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APPLYING THE BASIC CHAPLAINCY PRINCIPLE OF "MINISTRY OF CARING PRESENCE" TO CLINICAL CARE

My thesis is this: The Chaplaincy principle known as Ministry of Caring Presence can improve care delivery for the whole end of life care team and can be practiced by all of you.

To illustrate, I want to share two examples of when I failed to offer true caring presence. I hope this will be instructive and a good place to begin exploring this core principle of clinical spiritual care.

A 61-year-old female was diagnosed with stage 4 throat cancer a few months ago. My initial interactions with her represented a seasoned and "realistic" hospice and palliative care "professional" and her loving brother.

Two weeks after her devastating diagnosis, at the beginning of treatments, she told me, through my youngest sister, that she would rather I not call her. It was, she said, hard enough for her without "Bobby putting me in my grave, already."

I was stunned, remorseful, humbled. It taught me a lot about showing up as "helpful" but not truly present to the suffering needs of the person I was there to serve.

It took me two weeks to assure my sister that there would be nothing but positive support from me. I would serve her as she needed, not as I thought prudent. She said, "Great. We understand each other." She has recently completed her first round of treatments with good success and hope. I am so proud of her.

I had a former palliative care patient with colorectal cancer who had survived two years longer than his prognosis. He and his wife both believed this was done through positive thinking and love. I dropped in to see Ernie a couple of weeks ago and it was obvious to me that he was dying.

I asked him, in no-nonsense hospice fashion, "Are you afraid?" He scowled and said, emphatically: "What is wrong with you people? No, I'm not afraid! I'm just purging toxins."

In my arrogance and so-called "expertise," I wanted to say to him "Pushing death away is denying the life that is here right now! Time is running out for "meaningful" discussions!"

They knew what they needed. They had successfully supported each other for 33 years of love! They needed to deny death! That denial kept Ernie alive and them unified in love for two extra years! Ernie died peacefully a few days later.

Sometimes people NEED to be in denial and a chaplain is not ordained to be "truth-teller." Whose truth? I have no special knowledge of anyone's destiny!

The painful truth is that even with thousands of patient visits, I can fail to be present in the way I am most needed.

Being with suffering and dying requires more than clinical skills. We are often unable to "reach" a patient to manage pain, nausea, dementia, anxiety and family conflict. Both science and art are needed. Practicing caring presence can help.

I'm always surprised by people's different ideas of what chaplains do. We are seen varyingly as useful if someone wants to pray and probably evangelical and patients often see us as harbingers of bad news or death. But Spiritual care is core to palliative and hospice care.

Today I lift the "sacred veil" and expose some of our occult workings so that part of what we do can be useful in your work.

Let's start with our training. Many believe we're just told by some church to "go preach to the sick." In fact, we don't preach at all.

The first level of our training is a Graduate degree in Divinity, learning to systematically analyze theologies. We learn ancient languages and translate sacred Scriptures, to understand the pitfalls of wrong translations that contribute to dangerous dogmas.

We study world history, spirituality, trauma psychology, and, if it's a good seminary, we question everything we believe about God and religion or spirituality. And yes, we learn to preach.

We exit this tunnel with a solid sense of what we believe, especially with respect to if, and how, God acts in our world. If God is all good and powerful, why does She allow the suffering *we* see every day?

Then there is residency – a year in a diabolical and sleep-deprived clinical boot camp.

For me, all-night on-call shifts included solo responsibility for 13 ICUs, the ER, and midnight family body viewings in the morgue. And of course, blessings, NICU deaths, and occasional weddings; then trauma debriefs in the morning for staff who had suffered through a tough code blue. Then rounds, classes and supervisory sessions all next day.

We are subjected to rigorous training with a supervised cohort and and trained, like psychologists and social workers, to chart, question and analyze everything we bring to patient visits – projections, assumptions, biases and counter-transference.

We learn to stalk our blind spots and have our weaknesses gleefully exposed by our peers. We are expected to show up to any patient, any faith tradition, socio-economic status or language. And with all, we go as deeply into their emotional and spiritual recesses as possible.

I am a spiritual hybrid… Raised Catholic with a Zen practice and a love of Native American spirituality and Christian mysticism. First trained as a philosopher, I took my Master of Divinity from a Protestant Seminary, but I'm Unitarian Universalist. I've studied Hinduism, Sufism, Islam and Earth Religions at Presbyterian, Jesuit, Buddhist, Lutheran, Unitarian and Interfaith seminaries.

I am most comfortable praying to the Great Spirit and our Mother Earth, alone and naked in the deep Death Valley Desert…

I am an interfaith chaplain.

Let's get back to our "ministry of caring presence" in pastoral counseling." What is it? How can you use it?

"Ministry" is defined as the service, office, duties, or functions of clergy, pastorally serving the spirit of a person or group. What does it mean to be a Pastoral Counselor?[1]

"Pastoral counseling" means addressing psycho-spiritual issues using psychology, theology and religious dogmatic understandings to care for a person's spiritual and emotional well-being.

Let's unpack that. Wikipedia says, "Pastoral counselors are representatives of the central images of life and its meaning…."

We are psychologically trained ministers, rabbis, priests and Imams who provide therapy services integrating modern psychological methods with traditional religious training.[1]"

We use clinical, psychological and theological resources to build and carry out a plan of care.

We are trained to sit in the presence of suffering, dementia, chaos and conflict; with any trauma, diagnosis or prognosis, and be a compassionate presence who can assess core spiritual needs and then utilize psycho-spiritual interventions.

Did you know Chaplains "assess and intervene?" We utilize different methodologies. I personally use a combination of a Hindu psycho-spiritual system[2] overlaid with the outcomes oriented Spiritual Assessment and Intervention Model[3] taught at the University of California in San Francisco.

But, with each and every patient we utilize "ministry of caring presence." We strive to be present and caring at the deepest possible level; to elicit memories, feelings and spiritual needs, and self-love.

We use active listening, psychodynamic and transpersonal psychology; but always, always, always, ministry of caring presence, which almost becomes our "ground of being," even our *reason* for being.

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[1] https://en.wikipedia.org/wiki/Pastoral_counseling

[2] Hindu yogas: Jnana, Bhakti, Karma, and Raja)

[3] *Spiritual AIM and the Work of the Chaplain: A Model for Assessing Spiritual Needs and Outcomes in Relationship*, THE REVEREND MICHELE SHIELDS, DMIN, BCC, ACPE SUPERVISOR,[1] ALLISON KESTENBAUM, MA, MPA, BCC, ACPE SUPERVISOR,[2] AND LAURA B. DUNN, MD[1,3] , Cambridge University Press, 2014 1478-9515/14 doi:10.1017/S1478951513001120.

Now, "Ground of Being" has a very specific theological meaning. It is another name for God, the Sacred Space, The Void, the Source of all things. It is Christ Presence, Great Spirit, Buddha Mind or Hindu Brahman. It is a space of possibility, patience and love, useful for clinicians because of its harmonizing effects on patient, family and care team.

At UCSF I was the dedicated clergy in Pediatric Oncology. I was asked to intervene with a 12-year-old male being treated long-term on the unit. He had been shot in the abdomen. By a friend.

This little man now had PTSD, colostomy, suffered regular surgeries, could no longer walk, and was "acting out." Tommy was variously aloof or belligerent. Nurses, social workers and doctors could not reach him.

I spent the first 30 minutes of my initial visit sitting quietly on the tile floor at his bedside while he chatted on his cell phone to a friend, studiously, and impressively, ignoring me. I just… waited.

When Tommy finally acknowledged my existence, I shared with him that I had once been shot. By a friend. I allowed him to ask ME questions, until he proudly showed me a picture of the kind of gun that forever altered his young life.

Did I overshare? Social workers here might say I did. But the candor and spiritual leveling worked. This fierce young man began allowing me to hold his hand and accompany him into his wound changes.

Ministry of caring presence is patience and vulnerability.

Another major responsibility at UC was the Adult Transplant Unit and Transplant ICU. I had a fascinating liver recipient who was paranoid and terrified post-transplant because of the anti-rejection drugs, steroids, and pain meds he was taking. His third day post-surgery the nurses called me because Barry was acting…well… crazy.

He thought his walker was a hamburger. I'm not kidding.

Now how should I assess Barry's core spiritual need? Was it "Reconciliation and the Need to Love and Be Loved," or maybe "Meaning and Direction?"[4]

Mostly he was scared shirtless and confused as hell. And he was hungry!

What should a caring presence do for Barry? Well, treat his phenomenology as *his* reality. Validate a crazy person's objective *unreality* just long enough to shift his awareness.

I asked him how much he really wanted to eat a three-foot hamburger made of metal and plastic!

Stop, breathe, validate person, not behavior, and love.

Ocean Beach in San Francisco is a dangerous place.

[4] Op. Cit.

Two children were pulled out to sea by treacherous currents. Joe, Gloria's husband and love of her life tried valiantly to save their children. He lies unresponsive in the ICU, a ventilator mechanically, methodically, forcing his lungs to breathe air that no longer makes any difference to his brain. Gloria's world is shattered.

She still has two children left, both under the age of 12. She wants… a miracle. She cries, "How could God do this to us?" "How can this be real?" (I don't know how many times I have heard this in ICUs and ERs) No!!! This can't be happening!"

The doctors around the crowded conference table have given up, but they don't know how to tell Gloria that Joe has no chance of recovery. Privately, they all agree. Resources should go to someone with a chance.

They are asking her to make *the decision* and remove her Beloved from life support. To kill him.

Ministry of caring presence? Listening, listening, listening. Then to risk alienating the six doctors who could ban me from future care conferences when I stepped on even one sacred medical toe.

Clinical but compassionate pastoral advocacy for all present. Advocating for the dignity of the unresponsive patient. Recognizing the tortured doctors who, behind lab coats and stoic faces cared but were powerless.

Caring presence meant interpreting "doctor-speak" to a bereaved wife who hadn't slept in days.

How? Stop the conversation. Look directly into exhausted eyes, dark abysses of suffering and fear, into the shattered spirit behind those eyes and ask: "Would Joe want to exist this way? Your doctors' lives are dedicated to hope - they hate to give up, Gloria. They can't bring Joe back to you. If God wants to perform a miracle, He doesn't need that ventilator."

Manuel was an ex-con out of San Quentin prison. He had tattoos everywhere. He also had rheumatoid arthritis so severely every limb and his spine were twisted. He couldn't bear to be touched. Even sound hurt. He had sepsis. He had liver disease. He was obnoxious to the staff because he was "difficult."

He was asleep when I arrived. I pulled up my chair quietly and I… waited.

I watched him and channeled love to his tortured body and psyche. He awoke and, opening his eyes said, after a long silent assessment … "Who the fuck are *you*?"

"Who the fuck do you think I am? I'm your hospice chaplain, Bob." We hit it off. I served him until he died.

Ministry of caring presence? Spiritual leveling, respect, silence, candor.

As a clinician, how could you better care for Manuel? Ask yourself, what did this tortured man need?

James was a devout Catholic. He was also a batterer, until he was too weak to punch. He had malignant melanoma with "mets" to the liver and brain. In person, a very nice guy who loved to pray. He had sunken laughing eyes past his jaundiced orbits. He would be dead soon.

His wife was angry, trying hard to forgive; for her own inner peace and relationship with God. Ministry of caring presence meant being a compassionate truth-teller; advocating for her self-worth and dignity, and the validity of *her* feelings; providing spiritual comfort to James.

Both expected me to be an authority on their relationships with God. Now with that, I am admittedly not comfortable, being barely an authority on myself, let alone God, let alone others' Gods. But we are often called to be this.

Always, always, always, compassionate listening, actively recreating their reality in our words, then questions to elicit re-membering and reconciliation of a life lived, a tragedy, a trauma.

Humans are story-telling creatures. Recreating the patient's story allows insight in re-telling, and the hearing.

This is an end-of-life group… what about ministering during active dying?

As a hospice chaplain I have witnessed so many deaths. Each individual and family is unique. Each death is uniquely demanding, sacred; requiring a unique presence.

Maria was an ancient grandmother visited by Jesus Christ, in flowing white robes at the foot of her bed. Jesus said to her, "Maria, it is going to be alright. We are all here." She reported this to us with her last words.

"That's right, Maria. Jesus is here for you. Go to him. Your work here is complete. *Todo esta bien. Todo esta bien."* And she died with a beatific smile on her face.

And globe-trotting Sylvia, the 97-year-old all-enduring holocaust survivor… She just couldn't let go! I asked her only son, "Have you told your Mom it is OK to go?

And David assured his mother he would miss her, but he had her strength in him and he would be fine. David gave his Mother permission to die.

Within two minutes she took her final breath and slid gracefully out of her body. David wept in grief softened by wonder at the beauty, peace and speed of her passing.

Caring presence saw that Gloria needed permission to die.

Notice that in none of these examples was there preaching or "saving" souls. That is not what chaplains do. If it were we could not be truly present to elicit deepest spiritual issues and consequent healing. Other clinicians are not aware of these conversations. They are private and mostly not in our chart notes.

I had one dying patient who confided in me his treasons and war crimes after carrying this burden alone, for half a century. He wasn't asking for forgiveness. He knew that was between himself and Eternity. He needed only the full presence of a human witness.

The chaplain's job is to harmonize spiritual, emotional and clinical needs to support symptom management, self-expression, reconciliation, forgiveness of self and others, connection to the divine, and spiritual healing.

You can do all of these things! None are clinically contra-indicated.

Ministry of caring presence means humility and Love.

I hereby ordain you all "Ministers of Caring Presence!" To be present *in* love, *with* love, *for* love and *from* love. Focusing your clinical skills and goals through the lens of service in the moment, through love.

This is especially relevant with dementia. Nothing is more important in communication with an Alzheimer's patient than to be precisely in *their* moment. What *he* says is *his* truth. Repeat it back to him, then direct his thoughts from there.

You can have amazing conversations if you stay in *their* moments. Follow the trail of their words into their minds and into their past, into their next thoughts to reach and comfort them.

Build on *their* moment, their truth. The most common mistake is attempting to educate a loved one with dementia about what is real and true; or not real, not true, as if for her own good. Why?!

The healing elixir of caring presence has a simple recipe: Two parts focused presence, two parts love, one part confidence, and one part simple syrup of surrender.

This takes practice, it is true, and requires the clinician to forget self and become one, in love, with both subject and object, I and Thou.

Strive, if you can, to look through the other's eyes and the eyes of a Greater Presence of love.

Be aware of what your body is telling you. If you are feeling fear or tension anywhere, pay attention. That is information about you or your patient. Notice your thoughts but don't linger there. Listen, listen, listen. Love, love, love.

That's it, it's that simple.

You can use caring presence to improve clinical outcomes and your own satisfaction, if you take a little more time at key moments.

Being present this way in no way compromises clinical effectiveness or objectivity. It doesn't make you soft. On the contrary, you are more one with the goal: to render service and guide others through the challenges of sickness, transition and death; and to heal the spirit.
Thank you.