy is already precarious in a time of shrinking budgets. If spiritual care is to occur in the hospital, then chaplains must articulate their purpose, and presence is a valid mode of care that aligns chaplains with the ends of the care team while still registering a limited complaint against their perception of the omissions and coercions of this setting – even if this complaint is never quite honest about chaplains’ own complacency in these omissions and coercions.

I also say that chaplains are doing enough in their practice, because, by consistently being with people who are dying, they also experience death, and as a profession within the hospital, they bring this experience into the realm of the hospital in a way that resists the omission of this experience in the turn to acceptance. Wendy Cadge, in her sociological studies of chaplaincy departments, claims that by being the professionals who consistently accompany dying patients,

care for grieving families, and facilitate family viewings of deceased bodies, chaplains in fact “become a part of the trajectory of dying for individuals and participate in the ways hospitals manage death as institutions.”<sup>91</sup> But this is not just becoming part of the trajectory of death in the hospital. Chaplains also shape this trajectory directly through their *presence* before the death of the other. By naming presence as being without agenda, chaplains elide the fact that their practices are being co-opted into the wider trajectories of the hospital; however, by stressing being with the dying person, they also open themselves to experience death.

Here, I am making a distinction between what it is chaplains *do* from what chaplains *experience*. I have argued in this chapter that when chaplains name their *work* as the non-conditional acceptance of the dying person, they leave this work open to being co-opted by a system that obscures death. However, when chaplains sit with a dying person, and experience themselves as not pursuing an agenda, they also leave themselves open to an experience of death itself. It is this experience then, rather than the work of acceptance in the chaplain’s presence, that I argue in the following chapters is the more potent realm of resistance to or subversion of the biopolitical trajectory of the health care system.

### III. Conclusion

What does it mean to be confronted by dying? What does it look like when the experience of dying as it is, as an inevitable part of life, integrates into the medical system? Throughout the last two chapters, I have alluded to dying as a reality that the medical system, and chaplaincy with it, has yet fully to recognize or articulate, but, like the system itself, I have omitted an examination of the experience of dying as loss. Instead, I have traced the continued omission of this experience, first in the mechanical medicine that actually employs the lessons

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<sup>91</sup> Cadge, *Paging God*, 189.

learned from the cadaver and autopsy towards the treatment of the living. I then examined the prominent ideals of progress, empowerment, and consumerism as the foundations of modern medicine, which push medicine towards treatment at any cost, to the burden of those who are dying and of those who cannot afford to buy into this system. Finally, I examined the biopsychosociospiritual response to the trends of burdensome and futile treatment, noting how this turn both mitigates the trajectory of treatment at any cost within medicine but still omits the experience of death by casting an ideal of acceptance over it. In this way, medicine continues to cast its power over dying, trying to control it rather than actually accompany it and be confronted by it. Thus, these chapters have not actually looked squarely at the experience of dying. To name what I mean by confrontation with death's reality, and the ways this confrontation might actually work to change the biopolitical trajectory of modern health care, will require a more direct examination of the actual experience of the chaplain in death care. Such experience is the focus of the final chapters of this work.



## CHAPTER 6

### LOSS AS SUBVERSION: TRACING THE CHAPLAIN'S EXPERIENCE IN CARE

In the preceding chapter, I analyze and critique various descriptions of the *work* of the chaplains and death care. I note biopsychosociospiritual medicine's turn to the dying patient, pursuing comfort care and pressing toward an attitude of acceptance of death. I also analyze the notion of pastoral presence without agenda, simply the chaplain's being with and for the patient. In both cases, while I appreciate the care of dying patients in these movements, which works to challenge some of the ongoing excesses within biomedicine today, I nonetheless critique these movements as continuations of the medical pursuit to *treat* and therefore to *cast medical power over* death. Though the practices of biopsychosociospiritual medicine in general and chaplaincy in particular turn their attention towards the death of the patient, they do so to mitigate its loss, to pursue a moral vision of acceptance and completion in death, which turns attention away from death's loss.

In this chapter and the next, I therefore make a subtle shift from the *work* of the chaplain to the chaplain's *experience*. Though these two blend into one another in the room as the chaplain accompanies and cares for those who are sick and dying, I separate them here, not only for analysis, but also to argue for a change in how chaplains describe who they are and what they do. Broadly, the literature by chaplains has described how chaplains work with their patients, how they function with and care for sick, injured, and dying people, the methods and aims of chaplaincy. However, as noted above, descriptions of such work is not enough of a turn towards the loss of death, the loss that cannot be spoken as it thwarts the biopolitical push of progress,

commodification, and treatment. As noted above, death has no place in the biopolitics of life, at least not visibly. However, at the same time, death appears constantly in the hospital, unexpected but ever-present. Chaplains attend such deaths, witness and feel them. Chaplains thus *experience* the deaths of others. Such experience is key to who they are.

Thus, my argument in this chapter is simple: to bring the experience of loss more overtly into the discourses and practices of the hospital, chaplains, as the professionals in the hospital constantly with dying people, must include their experiences of dying people in their literature and their self-reflection. Yet this experience of dying people is more than simply viewing or accompanying those who are dying. My argument is rather that chaplains' experience of dying people is also a series of momentary and fluid moments of self-loss. In this chapter, I examine this loss on two levels. First, I examine this experience psychologically, employing the psychoanalytic theories of Sigmund Freud and Julia Kristeva; I then move to the phenomenology of community by Jean-Luc Nancy. Though I argue that each of these theories touch only limited facets of this experience rather than capturing it fully, nonetheless they allow chaplains to understand and articulate the loss inherent to being with someone who is dying, an experience that I argue is prevalent in chaplaincy, yet seldom included in the self-descriptions of chaplains.

Examining loss through these lenses offers an avenue towards an experience that is subversive to the biopolitical trajectory of modern health care, or rather, that expands this trajectory, moving it not only toward the politics of life but also the inclusion of loss and death. In the hospital, where life, the obfuscation of death, and the systematization of patients are the prevalent mode, an emphasis on chaplains' experiences of self-loss brings stories and memories of community and loss back into the self-understanding of the hospital, loosening the rigidity of its biopolitical structure and trajectory.

## I. Self-Loss and the Turn to Experience

The delineation between work and experience is subtle and in some ways false, for experience happens during and through the chaplain's work. By tracing the experience of loss through her care of a dying person, I do not name it as a simple or pure resistance. In fact, it is precisely in fulfilling her role as outlined by the care team that such experience for the chaplain is at all available, a role that I have argued above is very much working in the advance of health care biopolitics, whether acknowledged by the chaplain or not. Yet, within the chaplain's experience is also a subversion of this trajectory, one that I characterize as self-loss.

Contemporary religious studies scholar Kent Brintnall, working primarily in dialogue with 20<sup>th</sup> century French theorist Georges Bataille's theories, contrasts the *experience* of self-loss from the labor of work<sup>1</sup>: "Work, through subject-object relations, produces its own kind of violence. In order to avoid it, we must be shocked, shattered, and shaken up so we can, however fleetingly and imperfectly, have a brief moment of clarity about the intimate connection between self, other and world."<sup>2</sup> Brintnall is distinguishing the violence of taking another person or the experience of another as an object of one's labor from the violence done to one's self-conception in the moment of loss. For Brintnall, as for Bataille before him, self-loss is a momentary experience of the loss of identity through an especially jarring or poignant experience with another person. Self-loss is thus inherently violent, yet the violence done to the self that Brintnall is writing about is not the violence that leaves marks on the body. Rather, for Brintnall the experience of self-loss is more like a fleeting moment of rending one out of one's self, one's

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<sup>1</sup> The distinction between work and self-loss is a prevalent theme in Bataille's work. See, for example, Georges Bataille, *Inner Experience*, trans. Stuart Kendall (Albany, NY: State University of New York Press, 2014), 50-55; *On Nietzsche*, 33-34; "The College of Sociology," in Georges Bataille, *Visions of Excess Selected Writings, 1927-1939*, ed. Allan Stoekl, trans. Allan Stoekl, Carl R. Lovitt, and Donald M. Leslie Jr. (Minneapolis, MN: University of Minnesota Press, 1985), 250-252.

<sup>2</sup> Kent Brintnall, *Ecce Homo: The Male-Body-in-Pain as Redemptive Figure* (Chicago: University of Chicago Press, 2011), 16.

work, role, place in the structure and hierarchy. Self-loss is a moment that “breaks, shatters, and undoes the sense we have of ourselves as autonomous, separate, isolated, discontinuous individuals...with the anguished ecstasy that comes from non-sense and un-knowing.”<sup>3</sup> Self-loss is the momentary disruption of the biopolitical system by an experience of one being taken out of that system.

It is such a disruption because self-loss is the experience of that which goes unacknowledged in the politics of life: breakage, loss, death. The politics of life turns life into a project. It sustains a population; it pursues treatment and cure; it systematizes people. As noted in the third chapter, such work employs death only to ward it off, to cast its power over death’s sphere.<sup>4</sup> In Bataille’s words, “The project...*is putting existence off until later*...It is not to die but to be dead.”<sup>5</sup> By this, Bataille means that the labor of life delays existence, or at least those parts of existence that amount to loss, that work against loss in the name of treatment, healing, survival.<sup>6</sup> Thus, in a political situation where loss cannot be seen or heard, to *experience* loss is in itself subversive. It stops the on-sided pursuit of mastery over death. *It answers the politics of life with the reality of death.*

What can cause such a moment of self-loss, and what language can we use to describe or grasp at such a moment? The rest of this chapter is devoted to such fleeting moments in the experience of the chaplain before and with dying people. Though the chaplain remains separated from the suffering of those she cares for – both in physical proximity as well as through the

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<sup>3</sup> Brintnall, *Ecce Homo*, 21.

<sup>4</sup> Though such patterns may also lead to the death of individuals excluded from this trajectory, as noted in the fourth chapter.

<sup>5</sup> Bataille, *Inner Experience*, 51.

<sup>6</sup> For Bataille, self-loss coincides with a mutual relationship with the other. Such a relationship, when it is truly being-with another rather than self-protection, is inevitably the movement of loss by merger with the other. One loses oneself in being-with the other: “Two beings are lost in a convulsion that binds them together. But they only communicate when losing a part of themselves. Communication ties them together with wounds, where their unity and integrity dissipates in fever.” “The College of Sociology,” 250.

innumerable channels of power that separate the patient from the chaplain – I argue that the chaplain also loses herself in the dying other, or rather in the community of dying and dead others for whom the chaplain cares. Such loss is always partial and fleeting, but nonetheless it is an aspect of our experience, a moment of self-loss in contrast to the steady progress of biopolitics that denies or covers over death with therapeutic imperatives.

## II. The Chaplain's Self-Loss via Freud and Kristeva

The death that I felt the most happened during my summer CPE internship a year before my residency. In fact I still feel it. Something seems caught in my throat every time I talk about it. Even as I write now, I feel the familiar soreness, the inability to swallow, like I am still holding back the tears that came that night years ago. I had been on call and in house for the night, a shift that I worked weekly that summer just as I did later in the residency, and it had already been a tough evening, with long hours sitting up with distraught family members as emergency surgery was performed on their loved ones. Around 11:00 that night, a two-year-old came into the trauma room. A pediatric case was rare for that hospital, because, though it had a small children's wing, much larger children's hospitals in nearby cities were usually responsible for trauma calls involving young patients. But this call originally seemed pedestrian enough; the child had been hit by a car backing out of her driveway, hit hard but not run over, and she entered our emergency department crying at the top of her lungs, which everyone took to be a good sign. In fact, I remember, as I stood by the trauma room door during initial examination, an EMS worker assured the child's mother: "Look, she's crying out. She's just scared. It will be alright." But during the examination in the trauma room, the toddler grew more and more lethargic, her crying hushed – a sign of internal trauma – and before I knew it, her physicians

were rushing her off to surgery. I remember looking at the child as her bed rolled past me out of the trauma room. Her bruised body was quiet, still.

Why does this case affect me in a way like no other before or since? Did I absorb the young parents' anxiety, waiting with them for an hour during the surgery in distraught silence? Or, at the beginning of my time as a chaplain, had I not learned to set the necessary defenses and boundaries from the pain all around me? Was there something especially poignant about seeing the death of a child for the first time in contrast to all the other deaths of adults I had witnessed before? I remember, the parents were *so* scared during the ultimately failed surgery, shaking, crying, angry. Later, after I had heard the child died on the operating table after having left the family momentarily for the office, I walked with the doctor, a few nurses, and security back into a private waiting room. I stood beside this young surgeon as his voice broke telling the parents that their daughter was dead, and then watched as the parents fell apart, actually falling down onto the floor, screaming into the carpet while other family members tried to hold them. Moments later, we moved together to see the toddler, her body lying on her stomach atop an infant-sized gurney, draped in a blue sheet, her head exposed, eyes closed. Somehow she looked younger in death than she looked in life, like a battered, sleeping baby. Again, her parents fell to the ground, while I and the nursing staff sat down with them on the floor, rubbing their backs, offering tissues. Many of the staff were crying themselves. My tears would come too, but only later. I cried throughout the morning briefing with the pastoral care staff the next day. That death was almost a decade ago now, and I have seen many more deaths since then, but this one still comes back to me. It has accompanied me. It was the worst.

Chaplains experience loss constantly in the hospital, so much so that other staff often associate spiritual care and chaplains solely with accompaniment of dying patients and the

bereaved. In fact, Wendy Cadge notes that in her sociological studies of chaplaincy departments, though she never directly asked about death, staff members would often just assume that her work was focused on death care.<sup>7</sup> Though chaplains must guard themselves against extreme feelings of loss, such that they are not overcome or haunted to the extent that I describe above, they nonetheless experience death in their accompaniment of the dying.<sup>8</sup> In this section and the next, I differentiate this experience on two levels: the psychological and the phenomenological. Explorations of the former, via the theories of psychoanalysis, elucidate how the chaplain experiences the death of another person as a moment of self-loss. Such an exploration is necessary, because chaplaincy has often employed the theories of psychology, as noted above in my analysis of the roots of humanistic psychology in current chaplaincy practice; however, chaplains use these theories more to explain their work rather than to articulate their experience. To bring the experience of death into the hospital, it is necessary to know the experience of death as it touches into the depths of the chaplain's psyche, an experience that I argue is that of psychological self-loss, a terrible but also releasing form of dissolution.

My focus in this section is on Kristeva's expansions of Freud's various treatments of death and loss. A key psychoanalytical insight beginning with Freud is the psyche is driven toward death on an unconscious level. While Freud does not connect the death drive directly to loss or the sight of death, Kristeva unites these, speaking directly to the psychic shattering in the face of death, which connects to psychological desires for release spanning from the early losses

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<sup>7</sup> Cadge, *Paging God*, 173. For more on staff emphasis on chaplains' association with death care, see Wendy Cadge, Katherine Calle, and Jennifer Dillinger, "What Do Chaplains Contribute to Large Academic Hospitals?" and Simon J. Craddock Lee, "In a Secular Spirit: Strategies of Clinical Pastoral Education," 350.

<sup>8</sup> Pastoral theologian and former hospice chaplain Philip Browning Helsel in fact warns that the boundaries chaplains erect can also cause repression of the grief they experience in death care, leading to burnout: "It is my contention that a chaplain's chronic grief, including its physical manifestations, is sometimes repressed in order to keep going in the difficult work. This form of forgetting the need to grieve may eventually crystallize into various forms of burnout in the life of the chaplain." "In Memoriam: The Disenfranchised Grief of Chaplains and the Recovery of Memory," *The Journal of Pastoral Care and Counseling* 62, no. 4 (2008): 338.

of childhood.<sup>9</sup> By naming an experience as “shattering,” I echo another contemporary Freudian writer, Leo Bersani, who employs the term to describe the experience of self-loss described by Bataille. According to Bersani, shattering is the “break[ing] down of barriers that define individual organisms and keep them separate from one another.”<sup>10</sup> It is thus a momentary loss of identity on a psychological level in the midst of a poignant or extreme experience with another. I also use the term “collapse” below to designate the same phenomenon. In what follows, I employ Kristeva’s theories because they illuminate how the loss of the other also resonates in and shatters our own sense of self. With Kristeva’s theories, we can see how the chaplain does not simply look at loss, like a dispassionate viewer. Rather, death resonates with longings already in the chaplain. The chaplain feels a sense of shattering that is also a taste of self-loss in the midst of the death of the other.

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<sup>9</sup> The self-psychology of Heinz Kohut too holds a revised notion of the death drive, though the primary difference between Freudian/Kristevan and Kohutian descriptions of the drive is that self-psychology describes the drive towards shattering only in pathological terms. For Kohut, any death anxiety or drive towards disintegration is the expression of a self poorly formed around insufficient self-objects: “Much as these fears might occupy the patient’s mind, however, leading to states of endless brooding, worry, or panic, these fears do not constitute the core of the disturbance, but have generated as the result of the patient’s attempt to give a circumscribed content to a deeper unnamable dread experienced when a person feels that his self is becoming seriously enfeebled or is disintegrating.” *The Restoration of the Self* (Chicago: University of Chicago Press, 1977), 105. On other occasions, Kohut revises the death drive in terms of a non-pathological self by denying its threat of psychological shattering, saying that a self properly supported in an affirming self-object environment will experience its death or the death of others as a fulfillment. As he states in a later work: “The human death can be and, I will affirm, should be an experience that, however deeply melancholic, is comparable to a fulfilled parting – it should have no significant admixture of disintegration anxiety.” *How Does Analysis Cure?*, eds. Arnold Goldberg and Paul Stepansky (Chicago: University of Chicago Press, 1984), 18. I thus employ Freudian rather than Kohutian theory at this point because the drive towards breakage speaks more to the chaplain’s everyday feeling of self-loss in the midst of accompanying dying people, which I would argue is a non-pathological form of stoppage in the midst of extreme and continual loss, no matter the strength of the self. Moreover, Kohut’s fulfillment model, which elides shattering altogether also misses the stoppage characteristic of shattering, a stoppage I argue is key to subverting the unrelenting politics of life in biopolitics.

<sup>10</sup> Leo Bersani, “Is the Rectum a Grave?” *October* 43 (1987), 218, n. 25.



## A. Psychological Self-Loss

What do the tears of the chaplain, the chaplain's speechlessness, her feeling of collapse in the midst of loss refer to psychologically? Why do we sometimes experience the death of the other as an experience of shattering, as a loss of ourselves? Why must we guard against feeling the loss totally, lest we lose ourselves in the midst of accompanying dying people every day? These questions point to our psychological response to and experience of death, why we are drawn towards its collapse, and how we guard against it.

In the classic psychoanalytic theory of Freud, death and desire are always close together, intertwined, merging, and separating. Writing in the aftermath of the First World War and in the lead up to the Second, Freud theorizes that humans must hold a fundamental thirst for death and destruction, both that of their enemies but also that of their own. Freud's notorious<sup>11</sup> theory of the "death drive" first appeared in his book *Beyond the Pleasure Principle* in 1922, where he theorized from his patients' continued compulsion to repeat harmful episodes of their lives a psychic drive to self-destruction.<sup>12</sup> The death drive was thus a late development for Freud, who had been tracing various iterations of the libido or Eros drive for decades prior.<sup>13</sup> Partly in response to the pure aggression and violence that he saw in the wars of his own time, Freud further theorized that the drive to self-destruction can be pointed outward, becoming aggression

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<sup>11</sup> An overview of the controversies among Freud's contemporary psychoanalysts regarding the death drive can be found in Peter Gay, *Freud: A Life for our Time* (New York: W.W. Norton, 2006), 403, 416, 552. Lucy Bregman notes the almost complete absence of death drive theory development amongst American psychoanalysis since Freud in "The Death Awareness Movement: Psychology as Religion?" in *Religion and Psychology: Mapping the Terrain, Contemporary Dialogues, Future Prospects*, eds. Daine Jonte-Pace and William B. Parsons (New York: Routledge, 2001), 323. Thus my turn to the Kristevan model.

<sup>12</sup> Sigmund Freud, *Beyond the Pleasure Principle*, trans. James Strachey (New York: W.W. Norton, 1961), 18-25.

<sup>13</sup> Freud recounts the history of drive development in the *New Introductory Lectures on Psycho-Analysis*, trans. James Strachey (New York: W.W. Norton and Company, 1965), 128-30.

and sadism.<sup>14</sup> On the one hand, for Freud the urge towards death is simply for the pleasure and release of death; it is “*an urge inherent in organic life to restore an earlier state of things,*” enlivened material returning back to lifelessness.<sup>15</sup> Just as libido in Freud’s theory sought to release the tension of the sexual urge, so too did the death drive seek release from the tensions of life itself.<sup>16</sup> But at other points in Freud’s theory, the death drive is less about the pleasure of dissolution; rather, it appears more as guilt, self-berating, self-censorship, the very opposite of pleasure. This is most strongly stated in Freud’s *Civilization and its Discontents*, where he theorized that human beings redirect their sadism “back from where it came from,” meaning the death drive, once directed outward from the self, comes back onto the ego in the form of guilt after one assumes society’s order, including its prohibitions.<sup>17</sup>

Thus, death takes a central place in Freud’s theory, as a complex psychological drive towards death. Freud’s theory helps us conceive and articulate our ambivalence towards death, the pleasure of its release from the physical and psychological pains of life contrasted – yet also aligned – with the guilt and fear we feel towards it. But what does this have to do with loss, with the experience of the death of another? To answer this question, the contemporary psychoanalytic theorist Julia Kristeva links Freud’s later theories of the death drive to his 1915 essay “Mourning and Melancholia.” In this essay, Freud contrasts two responses to loss: (1) mourning is the usual withdrawal of psychological investment or libido from a person or “object” (Freud’s term for the psychic representation of the person who was lost) while (2) in

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<sup>14</sup> In his *Reflections on War and Death* (New York: Moffat, Yard, and Company, 1918), Freud goes on to say that war reveals that “if we are to be judged by our unconscious wishes, we ourselves are nothing but a band of murderers” (p. 64-65).

<sup>15</sup> Freud, *Beyond the Pleasure Principle*, 43. Italics are original.

<sup>16</sup> *Ibid.*, 76. As Freud puts it in his *New Introductory Lectures*: “An instinct [or drive], then, is distinguished from a stimulus by the fact that it arises from sources of stimulation within the body...Its source is a state of excitation in the body, its aim is the removal of that excitation; on its path from its source to its aim the instinct becomes operative psychically” (p. 120).

<sup>17</sup> Sigmund Freud, *Civilization and its Discontents*, trans. Joan Riviere (Mansfield Centre, CT: Martino Publishing, 2010), 105.

melancholia, often due to the ambivalence of the loss – meaning that the loss is not as apparent or one holds mixed feelings about it – the ego does not release the object but rather internalizes it into the ego itself.<sup>18</sup> This internalization also means attaching the ambivalent feelings one holds towards the object onto oneself. Thus, for Freud melancholia is often displayed through “painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self reproaches and self-revilings” because the ego has now turned the negative feelings once held toward the object onto the self, negative feelings that are heightened by the loss itself.<sup>19</sup> In this way, Freud’s early theory of melancholia, which like the death drive is expressed as negativity and self-reproach, mirrors his later theories about death, yet here the psychological movement against the self is directly related to loss.

Kristeva expands upon “Mourning and Melancholia,” incorporating it more directly with Freud’s theories of death in her 1989 work *Black Sun*. The theory that she develops here elucidates the connection between experiencing death, for instance the experience of the hospital chaplain accompanying dying patients, and the threat and promise of self-loss. For Kristeva, the original melancholy in psychic life spans from the infant’s loss of the mother.<sup>20</sup> Originally, mother and child co-exist in a psychic merger for the infant, who is not yet a separate subject on the psychological level and therefore cannot tell her own body from the mother. This bond is broken however when the child assumes language, which implies separation, knowing oneself as

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<sup>18</sup> Sigmund Freud, “Mourning and Melancholia,” in *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. XIV*, trans. and ed. James Strachey (London: The Hogarth Press, 1957), 245.

<sup>19</sup> *Ibid.*, 244.

<sup>20</sup> Note Freud does not mention the loss of the mother during the Oedipal crisis in his original formulation of melancholia, though like Kristeva other theorists have read the essay through his early formulations of this developmental step. See, for example, Donald Capps, *Men and their Religion: Honor, Hope, and Humor* (Harrisburg, PA: Trinity Press International, 2002). Following this trend, I expand on much of the pastoral theological theories of melancholy and religious development in a recent article. See Richard Coble, “‘You Try to Control Me’: Yearning, Separation, and Protest in Teenage Male Spirituality.” *Journal of Childhood and Religion* 6, no. 1 (2015).

subject and referring to others as objects,<sup>21</sup> yet for the melancholic this break is never final. Rather, in melancholia, a condition that Kristeva describes as a common condition,<sup>22</sup> the psyche continues to long for a lost “Thing,” a connection that is not representable to the psyche because it precedes all language and images. Yet an unspecified longing for the “Thing” nonetheless lingers, a longing for fullness and connection.<sup>23</sup>

As longing, melancholia is akin to the death drive, pulling the psyche down towards a union that also means the unraveling of the psyche built around language. Melancholia is a longing for a connective state of being, which is in contrast to the separation inherent to the language around which the mind of the individuated subject is formed.<sup>24</sup> If the assumption of language is the loss of the mother-bond, then melancholia is the rejection of that which broke that bond. In Kristeva’s words, “‘I have lost an essential object that happens to be, in the final analysis, my mother’ is what the speaking being seems to be saying... Depressed persons, on the contrary, *disavow the negation*: they cancel it, suspend it, and nostalgically fall back on the real object (The Thing) of their loss.”<sup>25</sup> Thus, the melancholic refuses the full assumption of symbolic

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<sup>21</sup> See Julia Kristeva, *Revolution in Poetic Language*, trans. Margaret Waller (New York: Columbia University Press, 1984), 43. In the Lacanian theory that Kristeva is drawing on here, the break with the mother through language is the same as realizing the mother’s castration. For Lacan, the realization of the mother’s lack, meaning the lack of fullness one finds in her bond, which is tantamount to castration, is both mediated by as well as the beginning of one’s assumption into the phallogocentric symbolic. Jacques Lacan, “The Meaning of the Phallus,” in *Feminine Sexuality: Jacques Lacan and the école freudienne*, eds. Juliet Mitchell and Jacqueline Rose, trans. Jacqueline Rose (New York: W.W. Norton, 1985).

<sup>22</sup> In *Revolution in Poetic Language*, Kristeva posits that remnants of the affective bond between mother and child always refuse translation, remaining a “semiotic” connection between language and the bodily affect spanning from connection to the mother (p. 51). At times in Julia Kristeva, *Black Sun: Depression and Melancholia*, trans. Leon S. Roudiez (New York: Columbia University Press, 1989), Kristeva directly relates melancholia with clinical depression (p. 10-11); however, more broadly, in the Lacanian system from which Kristeva is drawing, mastery of language is always an impossibility. Any assumed mastery, in fact, is an imaginary sense of fullness like that which is understood to be lost when the connection with the mother is severed. Thus, as Jane Gallop puts it, one does not assume the symbolic via mastery of it. Rather, “The symbolic can be reached only by not trying to avoid the imaginary, by knowingly being *in the imaginary*.” *Reading Lacan* (Ithaca, NY: Cornell University Press, 1987), 60. In other words, one only assumes language when one realizes the translation into language and mastery of it is never complete.

<sup>23</sup> Kristeva, *Black Sun*, 13.

<sup>24</sup> *Ibid.*, 15.

<sup>25</sup> *Ibid.*, 43-44.

language. She holds onto words more loosely, feeling an overwhelming longing behind and independent from them. In fact, for the melancholic, suffering itself is a substitute for psychic collapse. The affect functions like an object, a psychical holding place, a final effort against following the longing all the way down to the dissolution of language and meaning.<sup>26</sup>

Thus, in her theory of melancholia, Kristeva unites Freud's theories of melancholia and the death drive, noting both the temptation as well as the dangers of dissolution. Moreover, the death towards which the psyche drives is not simply, as Freud put it, the return of the organic to the inorganic, but rather it is a longing for a lost fullness, a lost bond. Because of this development, Kristeva also goes further than Freud's stoic resignation to the reality of death, stated most strongly in *The Future of an Illusion*, where he recommends acquiescence to the cruelties of nature and death in comparison to religious wish-fulfillment.<sup>27</sup> Rather than resignation, Kristeva explains that the melancholic holds a more complex relationship to death. It is loss, but in its symbolic form, it also becomes, like suffering itself, the representation of the lost "Thing," a place to center one's longing for connection and the release of dissolution.<sup>28</sup> In this way, *representations of death* become ways to hold self-loss within life itself, to incorporate loss as a central part of life. As I will argue at the close of this section, this holding of loss itself is also subversive of biopolitics that can only speak of life, obscuring death.

Kristeva finds a connection to melancholic longing most pointedly in artistic representations that point to death, which she names "semiotic" rather than symbolic, meaning

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<sup>26</sup> Ibid., 19.

<sup>27</sup> Sigmund Freud, *The Future of an Illusion*, trans. by James Strachey (New York: W.W. Norton, 1961), 43-50.

<sup>28</sup> It is Kristeva's emphasis of the longing for connection and fullness at the root of the death drive towards shattering that separates her theory from that found in Leo Bersani, "Is the Rectum a Grave?" Though Bersani's emphasis on self-shattering at the end of this article itself spans from a sexual connection, it is ultimately non-relational. For Bersani, sex itself is primarily non-relational: "As soon as persons are posited, the war begins" (p. 218). Therefore, the self-shattering brought on by rectal penetration that Bersani theorizes at the end is also decidedly anti-social. Though anti-social shattering is also promising as a theory against the biopolitics of life, chaplaincy's own emphasis of care and connection makes Kristeva's theories of melancholia more pertinent.

that they establish a connection between affective longing for dissolution and the signs of representation.<sup>29</sup> A representation is semiotic when it resonates with this longing; it connects to affect deeper than words.<sup>30</sup> Kristeva finds a stark example of semiotic representation in Hans Holbein the Younger's work "The Body of The Dead Christ in the Tomb." In this Renaissance painting, created during a time of rising humanistic disillusion with religious doctrine, Holbein depicted the corpse of Jesus alone in his tomb. As Kristeva describes the painting, "The tombstone weighs down on the upper portion of the painting, which is merely twelve inches high, and intensifies the feeling of permanent death: this corpse shall never rise again."<sup>31</sup> Holbein's painting speaks to death's stark reality and finality, depicting a dead Christ who does not rise to new life. It is a depiction of death that addresses *only* death's loss, rejecting any promises of gain or fulfillment. As such, the painting jars and resonates with our desire for dissolution, our desire for release from the meaningful, individuated world of symbols that turn us into subjects and objects.<sup>32</sup> It points to the connection that we long for in the dissolution of language.

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<sup>29</sup> Both here and below, by "sign" I simply mean, as the dictionary defines it, "an object, quality, or event whose presence or occurrence indicates the probable presence or occurrence of something else." For example, a word is a sign indicating the presence of the thing it signifies. Elizabeth J. Jewell and Frank Abate, eds. *The New Oxford American Dictionary* (New York: Oxford University Press, 2001), 1587.

<sup>30</sup> See Kristeva, *Black Sun*, 24. As symbols, semiotic representations are not simply translations of longing into words and pictures. Whereas symbolic representation leaves the mother behind for the new logic of the symbolic, the semiotic offers an affective bridge between the two modes.

<sup>31</sup> Kristeva, *Black Sun*, 110.

<sup>32</sup> At one time, according to Kristeva, religious art, specifically Christian art, served as psychological aids to mourning the loss of fullness in the mother and the adoption of language. See Julia Kristeva, *In the Beginning was Love: Psychoanalysis and Faith*, trans. Arthur Goldhammer (New York: Columbia University Press, 1987), 37-44. Christ's passion followed immediately by the resurrection was a religious symbolization that mirrored the severance with the mother, becoming risen new life in the world of subjects and objects (p. 134-135). Yet, Kristeva argues that the religious symbol system in the West has ceased to carry the same psychological weight as in prior ages, and thus, without this aid, as religious scholar Diane Jonte-Pace has pointed out, melancholia has become almost universal. Diane Jonte-Pace, "Julia Kristeva and the Psychoanalytic Study of Religion: Re-reading 'Mourning and Melancholia,'" in *Changing the Scientific Study of Religion: Beyond Freud? Theoretical, Empirical and Clinical Studies from Psychoanalytic Perspectives*, ed. Jacob A. Belzen (New York: Springer, 2009), 304. See also Grace M. Jantzen, "Birth and the Powers of Horror: Julia Kristeva on Gender, Religion, and Death," in *Rethinking Philosophy of Religion: Approaches from Continental Philosophy*, ed. Philip Goodchild (New York: Fordham University Press, 2002).

Rather than simply a symbol of our stoicism before death,<sup>33</sup> “The Dead Christ” then speaks for Kristeva to a melancholic desire, the death drive, longing for a fullness and loss that dissolves words and meanings, spelling death. But it also allows us to touch this longing semiotically while also in life. As Kristeva puts it, Holbein’s work “invite[s] us to change the Christly tomb into a living tomb, to participate in the painted death and thus include it in our own life, in order to live with it and make it live.”<sup>34</sup> It thus resonates with the melancholic’s longing for a fullness that also means death, yet this resonance itself also wards off psychological death, or rather, it creates a bridge between the living world of signs and the rhythmic, affective space of the drive. In artistic renderings of death, the melancholic finally sees a representation of her desire in the world of signs. The semiotic representation is a sign that stands for and resonates in the longing that she has felt all along. The yearning for connection that also means dissolution is represented before her in the image of the dead Christ. In this way, “The Dead Christ” for Kristeva is a connection to self-loss that nonetheless keeps the melancholic within the world of signs.

#### B. Self-Loss in Chaplaincy Experience: Implications and Limits of Psychoanalytic Theory

After the dead Christ, what other representations of loss represent for us the longing and the threat we feel towards collapse? Whereas Kristeva primarily employs art and literature as an avenue to illuminate lived experiences of loss and longing in *Black Sun*, my own experiences with such shattering have happened much more in the midst of being with patients as they die. As I was with that dying and dead child and those collapsing parents years ago, I felt strongly a wave of emotion in the face of death that shattered the professional and social boundaries I had

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<sup>33</sup> Though at times, Kristeva proffers a similar stoicism before death as Freud: “To be swallowed up by death, or perhaps to see it in its slightest, dreadful beauty, as the limit inherent in life.” *Black Sun*, 137-138.

<sup>34</sup> *Ibid.*, 113.

erected to protect myself and my identity as a hospital chaplain and caregiver. Chaplains feel a similar pull towards shattering in the midst of death, especially when we let our guard down, when we step out of our roles and boundaries and experience death as the loss of another human being. We experience in our relationship with the dying other our own pull towards dissolution, a threat of collapse that speaks to the very foundations of the psyche.

Chaplains feel fleeting moments of shattering as they are before the face of death in their care of others, though this experience is often only on the periphery of the literature, a supplement to chaplains' descriptions of their work with patients. For example, in a vignette describing his conversations with a palliative care patient he calls "Daniel," Steve Nolan remarks on the feelings that he experienced in being with Daniel as he came to the realization that he was dying: "As he told me that he felt the drugs weren't working and as he said, without saying, that he knew he was dying, something touched me with the presence of the dying he was living... While I was with him, I began to touch some of his scared-ness, and the longer we were together the more I seemed to feel his scared-ness."<sup>35</sup> "Scared-ness" is an awkward and vague description. Nolan does not elaborate, and he employs his work with Daniel to speak of the chaplain's sense of hope that moves past the denial of death. But perhaps "scared-ness" is a place-holder for Nolan for an unnamable feeling, pointing to the dread, release, and shattering that one feels as the drive to dissolution, a shattering that the chaplain feels inside her own life as she accompanies one moving towards death. In another instance, Robert Dykstra speaks of his experience as a chaplain on a trauma response team as moments of self-loss: "When I am called, for instance, by the emergency room staff to be with a person facing a sudden loss of a loved one, I often experience...somatic tension; a sense of unreality, floating, or the slowing down of time; guilt...All of these are common companions of mine and of many other hospital chaplains

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<sup>35</sup> Nolan, *Spiritual Care at the End of Life*, 22.



I know.”<sup>36</sup> Dykstra points to the pull to self-loss as a constant threat accompanying the hospital chaplain.

Yet, on the same page, Dykstra employs this self-loss towards a reflective theological understanding and rationale for the hospital chaplain’s presence on the care team:

Yes, verities are lost in traumatic crisis situations, but the theological gift that the chaplain receives in them is to be found precisely in the lost verities. That is to say, in coming as a stranger to strangers in a situation of strangeness, the chaplain can find orientation in the knowledge that he or she stands in a firm tradition that has continuously acknowledged the God-bearing power of strangeness itself.<sup>37</sup>

Chaplains consistently feel the drive to self-loss in the midst of dying people. Yet, often, when moments of self-loss are described in the literature, the experience is sidelined, becoming a step towards a more robust emphasis on their work with dying people.

I am not critiquing chaplains for the necessary task of explaining and improving upon their work, nor is it wrong to employ the experience of self-loss in these explanations. I have done so in my own writing.<sup>38</sup> However, such utilizations of the experience also betray self-loss. On its most basic level, the loss of self refuses to become a tool of chaplaincy or of care. Any translation of the experience of loss into the work and best practices of death care turns the fleeting sense of dissolution into a device or instrument, something else other than the shattering of professionalism and the momentary loss of identity that is self-loss. When employed to justify or elucidate the *work* rather than the *experience* of the chaplain, loss itself becomes another tool, a gain rather than a loss.

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<sup>36</sup> Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” 152.

<sup>37</sup> Ibid.

<sup>38</sup> See Richard Coble, “Recognition and the Fleeting Glimpse of Intimacy: Tracing the Chaplain’s Response to Ungrieved Death,” *Journal of Pastoral Care and Counseling* 60, no. 1 (2015).

Chaplains feel such moments of breakage as we walk with people moving towards death. We move with them, not following them into death ourselves, but peering into that void with them, however partially. As chaplains, we feel death in the midst of our lives, resonating in a movement towards dissolution. In part, my falling apart on the morning after that death years ago was a brief moment of release. It was the letting go of tension, the strains of having to be a chaplain, a care-giver, a student, a co-worker in a place where appalling things happen like the death of children. Of course, tears are not death. I soon left the hospital, recuperating my composure, and I returned to work the next day. But, did being with that broken child and family not also shatter something within me, even momentarily? The night certainly jarred me out of the confines and snares of professionalism, the medical hierarchy, the powers of biomedicine and biopolitics, if only for a moment. As chaplains experience such moments, the accompaniment of the dying is littered with partial, fleeting moments of self-loss, an experience of forfeiture and release that may rightly be called a death drive. Psychoanalysis thus points to a way to name the experience of death in a place where death is increasingly unnamable. It theorizes an experience of self-loss within life, a direction counter to a biopolitics of life that insists on either denying death or obscuring it with assessments and ideals.

Kristeva's theory provides a rich understanding of experiences of loss, both the constitutive losses of psychic development as well as the moments of self-loss before the dying other. Chaplains reading, understanding, and employing her theory in their own reflections will have a chance to acknowledge, rather than repress, the losses of their own lives, and will therefore be able to face moments of self-loss by a patient's deathbed without turning away from its momentarily shattering effects. At the same time, however, because Kristeva's theory is meant to deepen the understanding of our own psychic lives, especially as we come to terms with

loss and death, I find that a full understanding of self-loss in chaplaincy also needs to be complemented with the phenomenology of Nancy for two reasons: First, because Kristeva focuses on the psychic life of the individual, her theory does not prioritize shared experiences of loss, or what I will call in the coming section and the next chapter, communities of loss. Her focus is on the psychic life of the individual in *Black Sun*, and therefore we also need a theory about how the experience of loss is shared between people, how death is shared between the dying patient, family, and chaplain. Second, because Kristeva is focused on the individual's psychic life, she necessarily must look to foundational losses, such as the loss of connection with the mother, to understand an individual's present experience of loss before the sight of death. However, because my aim is to theorize the chaplain's direct experience within the hospital room, I believe Kristeva's psychoanalysis also needs to be supplemented with a theory that speaks directly and only to the experience of loss, without recourse to ideas of psychological development. Kristeva's theories are important avenues into the experiences of chaplains, especially in understanding why certain losses, such as the one I describe above, seem to shake us to our core, shattering us while touching us deeply in our desires and our fears. But, there also must be a way to talk about death and self-loss and to talk only of *this* death, this one right here, in the room, the dying person who is in front of or with me and no other. With these issues in mind, I turn to phenomenology.

### III. Jean-Luc Nancy, Being-with, and Self-loss as the Exposition of Finitude

Since that child's death years ago, I have learned to distance myself in the midst of the death of others, to set the necessary boundaries. Yet such distance does not mean that the death of others does not touch me at all. Rather, instead of being affected by a single death in such a

shattering way, now in moments of being with dying people, I often find myself touched, not only in a singular way, but also and increasingly these days, every death is the occasion for me to remember many other dying people. The darkened ICU rooms, the brightened trauma centers that remain the settings of death are also reminders for me of many other broken or faltering bodies, many other fading people, many other grieving families.

Just a few weeks before writing this chapter, in fact the same day that I met the woman doubting her salvation in the opening vignette to the fourth chapter, I saw another child die, or rather, watched the doctors determine that CPR was of no avail to a child who had come to our hospital dead on arrival. This boy was younger, less than a year old, his body already blue when he entered our hospital, having been killed instantly in a violent motor vehicle accident. Yet, even though they happened years apart, I could not help but remember and connect this child's death to the one I describe in the preceding section. In the moments of care with his grieving family and for days afterward, I held memories of both children in my mind as acute visions of life's precariousness – children with their entire lives before them, both struck down by vehicles driven by absent minded drivers.

Just a month before the day that second child died, I stood beside a man maybe ten years older than me as a respiratory therapist removed the vent from his partner, also a young man, but one whose youthful image had been sapped by metastasized lung cancer. The dying man had looked almost already dead, eyes closed and still, except for the machine pumping air through his neck and into his lungs, which caused his body to stir abruptly in a rhythmic, mechanical fashion. Yet, when the trach tube was finally removed from his throat, the dying man's eyes and his mouth both opened suddenly, like he was struggling for breath just for a moment, before he resumed his prior, sleeping posture and drifted off to death. Again, I was reminded of so many

similar deaths, watching death come after life support was finally deemed futile and dying bodies were allowed to die. One memory stood out poignantly, one of the first deaths I ever saw, that of the wizened treasurer in a church where I had worked as a youth minister in college. I thought about watching her too slide gently into death in a darkened hospital room, as I stood beside this man, his partner, and their cumulative loss.

My self, these memories, these dying people, together we are a type of community, a community of people meeting in the face of life's limitations, together in our collective experiences of finitude. In this section, I examine chaplains' constant exposure to and accompaniment of dying people through the lens of community as theorized by the contemporary French phenomenologist Jean-Luc Nancy. I do this because Nancy, unlike Kristeva and psychoanalysis, seeks to examine the experience of self-loss in its immediacy, without recourse to theories of the unconscious or prior loss hidden in the psyche. Nancy's project is a continuation and modification of the German philosopher Martin Heidegger's perennial work *Being and Time*. A full examination of Heidegger's project is outside the scope and possibilities of this chapter. Stated broadly, he sought to grasp Being free of any metaphysical presuppositions, from the point of view of that which is interested in the question of Being: Dasein (being-there), the immediacy of existence.<sup>39</sup> I also turn to Nancy, because, continuing in this philosophical tradition, he seeks to articulate, or rather, as he puts it, "touch"

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<sup>39</sup> See Steven Shakespeare, *Derrida and Theology* (New York: T&T Clark, 2009), 86. However, this does not mean understanding Dasein free of its entanglements with the world. Existence is already given in such entanglements. Thus, the phenomenological project lies in seeking to grasp being in its immediacy, always already given as entangled and therefore never its own foundation. In fact, for Heidegger the phenomenological project is to grasp or own one's being in its foundationless, entangled immediacy: "Ownness...is not an extraordinary or exceptional way of living that would set me apart from everyone else. Rather, it is making my own the fact that I am not the ground of my existence, my world, my possibilities. In other words, ownness consists of nothing more than merely existing as I already am, that is, exposed to limits that are not at my disposal: birth, death, world." Marie-Eve Morin, *Jean-Luc Nancy* (Malden, MA: Polity Press, 2012), 22-24, 25.

the immediate experience of *community* where death is a constant reality.<sup>40</sup> Nancy's square focus on the immediacy of the experience of community as one constantly revealing life's end and finitude illuminates the chaplain's experience of regularly being with sick and injured people and thus being exposed to death. His theories help to articulate what community is for the chaplain, and how the chaplain's experience of community reveals patterns of life and death that are obscured in the biopolitics of the hospital.

#### A. Nancy on Community

To understand what Nancy means by the experience of community, and its link to death, it is helpful to contrast this experience with the notion of community as an "essence."<sup>41</sup> Community as essence is a higher ideal to which its subjects give themselves, their service, even their lives at times of war. The state, the market, or the people are various iterations of community envisioned as essence.<sup>42</sup> It is a collectivity, the sum that is greater than its parts. For Nancy, this view of community is both politically and philosophically damaging. Politically, community as essence is akin to the biopolitics of immunity theorized by Roberto Esposito. The political body that subsumes and objectifies its subjects will ultimately also divide them, deciding on healthy and pathological forms of life and dispelling sick elements or treating others

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<sup>40</sup> "Touch" is something that happens in the acts of writing and reading for Nancy. Signification is always necessarily one step removed from experience. Words name the body but fail to capture the experience of the body, but in writing and reading (in contrast to the words written in themselves) a touch of experience is possible. We cannot capture the experience; we can only experience the experience via the touch of writing. In Nancy's words, "It doesn't happen exactly in writing... But along the border, at the limit, the tip, the furthest edge of writing nothing but that [touch] happens." Jean-Luc Nancy, *Corpus*, trans. Richard A. Rand (New York: Fordham University Press, 2008), 11. As Nancy states his project a few pages earlier: "How, then, are we to touch upon the body, rather than signify it or make it signify" (p. 9).

<sup>41</sup> Jean-Luc Nancy, *The Inoperative Community*, ed. Peter Connor, trans. Peter Connor et al (Minneapolis, MN: University of Minnesota Press, 1991), 3.

<sup>42</sup> See Timothy C. Campbell, *Improper Life: Technology and Biopolitics from Heidegger to Agamben* (Minneapolis, MN: University of Minnesota Press, 2011) for a history and overview of the on-going controversies in biopolitical theory concerning the possibilities of community and their connection to life deemed pure and impure.

like instruments of its own use rather than subjects<sup>43</sup>: “If one’s ‘true’ or ‘higher’ or ‘more universal’ self is found in a shared communal identity, it becomes the work of politics to acknowledge and bring forth that immanent communal identity. This will entail the assertion and purification of the community, and hence involve conflict with other communities.”<sup>44</sup> Each person will give her life to a promised cause, a final fullness that will in fact never come.<sup>45</sup> Philosophically, community as essence is also problematic in that it assumes a community as its own source and foundation. For Nancy, we can no longer assume such a foundation, a meta-narrative, a universal or essential political rationality. Such meta-narratives have revealed themselves as ideologies of power in light of the devastation they have wrought:

The sense of this world appears to consist merely in the accumulation and circulation of capital, accompanied by a clear aggravation in the gap between the dominating wealthy and the dominated poor, as well as by an indefinite technical expansion that no longer provides itself – except very modestly and with disquiet or anguish – the finalities of ‘progress’ and the improvement of the human condition. Humanism open onto inhumanity; such may well be the brutal summary of the situation. And the West does not understand how it managed to come to this.<sup>46</sup>

In such a collapse, Nancy argues for the abandonment of notions of the absolute, a higher power, or community-as-its-own-foundation: “There is no longer any world: no longer a *mundus*, a *cosmos*, a composed and complete order (from) within which one might find a place, a dwelling, and the elements of an orientation.”<sup>47</sup> In contrast, our experience of community, when it is not

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<sup>43</sup> Nancy, *The Inoperative Community*, 12: “In this State, each member has his truth in the other, which is the State itself, whose reality is never more present than when its members give their lives in a war that the monarch...has alone and freely decided to wage.”

<sup>44</sup> Andrew Norris, “Jean-Luc Nancy on the Political after Heidegger and Schmitt,” in *Jean-Luc Nancy and Plural Thinking: Expositions of World, Ontology, Politics, and Sense*, eds. Peter Gratton and Marie-Eve Morin (Ithaca, NY: State University of New York Press, 2012), 145.

<sup>45</sup> As Nancy puts it, “In truth, death is not sublated. The communion to come does not grow distant, it is not deferred: it was never to come.” *The Inoperative Community*, 13.

<sup>46</sup> Nancy, *Dis-Enclosure*, 30.

<sup>47</sup> Jean-Luc Nancy, *The Sense of the World*, trans. Jeffery S. Librett (Minneapolis, MN: University of Minnesota Press, 1997), 4. The parenthesis is original to the translated text.

understood as its own essence, is the meeting of two or more people, or rather, beings being-with one another.<sup>48</sup>

For Nancy, it is the experience of being-with that both constitutes and exposes us as the experiencing, communicating, and finite beings that we are.<sup>49</sup> Nancy stresses that our only experience of ourselves is in our being-with others. This being-with does not then subsume each person or being into some prior foundation, nor does it place us within a larger state or political body.<sup>50</sup> Rather, the experience of community is the opposite of the collective community as essence; it is simply our exposure to one another and to ourselves, constituting us as finite beings always side by side with one another: “exposed, body to body, edge to edge, touched and spaced, *near in no longer having a common assumption, but having only the between-us of our tracings.*”<sup>51</sup> I exist only through my experiences, past and present, with others, and any transcendent meaning outside of this experience, which tries to subsume or explain it via some prior rationality or plan, takes me a step away from this immediate experience of myself.<sup>52</sup> For Nancy, being is always being-with; we always and immediately experience ourselves as being *with* one another. Further, this “with” reveals to us both our being together and our limit: I am not you, but I am with you. I am thus finite, constituted as finite precisely by my being-with but not fusing-with another. As Nancy puts it, “Community cannot be presupposed. It is only

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<sup>48</sup> Note: I use the hyphen to designation “being-with” as an ontological category, as explained below.

<sup>49</sup> Jean-Luc Nancy, *Being Singular Plural*, trans. Robert D. Richardson and Anne E. O’Byrne (Stanford, CA: Stanford University Press, 2000), 30: “If Being is being-with, then it is, in its being-with, the ‘with’ that constitutes Being; the with is not simply an addition... The ‘with’ is at the heart of Being.”

<sup>50</sup> Anne E. O’Byrne, “Nancy’s Materialist Ontology” in *Jean-Luc Nancy and Plural Thinking: Expositions of World, Ontology, Politics, and Sense*, eds. Peter Gratton and Marie-Eve Morin (Ithaca, NY: State University of New York Press, 2012), 91: “There is no accounting for the fact that we are here; there is no sense to our being here, *other than our being here.*” Italics are original.

<sup>51</sup> Nancy, *Corpus*, 91. Italics are original.

<sup>52</sup> Thus, Nancy stresses the “sense” that we create together in being with one another over against a transcendent or universal “sense” of the world. There is no world but the world that we make moment to moment with one another: “Thus, the world *no longer has* a sense, but it *is* sense.” *The Sense of the World*, 8.



exposed.”<sup>53</sup> In other words, community is not something more than us that we seek to accomplish or belong to. Rather, community is precisely our exposure with one another as the finite people we are.

I name the chaplain *with* dying people and her memories *of* dying people as an experience of community because this experience does not incorporate us into a higher power or narrative, but rather it exposes us to ourselves as people who have finite limits. The chaplain’s experience is especially revealing because our community every day is not just that of bodies meeting other bodies but bodies meeting other bodies *that die*. This meeting is in fact a revelation, or rather an exposure, because it also reveals to us something about ourselves that is outside of our experience. No one ever experiences her own death. One can experience illness and decline, but the entrance into death is the eradication of experience itself, at least in its current, mortal mode.<sup>54</sup> The same can be said of birth: no one experiences coming into this world, that moment, whenever it is, that one awakens to life. Yet we do experience ourselves as beings who die (and also who are born) because we experience ourselves with others who die. In Nancy’s words, “A community is the presentation to its members of their mortal truth...It is the presentation of the finitude and the irredeemable excess that make up finite being: its death, but also its birth, and only the community can present me my birth, and along with it the impossibility of my reliving it, as well as the impossibility of my crossing over into my death.”<sup>55</sup> For Nancy, this is all that community is: our constant exposure to ourselves, to others, and to our mortal finitude through our being-with others, immersed in “a rhythm of bodies being born,

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<sup>53</sup> Jean-Luc Nancy, *The Inoperative Community*, xxxix.

<sup>54</sup> Nancy thus takes Heidegger’s conception of death as that which makes Dasein whole but also erases it: “When Da-sein reaches its wholeness in death, it simultaneously loses the being of the there. The transition to no-longer-being-there lifts Da-sein right out of the possibility of experiencing this transition and of understanding it as something experienced.” Martin Heidegger, *Being and Time*, trans. Joan Stambaugh (Albany, NY: State University of New York Press, 1996), 221.

<sup>55</sup> Nancy, *The Inoperative Community*, 15.

dying, open, closed, delighting, suffering, being touched, swerving.”<sup>56</sup> We meet ourselves as the bodies and people we are as we meet one another.

Such experience is also self-loss. In being exposed with others who are born and die, we meet aspects of ourselves that we cannot fully know; we experience something about ourselves that we cannot fully experience. We are exposed to the proximity of our own deaths. For Heidegger, death cannot be thought of something that *will* happen to us at a distant point in time.<sup>57</sup> Such a thought puts our death at a distance from us, denying the reality that death can come at any moment, like the car of an absent-minded driver careening out of nowhere.<sup>58</sup> Nancy connects this utmost proximity of our own deaths to our experience of the deaths of others. As Nancy scholar Marie-Eve Morin points out, this is a central point of Nancy’s modification of Heidegger: “The problem with Heidegger’s thinking of finitude is that he does not integrate being-toward-death into his conception of being-with.”<sup>59</sup> For Heidegger, death individualizes. No one can die my death except me.<sup>60</sup> Nancy modifies this by emphasizing the shared fact of finitude in being-with. The stark reality and proximity of death is something that is shared, because – and this is especially true for chaplains – death is all around us.<sup>61</sup> In being exposed to this fact, we lose ourselves, or rather, in our shared exposure as beings who die, we are constantly opened to our reality.

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<sup>56</sup> Nancy, *Corpus*, 65.

<sup>57</sup> Heidegger, *Being and Time*, 234: “In such talk, death is understood as an indeterminate something which first has to show up from somewhere, but which right now is *not yet objectively present* for oneself, and is thus no threat.”

<sup>58</sup> Contemporary theologian George Pattison traces this theme in Heidegger to Kierkegaard, who himself was analyzing Jesus’s parable in Luke 12:20: “This night your life will be demanded of you.” *Heidegger on Death: A Critical Theological Essay* (Burlington, VT: Ashgate, 2013), 28.

<sup>59</sup> Morin, *Jean-Luc Nancy*, 77.

<sup>60</sup> See Heidegger, *Being and Time*, 243.

<sup>61</sup> See Morin, *Jean-Luc Nancy*, 78.

In the midst of such exposure, we never have a final grasp of ourselves. We are always losing ourselves because we are exposed to our proximity to the limits of experience itself.<sup>62</sup> In being-with others, we see our intimacy with death, this part of ourselves that also means our end. As Morin – commenting also on Heidegger – puts it, “Birth and death represent inappropriable limits: I am opened to these limits...I slip out of myself (again, this formulation is imprecise; it seems to imply that I was myself before this slip, but on the contrary, I am only this slip.)”<sup>63</sup> This is what the community exposes us to: the constant self-loss that makes us slip out of ourselves as we are exposed to bodies, others, births, and deaths. The self is given to us as lost in the experience of community.

Yet self-loss is also subtle for Nancy, threatened, because as soon as we try to grasp it, we lose it: “*Bodies don’t take place in discourse or in matter. They don’t inhabit ‘mind’ or ‘body.’ They take place at the limit, qua limit.*”<sup>64</sup> In other words, our being is never captured in some sort of overarching narrative, a method, or theory. In our lives, we do not grasp the body (its living, its dying); we experience it, and this experience is always exceeding our grasp. We are always more than we can understand, more than we can say, write, or think. Thus, Nancy’s emphasis on touch. Touch is the fleeting experience of our being-with one another and the sense that we make out of it together in the moment. Thus, for Nancy, “There is not ‘the’ body, there is not ‘the’ touch,”<sup>65</sup> rather there are only bodies always coming together and thus coming to themselves.<sup>66</sup> As soon as we try to turn this experience into a system, a theory, a narrative, we have already stepped away from the experience. In this way, the experience of bodies, of their

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<sup>62</sup> Nancy, *Being Singular Plural*, 90: “The other dies insofar as the other is with me and that we are born and die to one another, exposing ourselves to one another.”

<sup>63</sup> Morin, *Jean-Luc Nancy*, 77. What Nancy adds to this formulation is that one does not just grasp ahold of one’s nearness to slipping into nothingness alone. We grasp it together, precisely in being with one another.

<sup>64</sup> Nancy, *Corpus*, 17.

<sup>65</sup> *Ibid.*, 119.

<sup>66</sup> See Nancy, *The Sense of the World*, 155.

living and dying, is constantly coming to us and also always slipping from our grasp. Nancy himself is seeking the “touch” of the body in writing, knowing that as soon as it is written, the experience fades: “Let there be writing, not *about* the body, but the body itself. Not bodihood, but the actual body. Not signs, images, or ciphers of the body, but still the body.”<sup>67</sup> Let writing touch the body, not grasp it, not summarize it, but let the acts of writing and reading touch – or resonate with – the experience of bodies. In this way, we try to understand ourselves, our being, our experience, yet we can only touch it and be touched by it, as it slips away, as we slip away, always more than we can grasp.

#### B. Self-Loss, Chaplaincy, and Biopolitics: Implications and Limitations of Phenomenology

To the extent that I have been with children who have died in front of me, I am given to myself in the extremities of my vulnerability. I am reminded of myself as a child, as one who just as easily could have been killed in an accident like these children. Of course, this reminder is precisely what biopolitics seeks to shield us from: the imbalances of power and access to health care, our various systemized roles, my designation as a chaplain (and also as white and male), all work to separate me from my patients and others. In the trauma room, my roles and my identities function as a boundary between my self and the child trauma patient. These are the separations built into our community to stop the experience of community as common exposure and self-loss. This is what Esposito means by the immunization of community with what it is not: biopolitics seeks to block community as the experience of self-loss for the sake of a community of institutions, systems, and roles.<sup>68</sup> In Esposito’s words, “Life had to be separated off and closed up inside progressively desocialized spaces that were meant to immunize it against anything

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<sup>67</sup> Nancy, *Corpus*, 9. Italics are original.

<sup>68</sup> See Esposito, *Communitas*, 139.

arising from community.”<sup>69</sup> Between that child and me are tangible and intangible borders and blockages that thwart the experience of community as the experience of our common vulnerability and exposure.

Yet biopolitics does not block such exposure completely. Community appears precisely in the experience of the chaplain exposed in a community of sick, dying, and dead people. As much as chaplains work with the health system to shield us from dying bodies, in the very place where dying bodies are most present, they nonetheless appear before us. Chaplains are called up to these rooms. We suddenly come upon dying and dead people, and to the extent that we do not obscure the scene, taking it over in a professional posture or a therapeutic agenda, we are also opened up, lost as we face our own mortal truth.<sup>70</sup> Yet, it is not just seeing the body, taking it in like an object, that constitutes community. If it were just the sight of the dead body, self-loss would happen every day in the hospital (and perhaps it does).<sup>71</sup> *But the putative lack of agenda of the chaplain, in spite of the fact her presence certainly serves an agenda, nonetheless can allow for moments of community, simply being there with dying people, seeing oneself in and with the death of another.* To the extent that we do not turn the reality of death into another work, we experience community, however fleetingly. Of course, something always must be done when death happens in the hospital, but the chaplain, as the one who is just supposed to *be* there, meets

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<sup>69</sup> Esposito, *Immunitas*, 140.

<sup>70</sup> Nancy, *Corpus*, 47: “To see bodies is not to unveil a mystery; it is seeing what is there to be seen... The one who sees *compears* with what he sees.” Nancy uses “compearance” to denote both the appearance and the coming of one to oneself in being with another.

<sup>71</sup> As Greg Garrett, reflecting on his experience in a CPE internship, expresses: “A hospital... is a setting that can be hyper-realistic, dramatic, life with most of the boring parts taken out and more dramatic moments inserted... [T]he stories that emerge from the hospital setting can crystalize questions that might take us decades to explore in the course of a relatively happy life.” *Stories from the Edge*, xiii. Common exposures can be prevalent in such a setting, despite its rigid systematization.

death with less to do, and thus may actually meet it. As Nolan writes, “being-*with* is *all* that the chaplain has to offer.”<sup>72</sup>

Again, the experience of community for the chaplain is ambiguous in the literature by chaplains. We meet it and mention it, but then we turn away. This simultaneous motion towards and away from community by chaplains is exemplified in Nolan’s notion of hope. Nolan himself draws on Heidegger’s conception of death as that which is inscribed into our very being, not as something off in a distant point in time but an own-most possibility, a possibility always right beside us. As Nolan states, “caring for people who are dying confronts healthcareers with the reality of our own death.”<sup>73</sup> Nolan then charges the chaplain not to forsake this confrontation through professionalism, but to live with it, to take in: “being present to ourselves *here now* means recognizing and *owning* our own anxiety about death and allowing that death anxiety to inform, but not to intrude upon, our being *with* a dying other.”<sup>74</sup> Though Nolan does not use Nancy’s language, he nonetheless is speaking of the experience of exposure, an experience that he pursues as a chaplain, being opened to one’s own dying. Yet at the same time, Nolan turns away from the possibility of self-loss, incorporating exposure rather into a therapeutic mode of hope: “chaplains aim to model a way of being-*with* dying others that itself becomes a *hopeful presence*. Chaplains reconceptualise [*sic*] hope as ‘hope in the present.’”<sup>75</sup> Death-anxiety, as Nolan puts it, informs the chaplain’s work. It creates a therapeutic agenda centering around hope. As soon as Nolan turns toward the experience of exposure, he turns away from it, describing being-*with* as the chaplain’s work, thus one step removed from the experience itself.<sup>76</sup>

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<sup>72</sup> Nolan, *Spiritual Care at the End of Life*, 105. Italics are original.

<sup>73</sup> *Ibid.*, 115.

<sup>74</sup> *Ibid.*, 117. Italics are original.

<sup>75</sup> *Ibid.*, 127. Italics are original.

<sup>76</sup> Nolan senses this paradox of describing being-*with* as without agenda yet turning it into a therapeutic stance: “Unlike other healthcare professionals, chaplains do not identify hope-fostering as an explicit aspect of their care for people who are dying. However, they do regard hope-fostering as a valuable outcome of their work, one that

I do not fault Nolan for this turn. Turning the experience of self-loss into a mode of solidarity with one threatened by death is a task for the chaplain. Yet in doing so, Nolan has yet to center on the experience of self-loss alone. Nolan perhaps comes closest in the literature that I have read, yet he too is concerned with the chaplain's work, an emphasis that by necessity must take a step away from the chaplain's experience. My argument is not to turn away from our care as chaplains, but I believe chaplains also need to focus squarely on their own experiences with dying people: We experience self-loss in our being with another, *period* – not I experience loss and this informs my work in such and such a way. Until we have focused more on our own experience, we have yet fully to articulate loss within the hospital, and this omission then furthers biomedicine's long history of neglecting the realities of death in the name of life and progress. The literature has yet to touch squarely and only on the self-loss that chaplains so often experience in their being with dying people.

And yet, something of the experience of self-loss is also missed when employing Nancy's phenomenological analysis alone. By bracketing the experience of self-loss as psychological shattering, his analysis of immediate experience stays primarily on an ontological level, detailing our experience of who and what we are: limited, finite beings always already with one another, losing ourselves in the exposure of our limits. Such a focus omits a complete description of the psychological impact of such experience, as well as the connections it holds to prior losses, which are precisely Kristeva's focus. In other words, though the referral to prior losses takes us away from the immediate experience, this referral is nonetheless a part of the experience of self-

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is engendered by their presence rather than anything they may actually say or do. As such, hope-fostering is an unsought-for, but nonetheless not entirely unexpected outcome of a chaplain's being-with." Ibid., 110. Such hair-splitting is a necessary result of trying to articulate the chaplain's work while seeking to name it as without agenda. My argument, in contrast, is to name being-with as the *experience* of the chaplain, an experience that we must articulate as separate – yet ultimately fused with – the chaplain's *work*.

loss for the chaplain. There is no other way to explain the feelings that accompany moments of loss without examining their depth psychological impact.

The omission of this facet of the experience is brought out in Nancy's conversations with another French philosopher Maurice Blanchot. Though Nancy and Blanchot describe community in very similar terms, Blanchot's analysis of Nancy's work moves the focus away from an analysis of "being" and "being-with," and more to the immediate experience of the self with the dying other. "What, then, calls me into question most radically?" asks Blanchot, "Not my relation to myself as finite or as the consciousness of being before death or for death, but my presence for another who absents himself by dying. To remain present in the proximity of another who by dying removes himself definitively, to take upon myself another's death as the only death that concerns me, this is what puts me beside myself, this is the only separation that can open men, in its very impossibility, to the Openness of a community."<sup>77</sup> Here, Blanchot is characterizing the moment of lost-ness that happens before one who is dying: I view death and in the ecstatic moment, my identity blurs with that of the dying other; I get lost in the face of the one who dies.<sup>78</sup> In other words, Blanchot is pressing Nancy on the experience of two people on something akin to the psychological level.

Nancy in turn rejects Blanchot's modification, stating that he reads community solely as a negative experience, the experience of finitude as limit: "Blanchot asked that I stop with the negation of communal community and that I think farther than this negativity, toward a secret of the common."<sup>79</sup> In other words, by focusing on something akin to the psychological experience

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<sup>77</sup> Maurice Blanchot, *The Unavowable Community*, trans. Pierre Joris (Barrytown, NY: Stanton Hill Press, 1988), 9.

<sup>78</sup> See Morin, *Jean-Luc Nancy*, 86. Paraphrasing Blanchot: "The death of the Other is the only death that I can die and in this dying I substitute myself for the Other, who cannot die, cannot experience her own death."

<sup>79</sup> Jean-Luc Nancy, "The Confronted Community," trans. Jason Kemp Winfree, in *The Obsessions of George Bataille: Community and Communication*, eds. Andrew J. Mitchell and Jason Kemp Winfree (Albany, NY: State University of New York Press, 2009), 24.



and implications of self-loss, Blanchot, according to Nancy, is turning self-loss into something other than loss.<sup>80</sup> Blanchot is asking what loss does, as if self-loss were a type of project or work. Marie-Eve Morin clarifies the disagreement in this way: “For both, the death of the Other is what places me outside of myself. Yet Blanchot thinks this interruption of communion as substitution – to die the one for the other – while Nancy thinks it as sharing – to be exposed to the limit where the Other withdraws.”<sup>81</sup> Nancy’s emphasis is thus more on the negative side of community. It gives to me my very self as my own limit; it exposes the finitude that I am. This exposure to loss is all that community is for Nancy.

However, Nancy’s refusal to explore the psychological experience of self-loss also misses a facet of this experience: one’s own feeling of death or the shattering that takes place in the midst of the dying other. This omission is a consequence of Nancy’s method, to look at experience in its immediacy, without recourse to theories of the psychology underlying such experience. I turned to Nancy’s phenomenology precisely because of his focus on the immediacy of the experience of loss. By referring the loss to a prior unconscious loss, psychoanalysis in contrast moves us a step away from the immediate experience of self-loss before a dying other. But at the same time, without recourse to such a theory, something else is lost, an explanation for the desperate moment of shattering, such as what I felt before the death of that child at the beginning of my CPE training, and really felt myself fall apart. That sense of shattering is more than simply self-loss as the exposure of finitude. It reaches back into the core of the psyche, tearing at its foundations.

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<sup>80</sup> An additional concern for Nancy is that by focusing solely on the psychological experience of self-loss between two people, the experience of community would be limited to the ecstatic experience of discreet pairings of lovers rather than an exposure of our common finitude. Thus, Nancy rejected Bataille’s community of lovers – which Blanchot embraced – as expressed in, “The College of Sociology,” 249-253.

<sup>81</sup> Morin, *Jean-Luc Nancy*, 86.

Thus, I conclude that Kristeva and Nancy each help articulate two different levels or aspects of the chaplain's self-loss. They theorize similar experiences through two dissimilar theoretical lenses, and thus neither can grasp the moment in its fullness (and its emptiness). They each touch various aspects of such experience, and through this touch, they allow me, as a chaplain, to articulate and understand something that I have experienced at the deathbed. On the one hand, the chaplain is certainly exposed to a community of finite others, constituting the chaplain herself as a finite being, given over to the experiences of birth, death, and bodies, experiences that always exceed the chaplain's own sense of herself. In such exposure, the chaplain loses herself. On the other hand, the chaplain also feels these losses on a deep psychological level, calling her back to prior loss, in fact, to our melancholic constitution through loss. Entering the world of objects, words, and meanings ultimately makes us lose a sense of fullness, or at least to feel like we have lost such a sense of fullness in our lives, if it ever existed. In self-loss, we are exposed, *and* we are pulled apart. We find ourselves joined in a community of loss, yet we also feel particular losses deeply, as shattering. These two theories help us name our experience. We chaplains experience death, or at least we experience our proximity to death, our self-loss in our constant exposure to the deaths of others we care for.

#### IV. Conclusion

The aim of this chapter is not to capture the fullness of the experience of self-loss in a single narrative or theory. Rather, I have argued for a turn within chaplaincy literature, moving away from the necessary but ubiquitous explanations of what chaplains *do* to an attempt to trace and touch the chaplain's experience when she is with dying people. Reading such experiences through the theoretical lenses of Kristeva and Nancy has provided theoretical tools – though they

are certainly not the only lenses for such reflection – to understand and articulate such experience, even as I argue their theories necessarily only capture limited facets of it. Such theories nonetheless help chaplains understand what the experience of self-loss, that which we *feel* so often, *is*: the exposure of limit, the drive to shattering. As we work, we chaplains experience these facets all the time. It is a consequence of who we are and what we do, though we have yet to speak and write of our self-loss fully. Thus, we have yet to face this loss, to dwell in it. Such a failure has meant that chaplains have yet fully to articulate their experience within their biopolitical realm. A turn in the literature, which I have sought to inaugurate here, would begin, then, to change the messages of our setting. Yes, biomedicine is a place of progress and healing, but it is also the setting for real loss, for the death that we are all destined for and thrown towards.

However, does this failure mean that chaplains have yet to articulate their experience of loss completely? This is the question for the next chapter: Is self-loss silent in chaplaincy care today? And if it is not, how do chaplains (as well as families and loved ones of those who die) then turn towards and speak self-loss, when the language of loss seems absent from the hospital setting? What words do we use to speak it, to reach into the void left by loss? I have already noted that by aligning themselves with spirituality, chaplains have put themselves at odds with the rest of the biomedical system, with its specified tasks and discreet, measurable outcomes. However, I also believe that chaplains bring their experiences of loss into spirituality, that the words of spirituality also carry or reach towards loss. In other words, though chaplains have yet to explore self-loss in their literature, I nonetheless believe that chaplains still speak of loss, precisely in the language of spirituality. Perhaps this is precisely what spirituality *is*: our way of articulating and reaching toward moments of community and loss that happen in patient rooms,

despite the system's fierce immunization against it. In the next and final chapter, I examine the connections between self-loss and spirituality, particularly the name of "God," connections and symbols that I argue surround the person of the chaplain, at once advancing and subverting the biopolitical trajectory of the hospital itself.

## CHAPTER 7

### SPEAKING LOSS IN THE LANGUAGE OF SPIRITUALITY: ON “GOD” AND GOD’S WITHDRAWAL

In the preceding chapter, I argue for a subtle change within chaplaincy literature from its dominant concentration on the tasks performed in care to more focused attention on the experiences chaplains have during this care, particularly the experience of self-loss that accompanies care of dying people. In this chapter, I move from this call for a change in the literature to an analysis of how chaplains and patients are already talking about this loss within the hospital. If self-loss is a prevalent experience within chaplaincy, and if patients and families are actually losing their selves as they lose their lives and the lives of those they care for most deeply, how are we articulating this loss? How is this ever-present experience being talked about now?

Of course, one of the central issues of this project is the fact that such loss is *not* being discussed, that in the midst of death, doctors avoid negative prognoses, billing systems fail to produce codes for dying, and overall the system treats patients simply as consumers buying health care services rather than mortal bodies tending towards inevitable decline. Even in the biopsychosociospiritual turn, palliative care nurses, doctors, and chaplains discuss death as a path towards and a task of acceptance rather than examining the experience of loss in death. Chaplains do their assessments and make charts to document where the patient is in the dying process, attributing to the medicalization of dying viewed as a determined pathway, heavily laden with a moral teleology, rather than speaking of death as self-loss, the entrance into the void, the shattering of all visions, the end of experience.

Yet despite such obscurantism, I argue in this chapter that talk of self-loss nonetheless is happening within the hospital, though indirectly, in fact covertly. I argue that we talk of such loss precisely within the discourses of spirituality. As note in chapter 1, “spirituality” is a broad and contested term within chaplaincy literature, often defined as a capacity for meaning making and a connection to transcendence. In this chapter, I fill these terms out more substantially, connecting spirituality to the entrance of death and loss in the hospital. Specifically, I focus here primarily on spirituality as the invocation of the name of God,<sup>1</sup> understood broadly, not as the deity of any particular tradition, but as a marker for withdrawal itself, or rather, for our way of reaching out towards withdrawal.<sup>2</sup>

Spiritual talk in general and the name of God specifically are most present in the hospital around experiences and anticipations of loss. Here I mean loss broadly understood, not just the presence of death, but the ways the illness and injuries that require a hospitalization also bring one to anticipate one’s own death or at least are reminders of one’s mortality. Of course, the words of spirituality are often employed in ways to deflect the “sting” of death, as Paul writes in the first epistle to the Corinthians; however, I argue such language is also our confrontation with death itself, the void of death, the loss of self that is death. In order to make this argument, I employ the philosophy of religion found within the work of Jean-Luc Nancy – supplemented with theories by Jacques Derrida and John Caputo – because Nancy makes this connection

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<sup>1</sup> Focus on the use of the name of God will hold relevance for the majority of chaplaincy encounters. According to a Gallop poll conducted in 2011, 92% of Americans report believing in God. Frank Newport, “More than 9 in 10 Americans Continue to Believe in God,” *Gallup*, June 3, 2011, accessed June 15, 2015, <http://www.gallup.com/poll/147887/americans-continue-believe-god.aspx>. Note: Harold Koenig cites this same poll to argue for the necessity of spiritual care within health care. See *Spirituality in Patient Care*, 24.

<sup>2</sup> However, as will become clear below, I am not taking a confessional or theist stance here. Rather, my focus is on the human gesture implied in the name of God, a gesture that is itself a movement towards meaning making and community. Thus, even with this narrowed focus on spirituality as the invocation of the name of God, my argument still holds relevance for wider definitions of spirituality as a meaning making capacity. Consequently, I do not mean to draw an exclusive boundary around the name of God as our *only* access to articulate loss and reach toward community.

between the name of God and the experience of loss, arguing that this term holds within it our confrontation with the experience of abandonment and withdrawal, precisely *in* its invocation of presence, the fullness of the divine, the transcendent.

But, in addition to this philosophical argument, I also make this connection out of my own experiences with the language of spirituality, particularly with the name of God, when I have invoked it in the care of dying people. In my work, I have yet to say the name of God while basking in God's fullness, in a feeling of complete presence. Rather, when I invoke that name, especially in prayer with or over sick, dying, or dead people, I repeatedly feel – or feel myself grasping toward – a mixture of fullness and emptiness, presence and absence.<sup>3</sup> I grasp toward that which is *more* than merely the materiality of dying and dead bodies when I invoke God, yet the word “God” also fails, if in it, I am grasping towards assurance, the presence of *something* transcendent, something reorienting. Goodness, orientation, and presence do not simply return with the name of God. No one and nothing come when I say the name of God. So why do I speak it?

I do so because I do not simply feel absence with that name either, not simply the loss of God – if I did, there would be no reason outside of convention to say the name at all. Rather, I also sense in it or through it a sense of togetherness, of coming together, or being-with, between myself and others, families, communities of grief, and departing people. But with this being with others and saying the name of God, I also feel us all reach out, together reaching out, not necessarily toward *someone*, towards a person or thing named “God,” but a *reaching* nonetheless, an appeal, a gesture outward. It is precisely this reaching that occurs in and through the name of God that I want to examine here, that the philosophy of religion is already

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<sup>3</sup> As Nancy describes it: “The departing [*la partance*] is inscribed onto presence, presence is presenting its vacating.” *Noli me tangere: On the Raising of the Body*, trans. Sarah Clift, Pascale-Anne Brault, and Michael Naas (New York: Fordham University Press, 2008), 28.

examining, but has yet to bring it in conversation with care of dying people, nor has it fully examined this spirituality as an internal subversion of the biopolitical trajectory of modern health care, as I do at the end of the chapter.

### I. Experiencing a Community of Loss

A few weeks before I began to write this chapter, I entered a momentary community of loss quite suddenly and unexpectedly. The hospital where I currently work on a per required need (PRN) basis called on a warm Sunday afternoon in late Spring when I was out walking my dog around the neighborhood; the call reminded me that I had agreed earlier in the month to take the on-call shift for that evening to cover for a co-worker, a fact that I had forgotten. Unlike my residency, where the on-call chaplain stayed in the hospital overnight, my current position allows chaplains to remain at home when we are on-call. Two local hospitals have our cell phone numbers, and they call us in when we are needed during our designated nights on-call. So I rushed home, threw on a collared shirt and tie, and made my way to the hospital.

There I saw a man in his forties struck down suddenly by a drug overdose of opioids. I learned later that he had been the patient of a local pain clinic for several years, having suffered a crippling back injury and needing constant relief for the lingering effects of the injury on the nerves of his lumbar. The ensuing years had been a drawn out struggle between the necessity of the pills and the dependency they created. Just the day before my visit, the man had been found by his adult son, unresponsive and not breathing on the bathroom floor. Now only a day later, the life support machines of the ICU were deemed futile, only prolonging the body's deterioration and suffering, and the family was ready to say good-bye.



Being called in to pray before the withdrawal of life support is hardly unusual for a hospital chaplain. What makes this call stand out in my mind, rather, is the crowd that encircled this dying man. When I first entered, only the man's son and his mother sat by the bedside, but slowly, as news came that the chaplain had arrived and the immediate family was ready to withdraw support, a crowd formed, coming in from nearby waiting rooms and hallways. I greeted those who entered while also asking the mother, who was standing immediately beside me, about the life of the patient, trying to learn more about the person whose life was vanishing in our midst. Soon the room was filled to capacity; from wall to wall the crowd assembled. I felt shoulders rubbing up against my sides and back. The air began to feel heavy, as so many people breathed out sighs or stifled cries, coughing, sniffing; all the bodily noises of grief materialized and danced around the room.

This family was Baptist, and they had requested a chaplain precisely so a religious figure could pray as support was withdrawn, so I knew that prayer was my primary task with this family. Accordingly, together we prayed, first silently, with heads bowed. During this time I made furtive glances around the room, seeing many people holding hands, other grasping shoulders, everyone almost leaning in on one another, as if each person was propping up another, like we were forming a fragile pyramid of human bodies, all pointing inward to the patient's bed, standing as the pinnacle. And then, slowing, I prayed to God, not using any overtly doctrinal language, but just letting that word stand for whatever each person understood as transcendence, love, presence. Yet, as presence, this "God" was also not a full presence. Rather, much more, "God" designated a withdrawal at that moment. We were entrusting the patient to God. "God" then designated the withdrawal of this life away from us, and thus also the withdrawal of the prior lives these people had with this man, also flying away from us there in the room. Together,

we formed this community of loss, articulating this being-with each other and with loss through that name “God.” And with this name, this withdrawal was holy, revered, a thing for which people bow their heads.

This moment is the starting place of the next two sections of this chapter. In the first section, in conversation with pastoral theologian Charles Gerkin, I designate the chaplain as the carrier of memory and questions of transcendence within the hospital. In what follows, I expand my earlier argument against reductionist readings of spiritual care by examining the excess of meaning that encircles the person of the chaplain, an excess that goes beyond simply her own memories or intentions. Horizons of tradition and questions of transcendence and meaning also encircle the chaplain’s person, simply by her addressing the name of God in extreme situations of the hospital.

## II. Chaplain as Marker of Meaning

Why did the family request a chaplain to pray that afternoon, at the withdrawal of life support from that man? This question elicits a range of explanations, many of them likely idiosyncratic to the personal beliefs of the immediate family, the past religious life of the patient, and the doctrines of God and salvation held in the Baptist tradition or traditions of the people in the room. But also the person of the chaplain – myself in this case – must have held some sort of significance, some link between this situation of loss and questions of meaning, value, and transcendence. Not that the chaplain is somehow transcendent or in greater proximity to such value – I make no such claim – but rather that the chaplain signifies or even personifies questions of meaning.

## A. Charles Gerkin and the Hermeneutics of Pastoral Care

Charles Gerkin was a student of Anton Boisen, the founder of the chaplaincy department at Grady Memorial Hospital in Atlanta, and longtime professor of pastoral care at Emory University.<sup>4</sup> Today his outline of pastoral care as the fusion of horizons of meaning still holds relevance when understanding what the person of the chaplain embodies when she enters a community of loss. The linkage between the person of the caregiver and the horizon of meaning that she represents is the basic concern of what Gerkin calls his “narrative hermeneutical theory of practical theology.”<sup>5</sup>

In this theory, Gerkin is outlining the purpose and method of pastoral care and counseling, which has close ties to hospital chaplaincy, especially because the notion of the “living human document” by Boisen is central to his theory. As I note in the first chapter, Boisen sought to create a scientific rationale for chaplaincy through empirical research into the religious nature of mental illness and the healing presence of pastoral caregivers. By naming the patient as a “living human document,” Boisen was claiming that religious experience holds as much potential for knowledge as traditional religious texts.<sup>6</sup> Gerkin takes Boisen’s insight as his starting point to explore how human knowledge and meaning are rooted in personal experience and one’s on-going conversation with various traditions of knowledge. Gerkin terms his theory hermeneutical because it focuses on human knowledge and interpretation; according to Gerkin, “the life of the soul is a continuous life of interpretation,” meaning that significance and meaning

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<sup>4</sup> See Pamela D. Couture and Rodney J. Hunter, “Charles V. Gerkin,” in *Pastoral Care and Social Conflict: Essays in Honor of Charles V. Gerkin*, eds. Pamela D. Couture and Rodney J. Hunter (Nashville: Abingdon Press, 1995).

<sup>5</sup> Charles Gerkin, *Widening the Horizons: Pastoral Responses to a Fragmented Society* (Philadelphia: The Westminster Press, 1986), 59.

<sup>6</sup> Boisen, *Out of the Depths*, 187: “In a time when students of religion were making little use of the methods of science, and scientists were failing to carry their inquiries to the level of the religious, we were seeking to make empirical studies of living human documents, particularly those in which men were breaking or had broken under the stress of moral crisis.”

are primarily derived from our ability to understand our experience.<sup>7</sup> For Gerkin, the trouble or illness that Boisen's vision sought to heal is the experience of interpretation becoming blocked or distorted in some way.<sup>8</sup> Reading the living human document to understand the patient's sense of ultimate significance and to remove her blockages of interpretation are then the central steps towards healing.

Outlining the task of pastoral care in this way brings Gerkin to questions about how the horizons of meaning that the caregiver draws upon interact with the situation and blockages of the care seeker.<sup>9</sup> Gerkin sees the task of care primarily as dialogical. First, the caregiver must be intentionally steeped in the traditions of meaning that she represents. Here, Gerkin primarily envisions a pastoral counselor or caregiver working within a Christian parish setting, so he has a specific tradition in mind.<sup>10</sup> However, he is neither systematic nor doctrinaire in how the caregiver draws upon the tradition. Rather, Gerkin describes his own practice of approaching "these texts of the tradition in search of images and themes, symbolic figurations and normative warrants that may prove formative for my ministry."<sup>11</sup> In other words, a religious tradition provides a series of images through which we can interpret and bring meaning to our experience. However, care is not simply the caregiver applying the correct symbol to a patient's situation in order to make an interpretation. Rather, these images come into dialogue with the specific situation of care as well as other explanatory systems or traditions both caregiver and patient

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<sup>7</sup> Gerkin, *The Living Human Document*, 104.

<sup>8</sup> *Ibid.*, 48.

<sup>9</sup> As I explain below, Gerkin is drawing on Hans-Georg Gadamer's hermeneutical theory throughout his presentation of the task and method of care. Gadamer defines "horizon" as follows: "Every finite present has its limitations. We define the concept of 'situation' by saying that it represents a standpoint that limits the possibility of vision. Hence essential to the concept of situation is the concept of "*horizon*." The horizon is the range of vision that includes everything that can be seen from a particular vantage point." *Truth and Method*, trans. Joel Weinsheimer and Donald G. Marshall. 2<sup>nd</sup> Edition. (New York: Continuum, 1996), 302. Thus, the caregiver represents one horizon, which can be fused and then expanded by her dialogue with another limited horizon of meaning contained within a text or another person.

<sup>10</sup> See Gerkin, *Widening the Horizons*, 19.

<sup>11</sup> Gerkin, *The Living Human Document*, 58.

bring to understand it, creating what German philosopher Hans-Georg Gadamer terms a “fusion of horizons”:

Gadamer takes the position that, since one always stands within the flow of historical process, it is erroneous to consider the hermeneutical task in subject-object terms, as if one could stand apart and view the spoken, written, or other artistic expression of another as an object to be examined and analyzed as from an ahistorical position. Rather, Gadamer says, it is much more like a dialogical process in which what is hoped for is what he refers to as a merger or fusion of horizons of meaning and understanding.<sup>12</sup>

Gerkin explains that such dialogue puts all explanatory horizons at risk, because they are all subject to reinterpretation and reevaluation as they negotiate with the situation. In fact, such risk is necessary for Gerkin precisely because of the plurality of explanatory horizons available to us today in the age of secularism<sup>13</sup> as well as the possibly oppressive symbols or themes found in the tradition that are themselves in need of revision when applied to our current situation.<sup>14</sup> For Gerkin, a religious tradition becomes one of multiple conversation partners, each working to give the care seeker tools for more adequate interpretation and meaning in her life, yet in the process, the tradition itself is also subject to change as it is reinterpreted in this ongoing dialogue.<sup>15</sup>

Key to Gerkin’s vision of pastoral care is thus the person of the caregiver, specifically as she comes both to signify and bring the tradition into dialogue with the situation of the care seeker: “In certain important respects, the pastor is the embodiment of that tradition. The people called to be loyal to the Christian community and its tradition look to the pastor for interpretative guidance with primary attention being given to the faithful representation of that tradition.”<sup>16</sup>

This means for Gerkin that the caregiver serves as the link “at the point of interpretation of both

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<sup>12</sup> Ibid., 44.

<sup>13</sup> I follow the definition of secularism as outlined by Charles Taylor noted in my second chapter: “A move from a society where belief in God is unchallenged and indeed, unproblematic, to one in which it is understood to be one option among others, and frequently not the easiest to embrace.” *A Secular Age*, 3.

<sup>14</sup> See Charles Gerkin, *Prophetic Pastoral Practice: A Christian Vision of Life Together* (Nashville: Abingdon Press, 1991), 32-39.

<sup>15</sup> Ibid., 18.

<sup>16</sup> Ibid., 42.

the Christian narrative tradition and the contemporary living situations being confronted.”<sup>17</sup> The pastoral caregiver thus brings with her the horizon of the tradition into the moment of crisis. For Gerkin, this means primarily that she brings the symbols of that tradition into the conversation. The metaphorical world of the tradition houses the past wisdom of the many generations that came before who found meaning and understanding in that tradition. The Gadamerian concept of “effective history” is a facet key for Don Browning, another theorist of hermeneutic practical theology. As Browning describes it, “Gadamer develops the idea that the events of the past shape present historical consciousness...The past does not just die and exist as a frozen corpse totally inert, impotent, and unable to shape present events. The present is largely a product of the past. The past lives in the present whether we realize it or not.”<sup>18</sup> Here, Browning is lifting up the importance of past questions and wisdom embodied in current practices and traditions. Because the caregiver is intentionally steeped in the symbols and stories of the tradition, she comes to represent the tradition itself, the questions and the answers of past generations. She is a reminder, an embodiment of questions of meaning, ultimacy, and transcendence, not because she has any special access to the divine, but because she has learned to read her world through a religious tradition that bears these questions itself.

## B. The Strategic Hermeneutics of Interfaith Chaplaincy

Chaplains too embody religious symbols and thus the questions of transcendence and meaning that these symbols carry. However, whereas Gerkin’s focus is primarily in a parish setting, with a community formed around a single tradition or confession of faith, chaplains today are strategically interfaith in their work, ministering to people across a wide range of

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<sup>17</sup> Gerkin, *Widening the Horizons*, 100-101.

<sup>18</sup> Browning, *A Fundamental Practical Theology*, 40-41.

different traditions. This means that though chaplains are trained within a particular tradition, they may downplay their own religious affiliation in order to speak across religious differences. As Wendy Cadge observes, “While speaking the language of specific religious traditions might restrict [chaplains’] professional jurisdiction, speaking of spirituality and of wholeness, presence, and hope as broad concepts are jurisdictional expansion strategies intended to make the work of chaplains accessible to as many patients, families, and staff members as possible.”<sup>19</sup> From this observation, Cadge concludes that employing these broad concepts creates an “absence of presence or absence of talk connected to particular religious traditions by the professionals trained in these traditions in hospitals.”<sup>20</sup> In the first chapter, I describe chaplaincy care in similar terms and relate it to the profession’s needs to argue for its role in caring for the hospital population in general rather than only the portion that shares the tradition of a particular chaplain. If chaplains do not bring their own specific symbol systems into conversations with patients, what relevance then does Gerkin’s outline of pastoral care then hold for the spiritual care of chaplains in the hospital?

I argue that Gerkin’s work still remains key to chaplaincy care because he elucidates the connection caregivers retain to questions of transcendence, even when chaplains refrain from bearing outright the symbols of their own tradition. While Cadge is correct that chaplains are hesitant to bring their own tradition into outright dialogue with patients, she goes too far at other points when she then concludes that “descriptions of [chaplains’] work that emphasize hope and wholeness make the visible ways that religion and spirituality are present in hospitals seem almost devoid of content and conspicuously absent.”<sup>21</sup> Rather than simply being devoid of content, a more complex interplay is happening in spiritual care as the chaplain maneuvers

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<sup>19</sup> Cadge, *Paging God*, 82.

<sup>20</sup> *Ibid.*

<sup>21</sup> *Ibid.*, 15.

between the symbols of her own tradition and those of the patient. A thoughtful chaplain will not mischaracterize her own background, but she will also be mindful about revealing theological differences, so that her own faith identity does not impede the support she can offer through the symbols of the patient's own tradition. As Steve Nolan rightly points out, "The presence of a chaplain will evoke a response that is more to do with what the chaplain unconsciously represents for the person they are visiting than with who the chaplain is in herself."<sup>22</sup> As soon as a chaplain enters the room, the patient may automatically associate her with the patient's own religious background and experience with clergy (or lack there-of). Spending time correcting minute misperceptions or educating the patient on the chaplain's own tradition would then take valuable time away from the support the chaplain can offer. However, at the same time, the chaplain will draw upon her own theological symbols and resources as they are helpful in moments of care, producing a dialogue between the horizons of the chaplain and the patient, even if the dialogue is perhaps more subtle and strategic than overt as it is in a congregational setting.<sup>23</sup>

Nolan names the chaplain's presence as "evocative."<sup>24</sup> Her very person carries and brings forward questions of transcendence and meaning, creating moments of dialogue and fusion between the situation of the patient, the questions provoked by the chaplain's presence, and the chaplain's own tactical deployment of her tradition's symbols as they aid in her spiritual support. With Gerkin, I maintain that this stance is not one of mastery but rather of care. The chaplain guides questions of meaning, value, and transcendence by bringing to the forefront religious

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<sup>22</sup> Nolan, *Spiritual Care at the End of Life*, 43.

<sup>23</sup> Chaplain Martha Jacobs illustrates the discernment process a chaplain may take in deciding how and when to reveal her own theological background while debriefing a case study in interfaith care: "I had my own theology going in my heart, while I was also using professional chaplaincy skills such as reflective listening to allow [my patients] to affirm their theology with honesty and integrity. This dual-track mind-set and heart-set, I believe, is what enables professional chaplains to remain connected to their own theology while also supporting and enabling another's theology. "Creating a Personal Theology to Do Spiritual / Pastoral Care," 8.

<sup>24</sup> Nolan, *Spiritual Care at the End of Life*, 36.



symbols, either those of the patient or of her own tradition, to meet the situation at hand, but it is not strict application. As such, the symbols themselves are subject to revision, reinterpretation, and change as they are challenged by the situation itself.

### C. Transcendence and Self-Loss: Rethinking our Symbols beyond Gerkin

What we must think with and beyond Gerkin, then, is how the current situation of spiritual care today, particularly care of the dying and bereaved, impacts the symbols employed and embodied by chaplains. On the one hand, I have argued throughout this project that chaplains find themselves implicated within the wider power structures of the hospital, actively interrogating the patient's spirituality and degree of acceptance while their so-called agenda free presence is co-opted by the truths and knowledge of biomedicine. This movement within chaplaincy care has mirrored wider biopolitical trends within health care where experiences of death and decline are omitted in patient care in the name of progress, mastery, and consumerism. On the other hand, as I argue in the preceding chapter, chaplains *do* experience a degree of self-loss during their continuous care of and presence before dying people within the hospital. This experience exceeds the discourses of healing and acceptance so prevalent in this setting. In contrast to these discourses, chaplains experience a sense of breakage, shattering, and self-loss with and before the dying other. How does this situation in which the experience of death fails so often to be articulated yet self-loss is an experience of the chaplain then bear on the terms of spirituality?

Gerkin himself tends to connect the symbols – including the name – of God to presence and wholeness. Employing the idea of “eschatological identity” from the German theologian Jürgen Moltmann, Gerkin outlines, “one purpose of pastoral counseling...that of restoring

persons to an awareness of our eschatological identity within the history of God in relation to God's creation and in anticipation of the coming Kingdom."<sup>25</sup> However, when we connect the name of God to the situation in which it is invoked within the hospital, in the midst of not only uncertainty and loss, but also in a setting in which such loss remains unexpected, often unheard and unspoken, the name of God comes to bear the weight of loss itself and our being-with one another grasping toward this loss.<sup>26</sup> With Gerkin, I relate the chaplain's symbol system to a search for greater meaning and transcendence over the situation, here the strict materiality of dying bodies. Yet in contrast to Gerkin, in the next section I veer away from his invocation of presence, because I fear that such an invocation can too easily support the politics of life and the denial of death. While not denying that chaplains and family members still seek such presence, in invoking the name of God I also hear articulated the struggle to name the complex reality of loss in the midst of our being together. This is the subversive element that the chaplain herself embodies as she carries and speaks that name.

### III. The Withdrawal of God in Moments of Loss

As I mentioned in the last section, I agree with Wendy Cadge and other scholars who argue that the turn to interfaith spirituality as a broad category designating the meaning making capacity of the patient is a strategic move by chaplains to buttress their fragile place within the hospital. Simon Craddock Lee sums up this point well in his anthropological study of new CPE

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<sup>25</sup> Gerkin, *The Living Human Document*, 69. Gerkin tends to take a theist stance towards eschatological identity, connecting it to the Christian understanding of the Holy Spirit "in which and through which eschatology and history are mediated." *Ibid.*, 70. However, at other places, he characterizes eschatological identity as a symbolic or narrative tool for understanding the complexity of identity and wholeness: "Human identity is for Moltmann therefore always paradoxical, 'at the same time' embedded in the historical process of our lives and eschatological in its connection to the narrative of expectation of the coming kingdom." *Widening the Horizons*, 39.

<sup>26</sup> As Swift explains, "The conditions of meaning in the West do not, by and large, allow for a confident and meaningful discourse in the face of close personal loss. Time and again chaplains enter those situations where death has occurred and meaningful speech becomes a significant challenge." *Hospital Chaplaincy in the Twenty-first Century*, 139.

interns: “The transformation of hospital chaplaincy into ‘spiritual care services’ is one means by which religious healthcare ministry negotiates the secular realm of biomedicine and the pluralism of the contemporary United States healthcare marketplace. ‘Spiritual’ is a label strategically deployed to extend the realm of relevance to any patient’s ‘belief system,’ regardless of his or her religious affiliation (or lack thereof).”<sup>27</sup> Moreover, throughout this project, I have been in dialogue with scholars who have named the ways that the spirituality fostered by chaplaincy care contributes to the power relations of biomedicine and biopolitics. For example I have agreed with Winnifred Fallers Sullivan that the type of interfaith spirituality imagined by chaplains assumes it to be both non-dogmatic and universal, “excluding forms of religion that are perceived to threaten stability, sexual mores, or national security.”<sup>28</sup> I have also noted the contributions of scholars who describe the ways the spirituality of the hospital mirrors and contributes to wider trends of individualism and neoliberalism within the culture and politics of today.<sup>29</sup> By turning to the subversive element within the name of God here, I do not exclude or downplay the ways in which spiritual care contributes to the power relations of its setting. However, throughout my use and dialogue with these sources and others, I have also argued for the complex and multifarious character of spiritual care, which resists simple reduction to a tool of power. In this section, in dialogue with figures of the philosophy of religion, I therefore explore a subversive element housed inside the name of God, a part of the experience of speaking that name in the midst of death and loss.

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<sup>27</sup> Lee, “In a Secular Spirit: Strategies of Clinical Pastoral Education,” 339.

<sup>28</sup> Sullivan, *Ministry of Presence*, 140.

<sup>29</sup> See chapter 2, section I below.

## A. Différance and the Tensions of Presence

Understanding this subversive element within the name of God first requires an overview of the French poststructural theorist Jacques Derrida's analysis of *différance*, because it allows us to understand how the withdrawal of God and the articulation of loss is present within the notion of God, traditionally understood as a transcendent, fully present being or foundation.<sup>30</sup> For Derrida, *différance*<sup>31</sup> is "neither a word nor a concept" but rather the movement or play of differences between, behind, and within any type of sign or series of signs.<sup>32</sup> The "a" in *différance* that creates Derrida's misspelling of "difference" is purely graphic rather than phonetic. It is meant to signify the hidden trace within a sign of that which is within the sign but differs from it. "Différance" is also a play on the two meanings of the Latin *différer*: to defer and to differ. *Différance* is the play of differences within a sign or sign system that defers a presence from ever being complete. Rather, it is spaced out from itself through a series of differences that constitute it and give it the illusion of presence. This spacing is constantly creating the fluid distinctions necessary distinguish signs and to produce the perception of presence and stability within a sign.<sup>33</sup> However, *différance* does not refer simply to differences between signs; rather, this play of differences is also embedded within a sign itself. Its appearance as something present and unified is only constituted by its "keeping within itself the mark of the past element, and already letting itself be vitiated by the mark of its

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<sup>30</sup> A full overview of Derrida's *différance*, including Derrida's sustained critique of the metaphysical tradition and its binary of presence/absence is beyond the scope and focus of this chapter. Ellen Armour, *Deconstruction, Feminist Theology, and the Problem of Difference: Subverting the Race/Gender Divide* (Chicago: University of Chicago Press, 1999), especially its chapter "Nothing Outside of the Text," takes a careful look at Derrida's critique via a close reading of three of essays in *Dissemination*. Moreover, Armour deals closely with ongoing critiques of Derrida's work and argues for its relevance in white feminist theology's treatment (and omissions) of race.

<sup>31</sup> Jacques Derrida, *Margins of Philosophy*, trans. Alan Bass (Chicago: University of Chicago Press, 1982), 8.

<sup>32</sup> *Ibid.*, 3. See my definition of "sign" above, Chapter 5, n. 31.

<sup>33</sup> In Derrida's words, "*Différance* is the systematic play of differences, of the traces of differences, of the *spacing* by means of which elements are related to each other. This spacing is the simultaneously active and passive...production of the intervals without which the 'full' terms would not signify, would not function." *Positions*, trans. Alan Bass (Chicago: University of Chicago Press, 1981), 27.

relation to the future element.”<sup>34</sup> In this way, the sign contains within it traces of difference, the traces of what it is not, embedded into what it is. Thus, the sign is never simply present, but rather every sign spans or is stretched out through this play of differences housed within it. As John Caputo puts it, Derrida’s analysis of *différance* makes “us think twice about claiming that our discourse has accomplished what it set out to do.”<sup>35</sup> By this, Caputo points to the way Derrida’s work calls the stability of signs into question. They never quite say simply what we intend, but rather they are spaced out in a range of traces and referrals that we can neither fully intend nor capture. In this way, the sign or series of signs is also always open. Its full presence, complete in and of itself, is always being deferred by the innumerable traces within.<sup>36</sup>

From his analysis of signs, Derrida goes on to put into question the idea of presence itself, including the full presence of beings and subjects. He troubles the idea of a “transcendental signified,” meaning a final and complete thing or essence in itself to which a sign is meant to refer. Such a signified would in theory only signify itself, being completely self-referential. But, of course, such a transcendental signified is impossible, because “every signified is also in the position of a signifier.”<sup>37</sup> Every presence also refers to some other presence. Even my very being, the presence of this author, is also a sign of a long personal and political history, including a vast chain of relationships. When I appear before another, my presence also refers to or is a sign of these vast networks. If there is therefore no *thing* that simply refers to itself, then

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<sup>34</sup> Derrida, *Margins of Philosophy*, 13. In his later work, Derrida refers to “*hauntology*” and the specter. The specter is the trace, not present but embedded and stretching that which appears present back and forward. The specter is the ghost of the past, but always comes in the future: “A question of repetition: a specter is always a *revenant*. One cannot control its comings and goings because it *begins by coming back*.” *Specters of Marx: The State of Debt, the Work of Mourning, and the New International*, trans. Peggy Kamuf (New York: Routledge, 1994), 10, 11.

<sup>35</sup> John D. Caputo, *The Prayers and Tears of Jacques Derrida: Religion Without Religion* (Bloomington, IN: Indiana University Press, 1997), 15.

<sup>36</sup> As Ellen Armour puts it, “The specular economy requires ‘difference-between’ its various mirrors in order to function, but ‘difference-between’ also defers the economy’s closure and wholeness.” *Deconstruction, Feminist Theology, and the Problem of Difference*, 61.

<sup>37</sup> Derrida, *Positions*, 20.

“the distinction between signified and signifier becomes problematical at its root.”<sup>38</sup> The problematization of the sign therefore weighs on our understanding of presence itself, “thereby also diving, along with the present, everything that is thought on the basis of the present, that is...every being, and singularly substance or the subject.”<sup>39</sup> In other words, I, along with every other presence, remain incomplete, always stretching back into the past and moving along to the unforeseeable future through referrals and meanings I can never fully grasp or contain.

In the preceding chapter, I utilize Nancy’s phenomenology of community to speak of the chaplain’s self-loss before the dying patient. Looking back, we can now understand the extent to which Nancy’s theory of community is indebted to Derrida – who was at one time Nancy’s teacher – as well as to the analysis of *différance*. The singular person is constituted only through her being-with others, a vast chain of differences and referrals; she is only singular when she is plural; she is only who she is through her relationships, a vast and always-changing network.<sup>40</sup> Moreover, our being as being-with others also constantly exceeds our comprehension of ourselves. As I argued in the last section, we are constantly brought to a point of loss through experiences that speak to or reveal our very being but exceed our experience. We see the births and deaths of others, a loss of experience that is somehow intimately a part of our being, yet always beyond our grasp. Nancy’s community, as being-with that is also a loss, means that subjects are infinitely spaced out, always coming to themselves through their experiences with others, therefore constituted and separated by a vast and mobile chain of differences or *différance*.

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<sup>38</sup> Ibid.

<sup>39</sup> Derrida, *Margins of Philosophy*, 13.

<sup>40</sup> Nancy, *Being Singular Plural*, 85: “It is not individuality...it is at one and the same time, infra-/intraindividual and transindividual, and always the two together. The individual is an intersection of singularities, the discrete exposition of their simultaneity, an exposition that is both discrete and transitory.”

## B. Différance and the Withdrawal of God

Nancy goes on to relate the name of God both to his work with community and to Derrida's analysis of *différance*. Following Derrida's critique of presence, Nancy notes that the God of monotheism is "a powerful confirmation of metaphysics...through the production of a supreme, arch-present, and efficient Being."<sup>41</sup> God as supreme Being is the guarantor of all presence, *the* transcendent signified, complete and self-referential in God's self. Yet, within the logic of monotheism, Nancy sees also the movement towards an opening that he sees as internal – while at the same time in opposition – to the idea of God's pure presence. Nancy states that the God of monotheism is *also* the departure of the gods of polytheism from the world. In Marie-Eve Morin's words, "Monotheism occurs as a drastic and sweeping renunciation of the worldly immanence of the gods in the life of mortals."<sup>42</sup> Thus, monotheism begins as a new separation. The earth-dwelling gods of polytheism depart into a single divine known as the radically other.<sup>43</sup> Though monotheistic religions continue to speak of the fullness of God and messianic religions even proclaim the coming of God back into the world, monotheism then also houses the trace of the departure of God, the absence of God from this world: "The absolute of presence, ends by merging with the infinity of passage."<sup>44</sup> God becomes God's passage *from* the world; "God" becomes more withdrawal than presence, a sign of that which is other, that which has left the world.

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<sup>41</sup> Nancy, *Dis-Enclosure*, 7.

<sup>42</sup> Morin, *Jean-Luc Nancy*, 51.

<sup>43</sup> Nancy, *Dis-Enclosure*, 15-16: "Gods are departing into their myths...Such is the logical function that is substituted for the mythical function: the dual positing of a radical alterity (god and man are no longer together in the world) and of a relation from the same to the other (man is called toward god)."

<sup>44</sup> *Ibid.*, 147. Nancy goes on to claim that the absenting of God into the divine principle of the radical other then allows the substitution of God for other totalizing, orienting principles, such as the exchange principle of capitalism: "In opposition to the mythical function of the gods, monotheism establishes the one God as a radical alterity that serves as a first and final orienting principle...At this point, it is possible to replace God by other orienting principles that serve exactly the same orienting function." Morin, *Jean-Luc Nancy*, 53.

This is the *différance* internal to the name of God: inside the invocation of pure presence is also the trace of absence, withdrawal. I do not claim that either chaplains or patients and families feel only absence when speaking the name of God and praying to God. Rather, with Nancy, I am tracing an opening housed within that name for us today. Within the name of God is also a gesture of reaching towards something other, towards that which also withdraws from us. When we cry out, “My God!” in the midst of loss and tragedy, when we come together and pray “Our God!” in our coming together around a moment of death, housed within this invocation is also a feeling of the withdrawal of God, the feeling of God leaving us, of abandonment.

The hospital is a place oversaturated with the narratives of progress and healing. Yet in this place, where the actual experiences of dying and loss often go unspoken and unheard, the name of God *is* spoken often in times of loss. Even in this invocation of fullness, of reassurance and presence, the experience of absence and abandonment also remains, and the withdrawal of God, housed within the name of God, then becomes the opportunity to acknowledge such a feeling of abandonment. In Nancy’s words, “There is the god who approaches man to the extent of touching him, and the god who retreats from man to the extent of abandoning him infinitely. The two are the same.”<sup>45</sup> Even in speaking of the fullness of God, we can feel God’s withdrawal.<sup>46</sup> Or, at the very least, the trace of withdrawal is a mark internal to the name of God. Thus, speaking the name of God can also be the articulation of loss.

At times, Nancy equates God completely with the withdrawal of God: “The god who touches man touches him so as to leave him to himself, not so as to take hold of him and detain

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<sup>45</sup> Nancy, *The Inoperative Community*, 128.

<sup>46</sup> Steven Shakespeare summarizes how this tension within the name of God is also present in Derrida’s work: “Derrida is prepared to explore the otherness of God in a way that does not tie the divine down to ideals of presence. There are, in effect, two Gods. One is the reassuring God of presence who allows me to forget the difference, the nothingness that throws me into a life in time. The other God is the furtive one, the dispossessor, the elusive difference that separates me from myself. This God is not an absolute creator, but is perhaps creativity itself.” *Derrida and Theology*, 76.



him.”<sup>47</sup> Though Nancy’s description speaks strongly to my own religious experiences, I hold back from this conclusion and from proclaiming the end of religion, the end of the God of presence, because to do so would belie the hope and assurance spoken of by many of my patients, many of those who have felt God’s presence within the hospital room and in the midst of their losses, trials, and uncertainties. However, I follow Nancy insofar as I believe nonetheless in the element or trace of withdrawal within that name. Pastoral theologian Emma Justes, in her appropriately titled work *Hearing Beyond the Words*, writes that, “beneath, beyond, between, and around the words that are spoken lie pools of deep meaning.”<sup>48</sup> Thus, Justes counsels caregivers “to tune into, to be aware of, to be willing to approach, acknowledge, and sometimes inquire about the meanings of that which is communicated but unspoken.”<sup>49</sup> Behind the assurances spoken in hospital rooms, behind the notion of God’s complete presence and faithfulness, notions that I often hear spoken, lurk also feelings of abandonment, withdrawal, hopelessness. There is saturation in the name of God. We speak it as presence and absence.

### C. Openings within the Name of God

Yet the name of God does not simply reflect a neat tension between the opposites of presence and absence, the God who comes and the God who withdraws. Caputo writes rather of the event housed within the name of God. By event, Caputo simply means the coming of something new, propelled by a familiar term. The event housed within the name of God is not caused by the power of God the divine being or foundation, effected out of God’s fullness and

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<sup>47</sup> Nancy, *The Inoperative Community*, 128. As Nancy states earlier in *The Inoperative Community*, 122: “Forgetting the death of God, when not politically or commercially motivated, is tantamount to forgetting thought.”

<sup>48</sup> Emma J. Justes, *Hearing Beyond the Words: How to Become a Listening Pastor* (Nashville: Abingdon Press, 2006), 45.

<sup>49</sup> *Ibid.*

devastating presence. Yet, the event *is* something wholly unexpected, something totally new<sup>50</sup>; it is the unexpected that comes out of the admixture of “chains of promise and aspiration or chains of memories”<sup>51</sup> housed within that name, an excess of meaning that is “constituted not only in theological [or philosophical] discussion but also in deeds and actions, in rituals and practices, in ongoing historical traditions, in forms of life and modes of being in the world, which are organized around that name.”<sup>52</sup> In other words, the event housed within the name of God transcends both the presence and the absence of God. It comes out of the layers of history and tradition attached to that word, the overflow of meanings that we all attach together to that word, an excess greater than simply the sum of its parts. A play of differences dances within the name of God, as it is spoken and as it speaks to our hearts, and out of such excess comes the unexpected.<sup>53</sup>

When chaplains, patients, and families pray together, when we say the word “God,” we grasp for that which exceeds us, that which is beyond the material realities at hand, the strict materials of mortal bodies and the technologies of biomedicine. Chaplain and historian

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<sup>50</sup> Caputo is here drawing on Derrida’s notion of the messianic. For Derrida, the messianic should not be confused with incarnational theology, which substitutes promise with presence, ending the promise with completion and closure: “If one could *count* on what is coming, hope would be but the calculation of a program.” In contrast, the messianic is the emancipatory promise that comes out of the disjuncture of our time wholly unexpected: “These seismic events come from the future, they are given out of the unstable, chaotic, and dis-located ground of the times. A disjointed or dis-adjusted time without which there would be neither history, nor event, nor promise of justice.” Jacques Derrida, *Specters of Marx*, 212, 214. This too is the work or effect of *différance*. See Caputo, *The Tears and Prayers of Jacques Derrida*, 25.

<sup>51</sup> John D. Caputo, *The Weakness of God: A Theology of the Event* (Bloomington, IN: Indiana University Press, 2006), 3.

<sup>52</sup> John D. Caputo, *The Insistence of God: A Theology of Perhaps* (Bloomington, IN: Indiana University Press, 2013), 105.

<sup>53</sup> Caputo is outlining what he calls his theopoetics, which he characterizes as “a heretical version of Hegel.” *Ibid.*, 92. By this, Caputo means that he follows Hegel in understanding religion as a representation (*Vorstellung*), “a sensuous-pictorial embodiment of the truth... a world-picture, a world-praxis, a world-formation, a world-creation, an event of *poiesis*” (p. 94). However, whereas Hegel envisions an absolute Spirit that inevitably comes to self-realization via the historical movement, Caputo sees “God” as a *Vorstellung* at risk. “There is no absolute errancy in Hegel, no absolute waste, no errancy that reaches as far as the absolute itself... Whatever arbitrary chance befalls it, the Spirit will always and necessarily achieve its destination” (p. 125). In contrast, for Caputo there is no final guarantee on “God.” The name is a promise but not a guarantee, because there is no final presence behind it. “God” is a risky promise, coming out of an excess of meaning and history, and we can only respond as the finite people we are.

Christopher Swift writes, “Many chaplains encounter expressions of a latent expectation that life *should* have a purpose and meaning...It is manifested as a sudden and desperate desire rather than the disappointment of an expectation that had been largely assumed. Even the request for a chaplain to attend can be seen as part of that longing for a connection that family themselves are unable to make”<sup>54</sup> In the name of God, we therefore do not grasp only for the pure presence of God (though that is certainly a part of that name), nor do we simply articulate God’s withdrawal (though this too is present), but beyond this binary, we also simply *grasp* with this word; we reach out. The word itself, this sign that contains so much memory, promise, practice, and meaning, *is our reaching out*.

Nancy names such reaching as both “faith” and “adoration.” Faith is not simply belief for Nancy, not unsubstantiated knowledge or basking in the fullness of God’s presence. For Nancy, “faith consists in relating to God and to the name of God to the extent that God and his love are not present.”<sup>55</sup> Yet faith is also not exhausted as simply this exposure to absence either. Rather, it is the “relating to God” in God’s withdrawal that is key. This act of exposure is a reaching outward, what Nancy calls adoration: “Adoration signals a relationship to a presence that it would be out of the question to bring ‘here,’ that must be known and affirmed as essentially ‘elsewhere,’ with the effect of opening the ‘here.’”<sup>56</sup> In other words, adoration is our reaching out towards that which transcends us, and this very reaching creates opening: “It is not a presence of anything in particular, but that of the opening, the dehiscence, the breach, or the

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<sup>54</sup> Swift, *Hospital Chaplaincy in the Twenty-first Century*, 134. Italics are original.

<sup>55</sup> Nancy, *Dis-Enclosure*, 152.

<sup>56</sup> Nancy, *Adoration: The Deconstruction of Christianity II*, trans. John McKeane (New York: Fordham University Press, 2013), 9.

breaking out of the ‘here’ itself.”<sup>57</sup> Faith then is neither something done before full presence nor in simple nihilism before complete absence. Rather, the *gesture* that is faith itself becomes key.<sup>58</sup>

Faith and adoration are opening and not allowing this opening to close. By this, I mean adoration resists the closure of belief that is only assurance in one’s own certainty, either the certainty of reason found in atheism or the assurance in belief found in fideism. Adoration does not find God but gestures towards God,<sup>59</sup> and even though it never finds pure presence, complete assurance, it still holds on, holds open: “Adoration is addressed to this opening. Adoration consists in holding onto the *nothing* – without reason or origin – of the opening. It is the very fact of this holding on.”<sup>60</sup> Faith as opening then becomes the key when invoking the name of God for Nancy, well beyond – in fact in contrast to –certainty or disillusionment.

But can we define this gesture, this reaching out, this opening further in the setting of chaplaincy care? What does the gesture do? What does it acknowledge? I connect the reaching out within the name of God to the “longing for a connection” that Swift sees in patient rooms, the longing for purpose and meaning. Yet, even this longing for purpose and meaning needs more definition. Chaplains have come under critique by scholars such as Cadge precisely because they are hesitant to define words such as “purpose” and “meaning” with any more content, lest they be charged with indoctrination and religious exclusivity. I take the interfaith mission of chaplaincy seriously, but I believe that we can also fill out these words more fully. In fact, I believe open words such as “God” hold something inherently subversive to the biopolitical narratives of progress and healing. I believe that in the word of God we actually speak of loss, of

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<sup>57</sup> Ibid.

<sup>58</sup> Nancy, *Dis-Enclosure*, 154: “Faithful to what? To sense, and thus faithful to no other thing than to the very gesture of faithfulness.”

<sup>59</sup> For Nancy, the opening itself becomes “god,” not the God of theism, but the furtive name of the opening itself: “It is *the Open as such*, the Open of the proclamation, of the project, of history and faith, that, by the living God, is revealed at the heart of Christianity.” *Dis-Enclosure*, 154. Italics are original.

<sup>60</sup> Nancy, *Adoration*, 15.

self-loss, and our being together in self-loss. To make this argument, I move further into Nancy's philosophy of religion, which he also connects to his analysis of community, being-with, and thus to self-loss itself.

#### D. God, Power, and Community

In chapter 6, I review Nancy's contrast between community understood as an essence, which subsumes individuals, from community as each person simply being-with others, constituted by *being-with* but in that constitution also retaining each person's singularity. To understand spirituality and the name of God as a subversive element within the biopolitical trajectory of the hospital, it is necessary to link these notions of community with the name of God. As I note above, Nancy sees the name of "God" as the ultimate confirmation of presence. As such, it has also proven to be the transcendent foundation upon which all power can be based – in Caputo's words, "a massive ontological power line that provides power to the world."<sup>61</sup> This is exemplified by monarchs who stated that they ruled by divine decree, but a similar logic is present in imperialistic narratives such as neoliberalism that replace sacred stories as political metanarratives in the age of secularism. However, housed within the name is also the withdrawal of such foundation. In this way, like the word "community," the name of God fluctuates between the closure of an ultimate foundation, and the opening within this closure. The name of God corresponds for Nancy with the differing notions of community, either the community of the transcendent principle or the community of the *with*. On the one hand, the ultimate principle or foundation of the one God can become the rationale for unilateral power, the systematization of

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<sup>61</sup> Caputo, *The Weakness of God*, 13.

people, and the worst excesses of biopolitics. On the other hand, God can mean opening, the reaching out for something outside of such an enclosure, the gesture itself that opens.<sup>62</sup>

We have seen such a fluctuation within spirituality as well. On the one hand the spirituality fostered by chaplains is linked to the networks of power that biomedicine holds over its patients. The discourses of acceptance, the push against exclusivity in the name of commodification, the downplaying of difference to support chaplaincy's interfaith model are all subtle means of making patients and patient spirituality more manageable and systematized within the hospital. Spirituality as an essential, meaning making possibility is like a transcendent principle, a higher order to which particularity can be subsumed. By envisioning the patient as essentially spiritual, and then assessing and charting that spirituality as a quantity, the chaplain adds to the hospital's knowledge of and thus power over the patient's experience. In this way, spirituality as essential capacity does the same work as the idea of the transcendent God founding all political power: they both subsume individual particularity into a systemic collective. They both produce closure. For spirituality, this closure is its aid to the hospital's omission of experience, specifically the silence of the dying and talk of death, masked behind discourses of progress, healing, and acceptance. Thus the necessity for an opening within spirituality, a gesture that tears open such closure: "Without the opening of this possibility, there remains, perhaps, beyond good and evil, only the necessity of the worst,"<sup>63</sup> the "worst" here being the omissions of patient experience, death that cannot speak its name, spiritual care lending support to a larger system in which health is envisioned as a commodity that only those who can afford it can buy.

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<sup>62</sup> Caputo outlines these differences in stark terms: "The fluctuation between the sacrifice of others to my own will and the sacrifice of my will in service of others is built into the name (of) 'God' in just the way the best and the worst are built into other high-velocity words like justice and democracy, truth and love... It is the riskiest name we know and you cannot simply decontaminate it of its undecidability." *The Insistence of God*, 108.

<sup>63</sup> Derrida, *Specters of Marx*, 34.

However, on the other hand, throughout this project I have spoken of the complexity of spirituality, of tensions within chaplaincy care that, while being deeply implicated in the trajectories of biopolitics, also reach toward community and loss. Noting the complexity or subversive element of the name of God in the context of chaplaincy care necessitates then that I speak of the name of God more than simply as “opening.” We must fill out what the gesture of “opening” is, and this brings us back to my earlier characterizations of chaplaincy care as being-with and as self-loss.

For if chaplain, patient, and family reach out towards that which leaves us, that which withdraws, when we say the name of God together, then the name of God becomes the “with” of our being together: “‘God’ is nothing other...than this *with* itself.”<sup>64</sup> By this, Nancy means that the name of God, as opening, is also our opening unto one another. Through this name, we articulate how we are bound to one another, a binding that also surpasses and transcends us. As it was in the crowded room that I describe in the opening section of this chapter, the name of God becomes the name of our being together. In the moment, with heads bowed, we are together before loss through that word. “My God!” becomes our cry *together*, and though chaplains, patients, and families will all see something different in that word<sup>65</sup> – so soaked as it is in an

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<sup>64</sup> Nancy, *Adoration*, 40. Nancy sees God as “with” as the message of the Christ event and the doctrine of the trinity within Christianity: “With the figure of Christ comes the renunciation of divine power and presence, such that this renunciation becomes the proper act of God, which makes this act into God’s becoming-man. In this sense, the god withdrawn, the god ‘emptied out,’ in Paul’s words, is not a hidden god at the depths. Of the withdrawal or the void...He is a god whose absence in itself creates divinity.” *Dis-Enclosure*, 36. And elsewhere: “‘God’ effaces himself in yet another way: in the *Trinity*. It is a question neither of three gods, nor of a three-headed god. It is exclusively a question of this: God is relation. He is his own relation.” *Adoration*, 30.

<sup>65</sup> Of course, “God” is not the only word for such a relation. I am not drawing an exclusive boundary around that word, and I gladly admit that such a gesture is possible without the name of God. As Caputo puts it when outlining the “weak force” of the name of God, he is “all the while readily conceding that there are other names than the name of God. I am trying to save the name of God, not absolutize it.” *The Weakness of God*, 40.

excess of meaning across innumerable traditions – we nonetheless grasp out *together* with that word, and thus touch one another in our mutual reaching out.<sup>66</sup>

#### E. God, Withdrawal, and the Sense of Death

Reaching out toward one another is also then our reaching out towards loss. When death appears in the hospital, unexpected as it usually is, there is often the need to mark it, to honor the passing. But along with this is also the need to honor the effect that this passing has on us. In the face of intimate loss, there is, of course, a loss of self, a loss of being the person *I* – a family member, a lover, a friend – once was with this person who is now gone. I am no longer who I was when my spouse, my parent, my child was with me. I am no longer myself-with my loved one, and thus, I am thrown into the void left by the loss of this life. I am suddenly living the life of having lost my past self. This is part of the reason why people call the chaplain when dying people are extubated. The chaplain's person carries the symbols that mark the significance of this event. Encircling the chaplain are the symbols that enable us speak and reach out in such loss.

The opening created by the name of God holds profound implications for our experience of the death of others and thus our experience of self-loss before a dying person. In death, the other goes to God.<sup>67</sup> Yet, this does not necessarily mean that the soul continues living on another immortal plane; rather, it marks the significance of *the leaving* of the one we love.<sup>68</sup> Nancy sees

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<sup>66</sup> Nancy names this the on-going creativity of God. Via the opening that is our being-with, we experience our coming to ourselves by being with others, creation without a foundation. "God" is the *with* of our being but not the cause or foundation of our being. As Anne O'Byrne puts it, "This is certainly no dead God. God has passed into the world, and now we have the altogether more interesting story of an ongoing, never-finished, natal activity of emerging despite being posited by nothing." "The God Between," in *Re-Treating Religion: Deconstructing Christianity with Jean-Luc Nancy*, eds. Ignaas Devisch, Laurens ten Kate, Aukje van Rooden, and Alena Alexandrova (New York: Fordham University Press, 2012), 218. See also Jean-Luc Nancy, *Dis-Enclosure*, 24.

<sup>67</sup> Nancy, *Noli me tangere*, 17: "Finally, if Jesus says that he is going 'toward the Father,' this means that he is *leaving*, absolutely: the 'father'...is none other than the absent and the removed."

<sup>68</sup> Nancy here follows Heidegger in examining death solely as the end of experience. However, Heidegger brackets questions of the afterlife: "We cannot even *ask* with any methodological assurance about what '*is after*



this as the message of the resurrected Jesus, who tells Mary “Do not touch me” [*Noli me tangere*] in John 20:17 when she sees him in the garden by the tomb.<sup>69</sup> Mary is not to touch Jesus, because he withdraws from her, leaves her, and goes to the father. Yet Nancy describes the “Do not touch me” as itself a touch, a touch that marks the withdrawal of the one leaving into the significance of death: “No, nothing is available here... Don’t try to touch or to hold back what essentially distances itself and, in distancing itself, touches you with its very distance (in both senses: touches you with and from a distance.)”<sup>70</sup> The leaving itself becomes what is profoundly important. When we say that the one we love goes to God, when we entrust the dying one to God, we say and we honor, in effect, the flight of this one away from us, a flight that leaves us depleted. If being is being-with, we are left destitute by being-with one who departs: “It is not a question here of seeing *in* the darkness, that is, in spite of it... It is a question of *opening one’s eyes in the darkness* and of their being overwhelmed by it.”<sup>71</sup> In the name of God, we underline the importance of this moment, the flight of the beloved other, the significance and finality of death, and in underlining it, we mark its shattering effect on us.

Again, this loss is itself constitutive, because, for Nancy, being is always being-with, especially as being-with reveals our proximity to loss and death. Being-with death re-creates us, constitutes us and our world anew, as a world where people die, depart and disappear into the void. In his analysis of Mary meeting the risen and departing Jesus in the garden, Nancy notes that Mary hears her name in Jesus’s departure. Hearing the name, “‘Mary’ reveals Mary to herself, revealing to her both the parting of the voice that calls her as well as the dispatch to

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*death*’ until death is understood in its full ontological essence.” *Being and Time*, 230. In contrast, Nancy merges the death of God with the death of the other. Both essentially and infinitely withdraw. It is the lasting sense of this withdrawal that this makes for the significance of death, the opening that this withdrawal creates.

<sup>69</sup> The NRSV translates it, “Do not hold onto me.”

<sup>70</sup> Nancy, *Noli me tangere*, 16.

<sup>71</sup> *Ibid.*, 42.

which her name commits her: that she, in turn, is to leave and announce the departure.”<sup>72</sup> It is the loss itself that constitutes Mary, calling her by name. She finds herself as being-with, but only in being-with a loss, an absence. Likewise, we are only who we are in our being-with others, and thus being-with a dying other leaves a profound mark on us, in fact marking us by this withdrawal. We are left staring out into the void, this intimate part of us.

But self-loss is not simply loss. It also calls our name, calls us to respond. Being-with, even as loss, is “less a being-present than an engaged presence – engaged perhaps first in nothing other than being-*here*, exposed *there*.”<sup>73</sup> As her God and her beloved Jesus leave, Mary finds herself without foundation, but she nonetheless *remains*, left only with her name, spoken from the withdrawal of the one who leaves: “Remain true to that alone which remains in my departure: your name, which I utter. In your name, there is nothing to grasp and nothing for you to appropriate, but there is this: that it has been addressed to you...from the ground without ground that is always in the process of leaving.”<sup>74</sup> Left alone, with a foundation that infinitely withdraws, Mary is charged nonetheless to be, to respond.

Sometimes, in the wake of death, the hardest work is simply being in the exposure that is the loss of the one held so dear, just staying in the intensity of that loss, acknowledging the void it leaves. In the midst of death, we come to ourselves in a world where even our closest relations, our families, friends, and lovers, leave us, die. Just to be in the gesture that reaches toward the void left in the wake of a dead body, a departed loved one, to be there and not deflect it, is the hardest labor. The family members who cry out, who fall to the floor in the midst of death, make the appropriate response, naming loss and self-loss. So too, I argue, do those who stand around in prayer encircling a bed while nurses remove the tubes and machinery of life support. Both

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<sup>72</sup> Ibid., 46.

<sup>73</sup> Nancy, *The World of Sense*, 71.

<sup>74</sup> Nancy, *Noli me tangere*, 47.

acknowledge loss, holding onto its void as it forms us. It is being in this losing of our bearings, in the self-loss that is the loss of those we love, that is the work, the living with departure and void. Being-there is the response.

The name of God also means not being there alone. One is, of course, left alone in the departure of the other, left reaching out towards the hand the recedes from us. Yet prayers also often happen in hands held together. The chaplain and the family members join together when they pray, when they say the name of God and feel the withdrawal embedded in that name. Together, we reach out, being-with each other and being-with that loss. I am not saying that each person in the prayer feels the loss in the same way – the chaplain, of course, will feel it far less than bereaved friends and lovers. But nonetheless, everyone stands together in that moment of prayer, reaching out.<sup>75</sup> The name of God is a gesture, opening us to one another and to loss, at the same moment, in the same gesture. Even when spoken alone, the name is a gesture filled with significance by communities of others, connecting us to people who also speak that name time and again in the midst of loss.

As such, the name of God is subversive. As I note above, Caputo writes of the event housed within the name of God, the surprise of something utterly new coming out of the excess and layers of meaning attached to that name.<sup>76</sup> In the context of a chaplain praying that name in the midst of death and loss, that event is tied to the gesture of opening in the midst of death and withdrawal. Such an opening belies the system's overwhelming push towards progress and the

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<sup>75</sup> Nancy says this of prayer: "In the margins of prayer there is dance – and how many rites have been danced at the same times prayed! Prayer is the corroboration of an action, and that action is an availability to the outside, a being at the disposal of, the action of passivity or the passion that opens itself to the outside – to the incommensurable, in relation to which we are only poor." *Dis-Enclosure*, 138.

<sup>76</sup> In fact, Caputo aligns the name of God itself with remembrance of marginalized bodies. He writes that rather than "God" being taken as the cause and foundation of power and supremacy, "suppose instead we take our lead in thinking about God from images of the powerless remnants and marginalized bodies and nobodies, the little *me onta*, the obscure pockets and folds and hovels of the world?" In this way, remembrance itself is subversive: "The redemption is the remembrance, and the remembrance is the spark of hope that burns in remembrance, the breath of hope that breathes whenever we remember." *The Weakness of God*, 33, 96.

market of health care. In a place where death cannot speak its name, where it arrives only unexpected, where the void itself is displaced by therapeutic discourses and moral visions, the name of God as that which underlines departure and the void left in its wake is counter to the trajectory of biopolitics. As I have described it throughout this project, biopolitics is the politics of life, the perpetuation of the political body through a series of institutions and norms that rely on narratives of healing and progress. Thus, the subversive trace within the name of God counters the foundation that the political body is to itself by acknowledging the loss of foundations in death. If biopolitics can only move towards life, building the sumptuous biomedical apparatus around human fragility so as to ward off death, the chaplain saying the name of God before death and feeling the withdrawal and void embedded in that name is itself resistance.

#### F. Nancy and Gerkin in Conversation

In conclusion, the work of Gerkin needs to be tied closely with the experience of self-loss today, lest the symbols that the chaplain employs and that encircle her person become simply another means of obfuscating loss. His theories of pastoral care have yet to tie the symbols he proffers to the networks of power in biopolitics, the politics of life and progress that obscures the experiences of death and loss. Thus, he relies only upon the symbols of the God of presence rather than formulating the possibilities in the trace of God's withdrawal. At the same time, Gerkin reminds us that the symbols of transcendence and withdrawal that Nancy interrogates are not simply without setting. Nancy has yet to tie his analysis of God's withdrawal and the reaching out towards withdrawal in the death of the other to specific settings of death. Rather, he speaks broadly about how monotheism, specifically Christianity is "coextensive with the West

qua West” and its “self-surpassing” character in secularization.<sup>77</sup> This scope is necessary for Nancy’s project because he is tracing an opening in thought itself via the monotheism in which Western thought is rooted.<sup>78</sup> However, he then fails to analyze specific instances of the opening and the gesture towards opening. If such a gesture is nonetheless a trace upon the name of God itself, then Gerkin’s work grounds the language of withdrawal, because he formulates how such symbols encircle the person of the caregiver. It is thus the caregiver who carries the trace of withdrawal on her person, as she stands inside still hospital rooms, where the name of God is spoken on occasions of death and loss.

#### IV. Conclusion: Self-Loss and a Biopolitics of Life

I end the third chapter of this project by asking about the flexibility of the norms of biomedicine and chaplaincy care, whether they have become so rigid as to produce exclusions and omissions such that certain people and certain experiences are ultimately excluded or invisible to the system. Then at the end of the fourth chapter, I conclude after a review of the narratives of progress, healing, and consumerism of American health care that in fact such rigidity is starkly operative in our system, eliding first those who do not meet an imagined ideal of the consumer and then also failing to expect death or to reckon with the experience of death. While these trends continue despite the discourses of acceptance and presence in chaplaincy care, both of which I have critiqued as contributing to the obfuscation of death, nonetheless the analysis of the past two chapters also adds further specificity and complexity to these questions and conclusions.

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<sup>77</sup> Nancy, *Dis-Enclosure*, 142.

<sup>78</sup> Without such opening, Nancy fears that the closure of the metaphysics of presence and the notion of community as essence that it founds will continue to support the totalitarian politics of globalization: “The in-common finds itself orphaned of all religion, whether religious or civil.” *Dis-Enclosure*, 17. See also *The Inoperative Community*, xli.

Moreover, in the third chapter I also analyze through Roberto Esposito's biopolitical theory two notions of the immunity paradigm. On the one hand is the classic differentiation between the healthy body and the antigen, which when taken on a political scale becomes the difference between the healthy political body and the parasite, the foreigner, that which does not belong. In a political system imagined to function like this simplified vision of the immunity system, there is "the need...for immunitary barrier, protection and apparatuses aimed at reducing, if not eliminating, the porosity of external borders to contaminating toxic germs."<sup>79</sup> In the rigidity of our current health care system, death itself is a foreigner on the pure soil of biomedical healing, and thus strict borders exist between the narratives of medical progress and the experience of death itself. In chaplaincy care, barriers appear in discourses that speak about death only to deflect it, to cast it in medical and moral terms, to *talk* about something (acceptance!) other than the void and end of death. Chaplains participate in erecting such barricades around death, deflecting death precisely as we talk about it.

However, Esposito also offers another vision of immunitary logic based on the human body, one that complicates the imagined strict distinction between body and parasite, original and contagion. In contrast to the neat binary imagined in the first notion of immunity, the human body is in fact never pure or original. It is in a constant state of becoming rather than being, always incorporating difference into itself: "The self is no longer a genetic constant or a preestablished repertoire, but rather a construct determined by a set of dynamic factors, compatible groupings, fortuitous encounters."<sup>80</sup> In a political system imagined after the function of immunity in the body, the norm does not function as a means of simple omission and exclusion, but rather looks to incorporate difference when and where it is feasible: "the norm of

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<sup>79</sup> Esposito, *Immunitas: The Protection and Negation of Life*, 123.

<sup>80</sup> *Ibid.*, 169.

life, that is in play...rather than circumscribing life within the limits of the norm, opens the norm to the infinite unpredictability of life.”<sup>81</sup> As I note in the second chapter, such a system does not make clean separations but allows for commonality, looking for ways to merge across differences. Such merging then mirrors – though only in a momentary and partial way – Esposito’s idea of community as fusion and the loss of individuality. Rather than a strict division between original and foreign, parts can merge to create something new.

With the analysis of the self-loss of the chaplain in chapter 6 and the trace of a gesture towards loss embedded in the name of God in this chapter, I can now fill out how chaplaincy – while nonetheless advancing the exclusions of biopolitics – also subverts the neat exclusions of death in biomedicine, mirroring Esposito’s second vision of immunity. As I have stated, chaplaincy cannot simply rely on a de-politicized vision of community. Esposito’s analysis shows how political notions of individuality and systematization carry over into all modern interactions, *especially* those based in the hierarchies of patient care. To the extent that chaplains rely on the mirage of agenda-free pastoral presence to articulate their resistance to the extremes of biomedicine, they only end up contributing to its obfuscation of death, because such presence is already heavily laden with the hospital’s narratives and omissions. Conversely, as chaplains turn to their own experiences, noting the loss of self that happens within the rooms of dying people, the shattering and the meeting of the void that is death, they then articulate and invite a difference from dominant biopolitical narratives. Further, even in saying the name of God, and feeling that name to designate – along with its innumerable other meanings – a reaching into withdrawal, the withdrawal of foundation and the withdrawal of presence, they also introduce heterogeneity and an opening within the closed systems and trajectories of biomedicine. They

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<sup>81</sup> Esposito, *Bios: Biopolitics and Philosophy*, 190.

experience, articulate, and underline the significance of the advent of death and loss within the biopolitical sphere of the hospital.

However, let us not separate chaplains in their self-loss and spirituality too far from biomedicine. Rather, through their recognition of these losses, chaplains are changing biomedicine *from within*, as a *part* of biopolitics, in fact funded as staff by biomedicine. Chaplains introduce difference, partial and fragmentary moments of community as self-loss, into the system when they reflect on their experiences of loss and articulate loss in the words of spirituality. So far as chaplains will continue survive within the harsh budgetary competition of modern hospitals, they are thus contributing to what Esposito calls “an affirmative biopolitics.”<sup>82</sup> This is still a politics of life, but a biopolitics that also brings a fundamental part of life into its orbit: that of loss and death. While biomedicine is still a setting very much moving imprudently in the narratives of progress and commoditization, with chaplaincy, biomedicine also becomes, if ever so slightly, a sphere that also acknowledges, even incorporates death, loss, the void, and thus community.

Again, chaplains necessarily make their contributions to such biopolitics only partially. In addition to realities that make community itself impossible and disastrous in the political sphere, chaplains also face an increasingly difficult task in simply introducing narratives and awareness of self-loss within biomedicine. As I argue in the first chapter, the hospital setting increasingly relies on discreet, assessable tasks toward measurable outcomes in the patient’s health. Simply by being identified with an amorphous term like “spirituality” already marginalizes chaplains within biomedicine, and the profession cannot be faulted for taking the necessary steps to adapt to its setting, even if these steps contribute harm and omissions rather than care. At the same

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<sup>82</sup> Ibid., 194. Esposito remains hesitant to designate anything by this term. In outlining the reversal of normative biopolitics at the end of *Bios*, Esposito writes rather, “In such a move we can glimpse something that, while still not tracing the figure of an affirmative biopolitics, anticipates more than one feature.” Ibid.



time, chaplains can and do continue to change the trajectory of biopolitics. I end here by proffering three suggestions towards deepening this contribution, though I admit my list is neither complete nor exhaustive:

1. As I note in the introduction to this work, I am sympathetic to arguments that push chaplains towards greater adaptation to their hospital setting. After her substantial sociological study of secular chaplaincy departments, for example, Cadge recommends chaplains to (1) develop a body of literature of empirical evidence to ground their authority in evidence based outcomes (2) address their work outcomes to the problems of their institutions (3) increase their training in scientific education and (4) consider professional licensing.<sup>83</sup> I do not disagree with Cadge on these points. Changes like the ones she suggests are increasingly vital for the survival of chaplaincy as a profession.

However, I disagree with such an approach when it fails first to take into account the biopolitical trajectory of modern health care. Without such an analysis of the detrimental outcomes that current trends within biomedicine produce, chaplains uncritically adapt to a sphere that harms and excludes while it heals. Thus, accommodation *can only be a second step*. The first step is a sustained and critical investigation into the political setting and trajectory of biomedicine and chaplaincy's ongoing contributions to this trajectory. It is for this reason that I am especially hesitant towards Cadge's recommendation to move chaplain training from its current destination in the humanities towards interdisciplinary work. Education in the humanities via pastoral care courses and theology provides chaplains with the critical skills necessary to critique biomedicine from a unique perspective not available in current models of education in

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<sup>83</sup> Cadge, *Paging God*, 203-207.

health care.<sup>84</sup> Before further adapting the measures and procedures of the hospital, chaplains must first ask critical questions, such as: Who does our system exclude? What experiences are rendered invisible in it? What effect does the politics of life have on the lives sheltered and systematized in our hospital rooms? I have begun such a critique with this project, but I have by no means exhausted it. Before chaplaincy adopts wholeheartedly the procedures and assessments of medicine, the profession must assess whether and how such adaption will circumvent its mission of care and presence.

For example, Cadge suggests measures of “patient and family satisfaction or emotional adjustments to new health situations” as a possible starting place to measure spiritual care outcomes.<sup>85</sup> However, before implementing such a measure, further work must first be done to understand to what extent any assessments of satisfaction and adjustment are merely measures of what is otherwise called acceptance and self-realization. Moreover, chaplains must ask to what extent an (over)emphasis on satisfaction and adjustment clouds out realization and talk of loss. In other words, if chaplains solely look to solve the problems that the institution sees, then they will continue to advance the problematic biopolitical trajectory in which the system readily marches.

2. Postliberal scholars like Stanley Hauerwas, Joel James Schuman and Keith Meador critique generalized notions of spirituality, noting that it accommodates a market driven approach to religious needs. Echoing Jeremy Carrette and Richard King, Schuman and Meador critique the God of spirituality as one who heals without any further demands of

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<sup>84</sup> Cadge does, however, say that part of the interdisciplinary work she recommends be in medical ethics, which may provide other tools for such an assessment. *Ibid.*, 205.

<sup>85</sup> *Ibid.*, 205.

justice or community, further supporting a marketplace where health is sold.<sup>86</sup> As an alternative, Hauerwas, Schuman and Meador recommend a notion of healing that begins in a specific, historical tradition and community, such as those found in Christian contexts. However, in terms of chaplaincy care, my worry with suggestions such as this is that forefronting faith identity over generalized notions of spirituality will further reduce chaplains in secular and interfaith institutions where their place is already increasingly precarious. The move from religious identity to generalized spiritual care was a necessary, strategic move that helped bring chaplaincy into 20<sup>th</sup> century medicine, and withdrawing back into our various denominational identities can only work to undermine chaplaincy's place within the increasingly pluralistic and secular spheres of biomedicine.

At the same time, I am also sympathetic to these arguments so far as they push chaplains to provide more substance to notions of spirituality beyond generalized definitions of meaning making. In practice, such generalizations become empty signifiers, easily coopted to the trends of biopolitics and neoliberalism. However, I recommend that chaplains turn first and primarily to their own experiences within care rather than asking sectarian traditions or communities to fill out the meanings of spirituality. Chaplains do experience something very particular in the realm of spirituality and care when they are in the room, and I argue that such experience goes beyond the traditional scope of religious symbols and communities. In short, throughout this chapter I have argued that the symbol systems that patients and chaplains employ allow room for acknowledgement of loss, in fact reaching into the void of loss and underlining its importance as they say the name of God, *broadly* understood. Such reaching is not a balm, nor an instrument, nor a commodity. Rather, it is an experience of loss, an

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<sup>86</sup> Schuman and Meador, *Heal Thyself*, 8.

experience felt and spoken, even when death and loss are so often rendered obscure and mute in the hospital.

Chaplains do need to theorize what we mean by “spirituality” beyond generalities. Further, traditions are rich resources to fill in such terms, as Gerkin rightly points out, and to the extent that chaplains are strategic so that their use of tradition does not interrupt moments of care, continual involvement and education in one’s own tradition can only enrich our work. However, I ask that chaplains nonetheless begin with and always stay close to experience. The situations and the lives we meet in the hospital room should greatly impact our symbols, rather than the symbols dictating (or obscuring) our understanding of our experiences. Especially the experience of loss, which as I have argued is itself subversive of biopolitical trends, needs better articulation in the hospital. To the extent that our symbols help us speak, acknowledge, and reach into such loss, they should be employed to fill in what exactly we mean by “spirituality.”

3. My final recommendation is related to the first. Before chaplains devote themselves fully to solving the problems that the hospital sees as problems, like patient satisfaction and emotional adjustment, chaplains must first examine their own experiences and note the problems they observe. If chaplains first look to their own experiences, particularly the experiences of loss that they meet so often in the hospital, and then critically assess how such experiences continue to be obscured or rendered mute, then they will be articulating and working to solve problems from their own particular vantage point. They will be able to see problems that other health professionals, so engrossed in tasks of biomedicine, cannot see.

Chaplains know that self-loss happens in the hospital all the time, yet they have yet to explain to biomedicine the detriments to patients and families when such experience remains obscured and unspoken. Further, when chaplains and other palliative care professionals have sought to correct the silence of loss in the work of the hospital, they have only advanced its opacity with the discourses of acceptance. This however is the product of chaplains falling back on the moral visions of humanistic psychology, as I have argued, rather than an honest investigation of their own experiences. Beyond the message of acceptance, however, lies a more immediate experience of loss in the midst of care. This project has argued that such loss is ever present, yet obscured and silent in our hospitals. A more prolonged movement of searching and writing our experiences of such loss will, I believe, further reveal the omissions and detriments of biopolitics. It is problems rooted in such omissions that chaplains can expertly address, and this is where I recommend we continue to turn as we argue for our places within biomedicine.

In the preceding chapter, I describe my care during my first summer internship with the grieving family of a toddler hit by a car in her driveway. The child came in screaming, gradually grew quieter in the trauma room, as blood pooled around ruptured internal organs, and then she died on the operating table. The grief of those parents when they heard the news was so intense, falling to the floor and wailing, that I could only sit beside them, helplessly put my hands on their backs and shoulders. In reality, there was nothing for me to do than simply be there, with them. The morning after, I shed my first tears in front of my CPE group; my voice broke and I began to weep during morning report. About a month after that, the trauma surgeon who had cared for the toddler stopped me in the hallway. He recounted how horrible the loss was. We

shook hands, as if in solidarity, as if touching each other was a way of touching the loss we had both witnessed, both touched in our own way. Chaplains carry loss in and around their person, in their constant exposure to death and in the symbols of transcendence attached to their persons.

I carry that loss with me still today. Even now, even after having written out my narrative of that death months ago in the first drafts of the sixth chapter, right now I feel that familiar soreness in my throat. It pulls at me when I recount that shattering night. I carry that loss with me. I carry many losses with me. And I share them with you, dear reader, now. There is loss in our hospitals, real loss that no healing, no acceptance, no progress, no spirituality, and no care can ever take away. Sit with me around that void. Let us reach out together towards it. Because death is within life.

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