

# HOPE AND RELIGION IN THE INNER-CITY U.S. HOSPITAL: THE VIEW FROM CHAPLAINCY

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## Abstract

Religion and biomedicine each provide powerful ideological and therapeutic responses to uncertainty in the modern metropolis. Both address issues of physical and emotional poverty, stress, and violence that are the hallmarks of everyday life for many in urban centers, particularly in the United States, where various forms of inequality foster senses of alienation and despair about the future. This essay considers the large, inner-city university hospital as an institutional response to such social forces and highlights the ways in which activities within the clinical space can promote hopefulness. Such medical centers are often portrayed as purely secular, high-tech repair shops for afflictions sustained through urban life, yet these depictions overlook the substantial influence of religion, and particularly hospital chaplaincy, in healing processes. Through a narrative analysis of the interactions of a family of a trauma patient with a surgeon and a chaplain in an emergency room in the eastern U.S., I argue that religion can offer a unique form of hope that can serve as a counterbalance to the spiritual, physical, and cultural suffering induced by urban aggression.

## Introduction

Hope has received little attention from either clinical medical anthropology or the anthropology of religion, despite its prevalence in the lives of hospital patients in the urban United States. While recent research in these subfields has highlighted such variables as risk, uncertainty, and fear in the ways that individuals relate to the future within therapeutic environments, ethnographic studies have largely neglected the ways in which hope is imagined, configured, and deployed. In this paper, I shall highlight briefly some of the key theoretical attributes of hope and then move to an analysis of the social and psychological functions of religious hope within the ostensibly secular, highly technological social context of a hospital trauma bay, based on two years of fieldwork as a chaplain resident at a large, inner-city university medical center in the eastern U.S.

Scholarship on hope has historically been a mainstay of philosophers and theologians (Bloch 1986, Moltmann 1967), though in recent years a number of psychologists have attempted to describe some of its cognitive dimensions (Snyder 2000), and a few anthropologists have written important essays on hope as a sociocultural phenomenon (Crapanzano 2003, Miyazaki 2004, Novas 2006). No simple, uniform definition has emerged from these various strands of research, though we can note a few points of convergence: hope can be a process, as well as state of being. A person may be described as hopeful, and situations may certainly be labeled as hopeless, but in order to be meaningful, hope requires an object—a goal. That is, an individual does not simply hope; she hopes for something. Second, there is a wide range of factors that may contribute to a particular hope, such as a person's degree of consciousness, available information, affect, and memories of past instances involving hope. Third, hope implies limitations on a subject's power, on his ability to achieve a given end by himself. I do not hope for that which I already have, nor do I hope for that which I believe with reasonable certainty that I can achieve on my own. Fourth, hope can be something that one extends to another person. Indeed, a growing number of clinicians have argued for the benefits of conveying hope

as an outlook, or perhaps even as a commodity, as part of the treatment process (Good 1990, Clark 2002).

In this essay, I argue that hope, particularly in cases of grave illness and uncertainty, can function as a powerful interpretive device that shapes social understandings of temporality, scientific data, and the self. Moreover, the availability of space for dialogue between family members and clinical practitioners, in particular religious specialists, can lead to a powerful dialectic between biomedical knowledge and theological beliefs that can have important impacts on coping mechanisms, human agency, and future planning in ways that can be rationally empowering for patients, as well as for those who care for them.

### A Word on Hospital Chaplaincy

Religion, suffering, and medicine have long been intertwined in North America, and Christian denominations in particular have played instrumental roles in the work of hospitals in the U.S., from finance and administration, to the selection of individuals for admission, to support of patients at the bedside. While preacher and doctor were often the same person in colonial days (Watson 1991), the gradual division of labor between the scientifically-oriented healer and the religiously-oriented healer regarding the future presents important insights for the understanding of the hospital as a social phenomenon. For physicians, the growth of scientific knowledge has gradually led many a practitioner toward an atomistic gaze that relies on technological devices and procedures to pinpoint and manage specific somatic problems. Chaplains, meanwhile, have seen a shift from an emphasis on confessions and preparation of the soul for death in the 1700s, to moral encouragement and exegetical probing in the 1800s and early 1900s, to the reverent acknowledgment of “living human documents” that fosters personal growth in more recent years (Holifield 1983). Today, training for hospital chaplaincy involves a combination of classroom and hands-on clinical work with patients, family members, and medical staff in Clinical Pastoral Education (CPE) residency programs at selected medical centers throughout the U.S. and strives to understand individuals not only as embodied but also as culturally situated actors.

### Case Study

Bobby, as I shall call him, was by any measure impressive. A star on his high school track team, he was robust, loyal, and determined. He stayed clear of activities that plagued so many young males in his neighborhood—drugs, unprotected sex, gang membership—and focused instead on his education and regular church attendance. The second of three boys, he and his siblings lived with their mother, an administrator at a large corporation. Several close relatives lived nearby.

It was late in the afternoon when Bobby arrived in the trauma bay. He had been shot twice on his way home from school. Inside the bay, the medical team began a dramatic resuscitation attempt, yet they were unable to restart the patient’s heart. He was pronounced dead 17 minutes later.

Bobby’s grandmother and aunt were the first family members to arrive at the hospital. As the chaplain on call, I accompanied the attending trauma doctor to the emergency department waiting room, where we met the two women.

*Doctor:* (loudly) Is the Nelson family here? (grandmother and aunt approach nervously) Hi folks, I’m Dr. Lind, and this is the chaplain. (we move into the consultation room and sit) OK, what do you know about Bobby?

*Aunt:* (anxiously) All we know is that he was shot.

*Doctor:* Bobby was hit by two bullets. His heart had stopped by the time he arrived. The cops arrived first on the scene and put him in the back of their car to bring him here. (tension is growing in the room) When he came into our bay, he wasn't breathing, so we inserted a breathing tube and began CPR. Our team worked on him for close to twenty minutes, and we tried our best, but ... ultimately we were unable to revive him. (standing) Ma'am, I'm so sorry for your loss. The chaplain is here; he'll stay with you.

What are the grounds for being hopeful in the midst of such events? The trauma bay in particular is a place where desperate people go in search of hope. These persons seek sophisticated, high-tech interventions that will undo—or at least minimize—damage wrought by bullets, knives, speeding cars, toxic elixirs, gravity, and often raw stupidity. The hospital is an institution that is supposed to offer hope: it is a site full of expectation, one where individuals seek to trade despair for uncertainty and uncertainty for optimism. Today, the hospital is a space in which the afflicted arguably have both the right and duty to hope; it is a unique culture in which hope has become a socially conditioned activity that shapes decisions and expectations of patient, practitioner, and family member alike.

Yet is hope warranted in such an environment? Schneiderman, for example, believes that hope in Western medicine today is “almost always promoted for its impact on a single dimension—life prolongation” and speculates that in the case of particularly dramatic illnesses, “the central role of miracles in Christian mythology” may foster “the contemporary expectation, or at least hope, for medical miracles” (237). From the perspective of care providers, hope for cures—or at least a stable, long life—can have the effect of maintaining “both medical authority and patients’ reliance on and expectation of medical intervention” (Elliott and Olver 2002: 179). It is a powerful rhetorical tool in establishing the status and legitimacy of medical scientific endeavor, one that sees hope as fundamentally intertwined with the aspirational values of science (Elliott and Olver 2007: 141).

For many individuals, religious beliefs are tightly interwoven with biomedical hope and are significant interpretive tools in the clinical space. Faith in a higher power, particularly one characterized by love, goodness, and fidelity, can serve as a powerful device in a person’s ability to contend with the vagaries of the unknown. For Bobby’s family, the availability of sophisticated biomedical interventions and deeply held Christian convictions together shaped their hopes in the midst of a life-or-death situation, generating mindsets that would help them to cope with his uncertain status while awaiting word from the doctor. Hope was an organizing force, a paper-thin dam that kept social and psychological chaos from overwhelming them.

When the dam gave way, when hope for Bobby’s recovery became pointless, the hospital became a very different sort of space. I believe that his grandmother was being sincere when she told the physician that “you did everything you could,” meaning that the team fulfilled her expectation to do whatever it could to save his life. Nonetheless, whatever hope she brought with her to the consultation room was turned upside down by the doctor’s report and his abrupt departure from the conversation. Bobby as a living, breathing person no longer held any relation to his family’s earthly future. Whatever dreams, desires, or plans they had for Bobby’s life ceased to exist as objects of hope, and the hospital became a space of negative recognition: it was there that they learned how the future would *not* appear. From a biomedical standpoint, there was no reason to harbor hope for Bobby, and the relative lack of dialogue with the doctor seemed only to emphasize this point. His body had ended—there was nothing else to say.

Or was there?

While Bobby's recovery was the most prominent object of hope during the beginning of the family's interaction with the doctor and chaplain, it was not the only one relevant to this story. Indeed, it is crucial to recognize the varieties of hope at work in the broader social context of which this episode is a part, in order to understand the implications of these narratives. Hope for Bobby existed among his family members before he was shot; it was, from what I was able to gather, a stable, long-range hope that looked forward to his graduation from high school, college, and beyond. The actions of the assailants jeopardized these long-range hopes and stimulated the formation of hope on a much narrower horizon, namely for Bobby's immediate physical survival. That is, the bullets generated the conditions under which the hospital became a central factor in the family's constellation of hopes; the perpetrators—however unwittingly—made these hopes contingent on the actions of the trauma team.

Sophisticated as it is, biomedicine did not outwit death for Bobby. Its tools and interventions are today able to offer realistic hope in many circumstances that were once fruitless, but they still cannot guarantee the satisfaction of all patient and family hopes. That said, the ways in which practitioners interact with patients and family throughout the course of the clinical intervention can have an enormous impact on both the content and processes of hoping in the hospital setting, quite apart from the scientific tasks. In this episode, biomedicine undermined hope twice: first, in its failed resuscitation attempt, and second, through the physician's terse report, which had the effect of inhibiting the work of hope for the grandmother and aunt. His reluctance to be present with the family, to listen, to enter into dialogue with them, denied them the possibility of expressing themselves or processing their thoughts and emotions in the presence of someone central to Bobby's dramatic plight.

Such a lack of space for reflection with the trauma surgeon reflects a key opportunity for chaplaincy within the healing space. The availability of a religious healer for reflection in light of such dramatic information recognizes that processing such events can be helped in significant ways by someone willing to listen, acknowledge, and envision. Through the chaplain's spiritual outlook, words of comfort, and demeanor, he can convey to others a sense of patient optimism, supportive expectation, and thoughtful desire. Hope, in other words, can be contagious. It is a unique phenomenological state that can be sensed and received, for while it is difficult for many to hope without an inner determination to explore and imagine, this internal strength can be nourished by the solidarity of others and can be crucial to a person's ability to cope in such a foreign and overwhelming environment.

The value of this space for dialogue becomes particularly apparent as the conversation between the grandmother and the chaplain unfolds after the surgeon's departure. Consider the following remarks: "Well, at least he isn't suffering anymore. He's in God's hands now—he's gone to a better place. We don't understand why this has happened, but there must be a purpose for it. God will reveal it someday." Here, we can see that her mode of reasoning has shifted from one of initially haphazard uncertainty to one of conviction, from potential to attainment, from anxious hope to confident faith. Death changed her grandson's ontological status: he is in heaven with God. That is his location, his status, his future. Hope became superfluous for the grandmother regarding Bobby; that is, her religious beliefs brought her concrete answers that explained his future precisely because these answers were not contingent on human technologies or interventions. Dialogue with the chaplain in this case helped to clarify the nature of her relationship with her grandson: she needn't worry any more about his suffering here on earth; he is safe; she will meet him again when she joins him in paradise. The ability to articulate such

deeply-held convictions helps her to calm herself in order to direct her hopes and concerns elsewhere, both to the immanent arrival of her worried daughter, for whom she states that she must compose herself, and also to her other grandchildren, who will come to represent hope for her in new ways in the months and years to come.

What does it mean for a biomedical space to host such beliefs and reflections? On the matter of Bobby's future, biomedicine is silent. It lacks both evidence and technologies for assessing the continuation of a soul or self after the body ceases to function, yet bereaved family members continue to brood over such issues within its walls. The presence of an inter-faith chaplain on the payroll effectively states that people are free to hold—and express—whatever religious beliefs they want regarding an afterlife; biomedicine makes no comment over which it exercises no influence. Crucially, however, it is precisely through this silence, this lack of response to such pressing questions as life after death, that pastoral dialogue about hope gains its force as a way of both connecting events within the hospital with broader sociocultural and cosmological systems and legitimizing the right of family members to react to loss through words. This act of listening, of exploring, of grieving alongside, can serve as a space for reaffirming beliefs and for contemplating new hopes for the future, providing a modest but important sense of continuity in the face of potentially crippling ruptures.

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