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Susan Catherine Witty Date

PEACE BE WITH YOU, REST IN PEACE:
USING SCRIPTURE TO ADDRESS SPIRITUAL DISTRESS AT THE END OF LIFE

By

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Abstract

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The contemporary image of the hospital chaplain is remarkably multifaceted: a minister with an interfaith approach; a member of an interdisciplinary team model who provides emotional/spiritual support to patients/families/staff while demonstrating sensitivity to multicultural and multifaith aspects in all encounters and visits; one who strives to convey a nonjudgmental affect while providing strong active/reflective listening skills to those in need. Additionally, chaplains minister to a veritable cornucopia of ailment or crisis situations, generally defaulting to a "ministry of presence" in any *and all* circumstances. And ultimately, they are expected to assist individuals and families face the reality of our own mortality in the midst of incredible medical developments.

This study acknowledges the benefits of this type of ministry, and engages it, but asserts that the standard chaplain "ministry of presence" at times proves insufficient in facilitating a direct confrontation with end-of-life anxieties/fears. In fact, there are occasions in which the "ministry of presence," if that is all that is delivered, would be a ministerial disservice to certain individuals. Adults coping with a terminal cancer diagnosis who express specific spiritual beliefs benefit from chaplain visits in which the chaplain assumes a more assertive ministerial approach: utilizing Scripture to assist individuals in confronting their own mortality, thereby assuaging their spiritual distress. Additionally, a specific methodology should be employed whereby the chaplain is able to build rapport, glean an adequate sense of an individual's personhood, and determine pivotal, appropriate Scripture passages that can optimally address one's spiritual distress. This approach is specifically an individualized plan that draws from the Vanderbilt Revised Common Lectionary (although not exclusively) in order to honor given religious seasons while identifying, confronting, and ideally resolving an individual's spiritual distress.

Peace Be With You, Rest In Peace:
Using Scripture To Address Spiritual Distress At The End Of Life

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I. Articulation of the Problem

The contemporary image of the hospital chaplain is remarkably multifaceted: a minister with an interfaith approach; a member of an interdisciplinary team model who provides emotional/spiritual support to patients/families/staff while contributing "sensitivity to multicultural and multifaith dynamics" to all encounters and visits[1]; one who strives to convey a nonjudgmental affect while providing strong active listening skills to those in need. Additionally, chaplains minister to a veritable cornucopia of ailment or crisis situations, generally defaulting to a "ministry of presence" in any and all circumstances. And ultimately, they are expected to assist individuals and families face the reality of our own mortality in the midst of incredible medical developments.

This study acknowledges the benefits of this type of ministry, and engages it, but asserts that adults coping with a terminal cancer diagnosis who express specific spiritual beliefs benefit from chaplain visits in which the chaplain assumes a more assertive approach: utilizing Scripture to assist individuals in confronting their own mortality, thereby assuaging their spiritual distress. The standard chaplain "ministry of presence" at certain times proves insufficient in facilitating a direct confrontation with end-of-life anxieties/fears. Some, such as Thomas St. James O'Connor, have considered the question, "Can a patient deal with his/her spiritual issues *without* [theological] conversation?" only to conclude that "More research is needed here."[2] Thus, this study endeavors to pursue this area of needed research via the hypothesis that those suffering from end-of-life spiritual

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[1] Jerry Nussbaum, "Interdisciplinary Teamwork: The Role of the Chaplain," in *Spiritual Caregiving in the Hospital: Windows to Chaplaincy Ministry,* eds. Leah Dawn Bueckert and Daniel S. Schipani (Kitchener, Ontario: Pandora Press, 2006), 45.

[2] Thomas St. James O'Connor, "Making the Most and Making Sense: Ethnographic Research on Spirituality in Palliative Care," *Journal of Pastoral Care and Counseling*, 51.1 (1997) 36.

anxiety/distress may experience the type of healing that "manifest(s) itself as peacefulness, acceptance, [and] better coping" before they die through the pragmatic incorporation of Scripture into select Pastoral Care visits.[3] In short, spiritual distress may be assuaged – and peace instilled – by Scriptural affirmations and words of comfort.

In 1969, Elisabeth Kübler-Ross noted that "we may achieve peace – our own inner peace… – by facing and accepting the reality of our own death."[4] Nearly 50 years ago she perceived that people in the US confronting terminal illness experience a significantly lonelier, more "mechanical, and dehumanized" circumstance due to medical advancements and "life-saving" interventions.[5] This pervasive quandary provides the impetus for this study. A theological concern functioning in tandem with this problem is that hospital chaplains, as ordained, endorsed, board certified ministers, must be able to "recognize when there is great disparity between present practices and God's Word," and must "work diligently and with deliberation to bridge that gap."[6]

The present study concentrates its efforts within one urban hospital context in Philadelphia.[7] It explores a method that honors the "ministry of presence" while probing deliberate ministerial approaches, strategies, and conversations with individuals being cared for by our Palliative Care team on an inpatient basis who have self-identified as Christian. The purpose of exploring alternate ministerial techniques is to ascertain whether the incorporation of Scriptural reassurances in chaplain visits might positively impact an individual's

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[3] Christina M. Puchalski, *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (New York: Oxford University Press, 2006), x.

[4] Elisabeth Kübler-Ross, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families* (New York: Simon & Schuster, 1997, 1969), 31.

[5] Kübler-Ross, *On Death and Dying*, 21.

[6] Brent A. Strawn, "The Designated Reader Revisited: DMin Project Design Workshop Sermon" (delivered on 08/14/2017 at the 9am worship service in the Candler School of Theology teaching chapel).

[7] That is, improving urban hospital chaplain ministry to markedly reduce the likelihood of patients dying in distress and/or experiencing prolonged spiritual/emotional suffering. My own context is Thomas Jefferson University Hospital, a Level 1 Trauma Unit hospital in center-city Philadelphia, with a maximum patient capacity of close to 1,000 beds, in a region that historically has strong Catholic, Protestant and Jewish roots, with ever-increasing Muslim, Hindu, and Buddhist communities.

emotional/spiritual state of being and welfare prior to their death. The study will focus on patients – not their families or support systems – who have been informed by the medical team that their cancer is terminal and that a palliative treatment plan theretofore would be more judicious than "aggressive medical measures." The execution and assessment of this project will incorporate observable verbal *and* nonverbal feedback to determine which Scripture passages, under which circumstances, potentially possess the ability to resolve spiritual distress.

To be sure, a chaplain in any context must be cognizant of the reality that every hospital is different from the next, possessing unique aspects ranging from the socio-economic and socio-cultural profiles of the patient population to patient satisfaction scores to how research-oriented the medical staff and/or the institution might be. Thus, each chaplain benefits from a multitude of practices, not just one approach. Ministers must discern their methods amidst their own degree of pastoral authority. Even so, in my estimation, an over-emphasis on the "ministry of presence" can at times neglect (perhaps advertently) ministerial opportunities to address a Christian patient's expressed concerns. And when that occurs, existential anxieties may persist, causing emotional suffering and spiritual distress.

In what follows, I will first clarify the perceived potential problems of chaplaincy interactions and the effects of an over-emphasis on the ministry of presence. Then I will present an alternative model that incorporates intentional interventions on the part of the chaplain by reading Scripture passages with patients. The third section will cover the data gathered over several months, followed by an analysis of the data. I will then develop some conclusions for further consideration and propose suggestions for future work/research.

II. Elaboration of the Current Hospital Chaplain Model / Dilemma

A. Contemporary Status Quo Chaplain…

To provide a brief background, the model of chaplaincy that has developed over the past several decades emphasizes a "ministry of presence" involving a "generic spirituality…[that] respects religious and spiritual diversity"[8] and discourages chaplains from Scriptural discourse due to its risk of sounding "preachy" or even judgmental. Chaplains are generally trained, instructed, and expected to be skilled active/reflective listeners, and are *strongly* advised to "keep God language" out of the equation. Dating back to 1925, the history of the formation of Clinical Pastoral Education informs us that the original goal of hospital chaplaincy was to "break down the dividing wall between religion and medicine."[9] Anton Boisen's vision was very research-oriented (not pastoral per se),[10] incorporating Rogerian-based person-centered therapy principles into patient visits.[11] And indeed, it seems true to this day that for the vast majority of chaplain visits, a "ministry of presence" is the best approach for meeting patients where they are, for

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[8] Allen Verhey, *The Christian Art of Dying: Learning from Jesus* (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2011), 65. In this section of his book, Verhey does more than merely identify the "generic spirituality" as an ambitious means of striving to respect religious and spiritual diversity in various contexts. The entire quote from which this is captured actually seems to overtly chastise this model and question its appropriateness in 21st century chaplaincy: "…this generic spirituality refuses to name the Mystery because it wanted to respect religious and spiritual diversity, but generic spirituality can have an ironic result; it is not finally hospitable to difference. When 'spirituality' is reduced to some lowest common denominator, to something like 'the Ultimate Mystery,' then the ways in which it is named can be trivialized." This is the exact sentiment with which I have struggled in my own past decade of hospital chaplain ministry. I have found the "lowest common denominator" to ultimately ignore or disregard the specific needs of our patients – which has been particularly, painfully disturbing for me in ministering to dying individuals coherent enough to realize their own death is near (i.e. moreso with people dying of progressive cancer than of a massive heart attack or brain hemorrhage). The only specific religious need we seem to honor with any frequency is the need for a Catholic priest to administer the Anointing/Sacrament of the Sick to our Catholic patients.

[9] Robert Leas, "A Brief History," from the Association for Clinical Pastoral Education website: https://www.acpe.edu/pdf/History/ACPE%20Brief%20History.pdf , (accessed on December 10, 2017).

[10] Based on the information in the ACPE: A Brief History document, Boisen was at odds for a number of years with his successor at Worcester State Hospital, Carroll Wise, for "changing the program from a research to a pastoral emphasis."

[11] J. Brian Bartley, "The Pastoral Applicability of Person-Centred Therapy," (Term paper, Trinity College at the University of Toronto, 2006), 1-3. http://www.nvo.com/bartley/nss-folder/termpapers/Pastoral%20-%20Person-Centred%20Therapy.pdf , (accessed on January 10, 2018). Bartley notes that this model, which has been the bedrock of CPE for the past 50+ years, emphasizes the counseling qualities of congruence, unconditional (nonjudgmental) positive regard, and empathic understanding, which can help patients become more relaxed, less anxious, and more aware of the root cause(s) of their anxiety.

earning their trust, for helping to lessen their anxieties about their ailments, and for avoiding the imposition or judgment that a religious tone can set.

However, for a chaplain to *remain* in "ministry of presence" mode amidst encounters with individuals who are cognizant of their own imminent death could be perceived a ministerial disservice to the person dying. When people are counting their remaining days or weeks, and are experiencing considerable anxiety (or "spiritual distress") as a result, a *strong, confident* ministerial presence willing to identify and name Scripture passages that resonate with the patient is of infinitely greater value to the infirm individual than the quieter, more reticent role of the active/reflective listener. Such silence and passivity fails to deliver adequate ministry to those preparing to die – particularly in the event that the chaplain is the only minister they have.

Part of an ordained minister's role is to help individuals address and resolve theological, existential, and/or spiritual concerns they harbor. The *Ars Moriendi*, as well as the recent resurgence of interest in it, point explicitly and lucidly to this belief. Clergy are expected to provide spiritual guidance to lay people, particularly in times of distress. In her research on caring for terminally ill individuals, Helen Kruger outlines the "needs of the dying patient," first of which is on her list is the need for opportunities "to discuss the process of dying, body changes, losing control, *and what happens after death*."[12] She elaborates by asserting that "a strong sense of spirituality is the best coping resource for the dying process."[13] Christopher Vogt suggests that a Christian facing death needs to be able to express care for his/her caregivers; to

[12] Helen Kruger, "Caring for People Who Are Terminally Ill," *Spiritual Caregiving in the Hospital: Windows to Chaplain Ministry*. Leah Dawn Bueckert & Daniel S. Schipani, eds. (Kitchener, Ontario: Pandora Press, 2006), 158. Italics have been added by me for emphasis.

[13] Ibid, 159.

engage in other-directed activities while also receiving care; to experience patience, compassion, and hope throughout the dying process.[14]

Yet many hospitalized individuals currently seem to die in emotional or spiritual distress amid what is generally referred to as *heroic* or *aggressive medical measures* that can end up inflicting physical and emotional suffering,[15] preventing people from dying in peace as they otherwise could. It has been said that "Christians must be given a method of directing their own passing to a happy eternity," with which I concur.[16] I posit here that there must be a more optimal model for 21st century hospital chaplain intervention than that which tends to be the modern norm: the reflective listener adept at quietly delivering a ministry of presence, a model potentially ideal for the latter half of the 20th century, but that perhaps is in need of reconsideration in these changing times.

The Protestant Christian belief that grace is available to all points to the chaplain's role as spiritual conduit, helping those perched on the precipice of death confront their own mortality, recognize their own ability (or opportunity) to "penetrate to the kingdom of truth," and permit the Peace of Christ to enter their souls.[17] This ministerial responsibility stems from the growth of both religious pluralism and secularism in this country. Hospital chaplaincy emerged in this country during a time when the majority of individuals and families maintained membership

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[14] Christopher P. Vogt, *Patience, Compassion, Hope, and the Christian Art of Dying Well* (New York: Rowman and Littlefield Publishers, 2004), 111-120.

[15] Physical suffering could include (but is not limited to) chest compressions, intubation, transfer to ICU. Emotional suffering would involve depression and anxiety.

[16] Sister Mary Catherine O'Connor, *The Art of Dying Well* (New York: Columbia University Press, 1942), 6-7. See also: Jeffrey Campbell, "The Ars Moriendi: An Examination, Translation, and Collation of the Manuscripts of the Shorter Latin Version" (Ottawa: University of Ottawa, 1995), 9.

[17] Simone Weil, *Waiting for God* (New York: Harper & Row Publishers, 1951), 64. Weil wrote that any human being "can penetrate to the kingdom of truth…if only he [/she] longs for truth and perpetually concentrates all his [/her] attention upon its attainment… When one hungers for bread, one does not receive stones" – a beautifully articulated sentiment which seems particularly poignant in relation to individuals readying themselves for death.

with a given church. At this point in time, a significant shift has occurred whereby more than 50% of the residents of the Philadelphia region claim no affiliation. Currently, individuals may acknowledge being raised in a certain tradition or belief system; however, they no longer claim that faith or belief in their day-to-day existence.[18] As such, their religious language fluency seems to be dying, creating a need for chaplains to exercise Scriptural language more frequently and more confidently than in years past, in order to help the dying individual give expression to his/her situation and access spiritual reconciliation / peace before death.[19]

I feel convinced that the incorporation of Scripture into critical conversations with terminally ill individuals aids them in confronting their unresolved anxieties specifically by delivering to them the language they need, ultimately helping them attain a sense of peace *before* dying, in order to truly "rest in peace." As ordained ministers, chaplains should not shy away from such pivotal moments in the name of honoring the ministry of presence model – or even as a result of what may have become a habitual tendency toward this type of quiet, reflective-listener ministry over years of one's chaplaincy. In fact, it is our duty and privilege to facilitate the entering of the Peace of Christ into others' souls.

B. Re-Envisioning Chaplaincy for Specific Patients / Encounters

An ever-increasingly secular society with ever-advancing medical technology needs – and seems to long for – ministers adept at providing the spiritual language, the words of peace,

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[18] See http://www.city-data.com/county/religion/Philadelphia-County-PA.html . The survey analyzes data for "Philadelphia County, PA" from the 2010 census, comparing it to 2000 census information. As of 2010, 51.2% of Philadelphians claimed not to be "religious adherents" to any specific tradition or faith identity – a 280% drop from 13.6% in the year 2000.

[19] I draw upon Brent A. Strawn's cogent claim that "The Old Testament Is Dying" in identifying the loss of religious/scriptural language in the secular realm of the Philadelphia region. Strawn notes that "Just as language…allows us to make sense of the world and ourselves, the Old Testament provides a kind of grammar" to help us interpret our surroundings and predicaments (p. 8). I would expand this thought to say not only does the Old Testament provide this grammar, but in fact Scripture in its entirety does; and if one loses that language, s/he turns to those believed to be linguistic experts to help her/him access the language again. See Brent A. Strawn, *The Old Testament Is Dying: A Diagnosis and Recommended Treatment* (Grand Rapids: Baker Academic, 2017).

that the secular mainstream now lacks. Inclusion of Scripture in pastoral care visits specifically with terminally ill patients receiving palliative treatment could provide the guidance, words of comfort, and reassurances of peace that individuals in the process of transitioning into the "kingdom of truth" desperately crave.[20] Individuals who have faced stressful situations in the past "with open confrontation [as opposed to denial] will do similarly in the present situation,"[21] thus availing themselves to conversations about end-of-life existential concerns. As such, if the seasoned chaplain judiciously seizes certain opportunities to address a patient's expressed concerns, and suggests reading select Scripture passages prior to honoring that patient's request for a word of prayer, this may help the patient address her/his anxieties and fears more conclusively.

Something Elisabeth Kübler-Ross said back in 1969 – that "dying nowadays is more gruesome in many ways, namely, more lonely, mechanical, and dehumanized"[22] – only seems to have grown increasingly poignant over time. The dying process in the United States has become more and more complicated (i.e. lonelier, more dehumanized) in recent decades. Interdisciplinary team members working closely with the Palliative Care Team specialists tend to be quite concerned about patients' increased feelings of isolation, hopelessness, and "deep depression from which [they] may not emerge unless someone is able to give [them] a sense of hope."[23] Some medical professionals specifically identify this as *spiritual distress*, and rely on well-trained chaplain ministers to assist the patients with such spiritual / emotional crises. And yet, it has been noted that chaplains are at risk for "spiritual 'drift' [with] dangers of 'dumbing down the spirit'"[24] – a phenomenon I feel I have witnessed firsthand, both in myself and in the other chaplains in my

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[20] Weil, *Waiting for God*, 64.
[21] Kübler-Ross, *On Death and Dying*, 45.
[22] Ibid, 21.
[23] Ibid, 48.
[24] Christopher Swift, *Hospital Chaplaincy in the Twenty-First Century: The Crisis of Spiritual Care on the NHS* (Surrey, UK: Ashgate Publishing, 2009), 74.

midst. It is strongly suggested that chaplains become mindful of this phenomenon, and embrace "a more considered engagement…with theological roots and resources."[25]

Thus, this study incorporates reflections and quotes from chaplain encounters with people diagnosed with terminal and/or metastatic cancer, all of whom were – or are being – cared for by our Palliative Care team specialists (physicians and nurse practitioners). The reflections specifically revolve around the role of a few select Scriptural passages in chaplain-patient (one-on-one) encounters. And although palliative care tends to involve more of a focus on pain management than actual "comfort measures," because this study spans a 2-year time frame focusing on *terminal* diagnoses, many of the individuals represented will have died by the completion of this project. Finally, while reading this project, one must keep in mind the backdrop of the contemporary "dying with dignity" / "medical aid in dying" movement that has been gaining momentum (both philosophically and litigiously), in part due to the national publicity of Brittany Maynard's last several months of life prior to her death in 2014.[26]

III. Data Analysis (Patient Encounters & Observations; Artifact Analysis)

A. Case Studies / Patient Encounters

The following section reflects upon the pastoral relationships I built with fourteen individuals. With each, I set a requirement for myself of a minimum of three ministerial encounters through which I could build a relationship. I have included reflections on five of

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[25] Swift, *Hospital Chaplaincy in the Twenty-First Century*, 74.

[26] In recent years, a shift in mindset has begun to transpire wherein people are reclaiming their own abilities and rights in the end-of-life decision-making process. Brittany Maynard was a 29-year-old diagnosed in 2014 with a glioblastoma, a fast-growing, deadly form of brain cancer, who made very deliberate decisions to determine how to spend her last few months of life. See http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/index.html . See also the Compassion and Choices website: https://www.compassionandchoices.org/research/speakers/speaker-dan-diaz/ , through which her husband, Dan Diaz (a lawyer), continues to promote "medical aid in dying." The Compassion and Choices website notes that "Dan advocates for expanding the availability of end-of-life options for terminally ill, mentally capable individuals."

those relationships (or "case studies") within the body of this paper; the remaining nine can be found in the Appendix. The names of all individuals have been changed[27] in order to protect their privacy and respect Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.[28] The patient pool I discuss incorporates a variety of ethnicities and age ranges, and strove for gender balance as well; however, the majority of the individuals ended up being females of European descent, in part because there continues to exist among non-Euro individuals and families a hermeneutic of suspicion regarding palliative and hospice care.[29] All patients included for reflection in this study consider themselves to be Christian (either Protestant or Catholic), with varying degrees of involvement in their own churches.

When I embarked upon this study, I surmised that there would be one ideal, pivotal Scripture passage that would function well for all patients. As a former special education teacher who believes whole-heartedly in individuality and the individualization of educational instruments or pedagogical approaches, I'm not sure how I could have been so naïve. Thus, at the close of the first patient encounter reflected upon for this study ("Leah"), I realized that what was appropriate for Leah would likely *not* be appropriate for others. An informal quasi-equivalent of an Individualized Education Plan/Program (IEP)[30] quickly became the model for

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[27] In creating pseudonyms for each patient, I selected biblical names whose meanings seemed to resonate with each individual's unique personality. This is made fairly evident with my use of the name "Miriam" for someone who had been a dancer and singer as a young adult, for example.

[28] See https://www.hhs.gov/hipaa/index.html for more information about HIPAA rules and regulations.

[29] Publications such as Rebecca Skloot's *The Immortal Life of Henrietta Lacks* (New York: Crown Publishing Group, 2010) and other works of recent decades have brought to the public forefront of the nation's consciousness our collective history of manipulating people of minority status in ways that have benefited the medical establishment. Mistrust stems from "historical racism, forced sterilization of black women, and the infamous, government-led Tuskegee syphilis experiment that denied effective treatment to black men" (Melissa Bailey, "Taking on Planning for the End of Life: A Preacher and Physician Uses Her Insight to Get Her Flock to Consider Hard Choices that Need to Be Made," *The Philadelphia Inquirer*, January 14, 2018. Accessed January 14, 2018).

[30] According to the *Medical Dictionary for the Health Professions and Nursing*, an IEP can be defined thus: In the U.S., an education program tailored to a particular student with a disability, the provision of which is mandated by law. Mandated by the Individuals with Disabilities Education Act, an IEP has two parts: the plan itself

this research process shortly after its commencement. I refer to this as an Individualized Scripture Plan.

Rooted in my own background of working with teenagers and young adults with intellectual and/or learning disabilities, the development of an Individualized Scripture Plan[31] for each patient based on her/his unique spiritual, emotional, and even social needs revealed itself as the most judicious approach. Ministerially speaking, I felt convicted that the best – if not only – way to honor someone's dying needs was to be critically attentive to her/his personal expressions, interests, beliefs, and desires. This approach was (and is) admittedly intuitive in nature and does not necessarily follow a specific methodology. In the same vein as creating pseudonyms for each individual based on his/her emotional affect and interests, the scriptural passages I selected tended to be based on deductions made from the first two encounters I had had with each. Although the lectionary texts became a reference point for me (which will be explained later in this paper), a minister still has the opportunity to choose from several lectionary passages. The passage ultimately chosen for each patient was based on my own instinctive sense about the individual's spiritual and emotional needs (or, in other words, asking myself, "Which text will resonate most closely, deeply, and profoundly with this person?").

Leah[32]: Leah was a Filipino woman, 71 years of age, a self-described Evangelical. She was the first patient within the parameters of this study to whom I said, "Would it be ok if I read some Scripture with you?" Even from my first encounter with her, she made it clear that prayer helped ease her pain and assuage her anxiety. As I have found to be the case with most

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and the written document supporting it. See *Medical Dictionary for the Health Professions and Nursing*, https://medical-dictionary.thefreedictionary.com/Individualized+Education+Plan. (accessed on January 6, 2018).

[31] To the best of my knowledge, this is not already an existing term. I created this term based on what I perceived as its close correlation to the Individualized Education Plan/Program of the U.S. educational system.

[32] One translation for the Hebrew name, "Leah," is weary. This patient indeed seemed very weary from her trials.

individuals over the span of my hospital ministry, she did not have any particular passage in mind, but rather *relied on me to choose a text for her*. Per the suggestion of a fellow chaplain who had also once visited with her, I selected the passage from Matthew 26:36-42.[33] Like Jesus in this passage, she never gave up hope that this might be possible, even as physicians continued to provide difficult medical news of her cancer's progression. She repeatedly expressed feeling hopeful that God might respond to her plea, remove her pain, and at least impede the growth of her cancer (if not remove it all together). I believe my colleague was correct in determining that this passage might resonate with her feelings most closely. As I read to her the words from verse 39 ("…let this cup pass from me; yet not what I want but what you want"), she stopped wincing from her pain for a brief moment. I chose to repeat that verse a second time, and then a third. I then continued reading up through verse 42, at which point I took a risk in asking her directly if hearing these words was helpful.[34] She nodded affirmatively, whispered, "Yes, yes." But after several moments of silence, she then cried out in pain again. After this encounter, she was discharged to hospice later that evening. I never saw her again. I can only surmise that correlating her situation to that of Jesus at Gethsemane (via this Matthean text) helped assuage her anxieties and provided some affirmation that God is with her.

[33] Matt 26:36-42 (NRSV) depicts Jesus at Gethsemane. According to Matthew's version of this incident, each time Jesus prays, his prayer involved an element of hope: "…he threw himself on the ground and prayed, 'My Father, *if it is possible*, let this cup pass from me; yet not what I want, but what you want'" (v. 39); and "…he went away for the second time and prayed, 'My Father, *if this cannot pass* unless I drink it, your will be done'" (v. 42).

[34] I say that I "took a risk" because, as a general rule, chaplains are instructed to avoid asking questions to the greatest extent possible. The rationale behind this practice is that every other professional in the hospital bombards patients with questions and interrogations; it is the chaplain's role to be "safe space" from that interrogation. Thus, chaplains attempt to frame all expressions in a statement or observation form. (For example, saying, "It seems like you feel sad," or "That could feel overwhelming," rather than "How does that make you feel? Are you sad?") The other aspect of this theory is that questions can at times feel like loaded judgments; to avoid asking questions hopefully (or ideally) contributes to the absence of judgment in the encounter.

Admittedly, although this passage did seem appropriate for this particular individual, there was something extremely disconcerting for me about reading it to a dying person. Consequently, she is the only person for whom I selected a "Garden of Gethsemane" passage.

Miriam[35]: From the first few minutes of my initial encounter with Miriam, I felt a deep, personal obligation to help her navigate her diagnosis. A 70 year old Protestant woman of European descent, she suspected that the cause of her cancer could be traced to the Lockheed-Martin engineering plant near where she lived in Moorestown, NJ – a corporation that employed my father for over twenty years. Miriam was a very artsy individual who had been a dancer in her younger years. She spoke of "rubbing elbows" with celebrity dancers such as Gene Kelly, Debbie Reynolds, and Donald O'Connor. She also openly indicated that she felt she needed to draw upon inner strength in order to confront her terminal situation, as her husband was not able to be strong for her.

The reflective listening I employed with Miriam tended to mirror the creative spirit and inner strength I witnessed within her; I thought she would benefit greatly from some simple reminders about her own core strength. I also determined that Exodus 15:1-21[36] would both resonate with *and* inspire her. She nodded silently as I read, "The Lord is my strength and my might, and has become my salvation…" [37] and "Who is like you, O Lord, among the gods? Who is like you, majestic in holiness, awesome in splendor, doing wonders?"[38] But when I read about

[35] One of the meanings for the Hebrew name, "Miriam," is "beloved." To me, this individual not only seemed in love with all of creation, but also seemed to *be* loved *by* creation – and by the Creator.

[36] Exod 15:1-21 (NRSV) is a fairly lengthy passage that perhaps need not be included in its entirety here. Verses 1-19 are referred to as "The Song of Moses," proclaiming that the Lord is the source of strength and might, the greatest of warriors, who overturned Pharaoh's chariots and army. Verses 20-21 are then "Then Song of Miriam" which notes that "The prophet Miriam, Aaron's sister, took a tambourine in her hand; and all the women went out after her with tambourines and with dancing. And Miriam sang to them: 'Sing to the Lord, for he has triumphed gloriously; the horse and rider he has thrown into the sea.'"

[37] Exod 15:2, NRSV.

[38] Exod 15:11, NRSV.

Aaron's sister, the prophet Miriam, leading a dance with tambourines,[39] her face absolutely lit up. She indicated that she had never heard this passage before. The words of celebratory dancing seemed to help her heart feel light, and strengthen her spirit. During the encounter in which I shared this text with her, she had been out of bed (for the first time since I had met her), seated in the recliner chair in her room; lights off in her room; a somber expression on her face. However, the *next* time I saw her a few days later (which happened to also be the *last* time I saw her), she was ambulating down the hall with a nurse assist on one side, with an expression of peace and relative joy on her face. A smile even periodically flashing across her lips. She is one individual I firmly believe I helped by employing a more active form of ministry. It is my deep conviction that this one encounter helped pull her out of a dark emotional place, reminded her of who she is, and allowed her to see that she has much yet to give – and to live.

Gemariah[40]: I met Gemariah less than an hour after he had reconciled the medical concern that he would be "DNR/DNI" and seek no further cancer treatment.[41] In fact, while I sat with him and his wife in his room, an oncologist came in to discuss his decision with him – to ensure that Gemariah fully understood any and all ramifications of this choice. On a second visit, after listening to his emotional/spiritual concerns and ruminations, I prayed with him and his wife just before his three children (ages 14, 19, and 21) arrived. My third visit with Gemariah involved his wife, their three children, and a longtime friend who were all present in the room. At that time, I requested his permission to read from Scripture before we prayed together. Realizing that Gemariah and his family identified as Catholic, I took a moment to explain the

[39] Exod 15:20-21, NRSV. See footnote 35.

[40] Germariah may be translated from Hebrew as, "God has accomplished." I feel that this individual accomplished the admirable feat of confronting and reconciling all significant issues and life-matters within the few days-to-weeks prior to his death. As such, God accomplished admirable feats through him.

[41] In medical language, these abbreviations stand for "Do Not Resuscitate/Do Not Intubate."

Protestant lectionary system, and then noted that Psalm 147 was one of the optional readings for Sunday, January 7, 2018. "With your permission," I said, "I would like to read parts of this psalm for you before we pray. He and his wife both said they thought that would be very nice.

I read Psalm 147, vv. 12-16 and 20,[42] paused, and then led them in a prayer about the beauty and blessing of Gemariah's own family, his children, and his and his wife's strong intellects; then I sought God's peace and strength to sustain them all in the days to come. Being that his children were in the room listening to all that I said, the part of verse 13 referring to God blessing the children (of Zion) seemed to fit profoundly to the situation. Gemariah did not cry. Instead, after the prayer, he relied on his intelligence and his where-with-all to begin sharing what he knew of early Ancient Near Eastern religions with everyone gathered. He informed them that, during the past two years as he drove to and from chemo treatments, he managed to listen to an audio version of the entire Bible a minimum of two times, probably more. Everyone listened quietly and attentively, imprinting in my mind the image of disciples gathered around the dying man's bed, gleaning wisdom from him during his last days of life, his last words, his last breaths. It felt at the time like both a profoundly intense *and* intensely profound moment. His wife later confirmed that it was indeed as pivotal for him (and them) as it felt for me.[43]

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[42] Psalm 147, vv. 12-16 and 20 (NRSV) reads, (v.12) "Praise the Lord, O Jerusalem! Praise your God, O Zion! (v.13) For he strengthens the bars of your gates; he blesses your children within you. (v.14) He grants peace within your borders; he fills you with the finest of wheat. (v.15) He sends out his command to the earth; his word runs swiftly. (v.16) He gives snow like wool; he scatters frost like ashes. (v.20) He has not dealt thus with any other nation; they do not know his ordinances. Praise the Lord."

[43] He was discharged from the hospital on 01/05/2018 to home hospice care. His wife returned to the hospital on 01/26/2018 to thank a few of his caregivers and to let them know he died peacefully at home three days later (01/08/2018). She named me as one who made a tremendous impact on him and the family. My last visit with them (on the afternoon of 01/04/2018) in which I read Scripture and then prayed with them was the impetus for this typically quiet, reserved man to begin giving voice to things in life he found to be most important. Later that evening, when it was just him and his wife, he shared with her a list he had made concerning funeral logistics, what he wanted to wear, who it was important for him to see again before he dies, etc. His wife attributed this "opening up" to my reading of Scripture and my subsequent prayer. She identified this one moment as being exactly what he needed in order to address things before dying. "In that one final act," she said, "you brought faith to him when his faith was wavering. You helped him find his way." I can almost guarantee this would

Cyrus[44]: Sixty-year-old Cyrus is arguably one of the most fascinating characters I have ever met. He was an enigmatic African American man who identified himself as Protestant Christian but expressed multifaith perspectives that included a respect for Jewish and Muslim faith traditions. He frequently spoke of the Qur'an, Torah, and Bible collectively in one breath. During each of my visits he seemed to take much glee in sharing with me his belief that God is a woman, that God wants peace and harmony, but that man creates war. "But," he would say, "That's all right. Out of chaos, order is born." And from there he would launch into discourse about various religious writings (such as the book of Genesis). Although in my mind he was "only 60," he expressed that he felt ok about dying. He spoke at length about death in terms of atoms – how we are all made up of atoms and, when we die, we will continue on as atoms. In fact, he identified our ongoing presence in atoms as the true "stuff" of the Resurrection. He articulated an integration of theology with science & math, as to say they are all inter-related.

My numerous encounters with Cyrus consistently felt reminiscent of Wisdom Literature. Therefore, I felt inspired to draw from Ecclesiastes for him. I introduced Ecclesiastes 3 to him by saying, "Are you familiar with this writing? The band, "The Byrds," had a song about it[45]: To everything, there is a time and a purpose under heaven – a time to be born, a time to die…" He instantly lit up. "Oh, yeah! I know that!" Then I skipped down to Ecclesiastes 3:10-15[46] and said,

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not have happened had I not introduced the Scripture reading – which I would have felt was against the principles of the "ministry of presence" even a year ago. To me, this is concrete proof of how critical this study is.

[44] Cyrus can be interpreted as, "Far-sighted, young." This individual had a life-altering experience as a teenager. In addition to that, he struck me as very youthful and jovial in his affect and attitude.

[45] The Song, "Turn, Turn, Turn," is attributed to Pete Seeger, who composed it in the late 1950s. The band The Byrds popularized it in the mid-1960s. The Byrds recorded and released their version of the song in 1965, reaching number one on the Billboard chart in December of that year. See http://www.songfacts.com/detail.php?id=246 (accessed on January 12, 2018). See also https://www.youtube.com/watch?v=W4ga_M5Zdn4 (accessed on January 12, 2018).

[46] Ecclesiastes 3:10-15 (NRSV) states, (v.10) "I have seen the business that God has given to everyone to be busy with. (v.11) He has made everything suitable for its time; moreover he has put a sense of past and future into their minds, yet they cannot find out what God has done from the beginning to the end. (v.12) I know that there is nothing better for them than to be happy and enjoy themselves as long as they live; (v.13) moreover, it is

"This is what it says just after that…" He listened as I read slowly and methodically through the verses. "That's *it*!" he proclaimed. "*That's* what I'm talking 'bout!!" I don't necessarily believe my incorporation of Scripture into our visits impacted him on a deep, profound level as it seemed to for other patients. Cyrus seemed to have reconciled his own anxiety on his own terms, and seemed genuinely relaxed and at peace with his own transition-to-death process. Reading Scripture to Cyrus was less about confronting or resolving anxiety prior to death, and more a means of affirmation. But the validation he received by my pinpointing a passage that spoke directly to him seemed to help create a strong rapport between us which would not have existed had I remained in a ministry of quiet presence. In other words, with him, I became more than just a good listener. I became his pastor.

Abigail[47]: I first met 53 year old Abigail on the evening of "Super Bowl Sunday" (February 4, 2018). She immediately expressed gratitude for a Pastoral Care visit. A devout member of her United Methodist Church in Leesburg, Virginia, she had come to this Philadelphia hospital specifically for the expertise of its neuro-oncology physicians and medical staff. She received the diagnosis of a glioblastoma – potentially the worst (most aggressive, most fatal) form of cancer one could have – in October, 2017. She felt painfully aware that "the clock was ticking" for her, since the average lifespan from time of diagnosis is 13 months. After sharing details of her life story with me (including mission trips to Mexico and the Dominican Republic, as well as living in Afghanistan for 30 months as part of her job with in the auditing

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God's gift that all should eat and drink and take pleasure in all their toil. (v.14) I know that whatever God does endures forever; nothing can be added to it, nor anything taken from it; God has done this, so that all should stand in awe before him. (v.15) That which is, already has been; that which is to be, already is; and God seeks out what has gone by."

[47] The Hebrew name, "Abigail," can be translated as "My father rejoices." From what I saw and what I knew of this individual, I cannot help but believe God rejoices very, very much in her being and in the way she has lived her life.

department of the federal government), she asked me to pray for her. She squeezed my hand tightly, almost as if for dear life. She didn't request a prayer of healing, but rather a prayer of strength to face each day with gratitude, clarity, and dignity. She confided that what she sought most was discernment on how to use her own diagnosis – her own suffering – to help ease the suffering of others who might find themselves in a similar situation.

On the second visit, she shared that she was born and raised in California. She ended up in northern VA (Manassas) for work, and settled there. About ten minutes into this visit, a hair stylist contracted by the hospital came to her room per her request to have her head shaved. I stayed nearby in order to gauge her comfort or anxiety level with this process. I've known women for whom this act caused much grief, emotional pain, and many tears. Abigail, however, came across as brave, strong. She shed no tears. She simply said she was "ready."

My third and fourth visits with her were fairly brief. But during the fifth visit, she revealed emotional vulnerability again. She spoke of the results of her colonoscopy, tying it into her concerns about having to stay in the hospital longer than originally anticipated. She mentioned not understanding why it was part of God's plan for her to contend with this diagnosis, but expressed a deep conviction she was being called to help others going through similar processes or experiencing a similar form of personal suffering.

I had come prepared with a document I had created utilizing several passages from Paul's second letter to the Corinthian community.[48] I introduced it to her by saying, "I hope you don't mind that I took the liberty to pull these passages together, but I remembered you saying a few days ago that you were struggling with the concept of suffering." She nodded, and in fact began crying – I think because she was surprised that I had been so attentive to her, had followed up

[48] The passages from 2 Corinthians include chapter 1:3-7; chapter 3:17-18; chapter 4:5-8 and 16-18; and chapter 6:16-18. All were from the NRSV.

with this previous conversation, heard her, validated her feelings, and brought this to her, *specifically for her*. I surmise that my deliberation helped her feel authentically valued. Additionally, because she was aware that the GBM (or the chemo treatments, or both) was/were impacting her short-term memory, she expressed gratitude that I had produced the passages for her in written form, which she could read and re-read as needed or desired.

I only had one more visit with her before she was discharged from the hospital. During that visit, I brought with me a print-out of Psalm 103, but left it out in the hall closet in order to assess whether it would be something she might want in that particular moment.[49] For the most part, this visit seemed fairly "light" in nature. But toward the end, Abigail mentioned believing that even though suffering is painful, there must always be some reason for it; and there must also always be some reason to give thanks in the midst of (or in spite of) the suffering. With that, I asked her if she would mind if I shared with her a "Psalm of Thanksgiving." She said she would deeply appreciate that. And with that – with the reading of Psalm 103 – my final visit with Abigail came to a close.

B. Artifact Analysis

Every aspect of this study is specific to this level-one trauma center teaching hospital in center-city Philadelphia, which also serves as an ACPE-accredited Clinical Pastoral Education site. A number of parameters were considered and created from the outset, including (1) the requirement that the Palliative Care team is actively involved in the patients' plans of care (2) due to a terminal cancer diagnosis, and (3) that a minimum of three chaplain visits transpired for

[49] From my perspective, my actions and deliberations reflect the critical significance of a paramount need for chaplains to permit a spiritual assessment to be not a type of one-time inventory, but rather more of a living, breathing document that is open to change. I come prepared, but I do not impose. I bring with me items of religious significance, but leave them outside the door until the ongoing informal assessment assures me that the time is right for sharing such items. This is part and parcel of being an ethical, respectable, trustworthy chaplain.

each patient as part of an ongoing assessment to determine the appropriateness of integrating Scripture into a visit. Verbal and nonverbal behaviors were recorded in a journal[50] in order to assess the validity of this project's assertions. Autoethnography was the primary method of measuring and assessing myself and this approach to chaplain ministry, since analysis in the type of research hinges on observations rather than specific quantifiable statistical evidence.[51]

First, the "artifact" itself is the Scripture incorporated into the third (fourth, fifth, etc.) encounter the chaplain has with a given patient. Initially, it was thought that one specific, constant biblical passage could be utilized with all patients, thus becoming *the* "artifact." However, as noted earlier, it became almost immediately evident after encounters with the very first patient of this study ("Leah") that this "one size fits all" ideology was completely inappropriate. Thus, the development of an Individualized Scripture Plan for each patient based on her/his needs and expressions became the "go-to" approach. All individualized artifacts came from either NRSV or NIV Bible interpretations (identified in each footnote). Use of the Vanderbilt Divinity Library Revised Common Lectionary was an additional component of the "artifact," as patients with lengthy hospitalizations seemed to benefit from timely seasonal readings such as those designated for Pentecost or the Season of Advent.

Next, implementation of the artifact was conducted in the manner of the chaplain reading a given passage aloud to a particular patient, often repeating parts of the text or the whole text in order to add emphasis. It is noteworthy that texts were *not* selected via cell phone in the presence of a patient; rather, passages were determined ahead of time through careful, methodical

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[50] For clarification, a written journal was kept – *not* a video- or audio-recording type of journal.

[51] Autoethnography is to be understood as "an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience," as well as spiritual and religious experience, I would argue. See Carolyn Ellis, Tony E. Adams, and Arthur P. Bochner, "Autoethnography: An Overview," *FORUM: Qualitative Social Reseach Sozialforschung,* Vol. 12, No. 1, Art. 10 (January, 2011), from http://www.qualitative-research.net/index.php/fqs/article/view/1589/3095 , (accessed on February 24, 2018).

planning. A specific passage was selected deliberately for a given patient *prior* to entering the room, and that passage was printed out on a plain white piece of paper.[52] Each visit was planned in advance, and each passage was read several times during the planning process in order to consider both potential positive *and* negative aspects of reading the passage to the patient.[53] Throughout the planning, several translations were considered (NRSV, NIV, NKJV, ESV, New Jerusalem Bible) in order that the one chosen might have the optimal intended effect of helping the person process end-of-life circumstances by providing a calming sense of peace.

Another significant aspect of the implementation of Scripture is that *never* did the chaplain walk into someone's room and immediately began reading the passage. The typical ministry-of-presence was *always* (100% of the time) employed until the time seemed appropriate for the chaplain to offer reading Scripture to the patient, generally determined through comments a patient would make regarding spirituality, prayer, or theological insights/musings. But prior to presenting the possibility of sharing a passage from Scripture, the patient's mood, affect, and even mental/physical/medical condition that day was carefully (albeit informally) assessed: Was the patient nauseated? Did s/he have a fever? Were the lights out, shades drawn, and the blanket pulled over his/her head? Or did s/he seem to welcome the chaplain into the room, talk freely and

[52] I recall once during the first few months of my CPE residency walking through the hospital with a Bible, preparing to visit with a few patients. More than one staff chaplain chastised me for this, saying, "Carrying around a Christian Bible doesn't help us present ourselves as interfaith ministers…" Therefore I think it is significant to mention here that I did not walk into patients' rooms carrying a Bible; I carried only a folded-over white sheet of paper – which in itself stands in contrast to the way I typically carry absolutely nothing in my hands. Even if I was headed directly to a given patient's room, there is the ongoing concern that others in the hospital (patients, families, staff) would see the Bible in my hands and formulate instant judgments about it. However, given that we do periodically provide patients with Bibles, Qur'ans, etc. (as noted in one of the case studies) per their request, I may concede in the future to an internal voice of pastoral authority advising me to read directly from a Bible – likely either NRSV or NIV translations.

[53] Throughout the planning process, I asked myself a series of significant questions: "Does this passage seem too adversarial? Does it invoke (false) hope? Could it provoke depression? Or (as was my primary goal), is it a passage that the patient will likely feel gives expression to what he/she is feeling? Should I preserve the integrity of the passage by reading every verse, word-for-word? Or should I omit this verse or that verse?

uninhibitedly, and generally present himself/herself with an attitude of openness to the pastoral care visit? All of these environmental factors matter immensely.

A final consideration is that the majority of implementation occurred shortly before or during the Advent season. It is plausible that the season itself sub- or un-consciously could have impacted each individual's receptivity of Scripture. There is a sense of readiness – or of openness – that accompanies the anticipation of the birth of Christ. Even if people feel depressed or overwhelmed by their illness, they still seem to be *seeking, hoping, longing* – emotions that lend themselves to allowing an individual to be open to the presence of the Holy Spirit.

Innumerable lessons could be learned from this entire process. Perhaps the most critical thing learned is that the hospital chaplain may very well be the *only* minister a dying person has at this point in his/her life. The chaplain may be the one – and only – minister available to this person, to help her or him become emotionally, mentally, and spiritually ready for death. And, as I noted in the first section, it is quite possible that a chaplain can help individuals achieve internal peace by assisting them in confronting and accepting the reality of their own imminent death.[54]

On a personal note, I learned that I feel much more valid as a chaplain and Pastoral/Spiritual Care-giver when I conceive of myself as a minister adept at speaking directly to a person's heart and soul by delivering the Word that s/he seems to desperately need. More specifically, I feel more effective as a chaplain minister when I am actively striving to keep the language of Scripture alive in the midst of dire circumstances where it is arguably needed the most – on the precipice of death, where words of comfort, peace, hope, and affirmation are paramount. A final invaluable lesson learned is that the ministry of presence may unlock and open the door into a castle frigid with fear and anxiety, but delivering appropriate and timely

[54] Kübler-Ross, *On Death and Dying*, 31.

Scripture can in essence turn on the heat in the castle, making the environment warm, comfortable, safe, and even like Home.

IV. Reflections on Data Analysis

A. Inclusion of Scripture vs. Absence of Scripture in Patient Encounters

This study specifically reflects on the inclusion of Scripture into prudently selected hospital chaplain pastoral care visits. As a general rule, this practice is discouraged in this specific urban hospital context, which functions as a center for Clinical Pastoral Education residents and interns. In other words, reading and/or use of Scripture tends to be absent from pastoral care visits, as do prayer and any form of "God language." A Rogerian person-centered approach to pastoral care visits is the norm.[55]

As Allen Verhey and others have noted, however, this type of generic spirituality leads not only to a dumbing down of the spirit, but arguably also to an irresponsible model of ministry. Ordained chaplain ministers must develop the skill set to judiciously discern when to apply the ministry of presence and when to assert a more proactive, lead ministerial role.

In reflecting upon inclusion versus omission of Scripture in pastoral care visits, it seems that "no sooner than the third visit with a given patient" was/is a sensible starting point. This allows for at least two previous encounters in which a chaplain can build rapport with a patient while simultaneously gauging that patient's potential receptivity to Scripture, an offer of prayer, etc. In terms of the individuals incorporated into this study, Scripture seemed of value in every case but one ("Keturah"). However, in terms of the goal that reading Scripture could be a vehicle

[55] In the ten years I have functioned as a hospital chaplain in this particular context, I have probably prayed with patients and/or families *twenty times or less* over the course of that entire decade. Prayer is rarely requested. And within our department, a strong hermeneutic of suspicion exists regarding prayer alone, never mind theological discourse with patients, families, and staff and/or conversations involving Scripture.

to help terminally ill patients work through their anxiety about dying to develop a sense of peace before they die, it could only be said with certainty that nine out of fourteen exhibited clear signs of peace and assuaged anxieties after Scripture was read.

The fourteen individuals included in this study, and the impact this study may have had on them, could be summarized as such:

> **Leah** – yes, she demonstrated signs that hearing about Jesus in Gethsemane helped her
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> **Reuel** – not really; he already indicated a sense of peace and calmness about his process; however, he expressed gratitude and pleasure over hearing the words from Isaiah.
>
> **Rhoda** – yes, Psalm 62 in fact seemed to help provide clarity in her decision to seek no further chemo treatments but rather to go home on hospice.
>
> **Keturah** – no; for her, Scripture may have mentally returned her to her young Catholic days, for which she was emotionally unprepared.
>
> **Miriam** – yes; in fact, it seemed to inspire her to get back up on her feet and seize whatever time she had left.
>
> **Lydia** – yes; however, Lydia's cancer continues to progress as I write this, and her level of anxiety continues to ebb and flow. I do believe ongoing visits with Scripture readings could be helpful to her peace of mind throughout her process.
>
> **Chloe** – yes; however, it was already within her, looking for someone to support her through her own resolution of life's challenges.
>
> **Keziah** – difficult to say; for her, the simulation of Mass was what she needed. Thus, she is the one I deemed as "unclear response" in my analysis.
>
> **Gemariah** – yes; although he was confronting his own DNR/DNI status, he was nervous about it. Hearing the psalm with his family gathered around him seemed to provide a much-needed sense of peace and affirmation.
>
> **Michal** – yes; Psalm 80 brought peace to her heart and alleviated her fears.
>
> **Tirzah** – yes; the text from Mark 1 seemed to touch her deeply and profoundly, chasing "the devil" from her heart and thoughts.

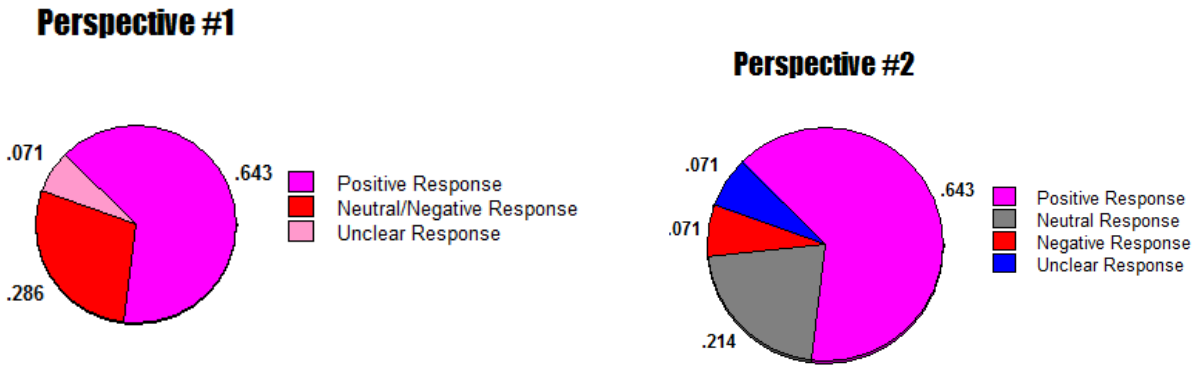
> **Cyrus** – not really; he had already said he was ok with dying. Nonetheless, the passage from Ecclesiastes provided some semblance of joy in its affirmation.
>
> **Abigail** – yes; the words of Scripture alone seemed to touch her spirit and mood, but also the gift of bringing specific passages selected with her in mind seemed to mean the world to her.
>
> **David** – not really; he was quiet and resigned in terms of both verbal and nonverbal expressions (or with what medical professionals might refer to as a "flat affect"). But he is one patient who *consistently* requested pastoral care visits *every time* he was admitted to the hospital.

This information could be depicted or charted in a number of ways. Consider the following:

> Nine out of fourteen gave clear indications that it helped.
> Four out of fourteen gave indications that it did not (necessarily) help.
> One patient gave unclear indication of whether or not it was helpful.

However, this could be broken down even more and analyzed from a few different angles. For nine individuals, it was fairly explicit (either verbally or through their actions and nonverbal behaviors) that they experienced a positive emotional / spiritual change as a result of hearing Scripture. For the four that I stated "it did not help," the reality is that from my very first encounter with *three out of four* of these individuals, I detected a degree of spiritual resolution regarding their own death; they may have expressed that the biblical readings were "nice," but they themselves had already resolved their own anxieties and confronted their mortality on their own terms. With only one individual did it seem that the readings conjured up old negative memories from her Catholic upbringing, giving a clear indication that not only was hearing Scripture *not* helpful, but some might surmise it was harmful in its own way. And with the final patient for whom results seemed unclear, she requested – and responded positively to – the in-room experience of Catholic Mass; however, the cancer had already begun impacting her cognitive processes causing periodic flashes of what is described medically as an "altered mental status."

Thus, the following graphs could apply to the collected data depending on the perspective one wants to take:



With the first perspective, it can be said that 64.3% of the individuals in this study demonstrated an overt positive response to hearing Scripture. However, the second perspective lends the possibility that, since "neutral" is neither positive nor negative, one could combine the 64.3% (positive) with the 21.4% (neutral) in order to assert that 85.4% of patients respond *favorably* to hearing Scripture. Either indicates that the majority of patients benefited from hearing Scripture, but the latter makes it more explicit that utilizing Scripture in pastoral care visits is a judicious method of engaging certain patients.

Given the relationships I built with these patients, I would be inclined to argue the latter perspective. The 21.4% that might not have necessarily *needed* to hear Scripture to help resolve spiritual anxieties or distress benefitted nonetheless from hearing Scripture. They were individuals who conveyed a solid Christian faith/belief system. And for all three, no outside clergy person came to visit them. Thus, I became their only minister at this critical juncture in their lives.

B. Reflections on Scripture Passages Used

The idea of using the Revised Common Lectionary to assist in selecting texts came fortuitously (but admittedly) somewhat by accident, as did the idea of creating an Individualized Spiritual Plan for each patient. And yet, it seemed to work. By reviewing the lectionary texts (including the "alternate" texts) after having already met with a given patient at least twice, it usually felt fairly straight-forward which text would resonate best with the patient and provide the most comfort. When I began this process, I somehow anticipated that I would draw mostly from the New Testament. However, as the process unfolded, I felt grateful to be able to utilize passages from either the Old or New Testament – not just one or the other.

Intriguingly, with the exception of a few well-known passages (such as the selection from the gospel according to Mark that I read for Tirzah), somehow each patient seemed fairly astounded by the words of Scripture. In short, they seemed pleasantly surprised that Scripture was so relatable and pertinent to their situation. I didn't intend for these end-of-life ministerial encounters to be educational moments; I had only hoped they would help bring the peace that surpasses all understanding to each individual's heart. And yet, it brought joy to my heart to witness a sense of wonder in their eyes upon hearing The Word.

V. Conclusion

As noted in the third section of this paper, perhaps the most critical conclusion drawn from this study is recognition that the hospital chaplain may very well be the *only* minister a dying person has at this pivotal juncture in his/her life. The chaplain may be the only minister available to help a dying person become emotionally, mentally, and spiritually ready for his or

her own death or "transition." And I do believe that an ordained chaplain can possess or develop the ability help individuals achieve internal peace.[56]

Personally speaking, I learned that by becoming a minister adept at speaking directly to a person's heart and soul by delivering the Word that s/he seems to desperately need, I felt (and continue to feel) much more valid as a chaplain and Pastoral/Spiritual Care-giver. More specifically, I feel more effective as a minister when I am actively striving to keep the language of Scripture alive in the midst of dire circumstances where I believe it is potentially needed the most – on the precipice of death. I have witnessed first-hand how transformative the biblical words of comfort, peace, hope, and affirmation can be for an individual facing his/her final days or hours. I have taken more ownership of the reality that I might be the only minister a person has, and might be the one s/he relies upon to help confront the final stage of life. While it is true that the ministry of presence generally establishes a fundamental starting point, builds rapport, earns trust, quietly conveys compassion, and ideally offers an absence of judgment, it is also true that delivering appropriate and timely Scripture can be the key to resolving an individual's spiritual distress. It can offer the spiritual, existential Truth that death does *not* have the final word. It can cause death to lose its sting.[57] It can be the true divine in-breaking of the phrase we so often exchange on Sunday mornings: Peace be with you.

[56] Kübler-Ross, *On Death and Dying*, 31.

[57] See Isaiah 25:8 (NIV) ("He will swallow up death forever"); Hosea 13:14 ("I will redeem them from death"); and 1 Corinthians 15:54-56 ("When the perishable has been clothed with the imperishable, and the mortal with immortality…").

Appendix

Reuel ("Friend of God"): A very kind-hearted 47 year old African American man, Reuel identified himself as Protestant Christian. He had suffered the effects of esophageal cancer for a few years by the time I met him. My encounters with him consistently felt deeply moving. I had initially attempted to meet him several times without success (he was sleeping, or out at physical therapy, or in a procedure). But when I finally *was* able to meet him, I found our visits to be quite memorable and engaging. Upon introducing myself and our Pastoral Care services, Reuel requested a Bible. After I delivered one to him, he began to talk openly about his spiritual beliefs and his desire to overcome this period of darkness in his life. He indicated that he is not a "Why me, God?" kind of person, but rather is one who says to himself, "Well, why not me?" He expressed a strong belief in humility, in counting his blessings, in loving his family, and in believing that he has it "better than a lot of people on this unit." He expressed appreciation for Pastoral Care support, and requested ongoing visits. Sadly, I had not even realized that he died in our hospital emergency department until I began to review his chart information for this study. The last time I saw him, he was on the oncology unit being transferred out to a rehab facility.

With Reuel, I believe I could have selected any number of Scripture passages and he would have been open and receptive to them all. But for him, I opted to search for passages that resonated with his "Why *not* me?" frame of mind. The one I ultimately chose was Isaiah 40:28-31, [58] a passage that essentially echoes his own words of finding strength in God and being self-aware enough to realize that his faith renews his strength. "Yes. *That* is the Word. That is exactly what I needed. Read that last part again." So I repeated that even though some may grow weary, stumble, and fall, "those who hope in the Lord will renew their strength" (vv. 30-31). He began crying, but assured me emphatically that they were a "good kind of tears," that he felt deeply moved by these words. I wished I could have done more. I wished I could have taken away his disease.

Rhoda ("Rose"): Rhoda was a 70 year old Catholic woman of European descent who, with her husband, had been leading what I would consider to be quite an enviable life of travel – not of the extravagant sort, but of the type involving camping and striving to be one with nature. For example, a few years ago she and her husband spent two months camping throughout Alaska, bearing first-hand witness to the wildlife native to each given region. I was only able to meet with Rhoda (sometimes with her husband, sometimes with just her) a handful of times over her two hospitalizations before she determined she would prefer home hospice care. During my introductory encounter, her primary desire was a visit from a Roman Catholic priest for a blessing / Anointing of the Sick. It was only through the follow-up encounters that I felt she permitted me to "journey" with her (as some say), which helped me feel confident in asserting myself to inquire if reading scripture with her would be welcomed. Her view of her cancer treatment might be considered "realistic" – hoping for the "best," but mentally and emotionally preparing for the "worst." Her husband was ever-present throughout her hospitalizations, but he

[58] Isaiah 40:28-31 (NIV) states, (v.28) "Do you not know? Have you not heard? The Lord is the everlasting God, the Creator of the ends of the earth. He will not grow tired or weary, and his understanding no one can fathom. (v.29) He gives strength to the weary and increases the power of the weak. (v.30) Even youths grow tired and weary, and young men stumble and fall; (v.31) but those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint."

generally stepped out of her room when I would appear, waiting out in the hall in order to honor her potential need for privacy. Each time I met with her, we prayed together per her request. Upon what would end up being my last visit, I asked if it would be ok for me to read some scripture to her. I inquired if she had any favorite passages, but she indicated that she did not, and would be happy with whatever I selected. For her, I chose Psalm 62:1-2, 5-8, 11-12.[59] The musical, repetitive nature of the sections I read seemed to create a connection with her. She held her head down, quietly listening, as I read. When I finished, she raised her head, revealing the tears streaming down her cheeks. She reached for my hand, held it tightly, and thanked me quietly through those tears.

Keturah ("Incense"): This patient had an initial intrigue not unlike incense. From the first day of her leukemia treatment, she requested the assistance of a chaplain to help her make sense of everything. She was a 63 year old female of European descent, had a strict Catholic upbringing, but had been secular for years. Despite her lengthy absence from the Catholic church, she expressed the fear that she will go to hell if she dies. I anticipated that she would be a good candidate for this study due to her eagerness to reconnect with her own articulate religiosity. However, over time and through the course of her treatment, she grew elusive like the smoke that incense produces. The pattern that developed over the course of our dozen or more encounters revealed that she primarily appreciated chaplain visits for fulfilling the role of an anonymous reflective listener – someone not involved in her typical day-to-day life like a friend or family member – or of non-priestly minister who could unofficially hear her confession to help her lay down her emotional / spiritual burdens. The first few visits, which transpired within a week or two of her original diagnosis, were very Christo-centric in nature. During those visits I felt comfortable assuring her that I could arrange a visit from a Catholic priest for Confession or Anointing if she desired (yet each time, she declined). I also felt it appropriate to ask her permission in reading some Scripture with her. She requested that we recite the Lord's Prayer[60] and the Catholic Hail Mary[61]. Of all of the patients included in this study, Keturah is the only patient for whom it might be said that the reading of Scripture coincided with a *reduction* in desire for spiritual support and / or an increased anxiety about her medical predicament. I would *not* assert a causal relationship between the inclusion of Scripture and an increase in her level of

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[59] Psalm 62:1-8 (NRSV) reads, (v.1) "For God alone my soul waits in silence; from him comes my salvation. (v.2) He alone is my rock and my salvation, my fortress; I shall never be shaken. (v.5) For God alone my soul waits in silence, for my hope is from him. (v.6) He alone is my rock and my salvation, my fortress; I shall not be shaken. (v.7) On God rests my deliverance and my honor; my mighty rock, my refuge is in God. (v. 8) Trust in him at all times; pour out your heart before him; God is a refuge for us. (v.11) Once God has spoken; twice have I heard this: that power belongs to God, (v.12) and steadfast love belongs to you, O Lord. For you repay to all according to their work."

[60] Matthew 6:9-13 (ESV) reads, (v.9) "Pray then like this: 'Our Father, [who art] in heaven, hallowed be your name. (v.10) Your kingdom come, your will be done, on earth as it is in heaven. (v.11) Give us this day our daily bread, (v.12) and forgive us our debts, as we also have forgiven our debtors. (v.13) And lead us not into temptation, but deliver us from evil.'" We concluded with, "Amen." Then I summarized vv. 14-15 for her as well, encouraging her that if she "forgive others their trespasses," then God will forgive her.

[61] According to the Loyola Press Jesuit website, the contemporary translation is: "Hail Mary, full of grace, the Lord is with you. Blessed are you among women, and blessed is the fruit of your womb, Jesus. Holy Mary, Mother of God, pray for us sinners, now and at the hour of our death. Amen." See https://www.loyolapress.com/our-catholic-faith/prayer/traditional-catholic-prayers/prayers-every-catholic-should-know/hail-mary-prayer.

anxiety. However, I *can* say that in the visits subsequent to our Scripture-based visit, she seemed more detached, less comfortable, less open, and more anxious than in those prior to that pivotal encounter. This could have been a result of a number of variables.[62] But in any case, it surprised me, as I had thought that the inclusion of Scripture in my visits with her would have strengthened not only her trust in me, but also her ability to cope with the rigors of her intensive cancer treatment.

Lydia (Paul's first European proselyte, "trader of purple fabrics"): There was much in Lydia's personal story that resonated directly with my own. A single woman (African American), age 50, living alone in a two-story Philadelphia row home, no bathroom on the first floor, no family members who might be willing and/or able to aid her through her current life situation, she expressed feeling absolutely overwhelmed, isolated, and alone. Hers was a newly diagnosed multiple myeloma with a very poor prognosis (metastases to the brain, in need of a bone marrow transplant with <50% success rate), for whom Palliative Care and Pastoral Care had both been almost immediately consulted. My introductory encounter with her felt as though it were received defensively: she responded to my offer of emotional and spiritual support with, "I'm ok. Thanks, but I'm ok." However, with each subsequent visit she began to cry more and share her feelings more freely. In other words, once rapport had been established, her level of trust seemed to increase over time. The progression of the multiple myeloma had rendered her unable to walk even a few steps (for example, from hospital bed to bathroom) without a nurse assist. She expressed that she had been raised Catholic, and takes comfort in seeing the priests around Villanova University where she works as a security guard, but aside from these infrequent and brief encounters she has no contact with a faith community or specific minister.

Unprompted by me, she openly admitted through tears during my second visit that she would like for me to help her locate passages in the Bible that resonate with her spiritual/emotional level of strength, doubt, anxiety, depression, and so forth. Thus, during our third visit, I came prepared to read to her Psalm 43,[63] which not only seemed to resonate with her circumstance, but also was listed as an alternate reading for that upcoming Sunday, November 05, 2017, in the Revised Common Lectionary. I opted to omit verse four, though, for that line did not seem to fit her emotional mood or need at that specific time. But as I read verse two ("Why have you cast me off? Why must I walk about mournfully?") and verse five ("Why are you cast down, O my soul, and why are you disquieted within me? Hope in God, for I shall again praise him, my help and my God") to her, she energetically nodded her downcast head and muttered, "Yes, Lord!" several times in response.

I was able to visit her one more time after this, but that time it did not feel appropriate to share scripture. That time, she needed a good listening ear to which she could cry. As of March, 2018, she continues to receive a mix of inpatient and outpatient treatments, and thus I continue to

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[62] Among the conceivable variables resulting in this response are: existential concerns about her prognosis; impacts of the chemotherapy which can cause behavioral changes; residual feelings or concerns about religion carried over from her Catholic upbringing; her underlying desire or need for the help of a licensed, professional secular psychotherapist.

[63] Psalm 43 (NRSV), "Prayer to God in Time of Trouble": (v.1) Vindicate me, O God, and defend my cause against an ungodly people; from those who are deceitful and unjust, deliver me! (v.2) For you are the God in whom I take refuge; why have you cast me off? Why must I walk about mournfully because of the oppression of the enemy? (v.3) O send out your light and your truth; let them lead me; let them bring me to your holy hill and to your dwelling. (v.5) Why are you cast down, O my soul, and why are you disquieted within me? Hope in God; for I shall again praise him, my help and my God.

hope to share more Scripture with her at opportune times. But as for now, I feel my encounters with her have assisted her only minimally considering what might be possible over time in the future.

Chloe ("Green Shoot"): Chloe struck me as an open book yet a complicated read, not unlike Chaucer's *Canterbury Tales*. She is the only patient I have ever met who asked the nurses print out "The Daily Word" for her, to which they happily consented.[64] Like many in the Philadelphia region, she was raised Catholic and still appreciated some Catholic rituals and observances, but did not consider herself to be Catholic any longer. Somehow she was placed on our hospital Catholic census, and received Holy Communion from our Catholic Eucharistic Minister volunteers, but confided in me that she didn't agree with the recitation that "we are not worthy" (which apparently one Eucharistic Minister had said to her before she received the host). She believed too much in divine grace and God's love to permit herself to feel trapped in the quagmire of sin language, expressing instead that we are all part of God's creation and therefore are all worthy. Like Miriam, Chloe was the type of free spirit with gentle affect that seemed to garner favorable attention from the medical staff. Something about her pulled at their heartstrings. It could have been something as simple as her generous use of the phrases "please" and "thank you so much." It could have been that she had no visitors and spoke of a complicated past. It could have been that her prognosis was so bleak (the term "failure to thrive" was included in her chart). Or it could have been that after my very first encounter with her, she told the nurses each day that she would like a chaplain visit, which helped them feel they could "do" something (i.e., page me) to help this poor soul who otherwise was withering away before their eyes.

In contrast to the other patients reflected upon in this study, Chloe is the only one for whom I abandoned the process of methodically choosing a biblical passage. Because *she* had introduced *me* to this "Daily Word," it became a routine for her to ask me within minutes of my entering her room if I could read her "Daily Word" reflection to her.[65] I would begin with the Scripture passage (even though it was found *at the bottom* of the page), and then proceed to the reflection, then back again to the Scripture passage a second, third, and even fourth time. This, too, began at her prompting: "Could you read the Scripture passage again? I want to try to remember it." So in subsequent visits, I re-read the text without prompting, and found that it helped *my own* rumination of the passage while also helping her retention of it. The text was often something fairly concise, such as Proverbs 12:11.[66] After our own ritual of orally reading the reflection and biblical text, I gently provoked her to try to interpret a meaning for her own current situation. For example, with this text she contemplated working on her own past

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[64] "The Daily Word" is a website requiring an annual subscription: http://www.dailyword.com/ . Each day that I visited with her, the print-out was already on her bed or meal tray, indicating that a nurse must have printed it for her by 8am. As the name suggests, the website provides for members a daily reflection accompanied by a passage from biblical Scripture. She would ask various individuals (myself included) to read and re-read the day's reflection aloud to her, that she might be able to memorize it and integrate it into the corpus of her being by the end of the day. Prior to meeting her, I had never heard of the website. I was familiar with "Our Daily Bread" Ministries (www.ourdailybread.org), but not "Daily Word."

[65] Apparently the nurses would print it out for her and hand it to her or leave it on her tray table, but wouldn't actually read it to her. Her "failure to thrive" status impacted her vision as well as her energy level, so although the "Daily Word" lay in front of her, she didn't necessarily know what it said as no one was reading it to her prior to my visits.

[66] Proverbs 12:11 (NIV) reads, "Those who work their land will have abundant food, but those who chase fantasies have no sense."

challenges, forgiving those she felt had abandoned her, forgiving herself for her role in whatever circumstance or misunderstanding led to their abandonment of her. She surmised that if she did the "work" of forgiveness and letting go of grudges, the "abundant food" might involve a reunification with those people about whom she expressed care. As the fates would have it, she ended up reconciling with friends, cousins, and even her estranged son. The outcome in her case truly was a beautiful story of reconciliation, brought about in large part because she allowed herself to become willing to receive help (in a variety of forms) and open to change. I dare say that had the group of us[67] not responded to her in a proactive manner, it is quite likely she would have just died alone, without these significant interpersonal conflict resolutions – which the ordained minister in me identifies as dying in a form of spiritual distress.

Keziah ("Cassia, Cinnamon"): Church and her faith seem to have been the only salve for seventy-seven year old Keziah in her last several weeks of life. The progression of her cancer caused her to become increasingly disoriented, to the point that she once got up out of her hospital chair in her room without a much-needed nursing assist because "I have to get to Mass." The first time I met her, our encounter was no more than ten or fifteen minutes in length. A nurse referred her to me because she was worried about her mental and emotional welfare. Keziah immediately shared with me that she moved up here from Florida within the past two years in order to be close to her son and teenaged grand-daughter, the latter of whom she had learned had been molested by an undisclosed family member. She was consistently short with words throughout all of my visitations with her. For example, that first encounter was so brief because she essentially terminated the visit herself by saying, "That's all I needed to say. I just wanted to get it off my chest. It took a lot for me to share that. I feel better now. Thank you." And when I replied, "Would you like to talk about it?" she would say, "No. That's all. Thank you." It seemed clear to me that the visit was done. During the next visit I attempted to get her to explore her feelings about her cancer. She merely said, "Yeah. Well, that's how it goes. That's what I was dealt." She was not so much interested in sharing her feelings as she was in trying to simulate or recreate the routine of going to church with her sister.

It was anticipated by the oncology physicians that Keziah would need to spend no more than a week or two as an in-patient. But Keziah was admitted on October 23, 2017 and died in the hospital during that same admission on December 2, 2017. She was never able to physically make it back to church. I became her primary minister, along with our Eucharistic Ministers celebrating Holy Communion with her or the priest administering Anointing of the Sick once. Since the time she was willing to spend with me was always fairly short, I chose brief Scripture passages pertinent to the imminent Advent season. Two that seemed to have the most effect were sections from Psalm 70 and Luke 4:18.[68] She didn't say much in response; she only nodded and said, "Thank you. That was nice. Thank you." As her cancer progressed within her last two weeks of life, she became increasingly disoriented; Advent music became the only non-medical

[67] That is, the multi-disciplinary team, including nurses, dietary services, myself and a few other pastoral caregivers, and members of the Palliative Care team.

[68] Psalm 70:1, 4-5 (NRSV) (from Proper 27, 11/12/2017) reads, (v.1) "Be pleased, O God, to deliver me. O Lord, make haste to help me! (v.4) Let all who seek you rejoice and be glad in you. Let those who love your salvation say evermore, 'God is great!' (v.5) But I am poor and needy; hasten to me, O Go! You are my help and my deliverer; O Lord, do not delay!" And Luke 4:18 (NRSV) (from the third Sunday of Advent, 12/11/2017): "The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives, and recovery of sight to the blind, to let the oppressed go free…"

balm that could calm her disquieted state. Spoken words seemed to agitate her, unless they mentioned her beloved horses, her son, her sister, or her grand-daughter. I felt grateful that she permitted me, over time, to sit longer with her and read Scripture to her. I observed that it helped relieve her anxiety – particularly Psalm 70, which I read to her on a few different occasions. It seemed to speak directly to her particular circumstance, reassuring her that God is with her. It allowed her to imagine, for brief moments, that she was in Mass, which she described as a place where she experienced a sense of comfort and of peace within herself.

Michal ("Brook"): Due to her extended hospitalization (more than three weeks) during the Advent season, I decided to focus on lectionary texts for the first Sunday of Advent. She had expressed feeling in a very dark place, where she felt like dying. Michal was only 56 years old, and had always been an enormously active individual – one who always taught herself new things and always sought growth. Only several years ago, she learned how to ride a motorcycle and bought herself a Harley-Davidson! But at this current juncture in her life, a tumor pressed on her brain, causing some paralysis on her right side, particularly her arm. She wept over the way it impacted her day-to-day functioning and robbed her of her freedom, while in the same breath she thanked God that she still had all of her cognitive faculties intact. At one point, she wondered aloud, "Where is God? Why isn't God helping me (or responding to my prayers)?" After saying that, she retracted it and again mentioned how grateful she was for the things she *did* have.

I opted to read portions from Psalm 80[69] to her on our third or fourth visit, pointing out to her some similarities between her own feelings of emptiness and separation from God with the Psalmist's expressions of grief and despair. Then I prayed with her, per her request. She expressed that it helped her feel better, and she seemed much calmer. After that encounter, she also seemed to eagerly anticipate my visits. I didn't read Scripture to her every time; only on a few occasions. But I found that with her in particular, reading these passages opened some emotional door, permitted her to trust me, and causing her to look forward to our time together. In other words, it seemed to bring her a clear sense of comfort.

After the encounter in which I read Scripture to her, Michal underwent a craniotomy to have her brain tumor removed. Thankfully (and miraculously), not only was the operation successful in terms of removing the tumor; she also regained almost full mobility of her right arm, hand, and foot. I saw her again on an unexpected admission in early January, and her face actually seemed to light up at seeing me. She thanked me profusely for my ministerial presence during her previous admission, for having prayed with her, and for reading Scripture to her. She treated me as though I was her best friend, and expressed what I perceived to be genuine gratitude for my presence in her life. I may be wrong, but I don't believe my experiences with her would have felt the same for her had I strictly remained in a "ministry of presence" mode.[70]

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[69] Psalm 80:3-5, 7, 14-19 (NRSV) reads, (v.3) "Restore us, O God; let your face shine, that we may be saved. (v.4) O Lord God of hosts, how long will you be angry with your people's prayers? (v.5) You have fed them with the bread of tears, and given them tears to drink in full measure. (v.7) Restore us, O God of hosts; let your face shine, that we may be saved. (v.14) Turn again, O God of hosts; look down from heaven and see; have regard for this vine, (v.15) the stock that your right hand planted. (v.16) They have burned it with fire, they have cut it down; may they perish at the rebuke of your countenance. (v.17) But let your hand be upon the one at your right hand, the one whom you made strong for yourself. (v.18) Then we will never turn back from you; give us life, and we will call on your name. (v.19) Restore us, O Lord God of hosts; let your face shine, that we may be saved."

[70] Heart-wrenchingly, I was on duty when she was brought back into the hospital in severe pain, admitted directly to our Medical ICU, and died three days after admission, on 01/24/2018. I could not express to the family

Tirzah ("Favorable"): I first met 52-year-old Tirzah with her daughter the day after she had been admitted with a new diagnosis of acute leukemia. She'd had a history of cervical cancer from fifteen years ago, was a smoker, and had a note about alcohol-related cirrhosis in her chart, although her liver functioning seemed to be fair at the moment.

The first encounter was no more than a few minutes (perhaps due to her daughter's presence): "Hi. Nice to meet you. I'm ok right now. Thanks." Knowing she would be hospitalized for at least a month, I planned to meet with her a minimum of once per week. With each subsequent visit, she opened up more, and my length of stay with her grew longer each time. She began to increasingly express being very spiritual, "Christian" (code language around Philadelphia for "Protestant"), "putting it all in God's hands," and "trusting in the Lord." During my second visit, her son was with her; but this visit averaged about 15 minutes and she requested prayer near the end of it.

She was alone during my third visit with her, which is when she broke out into tears and gave full expression to her thoughts and feelings.[71] The visit lasted an hour. It actually was an unplanned encounter, as I was following up with other patients to whom I had been consulted. But when I saw Tirzah walking down the hall with her IV pole and a rather sullen affect, I spontaneously seized the opportunity to escort her – which I later recognized as divine intervention. She shared that she was running a fever again, felt nauseated, and her spirits were low, but that the medical staff had encouraged her to try "doing laps," as they call it. She completed one lap but then needed to rest, so I helped her back to her room. For the next ten minutes she attempted to uphold a brave face, saying merely, "I'll be ok. Just keep me in your prayers." At that point I continued to employ the ministry of presence and relatively silent (nonverbal) compassion, which ultimately gave way to her tears and a confession that she didn't know if she could make it. After crying for a few minutes, she engaged in a form of self-talk to encourage herself to focus on her blessings. She revealed that her nurse on New Year's Day shared her own recent struggle with cancer; Tirzah noted that the nurse seemed positive through it all, and saw her as a role model. I admitted to her that if it was me, I might struggle with depression, and that I could understand how some people might not be able to remain positive. Tirzah insightfully replied that moments like that are, in her opinion, "when we let the devil in." Although I don't necessarily subscribe to that theology, I replied, "I suppose so. I suppose you are right," which led to her expression of needing – *needing* – to stay focused on God and on positivity.

I last saw Tirzah on January 10, 2018. Throughout this encounter, she repeatedly stated, "I gave it all up to the Lord, and I feel much better. The devil tried to sneak in, but I gave it all up to the Lord." I elected to read the lectionary text fort the previous Sunday to her: Mark 1:4-11.[72]

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enough what an honor it was to have met her and spent time with her, and how sorry I was that she ended up "getting so sick."

[71] In my ten years as a hospital chaplain, I have found a consistent pattern among patients coping with a difficult diagnosis: when a patient is alone, s/he tends to confide infinitely more openly and honestly with me than when family or loved ones are present. I have been told by patients over the years that sometimes they feel they need to be strong in front of their loved ones, and other times they feel that when they attempt to be honest and candid with family, family respond by saying, "Don't talk like that! You have to be strong!" essentially shutting down the conversation and leaving the patient feeling s/he has no one to talk to. That is, until I arrive…

[72] Mark 1:4-11 (NRSV) reads, (v.4) "John the baptizer appeared in the wilderness, proclaiming a baptism of repentance for the forgiveness of sins. (v.5) And people from the whole Judean countryside and all the people of Jerusalem were going out to him, and were baptized by him in the river Jordan, confessing their sins. (v.6) Now

As I had suspected, she deeply, DEEPLY appreciated hearing verse 11: "And a voice came from heaven, 'You are my Son, the Beloved; with you I am well pleased.'" After reading it, I looked at her and said, "Tirzah, God is saying to you, 'You are my child, my daughter, my beloved; with you I am well pleased.'" I repeated it again. "You are my beloved! With you, I am well pleased!" She wept, and reached out to hug me. I prepared myself to leave her room as we chit-chatted a bit more, and then she hugged me again. "Thank you so much," she said. "Thank you." Again, I felt convicted that the words of Scripture helped her more than mere ministry of presence could have – although it felt obvious to me that a combination of the two (both silence *and* Scripture) was required in order to build her trust and confidence in me.

David ("Adored, Beloved"): I met David in May, 2017, after being paged to the ICU to help him prepare himself for his wife's memorial service. (Physicians made special arrangements for him to leave the ICU, participate in the memorial service, and then be immediately re-admitted back to the same ICU room.) He was brought to the hospital from a motor vehicle accident scene subsequent to being "t-boned" by another car. His daughter had been driving him to the funeral home to make arrangements for his wife, who had just died from lupus-related ailments. He suffered a cardiac arrest, from which he recuperated amazingly well. However, it was determined that he also had stage IV metastatic cancer, and thus the Palliative Care professionals were quickly consulted to be part of his care team. From my first encounter with him, I found him to be a quiet, soft-spoken man devout in his Catholic faith, who grieved the loss of his wife deeply and profoundly. Between May, 2017 and February, 2018, I had the privilege of spending time with him on numerous occasions / hospitalizations. And yet, throughout this time and amidst his requests for prayer, Holy Communion, and Anointing of the Sick from a Catholic priest, I never presented to him the idea of reading Scripture with him until his February, 2018 hospitalization.

When I saw him in February, his words seemed more sparse, his energy level low, and his resignation to his own mortality quite evident. A psalm of lament felt apropos, so I selected Psalm 86:1-12.[73] A man of few words, he didn't say much in response. He merely seemed to listen attentively, ruminate, and then thank me for its reading. I knew that he had just moved back to the Philadelphia area from Detroit within the past year, in order to bury his wife here and to move in with one of his daughters. So I was aware that he did not have his own church community nearby. I was his primary minister. I can only hope that I fulfilled this role adequately and with integrity.

John was clothed with camel's hair, with a leather belt around his waist, and he ate locusts and wild honey. (v.7) He proclaimed, 'The one who is more powerful than I is coming after me; I am not worthy to stoop down and untie the thong of his sandals. (v.8) I have baptized you with water; but he will baptize you with the Holy Spirit.' (v.9) In those days, Jesus came from Nazareth of Galilee and was baptized by John in the Jordan. (v.10) And just as he was coming up out of the water, he saw the heavens torn apart and the Spirit descending like a dove on him. (v.11) And a voice came from heaven, 'You are my Son, the Beloved; with you I am well pleased.'"

[73] Psalm 86:1-12 (NIV) reads, (1) "Hear me, Lord, and answer me, for I am poor and needy. (2) Guard my life, for I am faithful to you. Save your servant, who trusts in you. You are my God; (3) have mercy on me, Lord, for I call to you all day long. (4) Bring joy to your servant, Lord, for I put my trust in you. (5) You, Lord, are forgiving and good, abounding in love to all who call to you. (6) Hear my prayer, Lord; listen to my cry for mercy. (7) When I am in distress, I call to you, because you answer me. (8) Among the gods there is none like you, Lord; no deeds can compare with yours. (9) All the nations you have made will come and worship before you, Lord; they will bring glory to your name. (10) For you are great and do marvelous deeds; you alone are God. (11) Teach me your way, Lord, that I may rely on your faithfulness; give me an undivided heart, that I may fear your name. (12) I will praise you, Lord my God, with all my heart; I will glorify your name forever."

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