Earlham School of Religion

A Theology and Practice of Witness:
The Role of U. S. Healthcare Chaplains in Mitigating Harmful Effects of Bias against Racialized Groups

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ABSTRACT

This paper explores the topic of how healthcare chaplains can make a positive difference in the area of healthcare bias. On average, members of racialized groups in the United States experience worse healthcare, and worse health outcomes, than white people—a complex problem with deep historical roots. The discrepancy has many causes, including bias that is embedded in the design of clinical algorithms and medical instruments, bias that is calcified within aspects of healthcare culture, and biases that individuals hold. To the best of the author's knowledge, no research has been done on how, or whether, U.S.-based healthcare chaplains perceive this bias in the course of their work, or how they see a role for themselves in mitigating its effects. Interviews were conducted with eight people who have worked as healthcare chaplains in the U.S., and a qualitative analysis of the results shows ways in which some chaplains notice and grapple with the problem of healthcare bias. The results also show ways in which chaplains operate both as healthcare-system "insiders" who are colleagues to the medical staff, and as "outsiders" whose moral, ethical, and spiritual authority originates outside the walls of the hospital or clinic. This paper delineates more than twenty types of interventions that chaplains, as insiders who stand outside the system, can use to make a positive difference to the problem of healthcare bias. This paper also provides a theology that calls chaplains to bear witness to healthcare bias through active resistance and contemplative presence, one of many theologies that could be developed.

1. INTRODUCTION

Imagine a hospital chaplain on his way to the intensive care unit to visit a Black patient named Marcus, who was in a terrible car accident a few days ago.[1, 2] Before entering Marcus's room, the chaplain checks with the ICU staff to see if there is anything he should know. A staff member says of Marcus, "He'll tell you he's in a lot of pain, but he tends to exaggerate. He's doing okay." A red flag goes up in the chaplain's mind, because he knows that Black patients sometimes receive less pain medication than white patients who have similar injuries and similar self-reports of pain.[3] Is Marcus's pain being treated appropriately? Medical questions are not in the chaplain's wheelhouse, but ethical questions are, so this chaplain will stay alert to Marcus's situation.

He goes into Marcus's room, and soon Marcus is telling the story of his accident: He was going about seventy miles per hour in his SUV in the fast lane on the freeway when he looked in his mirror and saw an eighteen-wheeler moving into his lane, too close. He

[1] I have fictionalized the anecdotes in this paper to protect patient privacy, but the heart of the matter in each case is factual; for example, I have heard more than once from my chaplain colleagues about Black patients not being taken seriously when they say that their pain is not managed.

[2] By capitalizing "Black" but not "white," I am following the usage adopted by the *New York Times* in 2020. For a rationale, see Nancy Coleman, "Why We're Capitalizing Black," updated July 5, 2020, accessed December 1, 2022, https://www.nytimes.com/2020/07/05/insider/capitalized-black.html.

[3] Kelly M. Hoffman, et al., "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites," in the *Proceedings of the National Academy of Sciences of the United States*, April 19, 2016, https://doi.org/10.1073/pnas.1516047113. This 2016 study showed that a substantial number of white people in the U.S., including medical students and residents, held false beliefs about biological differences between Blacks and whites (for example, that a Black person's skin is thicker than a white person's skin). The study showed an association between these mistaken beliefs and racial disparities in pain-treatment recommendations.

stepped on the gas to get out of the truck's path, but it wasn't enough. The semi clipped his car, and the next thing he knew, he was surrounded by smoke, with firefighters yelling "Help us get you out!" After a terrifying escape from the car, a surreal ride in an ambulance, and a long surgery, Marcus is now recovering, but says he is in "so much pain, all day, all night, and they're not listening to me."

Just then the nurse comes in to change some dressings and check medications. "You might want to step outside while I take care of this," she says to the chaplain.

The chaplain hesitates. For some reason it doesn't feel right to leave just yet, because he wants Marcus to know that he is paying attention, not just to Marcus's spiritual and emotional well-being, but to what happens to him in the hospital. He instinctively wants to act as a witness, because he hasn't forgotten the comment about Marcus "tending to exaggerate" his pain.

"Actually," he says, "if it's okay with Marcus, I'll stay right here for now."

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This chaplain's decision to stay in the room for a few more minutes as a witness is a metaphor for the broader task of witnessing that chaplains can do. This chaplain knows something that it has taken me a long time to learn: Within U.S. healthcare systems, people who are members of racialized groups experience biases in the form of harmful discrepancies in their care as compared to people in non-racialized groups. Some of these discrepancies are the result of medical algorithms, processes, and systems that have

biases integrated into them, and some are the result of unconscious biases that healthcare staff, including chaplains, act out but do not perceive in themselves. Healthcare chaplains have a unique vantage point on some of these biases and the harms they cause. Likewise, racialized groups in the U.S. have worse health outcomes in general than non-racialized groups, a discrepancy that is caused mostly by factors outside the healthcare industry; for example, the effects of racism itself have been shown to worsen health outcomes. Injustices show up in some social determinants of health, such as socioeconomic status and race, and these injustices contribute to, and exacerbate, disease. Chaplains can be agents of healing for people who enter the healthcare system bearing wounds with deep roots, wounds that have a context much broader than the presenting episode.

Some chaplains see themselves playing a role in mitigating the harms caused by biases toward racialized groups, acting as healers who attend to the spiritual, emotional, and psychosocial concerns of those to whom they minister. The chaplain in the story above is part of the healthcare system and works within it, but he does not have a medical or administrative role, which puts him "outside" the system in a useful way. Can he contribute to Marcus's healing? Yes, and an important part in the process is his willingness to act as a witness, entering Marcus's situation and being a supportive companion to him. Marcus's chaplain would benefit from ongoing education, from information about the thought processes of like-minded colleagues, and from the development of recommendations based on anti-bias interventions used by other chaplains. That is the purpose of my research, and this paper. I explore how U.S. healthcare chaplains perceive and engage with biases against racialized groups in the

course of their work, and what it can mean, theologically and practically, to bring healing by acting as a witness to these injustices and the harms they cause.

This introductory chapter includes a personal statement, a statement of my thesis, and a discussion of terminology. In Chapter 2, I present and discuss existing research on discrepancies in U.S. health outcomes and healthcare, and existing research on implicit bias. In Chapter 3, I present my original research, which consisted of interviews with eight current and former U.S.-based healthcare chaplains. A theme emerged of chaplains working simultaneously as insiders and outsiders to institutional healthcare, which gives them a unique vantage point on injustice within the system. My interviewees told me many stories about bias that they had witnessed, and they offered almost ninety ideas, big and small, about interventions that chaplains might use in situations where bias causes harm. In my analysis, I grouped these ideas into eighteen categories, about half related to how chaplains can work within the system, and the other half related to chaplains' individual practices. My research also brought to mind several areas for future research. In Chapter 4, I develop a theology of witness that is based on the work of theologians including Shelly Rambo and Brian Blount. This theology calls us to bear witness to injustice through contemplative presence and nonviolent action; it is one of many theologies that can support anti-bias work. In Chapter 5, I present recommendations for how healthcare chaplains can make a positive difference in situations where racial bias causes harm, including several recommendations that my interviewees did not mention.

This paper focuses on biases against racialized groups within healthcare institutions and does not examine the many other reasons for disparities in health outcomes in the U.S.,

including social determinants of health. Neither does this paper go into biases related to gender identity, sexual orientation, disability, age, pregnancy, or mental health. This paper does not go into biases related to religion or immigration status per se, but does discuss biases toward religious groups that have been racialized in the U.S. (such as Muslims and Jews) and immigrant groups that have been racialized in the U.S. (such as Latinos who do not speak English).

Personal statement

In 2020, I completed a year-long Clinical Pastoral Education (CPE) residency at a hospital in Concord, California. My CPE year spanned the onset of Covid-19, and my cohort and I did our best to support hospital patients and staff while navigating our own pandemic-related fears and lifestyle changes. One night when I was on call at the hospital, I walked slowly down the hall in one of the hospital's Covid-19 units, seeing as if with new eyes. The patients were in windowed rooms, with information written on the outside of each window in erasable marker. "Lang: Span," "Lang: Span," "Lang: Span, ..." I read as I walked. Why, in a community that is about thirty percent Hispanic, with most of those people proficient in English, were seemingly half of the Covid-19 patients in our hospital Spanish-only speakers?

A few months later, George Floyd was murdered by a white police officer, and my Black CPE colleagues expressed profound grief, anger, and dismay. Their reactions called up a slower, but deeply felt, grief, anger, and dismay in me—along with regret that it had taken so much to get me to take seriously the evidence of structural racism that had been

available to me for most of my life. I wondered: What sorts of biases in the world outside the hospital had led to non-English-speakers being so plentiful in our Covid-19 unit at the start of the pandemic? Surely those biases had caused many harms, not just Covid-19. Were those harms being healed in the hospital, or compounded? Were these Spanish speakers receiving the same treatment as English speakers? And were Black patients receiving the same treatment as non-Black patients? If not, what else was I not perceiving about injustice in the hospital? Was I part of the solution, or part of the problem? I wanted to know more.

My Quaker Meeting regularly asks me to consider these questions. In February 2020, we approved a "Minute on Engagement to Uproot and Dismantle Racism in Strawberry Creek Friends Meeting" (shown in Appendix D), and at the close of each committee meeting, we consider how our committee work supports the goals stated in the minute. A powerfully worded minute is only a step toward change; it is the resulting actions that really make the difference. "When confronted with social evil, many people assert their good intentions, resist feeling guilty, and claim they are actually decent people," writes Sharon Welch. "My argument is that such good intentions are beside the point, for well-intentioned people are responsible for militarism."[4] She is writing about the dynamics of a military economy, but the principle holds: accountability requires action, which she defines as "the use of our power in concrete ways to implement the demands of justice."[5] I work as a hospital chaplain, and I wonder what actions chaplains can take

[4] Sharon Welch, *A Feminist Ethic of Risk*. Rev. ed. (Minneapolis, MN: Fortress Press, 2000) 17.

[5] Ibid., 35.

to mitigate the harms done by healthcare bias. Welch writes of an "ethic of risk," moving into action when I have no guarantee that I am correct or that my efforts will be helpful, and no definite control over the process and its results. Wanting credit for having good intentions is part of the "ethic of control" that Welch says suffuses the dominant (Euro-white) U.S. culture, but having good intentions does not involve risk.

It might be realistic to say that the economic, political, and social rights of racialized groups in the U.S. can only increase when they converge with the interests of non-racialized groups, as Derrick Bell said of the rights of Black people and the interests of white people in the U.S. And yes, anti-racist work is often performative, with no real substance or effect.[6] But I also believe it is not meaningless to try to do better. Almost by definition, an undercurrent of desire to maintain the status quo must animate my white, Euro-American self, because I was raised to see my whiteness as normative, and my privileges as earned. But I can strive to take real and moral action, amplifying the voices of those who are on the receiving end of biases that I do not experience, and using my own power as best I can, even though I operate from within the fog of my world view. As I take action, I will make mistakes, but it is worth that risk. My hope is that this paper will help me and other healthcare chaplains take more effective action for justice within the complicated realities of the U.S. medical system.

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[6] Alexis Hoag, "Permanence of Racism," Harvard Law Review Blog, August 24, 2020, accessed October 20, 2022, https://blog.harvardlawreview.org/derrick-bells-interest-convergence-and-the-permanence-of-racism-a-reflection-on-resistance/.

Thesis statement

Unjust systems and structures cause harm to racialized groups in the U.S., both inside and outside of the healthcare system. Many of these harms, and the biases that cause them, are well-documented, and they continue to be researched. Healthcare chaplains are in a position to lessen some of the harms that occur due to these biases, and they have a professional, ethical, and theological obligation to do so. My claim is that healthcare chaplains can make a difference in the area of bias within the healthcare system, and bias as it shows up within the sicknesses of people who enter the healthcare system.

Selected terminology

It might be helpful to the reader to know how I understand the following terms.

Clinical Pastoral Education (CPE)

Interfaith professional education for ministry, during which students have supervised encounters with people in crisis. CPE develops self-awareness and skills in interpersonal and interprofessional relationships.

cultural humility

Cultural humility is a commitment to a lifelong process of self-critique around issues of racial awareness. It includes ongoing work to fix power imbalances and amplify the voices of those affected by bias, and ongoing development of non-paternalistic

partnerships.[7] For white people in particular, cultural humility includes a willingness to be taught, which Rev. Michael McBride puts strongly:

> "[White Christians] have chosen to tolerate the conditions of injustice, violence, and dehumanization. They have chosen to profit from the morally bankrupt promises of false security, temporary safety, and retribution. Is this because the average white Christian is inherently too biased to sit and be taught by people of color?"[8]

ethnicity

Ethnicity is a classification of people based on commonalities in their race, nationality, language, tribe, or cultural background. People interpret the word "ethnicity" in different ways. In my research interviews, I asked my respondents how they describe their own race and ethnicity, letting them define the terms however they wanted. They framed their identities in a variety of ways, including in terms of the national origins of all their known ancestors ("Thai Mexican Scottish-English Norwegian"), a combination of ancestral origin and current location ("Latino Hispanic"), their family's religious tradition and line of descent ("Jewish"), and using the complicated word "Caucasian," which is sometimes used to describe either race or ethnicity.

implicit bias

Implicit biases operate without a person's intention or conscious control; as one of my interviewees put it, they are "these hidden parts of ourselves that silently govern us." Some implicit biases take form in the tendency to unconsciously associate negative ideas

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[7] Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," in *Journal of Health Care for the Poor and Underserved*, (May 1998; 9, 2), 117-125.

[8] Michael McBride, "Prophesy or Perish," *Review & Expositor* 114, no. 3 (2017): 441, https://doi.org/10.1177/0034637317724522.

with members of racialized groups. With effort, these biases can be acknowledged and worked against, even if they are never brought to conscious awareness.

Latino

"Latinx" is a gender-neutral term that is sometimes used interchangeably with "Latino," "Latina," or "Hispanic." The terms describe an ethnic category that includes residents of the U.S. and its territories who trace their origins to Spanish-speaking Latin American regions.[9] The Belonging and Equity Latino Task Force at John Muir Health, where I work, decided to use the word "Latino" instead of "Latinx," and for that reason, I am using the word "Latino."

racialization

To *racialize* something, for example a group, is to imbue it with racial characteristics, or to make it serve racist ends. Colonial power structures often create race as a tool for subjugating groups.[10] For example, African-Americans and Native Americans have been powerfully racialized in service to Eurpoean colonialism, with race used as a social and political construct to justify slavery and genocide. The Japanese colonization of Korea in the early 20th century resulted in the racialization of Koreans, who still experience discrimination in Japan. Before the 1950s in the U.S., the FBI began to racialize domestic Islamic groups such as the Nation of Islam and the Moorish Science Temple of America, looking at these groups through an already racialized (Black/white) lens. When Muslim

[9] Some sources also include Brazil, a non-Spanish-speaking country. For example, see https://www.epi.org/publication/latinx-workers-covid/.

[10] For a deep dive into colonialism, see Sylvester A. Johnson, *African American Religions, 1500-2000: Colonialism, Democracy, and Freedom* (New York, NY: Cambridge University Press, 2015).

immigration into the U.S. increased around 1950, U.S. intelligence agencies began to portray both domestic and foreign Muslims as "fanatical and hate-based," a move that helped the U.S. control certain Muslim foreign states and their natural resources.[11]

Bias against racialized groups in the U.S. includes anti-Blackness; Islamophobia; anti-Asian hate; anti-Semitism; and discrimination against First Nations Peoples, Latinos, non-English speakers, certain immigrants, and other groups that in some contexts might be described as "nonwhite."

racism

"Racism" includes any kind of bad treatment that is based on membership in a racialized category. Racism is a systemic condition, with personal racial animus as one possible manifestation of the condition. Because of my embeddedness in, and participation in, the white-dominated culture that has given economic and social advantages to me and my white ancestors, I consider myself to be a racist, even though I do not use racist epithets or practice obvious, conscious forms of racism. My parents taught me a subtle form of overt racism, along with subtle rationalizations that provide me with ways to dodge the whole idea, even now. My American grandparents showed me a less subtle form of overt racism that I was taught to scoff at, which gave me a way to feel virtuous about my attitudes. My inherited privilege, plus the subtle patterns of thought that I learned in childhood, and that are reinforced by my culture, make up my inherent racism; in turn, my inherent racism makes it hard for me to see the ways in which I perpetuate the

[11] Johnson, 379-82.

inequities and hierarchies that racism holds in place. I assume that I have significant blind spots in this area, and that working to see more clearly will be a lifelong practice.

I have heard the argument that inequity in U.S. culture should be looked at from the perspective of class, not race, because class is a "less divisive" issue. Helping everyone who is socially and economically disadvantaged will coincidentally help many nonwhite Americans, given the poverty levels in some nonwhite groups. However, while class is an important social determinant, people in the U.S. have not experienced systemic, organized discrimination, or genocide, based on class alone. To focus on increased justice for racialized groups is to acknowledge and work to redress specific wrongs that have been done; it is not to say that *other* injustices never occur.

In "Unhealthy Disparities," the conservative commentator Roger Clegg interprets racism to mean conscious racial animus, for example the attitude displayed by doctors who "deliberately or carelessly fail to give [nonwhite people] good care."[12] However, far fewer Americans are racist in this sense of the word than in its broader sense, and using Clegg's interpretation of the word allows for straw-man arguments.

Spirit; **God; God's Spirit**

This terminology reflects my personal theology, and I acknowledge that chaplains work from a wide variety of theological and philosophical foundations. A secular humanist chaplain, for example, might come to similar conclusions as I do about the importance of acknowledging bias toward racialized groups in U.S. healthcare, and might agree with me

[12] Roger Clegg, "Unhealthy Disparities," *National Review* website, article updated July 28, 2020, accessed March 30, 2022, https://www.nationalreview.com/2004/04/unhealthy-disparities-roger-clegg/.

about some of the ways in which chaplains can work against that bias, but might base their approach on a philosophy that does not include any reference to the divine.

2. DISCUSSION OF THE LITERATURE

This chapter presents and discusses existing research about discrepancies in U.S. health outcomes and healthcare, and also discusses ideas about implicit bias.

In Chapter 2 of *Caste*, "An Old House and an Infrared Light," Isabel Wilkerson develops a metaphor of the United States as an old house with all the idiosyncratic brokenness that comes with it.[13] None of us were present when this house was built, and many of us do not have ancestors who owned slaves or attacked indigenous people, but every person in the U.S. lives in this house now. The unseen skeleton of our house, Wilkerson says, is the caste system that maintains our social order by assigning power, resources, respect, authority, and assumptions of competence to certain people, but not to others. When you live in a creaky old house, you might accommodate the problems and come to see them as normal (putting out buckets when it rains, stepping over the floorboards that are rotting), or you might do what it takes to find the underlying causes of the problems (diagnosing the need for a new roof, getting an expert to check for termites in the wood). You cannot fix problems until you acknowledge them. One destructive problem with this old house, the United States, is that racialized groups of people have worse health outcomes, and receive worse healthcare, than non-racialized groups. In this chapter, I survey some of the literature that diagnoses these problems; I do this to provide context for the question I consider later in this paper, which is how U.S.-based chaplains can, and do, participate in the enormous project of rebuilding this old house.

[13] Isabel Wilkerson, *Caste: The Origins of Our Discontents* (New York: Random House, 2020), 15-17.

Discrepancies in health outcomes for racialized groups in the U.S.

Extensive research shows that English-speaking white people in the United States have better health outcomes than those who are not white, or who cannot speak English, and many researchers point to biases toward racialized groups in healthcare as one factor in these unequal health outcomes. Race-based health disparities in the U.S. are well documented and have deep historical roots. In *Just Medicine: A Cure for Racial Inequality in American Health Care*, Dayna Bowen Matthew documents many historical precedents for current race-based health inequities, including the effects of slavery, "Black codes," and Jim Crow laws on the health of Black Americans; the effects of land grants on the health of Native Americans; the effects of vagrancy laws on the health of Latino people and Native Americans; the effects of the demonization of Chinese immigrants after the Gold Rush on the health of Chinese Americans; the effects of the U.S. Supreme Court's 1896 Plessy v. Ferguson decision and the subsequent "separate but equal" health facilities that were far from equal; and more recently, the effects of the politically motivated "war on drugs" and mass incarceration on the health of Black and Latino people.[14]

Racism itself has direct negative effects on health. Scientists who study the long-term effects of experiencing explicit racism have found correlations with chronic stress, chronic low-grade inflammation, diabetes-related complications, childhood asthma,

[14] Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (New York: New York University Press, 2015).

infant mortality, low birth weight, accelerated aging, and more.[15] A 2006 study on the effects of allostatic load—the cumulative physical damage from repeated adaptation to stressors—found that the mean allostatic load for Black people was about the same as the mean allostatic load for white people who were ten years older, for all age groups.[16] Wilkerson cites several studies showing the negative health effects of experiencing prejudice and discrimination in the U.S., including the early onset of disease, narrowing of arteries over time, and increased risk of diabetes. The effects are not mitigated by affluence, because affluent people of color are "in contention" with the dominant caste system, which can cause ongoing stress.[17] In other words, simply being a person of color in the U.S. can take years off your life.

In *Medical Apartheid*, Harriet Washington charts the disturbing history of nontherapeutic medical experimentation on African-Americans, from slavery through the present. She covers well-known cases of abuse, for example the decades-long Tuskegee Syphilis Study, during which the U.S. Public Health Service prevented hundreds of syphilitic Black men from receiving treatment so that experimenters could observe the course of the untreated disease.[18] But Tuskegee is just the tip of the iceberg—Washington catalogs many other ethical lapses and medical abuses. In the Antebellum South, doctors bought

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[15] Rae Ellen Bichell, "Scientists Start to Tease Out the Subtler Ways Racism Hurts Health," (NPR, November 11, 2017), accessed June 2, 2021, https://www.npr.org/sections/health-shots/2017/11/11/562623815/.

[16] Arline T. Geronimus, et al., "'Weathering' and age patterns of allostatic load scores among blacks and whites in the United States," *American Journal of Public Health* 96,5 (2006): 826-33, https://doi.org/10.2105/AJPH.2004.060749.

[17] Wilkerson, 281–287.

[18] Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. 1st ed. (New York: Doubleday, 2006), 157-185.

or hired slaves on whom they performed risky, sadistic experiments. J. Marion Sims (the "father of modern gynecology") perfected vesicovaginal fistula surgery by performing surgeries on unwilling, unanesthetized slaves, performing more than thirty surgeries on one person alone, an enslaved woman named Anarcha.[19] Black bodies were exhumed from cemeteries for use in white medical schools during the 18th, 19th, and early 20th centuries.[20] Radioactive substances were injected into research subjects who probably did not give their consent.[21] Black people were enormously overrepresented in the forced sterilizations of the 20th century.[22] Black parents were tricked into allowing high-risk experiments on their children.[23] Disease-bearing mosquitoes were released in Black neighborhoods to test mosquitoes as vehicles of biological warfare.[24] And the list goes on.

Washington writes that ongoing mistrust and misunderstanding between medical researchers and Black Americans causes Black Americans to miss out on the benefits of ethically conducted therapeutic medical research. While her book makes a strong case for why Black people have reason to mistrust white medical researchers, she writes that her

[19] Ibid., 66.

[20] Allison C. Meier, "Grave Robbing, Black Cemeteries, and the American Medical School," in *JSTOR Daily*, August 24, 2018, https://daily.jstor.org/grave-robbing-black-cemeteries-and-the-american-medical-school/.

[21] United States Department of Energy, Assistant Secretary for Environment, Safety, and Health, "Chapter 3. Human Radiation Experiments Associated With DOE and Its Predecessors," in *HUMAN RADIATION EXPERIMENTS: The Department of Energy Roadmap to the Story and the Records*, February 1995, https://ehss.energy.gov/ohre/roadmap/roadmap/part3.html.

[22] Washington, 202-203

[23] Ibid., 271-283.

[24] Ibid., 360-361.

aim is to foster openness to therapeutic research among Black Americans while maximizing their protections from abuse. She says that to move forward in this, we must acknowledge the evils that have been done.[25] I will return later to this theme of needing to take a long look at the reality of the past in order to see and address the past's effects on the present.

Not everyone believes there is a racial basis for the wide gap that exists between the average health outcomes of racialized and non-racialized groups in the U.S. A large 2004 study cited in the *New England Journal of Medicine* concluded that Black Medicare patients are, in general, treated by physicians who are less likely to be board certified in their speciality, and less likely to have access to high-quality referral resources, than physicians who treat white patients.[26] Sally Satel uses this study to argue that inequality in health outcomes is unrelated to racism. She acknowledges the gap in health outcomes between Black and white Americans, and acknowledges the hard work and low pay that doctors working in predominantly Black communities often face, but sees the study as data in support of the idea that racism does not cause a meaningful part of the gap.[27] Roger Clegg, a writer for the National Review, sums up the study by saying "The problem is poverty and access, not race *per se*."[28] Both Satel and Clegg see the charge of

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[25] Ibid., 386.

[26] Peter B. Bach, et al., "Primary Care Physicians Who Treat Blacks and Whites," in *New England Journal of Medicine*, N Engl J Med 2004; 351:575-584, https://doi.org/10.1056/NEJMsa040609.

[27] Sally Satel, "Racism Is Not a Serious Problem in Modern Medicine," in *Medicine. Opposing Viewpoints in Context*, ed. Louise I. Gerdes (Detroit: Greenhaven Press, 2008), 30-36.

[28] Roger Clegg, "Health Disparities," *National Review* website, August 6, 2004, accessed March 30, 2022, https://www.nationalreview.com/corner/health-disparities-roger-clegg/.

racism as problematic in itself, because of their belief that citing racism when analyzing a problem that "has nothing to do with race" can cause racism that was not there.[29] However, this idea relies on the assumption that if a white person does not see a connection between race and a particular problem, then there is not a connection—an idea closely related to the problematic idea that it is a virtue for a white person to be "colorblind." Many individuals do perceive differences in race, and do hold harmful explicit or implicit beliefs about what these differences imply; to ignore race is to ignore the lived experiences of those who are on the receiving end of these harmful beliefs. And on a bigger scale than individual perception, some historical wrongs have compounded over the centuries (as with generational wealth) and embedded themselves in systems and processes (as with medical algorithms). Problems that might not seem related to race can turn out to be related to race when you look more closely.

To say that the gap in health outcomes can be explained without reference to race is to skip over some important facts. Race is intimately connected with social determinants of health, such as poverty, community context, environment, and access to high-quality education and health coverage. If worse health outcomes for immigrant Latinos, for example, are tied to the fact that these groups are more likely to live in neighborhoods without accessible healthcare, it is likely that race and ethnicity are factors in the state of this neighborhood, and therefore factors in the worse health outcomes. On average, white people in the U.S. are wealthier and have better health coverage than nonwhites; their better health outcomes are related to their better socioeconomic status. But that fact does

[29] Clegg, "Unhealthy Disparities."

not speak to what made the socioeconomic disparity possible in the first place, and what sustains it into the future. In another example, redlining and unethical mortgage practices have made it very difficult for Black families to build wealth and pass it along to later generations in some communities; wealth and desirable neighborhoods improve health outcomes. Given that race is a factor in many of the social determinants of health, race is a factor in health outcomes.

Discrepancies in healthcare for racialized groups in the U.S.

Race-based disparities occur not just in health outcomes, but in healthcare itself, meaning people's access to care, their use of care, the quality of care they receive, and the likelihood that they have health insurance. Once a year, the U.S. Department of Health and Human Services provides a comprehensive overview of healthcare quality and disparities in the U.S., and the Executive Summary of the 2019 report states that "[f]or about 40% of quality measures, Black people (82 of 202) and American Indians and Alaska Natives (47 of 116) received worse care than Whites. For more than one-third of quality measures, Hispanics (61 of 177) received worse care than Whites."[30] People of color are at increased risk of being uninsured, and Black people report more frequent negative experiences with healthcare than white people do.[31] Half of the first- and second-year medical students in a 2016 study endorsed one or more false beliefs about

[30] Agency for Healthcare Research and Quality, *2019 National Healthcare Quality and Disparities Report* (Rockville, MD: AHRQ, December 2020). AHRQ Pub. No. 20(21)-0045-EF. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf.

[31] Nambi Ndugga and Samantha Artiga, "Disparities in Health and Health Care: 5 Key Questions and Answers," Kaiser Family Foundation, published May 11, 2021, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

Black patients, for example that Black people have thicker skin than white people, or less sensitive nerve endings, beliefs that can lead to undertreatment for pain.[32,33]

Risk calculators that assess a patient's risk of having a certain condition sometimes adjust for a patient's identified race, a practice known as "race norming" or "race correction." Medical ethicists and healthcare researchers are scrutinizing this practice, arguing that it sometimes prevents people of color from receiving timely, adequate care.[34] A 2020 article in *The New England Journal of Medicine* examines thirteen clinical algorithms to show how the effects of racism are embedded within them, potentially causing more resources to be directed to white patients than to members of racialized groups. For example, a commonly used algorithm that predicts the risk of death for patients who are admitted to the hospital assigns three extra risk points to anyone who is identified as non-Black; therefore, all Black patients are seen as lower risk than they otherwise would have been. Clinicians use this risk number to guide referrals to cardiac care and other healthcare resources, so the algorithm could be directing care away from Black patients. The article encourages medical researchers and clinicians to revisit how they conceptualize race, and to carefully analyze the effects of clinical algorithms that include race correction.[35] Racial

[32] Kelly M. Hoffman, et al., "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites," in the *Proceedings of the National Academy of Sciences of the United States*, April 19, 2016, https://doi.org/10.1073/pnas.1516047113.

[33] Janice A. Sabin, "How We Fail Black Patients in Pain," Association of American Medical Colleges, January 6, 2020, accessed August 7, 2021, https://www.aamc.org/news-insights/how-we-fail-black-patients-pain.

[34] Fabiola Cineas, "'Race norming' and the long legacy of medical racism, explained," *Vox* July 9, 2021, accessed July 31, 2021, https://www.vox.com/22528334/race-norming-medical-racism.

[35] Darshali A. Vyas, Leo G. Eisenstein, and David S. Jones, "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms," in *The New England Journal of Medicine*, N Engl J Med 2020; 383:874-882, https://doi.org/10.1056/NEJMms2004740.

disparities can also be introduced when these kinds of clinical tools use input *other* than race. For example, researchers have found that a risk-determination algorithm widely used in U.S. hospitals takes as its input the medical costs that a patient has already generated, using the assumption that the more costs a patient has generated, the more sick they are. But because Black patients have often received less care than their white counterparts, and therefore have generated lower medical costs, on average the algorithm assigns the same level of risk to Black patients as to white patients who are less sick. The researchers estimate that remedying the algorithm's bias would more than double the percentage of Black patients whom the tool identifies for extra care such as referral to specialty services.[36]

The design of medical devices can also contribute to bias. For example, it has been known for over thirty years that pulse oximeters, small devices that are clipped onto a fingertip or an earlobe to measure blood oxygen saturation levels, overestimate oxygen saturation in darker-skinned people. A 2022 study found that for the studied group of non-Hispanic Black patients with Covid-19, the overestimation of blood oxygen levels led to significantly lower probabilities of being admitted to the hospital, and significant delays in treatment, as compared with non-Hispanic white patients (+37.2 minutes before receiving dexamethasone treatment, and +278.5 minutes before receiving supplemental oxygen).[37]

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[36] Ziad Obermeyer, et al., "Dissecting racial bias in an algorithm used to manage the health of populations," *Science* 366:6464 (Oct 25, 2019): 447-453, https://doi.org/10.1126/science.aax2342.

[37] Sylvia E K Sudat, et al., "Racial Disparities in Pulse Oximeter Device Inaccuracy and Estimated Clinical Impact on COVID-19 Treatment Course," *American Journal of Epidemiology*, 2022;, kwac164, https://doi.org/10.1093/aje/kwac164.

The Covid-19 pandemic has exacerbated structural inequities that have long harmed the Latino population in the U.S., and for this reason, the pandemic has had a hugely disproportionate effect on these communities.[38] Many barriers stand between immigrant Latino people and medical care, and if they do enter the healthcare system, immigrant Latino patients sometimes experience communication challenges and cross-cultural misunderstandings that affect every aspect of their care. Of providing care to non-English-speaking Covid-19 patients in Baltimore, authors from Johns Hopkins wrote that "[e]nd-of-life conversations left a bitter taste; even with skillful interpreters, many gestures, sentiments, and cultural nuances and expressions were lost."[39] The disease of those patients who died was one small part of the broader harm that they and their loved ones suffered when their spiritual and psychosocial needs were not met.

Is spiritual care itself biased within U.S. healthcare systems? Yes; for example, chaplains seem less likely to visit patients whose language they do not speak, and chaplains must, by definition, bring their own implicit biases into situations; at least a few of these biases are bound to be harmful. In healthcare institutions with few Black chaplains and a high census of Black patients, Black patients will sometimes receive less effective spiritual care; spiritual care, in turn, affects perceived quality of life, spiritual well-being, and

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[38] Andis Robeznieks, "Why COVID-19 hits Latinx at nearly double overall U.S. rate," AMA website October 23, 2020, https://www.ama-assn.org/delivering-care/population-care/why-covid-19-hits-latinx-nearly-double-overall-us-rate

[39] Kathleen R. Page, M.D., and Alejandra Flores-Miller, "Lessons We've Learned — Covid-19 and the Undocumented Latinx Community," *The New England Journal of Medicine*, N Engl J Med 2021; 384:5-7, January 7, 2021, https://doi.org/10.1056/NEJMp2024897.

patients' satisfaction with care.[40] Chaplain and CPE Certified Educator Karen Hutt points out that when caring for Black patients and families, Black chaplains can offer what non-Black chaplains cannot. It is her opinion that white chaplains can rarely provide adequate spiritual care to Black patients; she writes that the "diversity of the Black experience is rarely recognized by chaplains and often can cause stress to families, as the White chaplain's wide-eyed, gaping-mouthed curiosity and questions put genuine care on the backseat…. Black people find little refuge in the existing spiritual care centers of most hospitals."[41] She urges Black chaplains who are board certified, along with Black CPE Educators and Supervisors, to demand three things: Institutional cultural humility in healthcare institutions across the country, better education for chaplains about the Black religious experience and its history and diversity, and more Black staff chaplains working in hospitals.[42] This all makes sense, and individual chaplains can push for these changes to be made. They can support justice-minded hiring practices, seek continuing education about the history, diversity, and culture of the people who fill their hospital census or case load, and strive to cultivate cultural humility within themselves and their institution.

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[40] Robert W. Kirchoff, "Spiritual Care of Inpatients Focusing on Outcomes and the Role of Chaplaincy Services: A Systematic Review," in *Journal of Religion and Health* 60, no. 2 (April 2021), https://doi.org/10.1007/s10943-021-01191-z.

[41] Karen Hutt, "A Manifesto: Black Spiritual Care in American Hospitals," in *Spiritual Care in an Age of #BlackLivesMatter: Examining the Spiritual and Prophetic Needs of African Americans in a Violent America*, ed. Danielle J. Buhuro (Eugene, OR: Wipf and Stock, 2019), 190.

[42] Hutt, 191-193.

Implicit bias

Implicit bias refers to the unintentional, automatic ideas and feelings that people have in response to what they experience in the world around them. Implicit biases are mental shortcuts, and mental shortcuts are often benign or helpful; when the car in front of me stops suddenly, I slam on the brakes, and it is best if I do not take time to think it through. But implicit biases can be harmful when they cause people to make faulty assumptions about others based on irrelevant factors such as race, weight, or gender. Jennifer Eberhardt writes that "Without our permission or even awareness, stereotypes come to guide what we see, and in so doing seem to validate themselves…. The 'fictions and symbols' they represent are the thought paths that lead to expressions of implicit bias."[43] While studies have not found that healthcare providers have more implicit bias than the general population, there is a strong correlation between a provider's level of implicit bias toward a patient, and lower quality of care.[44] Some medical decisions must be made quickly, for example in an emergency where seconds count, and little quantitative data is available. But speed and ambiguity are strong triggers of bias, making bias an important topic for emergency medical personnel.[45, 46]

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[43] Jennifer L. Eberhardt, *Biased* (New York: Penguin Publishing Group, 2019), 35.

[44] Chloë FitzGerald and Samia Hurst, "Implicit bias in healthcare professionals: a systematic review," in *BMC medical ethics* 18, 19 (2017), accessed December 1, 2022, https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8.

[45] Mary E. McLean, MD, and Linelle Campbell, MD, "Implicit Bias Is Both Helpful and Harmful, so What Can We Do?," Emergency Medical Residents' Association, June 11, 2020, accessed October 19, 2022, https://www.emra.org/emresident/article/implicit-bias/.

[46] Eberhardt, 285.

Dayna Bowen Matthew cites evidence that social scientists have compiled showing that implicit biases can be changed, and that they can be changed much more quickly than they were formed in the first place. An implicit bias forms after a stereotype is activated, and a stereotype, Matthew reports, is "merely a pattern of activation that, at a given point in time, is jointly determined by *current input* (i.e. the context) and the *weight* of the new information's connection to existing and underlying beliefs."[47] Matthew writes that implicit biases are automatic, but not inevitable; they are sensitive to context, social pressure, and personal pressure, all of which are "inputs" that can be adjusted. Matthew describes a cognitive process that begins with the storage of social group knowledge and culminates in decisions and outward conduct. She describes interventions that affect this cognitive process at three points:

- The recommended intervention to affect what happens in a person's cognitive process after a stereotype has been triggered, but before an unconscious bias has been activated, is "stereotype negation training." This involves "repeated and prolonged exposure to new structural models of association," and it takes intention and time, something like the process of breaking a bad habit: first comes the decision to change the old habit, then come repeated reminders of the decision, along with repeated attempts to carry it out. One such training that was studied involved a semester-long course with Black male instructors. Students journaled about and discussed their own biases and ways to counteract them. Some of the discussions were heated, but at the end of the semester, students'

[47] Matthew, 156.

implicit and explicit anti-Black biases had been significantly reduced, according to several types of tests that were administered. Matthew contrasts this kind of training with less helpful training that promotes colorblindness and the suppression of unwanted attitudes, strategies that are not shown to reduce implicit bias.[48]

- The recommended intervention to affect the moment after an unconscious bias has been activated, but before a biased perception has formed, according to Matthew, is the promotion of counter-stereotypes. These can be introduced externally (for example, by watching videos about people in counter-stereotypical roles, or working with people who are in counter-stereotypical roles) or internally (by actively imagining people in these types of roles).[49]
- The recommended intervention to affect the moment after a biased perception has formed, but before the biased perception results in decisions or actions, involves social- and self-motivation. Matthew describes a series of studies that show "the extraordinary influence that perceived social consensus can have on reinforcing or dismantling implicitly held race stereotypes, and further, how consensus can reinforce or diminish participants' resulting negative racial behavior." But she cautions that at the moment in which social motivation can help, the work needs to happen at an *unconscious* level; instructing people to either appreciate or ignore

[48] Matthew, 159–161.

[49] Ibid., 161-164.

differences has been shown to backfire, as have "accusatory or 'politically correct' messages."[50]

Several years after Matthew published *Just Medicine*, a group of researchers reviewed hundreds of experiments that were done on prejudice-reduction interventions. Their analysis shows a pattern in which small studies report significantly stronger prejudice reduction than do large, well-designed studies.[51] Common problems in the smaller studies include a lack of transparency about data, data sets that are too small for meaningful analysis, and publication bias that causes only encouraging results to come to light. Also, the study finds that most research has been done on "light touch" interventions that take only a few minutes to complete and are inexpensive to implement. If these brief, inexpensive interventions actually work, the authors of the study argue, then we should do some large, high-quality studies to prove it; if they do not work, then we should "clear these red herrings from our path."[52] The authors also recommend more study of interventions that are actually used in the field, such as mass-media interventions and workplace diversity training.[53]

Even though much has yet to be determined about exactly what kinds of interventions can lessen harmful biases and their effects, and even though I am not convinced that implicit bias can be accurately measured with a test, it seems clear that harmful implicit bias does

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[50] Matthew., 165-167.

[51] Elizabeth Levy Paluck et al., "Prejudice Reduction: Progress and Challenges," in *Annual Review of Psychology* 72 (January 2021): 533–535, doi:10.1146/annurev-psych-071620-030619.

[52] Ibid., 555.

[53] Ibid., 536.

in fact exist. For example, hospital staff might label a Black patient as "difficult" because they ask a lot of questions, or might suspect that a young, tattooed Latino patient is drug-seeking, or might in some other way lean too quickly in the direction of a negative conclusion about a member of a racialized group, without any conscious bad intention. The staff who work on the hospital floors frequently encounter dangerous situations, and they are tasked with protecting vulnerable patients. When a patient or visitor becomes violent, the staff rightfully call a "Code Gray," which brings security guards hurrying to the scene. But both speed and ambiguity are involved when someone decides to call a Code Gray: If you think that you or someone else might get hurt, or has already been hurt, you *should* act fast, even if you do not yet have the whole story. It is the perfect time for implicit biases to be triggered; any association that might linger in the back of a non-Black person's mind between "Black" and "crime," for example, might hasten the decision to call a Code Gray.

One strategy for stepping around the idea of harmful implicit bias is to advocate for "colorblindness," which is often presented as a positive trait, and even a solution for racism. A person might say, for example, "I don’t see color, and I was raised to treat all people the same." Colorblindness might actually help matters if we lived in a country where white people experienced the same everyday realities as people of color, but that is not the country we live in. Implicit bias, along with the celebration of colorblindness, makes it possible for a white person like me to overlook inequalities. In the Code Gray example, a conscious awareness of race might cause a staff member to widen the scope of their gaze and take a moment before pushing that button: *This person is not of my race;*

what are my thoughts and feelings as I consider calling this Code? Would I proceed if this person were the same race as me? What is the wider context of this situation? Is there a less charged way to resolve it?

Being conscious of one's unconscious attitudes is impossible—attitudes are either conscious, or they are not. But implicit bias can be discerned by the shadows that it casts, and the ways that it shifts situations. Chaplains can look for these shadows and shifts, educate themselves and their colleagues about implicit bias, and work to diminish their own biases. And finally, even when harmful implicit biases remain, chaplains can work on the externals of the situation to prevent the discrimination that bias can cause.[54]

Conclusion

In this chapter, I have given a brief overview of the literature and research that show evidence of a serious problem: On average, members of racialized groups experience worse healthcare, and worse health outcomes, than white people in the U.S. These discrepancies have a long and complex history, and they are embedded in the systems and structures of American healthcare. Implicit bias and colorblindness can make this problem invisible to those who are socialized not to see it, or who are not directly affected by it.

[54] Betsy Mason, "Curbing implicit bias: what works and what doesn't," in *Knowable Magazine* June 4, 2020, accessed August 9, 2021, https://knowablemagazine.org/article/mind/2020/how-to-curb-implicit-bias.

While chaplains are sometimes part of the problem, they can become an increasingly effective part of the solution. But how? This question motivated my original research, which is the subject of my next chapter.

3. DISCUSSION OF ORIGINAL RESEARCH

Healthcare chaplains bear witness to intimate interactions among staff and patients, and they have a view into a cross-section of patient populations and departments within institutions. They are located inside the healthcare system, given that they are colleagues to the medical staff, accountable to professional standards, and sometimes present during intense medical events. But importantly, they are also located *outside* the healthcare system, given that they perform nonmedical tasks that are not easily quantified within a medicine-oriented system, and given that most professional chaplains are required to receive formal endorsement from a faith community to which they are morally, ethically, and spiritually accountable. Healthcare chaplains possess various kinds of authority that they can, and do, use on behalf of people who experience harmful bias, and the intention of my research has been to find generalizable knowledge to help chaplains more deeply integrate these kinds of anti-bias practices into their work. To find this information, I interviewed current and former healthcare chaplains about their perceptions of bias against racialized groups in healthcare institutions.

My eight interviewees described many examples of situations that seemed to be impacted negatively by race or ethnicity. In some of these examples, the interviewee wondered what they might have done differently, or felt that they could not change or solve the situation in any way. Other examples included descriptions of both the problem and the chaplain's intervention to help; for example, an interviewee told me about a non-English speaker not receiving the information and care that they needed, then went on to describe

the ways in which they intervened on the patient's behalf. My interviewees mentioned almost ninety nonunique interventions and practices, big and small, that could help chaplains work against harmful bias. I separated these interventions and practices somewhat arbitrarily into two broad categories: working within the system, and using individual practices. I describe these results in detail later in this chapter.

3.1 Description of interview-based research

Research question and rationale[55]

I have not found existing research about how healthcare chaplains perceive bias against racialized groups in healthcare, or how chaplains see a role for themselves in it, so I used my research to investigate the following question:

> How do healthcare chaplains perceive race-based and ethnicity-based biases in U.S. healthcare institutions, and what do they see as their role in mitigating these biases and the harms that they cause?

A better understanding of my research question has helped me develop a theology and practical recommendations to support chaplains in their work to promote justice for racialized groups, as discussed in later chapters.

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[55] I gained many ideas for how to design and conduct my research from Gary Myers and Rabbi Stephen Roberts's *An Invitation to Chaplaincy Research: Entering the Process* (HealthCare Chaplaincy Network, 2014).

Research methodology

I conducted one-to-one interviews with eight U.S.-based healthcare chaplains, then did a qualitative analysis of the narrative data that I gathered. I used interviews instead of a survey because I wanted to hear people's voices and reflect on the ways they told their stories. I wanted to know how they would tell their stories, not simply find out which boxes they would pick among boxes that I set before them.

Limitations of methodology

The subject matter that I studied was the stories that my respondents told me, and the affective color that they added to those stories. I myself was the "measurement instrument." It is a subjective methodology, and I do not expect that my respondents gave me unbiased, precisely accurate accounts of the events they described, nor do I expect that I have interpreted their responses without filtering them through my own world view. My own biases probably skewed whom I chose to interview, how I reacted to comments made during the interviews, and how I interpreted results. The research resources I have looked at recommend having someone else conduct and code interviews to minimize this kind of bias, but doing so was not feasible for me.

My research was self-reported, meaning that I asked my respondents to report on their own experiences, as they remembered them. Self-reported data is subject to *response bias*, measurement errors coming from the respondents themselves. Types of response bias that are relevant to my project include social desirability bias, acquiescence,

calibration differences, critical event and recency bias, and the so-called halo effect, which are all discussed below.[56]

Social desirability bias. All my interviewees have had CPE training, and most CPE programs provide education about racism. The very subject matter of my thesis might have told interviewees that I wanted to hear that they notice bias toward racialized groups and are concerned about it. I interviewed three of my co-workers, and it is possible that they gave answers matching what one is "supposed" to say within the culture of our diverse Spiritual Care department. Also, all of my interviewees had at least some knowledge of me as an individual. When a person learns that I am a member of a liberal Quaker Meeting, for example, they might assume that I want to hear answers that match a liberal outlook.

Acquiescence. Various theories exist about why some interview respondents tend to agree with whatever is presented to them by the interviewer; one possibility is that they feel themselves to be in a less powerful position than the interviewer. An acquiescent interviewee might think "You want there to be bias, so I'll find it." Also, respondents tend to agree more with vague or ambiguous questions, or when something about the situation is putting an extra cognitive load on them.

[56] Diane Dodd-McCue and Alexander Tartaglia, "Self-Report Response Bias: Learning to Live with Its Diagnosis in Chaplaincy Research," *Chaplaincy Today* 26, no. 1 (Spr 2010), accessed December 9, 2021, https://doi.org/10.1080/10999183.2010.10767394.

Calibration differences. People have different baselines for the way they process and present information. One person habitually sees the glass as half empty, while the other sees it half full.

Critical-event and recency bias. A recent event, or a dramatic event that stands out in a respondent's mind, is likely to get more airtime than a long-ago or routine event.

Halo effect. Halo-effect bias occurs when the respondent's answer to one question sets a pattern for how they answer subsequent questions. It could be that interviewees who answered one of my early questions with a certain scenario in mind then stayed with that scenario when answering subsequent questions not because the scenario was the most relevant to the question, but because it was fresh in their minds.

I addressed the possibility of self-report response bias as best I could. In hopes of lessening social desirability bias, I interviewed chaplains not only from my own workplace, but from five other workplaces as well. I tried to word my communications in ways that did not hint at "right answers" to my questions. I considered including the question "What pronouns do you use for yourself?" to show respect, and to signal that it would be safe for a person to tell me about nontraditional aspects of their life. However, the question itself signals the social desirability of a liberal point of view, so I left it out.

To minimize acquiescence, or "yea saying" bias, I tried to make my questions unambiguous. I considered starting with a question such as "Do you think all patients receive equal treatment in U.S. healthcare institutions?" But given that I said up front that

my research relates to bias, asking about equal treatment in general is a trick question: most people would assume that the answer I was looking for was "No."

As for response biases related to calibration, critical events, recency of events, and the "halo effect," I do not think I could have controlled for them. I tried to be aware of them during the interview process, and I acknowledge their effects in my analysis. To lessen the effects of my *own* bias, I used the same questions with each interviewee, and I read about implicit bias before beginning the interview process, in hopes that reflecting on it would help me become more self-aware.

Recruitment methodology and process

I recruited interviewees who have worked as healthcare chaplains in the U.S. I did not recruit any current CPE students, or anyone whose chaplaincy experience did not extend beyond the clinical hours that they completed for their CPE training. Other than the chaplain friend I recruited to help me test my interview process, I did not recruit any participant who might have felt a sense of obligation toward me—for example, someone for whom I wrote a recommendation. I compiled a list of forty-five chaplains meeting these criteria, trying for a mixture of races, ethnicities, faith traditions, and experience levels. Some people on the list were known to me, others not. I used a random-number generator to select names from the list, continuing until I recruited eight chaplains who agreed to participate. In my recruiting email, I described the purpose of my research, my interview process, and how I would use the information I received.

Each participant signed an informed-consent document and a recording-consent form, and I did not offer any incentives for participation. To protect the identities of my interviewees, I do not name any of them in this paper, and I obscure or fictionalize identifying details about them and the people they spoke about.

The following documents related to my recruitment and interview process are located in Appendix A:

- Research approval form from Earlham College IRB
- Earlham College Human Subjects Consent Form
- Earlham College Recording Consent Form

Interview process and script

I began by testing my process on a friend who is a healthcare chaplain. I asked this chaplain to sign my consent forms, and then I interviewed them using the questions and process that I planned to use for the rest of my interviews. Afterwards, I asked their impressions of the process and questions. Based on their feedback, I made a few minor wording changes in my questions. I then recruited seven other participants who signed the consent forms and agreed to be interviewed. Participants spent between thirty and ninety minutes on the phone with me, answering my questions about their experiences in healthcare chaplaincy. I recorded the interviews and used Otter.ai to transcribe them, then analyzed the transcripts by coding them according to themes that emerged. I reflected on the results and refined my hypothesis based on what I found.

The script that I used for each interview, as approved by the Earlham College Institutional Review Board (IRB), is shown in Appendix A. I would change two things about the script, if I had it to do over again. First, in the question about implicit bias, I would clarify the meaning of implicit bias and mention that everyone has it, and that many implicit biases are neutral or positive. The question as written usually caused a detour in the conversation while we discussed these points, but I could have taken us more quickly to discussions about *harmful* implicit biases. Second, I would change the way I explained the focus of my research in the opening paragraph of the script. My interest is not only bias that occurs within U.S. healthcare institutions—I am also looking at ways chaplains can help people to heal from the broader illnesses caused by bias against racialized groups in the U.S., biases that harm people long before they arrive in a healthcare institution. The wording change would be small, but meaningful.

3.2 Analysis of interview results

Demographics

Of my eight interviewees, five were previously known to me, and three were unknown to me. I found two of those three on LinkedIn, and one by way of a referral from a friend. All eight of my interviewees have done healthcare chaplaincy, and all of them have received CPE training. I did not ask about ordination status, age, or gender identity. At the time I interviewed them, six of my interviewees lived in the San Francisco Bay Area; one in Seattle, Washington; and one in Boulder, Colorado.

Question 1: How do you identify your race and ethnicity?

The answers to this question were nuanced, and in only a few cases did they match the choices typically offered on surveys and censuses. Five of my interviewees gave multi-sentence, or even multi-paragraph, answers, which are shown in Appendix B. In summary, my eight interviewees described themselves as "Black African-American," "Human Argentinian Eastern-European," "Latino Hispanic," "Caucasian/white Euro-American," "Asian-American," "white Jewish," "Thai Mexican Scottish-English Norwegian," and "white European-American."

Question 2: What is your faith tradition?

Two of my interviewees named their faith tradition as "Unitarian Universalist"; the other six named their faith traditions as "Buddhist," "Methodist/UCC," "Jewish-Buddhist," "Christian," "Muslim, informed by the Sunni tradition inside Islam"), and "Orthodox."

Question 3: How long have you worked as a chaplain, and in what contexts?

The interviewee with the least experience said they had about eight months of post-CPE experience. In no case did anyone answer definitely; everyone estimated. The person with the most experience calculated their number of years in chaplaincy by remembering the ages of their children, finally saying they had chaplained for "around twenty or twenty-five years." I think some of the respondents included CPE in their calculations, but either way, I interviewed people with a wide range of experience, approximately one, one, five, eight, eight, ten, thirteen, and twenty-five years. The results are shown in full in Appendix B.

Chaplain contributions, in general

Question 4: What are one or two ways you would say healthcare chaplains make a positive difference in healthcare settings?

Representative answers to this question are shown in Appendix C. The responses suggest that chaplains see their impact coming mostly from unquantifiable tasks such as bringing a certain kind of presence, offering a spacious quality of time, providing humanity, creating safe space, and providing spiritual support. The examples show chaplains as caring human beings whose default setting on the job is to come alongside others in supportive ways, listen deeply, and witness people in times of crisis. My work seeks to bring an analysis of bias as a further development of this basic orientation of "presence."

Situations impacted by race or ethnicity

Questions 5 and 6 relate to situations with race or ethnicity as a factor, so I will discuss them together:

Question 5: In your chaplaincy work, have you witnessed or been part of situations where race or ethnicity seemed to play a role in an interaction between healthcare staff and a patient or the patient's loved ones? Could you give examples?

Question 6: Have patients or their loved ones ever told you they have race-based or ethnicity-based concerns about their healthcare? Could you give examples?

After I coded the answers to these questions, I counted the number of times each coded idea was mentioned, as shown in Table 3.1, below. "Count" refers to the number of times the issue in the "Summary" column was mentioned.

In the "More detail" column, I indicate in parentheses the number of mentions for each type of issue. For example, regarding situations where people from racialized groups are seen by staff as problematic, I heard three examples of intense grief responses being problematized, and seven other examples where behavior was problematized.

Table 3.1. Situations negatively impacted by race or ethnicity (page 1 of 3)

Count	Summary	More detail; number of mentions in parentheses
11	Mistrust expressed by people from racialized groups	● Distrust of brain-death diagnosis, or family suspecting that their loved one was not getting the "good stuff" or the best options; Black patient requesting Black caregivers
10	People from racialized groups seen by staff as problematic	● Grief responses problematized (3) ● People from racialized groups problematized in general; quickly labeled as difficult or aggressive; security more likely to be called; family asked to leave when MD said they could be there; double-checking and extra vigilance around Black visitors; treating Black visitors in a controlling way (7)
8	Non-English speaker not well cared for	● Non-English speaker labeled as difficult without getting a real interpreter; staff dragging their feet about meeting the extra needs of big Hispanic family; non-English speaker seeming to receive worse care (3) ● Non-English speaker not getting questions answered; not fully informed about their own medical situation and options; experiencing stress, and maybe worse care, because staff not using interpreter (5)
7	Negative assumptions and judgments about people from racialized groups	● Black person's expression of pain seen as drug-seeking behavior (2) ● Trauma patients from racialized groups assumed to be criminals, drug users, gang members (1) ● Staff sharing judgments among themselves about people's behavior, or potential behavior (3) ● Stereotyping of Asian patient (1)

Table 3.1. (page 2 of 3)

Count	Summary	More detail; number of mentions in parentheses
7	Spiritual needs not well met	• Muslim not stating their faith during admission process, fearing bias or retaliation (2) • Staff not taking seriously the religious beliefs or practices of people different from themselves (2) • Non-English speaker's spiritual needs dismissed or not well-tended (3)
6	Lack of cultural knowledge; assumptions about dominant culture being "normal"	• Modest Muslim woman assigned male nurses (1) • Immigrant served food they don't eat (1) • Staff needing education re: non-familiar cultures (e.g., Roma family); patient needing advocate for special cultural needs (3) • At end-of-life, nonwhite family pressured to "make typical white middle-class choices" by discontinuing life-extending treatments (1)
6	Black pain and suffering not taken seriously	• Black person's pain discounted, or not treated (4) • Staff expressing indifference toward Black suffering in general; e.g., "Sure, it's right here in my community, but I'm not affected by it" (1) • Staff "less excited about running around to provide care" for Black man at end-of-life (1)
3	Racism experienced by staff	• Muslim nurse with head scarf treated badly by bigoted patient; patient repeatedly mistaking Black behavioral-health counselor for security guard; patients making assumptions about Asian chaplain (3)
2	Profound disrespect shown to some people from racialized groups	• The bodies of some Black male gunshot victims being treated with disrespect after death • MD reluctant to treat immigrant because of strong bias against the person's nationality

Table 3.1. (page 3 of 3)

Count	Summary	More detail; number of mentions in parentheses
1	(No examples)	• Interviewee could not think of any examples; "Everyone is treated well in my hospital"
1	Disparity not originating in hospital	• Disproportionate number of Hispanic people in the hospital during Covid pandemic

It makes sense that I heard many examples of mistrust expressed by people from racialized groups, because I asked a separate question about it (Question 6). Most of the eleven examples I heard about this phenomenon had to do with Black patients or family members expressing mistrust of white (or simply non-Black) caregivers. Karen Hutt writes movingly about this Black experience:

> For Black people, hospitalization ignites the hermeneutic of suspicion. Family members are summoned to take shifts '*to watch them*' as their loved ones receive care. Extra questions are asked about the medication regimens, large groups of family and community members take up residency in the family lounges to make sure '*Big Mama knows we are there with her.*' The stress and anxiety of *hospitalization while Black* leads to many challenges and conflicts for hospital staff and family members. It is during these tense moments that the assistance of a chaplain or social worker could make all the difference in advocating for or simply listening to patients. Although a chaplain's presence may be helpful in such a situation, there are very few, if any, Black chaplains or social workers in major urban hospitals serving a sizable number of Black people according to the hospital census. As a result, the psychosocial and spiritual needs of Black people are often ignored, dismissed, or ridiculed by White hospital staff. This lack of care increases the anxiety of hospitalization and lessens favorable health outcomes for Black people.[57]

When Hutt writes that "the psychosocial and spiritual needs of Black people are often ignored, dismissed, or ridiculed by White hospital staff," it is reminiscent of the ten examples I heard regarding people from racialized groups (mostly Black people) being

[57] Hutt, 187-188.

problematized by staff. I have heard my colleagues refer to this phenomenon as staff "pulling the Black alarm," meaning that the staff has called security or otherwise reacted to a Black person's behavior more quickly, and more controllingly, than they might have if the person were white. In this kind of a situation, the psychosocial and spiritual needs of the Black people in question might be ignored, dismissed, or even ridiculed.

One interviewee gave the example of a nonwhite family being pressured to "make typical white middle-class choices" about end-of-life decisions, and other interviewees spoke of families distrusting a brain-death diagnosis, or suspecting that their loved ones was not being offered the best end-of-life options. Katrina Hauschildt of Johns Hopkins University School of Medicine has researched and written about these dynamics. During end-of-life situations in U.S. healthcare institutions, the dominant culture's values tend to include three beliefs: that the end of a person's life should be as comfortable as possible (valuing freedom from suffering over more days of life); that keeping extremely sick, terminally ill people alive as long as possible is "futile" and therefore not how money should be spent (valuing thrift over more days of life); and that in end-of-life situations, decision-makers should consider what makes life "worth living" (valuing capabilities over more days of life). A 2013 Pew survey showed that white people tend to agree with this dominant norm, and Black and Hispanic people tend to disagree with it. When patients or their loved ones hold values that differ from the norm, they are often treated with suspicion and resistance, as if their desire to continue life-sustaining treatments stems from misunderstanding, lack of education, or lack of compassion. Even when an MD and other staff are sympathetic with the nuances of a patient's or family's position,

and even when the patient or family advocates strongly for what they value, and even when the patient or family are *white*, there are still ways in which American hospital systems are standardized to favor the dominant end-of-life values.[58]

Several of the longer stories that my interviewees told me, as summarized in Table 3.1 above, were deeply troubling. The example I heard about profound disrespect shown toward Black male gunshot victims came from a chaplain who for several years worked in a downtown teaching hospital in a large East Coast city, often during nights. That story contains several elements I would like to discuss, and so I quote it here in full:

> As chaplains, we felt conflicted at times because they'll crack open the chest, they're trying to massage the heart, and … then they die. And then all of a sudden they switch from—and they're often Black males—all of a sudden it switches from, 'Okay, we just went from saving this person,' to 'Now we're going to have a little medical-school lesson here. You see this here? You see that there?'...
>
> Some of our chaplains purposely had a blanket ready to put on the body, because you know, they're stark naked. They're just trying to respect the human body and the sacredness and dignity of the body. So being part of the system where … students are learning so that you can save future people, was a really hard thing to swallow. And then listening to my African-American colleagues reflect and share during staff meetings, some of their reactions to that, and their wonderings about it too, and feeling that tension as well … talking about, 'Do we need to have them just cover up their genitals, at the very least?' It feels disconnected sometimes. Those [events] were disturbing, a moral dilemma…. You would see that repeatedly.
>
> And sometimes people are really good about just having a moment of silence. 'Chaplain, come on, lead us.' But other times … it's, 'Okay, now on to the next thing.' There were times where I would stand there and purposely wait, kind of close to the attending, and then say, 'Can we have a moment of silence?' And then they'd be like, 'Oh, yes. Yes. Let's do that. Stop everything.' But the switch would happen real quick, from declaring them dead, to 'Now, let's look at this.' And sometimes it was almost on the borderline of blocking, it felt like.

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[58] Katrina E. Hauschildt, "Whose Good Death? Valuation and Standardization As Mechanisms of Inequality in Hospitals," in *Journal of Health and Social Behavior* (2022), https://doi.org/10.1177/00221465221143088.

> "So there's this tension, of like, am I contributing? Where's the line of, okay, you have to be 'strong' or 'detached' a little bit as a surgeon or doctor to continue to do this, through the shift, and through your work. And at the same time, not losing touch with this as a person. A human being who had a life, who has a family, you know, who touches things, and deserves a little moment of recognition, at the very least.

While this quote describes an extreme situation that few chaplains experience, I selected it because it vividly illustrates several points about healthcare chaplaincy. First, it shows the chaplain as *witness*. In each situation such as the ones this chaplain describes, the chaplain witnesses the death of a person whose family and friends are not in the room; they also witness the workings of a system that requires efficiency and cool objectivity, values that can erode human dignity. This chaplain asks "Am I contributing?" According to a theology of witness, the answer is *Yes*.

The chaplain in the quote points to the tension that chaplains experience when they are in a dual role, standing both inside and outside the system. In this sense, they are uniquely placed: sometimes healthcare chaplains do no more than bear witness while life-saving efforts go on in front of them, and in that sense they are outside. But they are also inside the system: they are professional colleagues to the medical staff, and, like them, they are accountable to professional standards. They have extensive education and training—usually an MDiv or other Masters' degree, plus a year of intensive CPE training. They have been officially endorsed by their faith communities, which in some cases is a lengthy denominational process that takes years to complete. Their job title grants them moral and spiritual authority that they are expected to use. In addition, many chaplains possess reputation-based authority, because staff members have seen their skill and learned to trust them. And while a professional chaplain in an interfaith setting

cannot ask for or expect "traditional" authority, the type of authority often given to faith-community leaders such as pastors and rabbis, some staff members grant it to them. And finally, there is the "assumed" authority that a chaplain can wield simply by acting authoritatively, or by using their interpersonal skills or charisma. Put all this together, and a chaplain has more than enough authority to ask for, and expect to get, a moment of respectful silence when a human being dies.

During a trauma response in an Emergency Department, events unfold with powerful momentum, and chaplains find ways to place themselves skillfully within these scenes. In the story above, the chaplain hovered near the attending physician so as to be ready to ask for a moment of silence before the medical teaching began; the chaplain's colleagues kept blankets on hand to cover bodies that no one else thought to cover. These actions are wedges that open up a small space for warmth and humanity in situations that are, by necessity, cold and sterile. The quoted chaplain went on to speak of their role in the death notifications and viewings that would follow these traumatic deaths, showing how a chaplain is sometimes the through line that connects the beginning, middle, and end of a patient's or visitor's time in the hospital. Chaplains bear witness to the trauma that violence inflicts on bodies, to the life-saving efforts of medical teams, to death itself, and to the fresh grief of a deceased person's loved ones.

This chaplain spoke about discussions that they and their chaplain colleagues had about their own moral distress, and about ways they might draw a line between acceptable and unacceptable behavior; for example, insisting that a staff person "just cover up [the patient's] genitals, at the very least." Several of my interviewees mentioned the

importance of working as a team, and two chaplains who have chaplained alone, in hospice work, spoke of the difficulty of *not* being part of a team. Clearly, being part of a spiritual-care team (not just an interdisciplinary team) can be helpful.

The chaplain's reflections and actions in the quoted story illustrate several of the tactics discussed in a later section of this chapter, "How chaplains can make a positive difference." In particular, this chaplain worked within the system to collaborate with medical staff; advocated for the dignity of those Black men and highlighted their humanity; debriefed with, and learned from, African-American colleagues; brought a people-oriented presence into a sterile setting; exercised creativity and authority; strategically used small windows of time; and compassionately bore witness to suffering and trauma. Could they have done more? Maybe, but to appropriately make space for humanity, spiritual care, and broader questions of justice while an Emergency Department trauma team is in full swing is not a trivial task.

Implicit bias

Question 7: Are you familiar with the idea of implicit bias, and if so, do you think it plays a part in the healthcare institution(s) where you work? If so, could you give examples?"

In answer to this question, one interviewee said that they do not see examples of implicit bias, and they attributed this to the excellent anti-bias training that their hospital staff receives. A number of other ideas were mentioned: we all have implicit bias and don't know how it affects our behavior; chaplains often have training in this area, for example

through CPE, their hospital system, or their denomination; anti-bias work can be done with gentleness, kindness, and humor; it is challenging to *experience* biased treatment; implicit bias sometimes takes the form of assumptions about shared norms. One interviewee mentioned that positive biases can lead chaplains to provide better care. They gave the example of having an instant connection to trans people and using this connection to provide extra care, knowing that trans people often experience negative bias from others. Several people mentioned that it is very hard to see and work with one's own biases: "Having [input from] other people, I think, is absolutely necessary to the implicit bias work," one person said. One interviewee mentioned that their Buddhist practice helps them work with their own implicit biases; that quote is discussed after Table 3.8, later in this chapter. Other representative quotes about implicit bias are shown in Appendix C.

How chaplains can make a positive difference

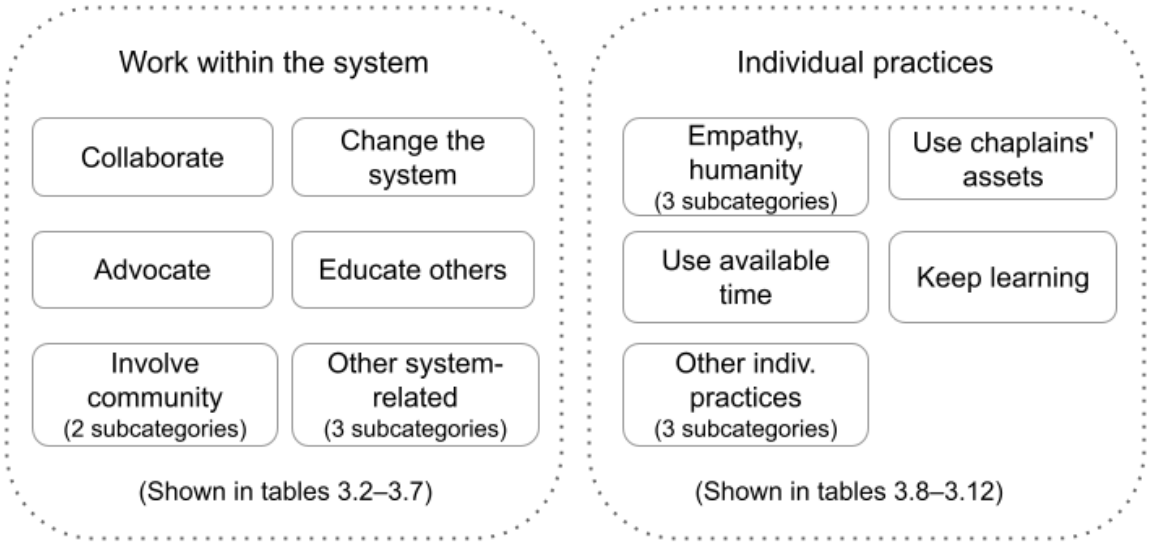
The next two questions are about the ways in which chaplains can make a positive difference when bias has caused, or could cause, harm. These questions bring us to the heart of my research question.

Question 8: How do healthcare chaplains make a positive difference when it comes to race-based or ethnicity-based bias in their workplaces?

Question 9: What practices can chaplains use to improve situations where bias is, or could be, causing harm?

In my interview transcripts, I coded every relevant idea that my interviewees offered, whether in answer to one of these two questions, or in a different part of the interview. Then I broke these eighty-eight ideas into eighteen categories. I put each situation-specific idea into only one category, although many of them could fit into multiple categories, making the categorization somewhat arbitrary. I noticed that the examples were of two types: work that chaplains do within, through, and on "the system"; and individual practices. The diagram below shows these two groups, and the categories that fit within them.

Diagram 3.1. Categories of ideas given by interviewees



The following tables go into deeper detail and show a summary of the ideas in each category.

Table 3.2. Work within the system: Collaborate

Category	Interviewees' ideas
Collaborate with staff, help them out, collaborate with chaplain colleagues	● Invite staff into your understanding of a patient's pain or spiritual need so that you can be a team. ● When a fear response might be activated in staff because of a trauma situation (violence, the presence of police, fast-moving frightening events, etc.), take them aside and acknowledge what might be happening; help ground them and bring them back to their body. ● Ask questions to open up a broader perspective when it seems to you that race is entering a situation; don't directly call it out, but give people space to see from a different perspective. ● Humanize people for the staff; tell a bit of their story to counteract the "grimace from afar" mentality, e.g., when staff keep their distance from people whose expressions of grief are intense. ● Support chaplain colleagues in the challenges of supporting staff while also advocating for marginalized people. ● Use storytelling to "pull up the empathy" in staff when you see them taking shortcuts in how they see and judge people. ● Build relationships with staff, including security staff, so you understand where they are coming from, and so you know how to work best with them as individuals. (2) ● Respect other staff's roles. Be careful not to explain medical things, take over a security person's task, "work around" people, or make other people look bad.

Table 3.3. Work within the system: Change the system

Category	Interviewees' ideas
Push for helpful changes to the system; support diversity	● When a patient tells you they experienced bias, or you see it yourself, but the patient doesn't want to say anything or report it for fear of retaliation, help to create a clear system for reporting it. ● Have chaplains (or their managers) included in institutional leadership hierarchy; build social capital with those who can change the system. ● Hire multilingual chaplains. ● Be aware of who's being asked to lead; ask "Do all the leaders have the same preconceived notions? Are there other candidates who might bring a wider set of beliefs and ideas?" ● Hire for more diversity in general, not just among chaplains; e.g., when a Code Gray is called, if there are a bunch of white people standing around a Black person, it's a sign that several things might be off. ● Do de-escalation training for security. ● Have the ethics committee read articles and books about bias in health care.

Table 3.4. Work within the system: Advocate

Category	Interviewees' ideas
Advocate	● Bear witness by staying present, physically, to keep a vulnerable person "safe" and to communicate that "if they demean you, I will see it." ● Be the voice of respect for a person's faith and religion, and the voice of reason for the MD: a person's faith and expectations affect their physical health, even if MD does not believe in God or the spiritual. ● Go up the chain to the CNO, or whoever, to press for exceptions for things that are deeply important to someone, e.g., allowing monks to come in to chant for a person who was dying during Covid. ● Advocate for making room for people, e.g., push to have that extra-long, multi-hour family meeting so there's time for all the questions from the patient's young-adult kids. ● Be determined; for example, push repeatedly for staff to find in the back of the cabinet, and then use, the mask called "The Communicator" for that patient who reads lips. ● Know how to navigate the system; e.g., advocate to security to get *all* family members upstairs for viewing of their deceased loved one. ● Tell the charge nurse, tell a colleague, look into who might be able to do something about the bias you witnessed; debrief with the person who experienced it and help them explore their feelings.

The interviewee who gave the example about talking with colleagues and debriefing with the one who experienced the biased treatment also spoke about the challenges and limitations of advocacy. Their story illustrates the point that some people do not want to draw attention to themselves by complaining, or by having a complaint lodged on their behalf, because they fear retaliation. I quote that story here in full:

> A patient that I interacted with was in a lot of pain. He was a Black man and had something pushing on his prostate, or something, and he was yelling out, and in a lot of pain. And one of the staff who was not Black, I don't remember what the race was, she threw a pillow at him to try to quiet him. I think she was frustrated, and [did it] out of frustration, to try to get him to be quiet. He communicated the story to me, and it was deeply disturbing for him…. [H]e ended up feeling really bad about his behavior, and feeling like he had to justify why he was screaming out, because he was in this pain. And he almost took it on himself as this shame about his behavior, and in some ways was minimizing the event, though he was clearly hurt by it.
>
> We explored his feelings, and at some point, he just, you know, he kind of wanted to apologize. He didn't end up, as far as I know, doing that. But it felt like definitely an issue of race bias to me, and sort of the, you know, the 'angry, violent Black man' [stereotype being applied]. I talked to the charge nurse to explain what had gone on, and she was a little bit dismissive of it also. But [she said] 'we're going to give him a different nurse' the next night, [and] she said, 'I appreciate you telling me.'
>
> Then I was thinking, who else? I don't know, it felt a bit unsatisfactory. The response. I mean, I don't know what I was hoping they would do. So I reached out to a colleague about patient engagement around, you know, when things happen like this, is there some other place to go? And she basically told me, 'these people, nothing is ever done'.... So anyway, I left that interaction in particular feeling a little rejected. It seemed, on many accounts, not addressed appropriately.
>
> (Interviewer) Your concerns weren't addressed. His pain wasn't addressed in a way that was appropriate.
>
> (Interviewee) Yeah. And at the same time, wanting to honor his, like—I could sense that the patient didn't really want to take this any farther anyway, maybe for fear that it could impact his future care if he made a big complaint about it. And so I think there's tension there, around highlighting this person individually in his care, and whether the institutional factors—. Or how something like this happened. And what is the recourse, while not putting someone who's in a vulnerable position in a *more* vulnerable position?

This chaplain's story brings up several important questions. How can a healthcare employee take strong action on behalf of a vulnerable person—a patient, a patient's family member, or a fellow employee—in a way that protects that person from retaliation and shame? And what does the chaplain do with their own sense of outrage when there is

not any way to take meaningful action? This chaplain bore witness to the patient's pain, attending carefully to the patient's complicated emotions about being treated with disrespect for expressing his pain the way he did. The chaplain aligned themself with the patient and viewed the story from his point of view, which caused the chaplain to experience an echo of the rejection and disorientation that the patient experienced: The charge nurse "was a bit dismissive" of the chaplain's story (an echo of the original nurse's dismissiveness about the patient's pain); the other colleague told the chaplain that "nothing is ever done" (an echo of the patient's unwillingness to make a "big complaint," perhaps fearing retaliation or sensing that to complain would be futile); the chaplain was "feeling a little rejected" (an echo of the emotional pain that the patient expressed to the chaplain).

The chaplain felt "a tension" between individual and institutional forces, and they feared "putting someone who's in a vulnerable position in a *more* vulnerable position" by lodging a more forceful complaint on the patient's behalf. This chaplain was employed by the hospital and was located inside the system, but in service to this patient, they placed one foot outside the system, so as to be a witness and an advocate. As a result, the chaplain experienced rejection, disorientation, and conflicted feelings similar to those felt by the patient, although less intense. The system did not have a process in which some kind of redress could occur after the nurse threw a pillow at the patient, or a restorative process in which things might be set right—or at least set *more* right. The existing process was to end the relationship between the patient and the nurse, cutting off any possibility of mutual understanding, apologies, personal amends, or learning.

While I understand that a lengthy restorative justice process would be impossible in the fast-moving world of a hospital unit, I wonder about small interventions that chaplains can do in the course of their work. The chaplain in this story used several excellent interventions: They listened to the patient without judgment, explored his feelings with him, and spoke up for him several times. I did not ask whether the chaplain followed up with the nurse who had thrown the pillow to hear her side of the story, and maybe ask some gentle questions. The feelings that this story pulled up in the chaplain, feelings that mirrored those experienced by the patient, gave the chaplain the impetus to try to get something done. But for the chaplain, "it felt a bit unsatisfactory"—another quiet echo of what the patient might have felt in the aftermath of this event. The chaplain, someone who is accountable to ethical and moral standards, also reported that "It seemed, on many accounts, not addressed appropriately."

Chaplains are constantly faced with the task of processing heavy emotions that they feel and witness in their work, along with moral distress that can result from perceiving a wrong but being unable to fix it. This story also illustrates the disorientation that can occur in the aftermath of trauma, disorientation that affects both the traumatized and those who bear witness and stand in solidarity with them, a phenomenon that is discussed in Chapter 5, "A Theology of Witness."

Table 3.5. Work within the system: Educate others

Category	Interviewees' ideas
Educate staff when necessary	● Provide cultural education for staff; increase Emergency Department staff awareness about grief and mourning. ● Provide staff with education around grief responses, when they pathologize them. ● Do "cultural interpretation"; educate staff about what's going on and how to behave when there's a patient with a very different culture than theirs; e.g., a Roma family. ● Correct misunderstandings, e.g., staff saying that the Roma family stole, when nothing was actually missing; correcting staff's "genetic memory" about Roma people. ● Appropriately remind staff that alcoholism is a disease, if they are judging. ● When you see staff showing bias, give direct feedback, when appropriate. ● Reason with staff about their biases, e.g., asking MD whether they think everybody of that nationality will be violent because of what one group of people did to another in their country.

Table 3.6. Work within the system: Involve wider community

Subcategory	Interviewees' ideas
Use your own faith tradition	● Create and use liturgies around race-healing work. "To be able to imagine anything different [than pervasive systemic racism] is a theological statement." ● Lean into your own denomination's cultural awareness and implicit bias training. ● Go deep into what your own faith tradition teaches about justice and race equality.
Make use of the wider community	● When you're not proficient in the patient's language or spiritual practices, connect with that Buddhist temple, etc., and find creative ways for care to be provided, even when you can't provide the care yourself.

Table 3.7. Work within the system: Other ideas

Subcategory	Interviewees' ideas
Learn to navigate the system and make use of it	● Bring up issues of race in ethics committees, debriefs, and during staff support (when relevant). ● Learn to navigate the system; e.g., understand the concerns of security and medical staff when a big grieving family is expressing their grief in intense or even scary ways, while also supporting the family. ● Know how the system works so you can help people navigate it; e.g., know how the security team works and how visitation policies work, so you can advocate for families seen as difficult. Help families understand what they need to do in order to be let in after someone dies. ● Know the laws that protect people, and make sure they're followed; e.g., know ADA and other discrimination laws; know what sort of treatment is illegal, in general, in the hospital.
Work to protect staff from racism	● When a patient has been demeaning toward staff, check with the nurse before visiting the patient to see how things are going; listen to the patient and dial things down to take the burden off the nurse. ● Support staff who face both microaggressions and overt racism from patients.
Use post-consult debriefs when working with a team	● Make strategic use of post-consult debriefs when working with a team; take time to slow down and notice racial dynamics of patient situations. ● Use informal debriefs when it is not your own team, e.g., "Was there anything in that conversation you and I just had with that patient that we need to circle back to?"

The chaplain who gave the example about using post-consult debriefs works with an interdisciplinary palliative-care team. This chaplain spoke about the usefulness of their debriefing practice in addressing issues related to bias. I quote the story here in full:

> I am a big promoter of post-consult debriefings. We pre-brief, and we debrief [after the consult]…. We now have posted on our wall our pre-brief and post-brief questions. What did we learn? What could we have done differently? How did it feel to be in the meeting? Who do we need to call, or what's next? By debriefing, we talk through some of the things that we could have done better, or things we learned from. And I can apply those [questions] with other people too, I can go up to the hospital doctors or the nurse, bedside nurse, or the social worker, and say, you know, 'I have noticed this about this person, this patient is really struggling in this particular way'....
>
> (Interviewer) So concrete practices, like the pre-brief, and then debrief, but also having the perspective of being a little bit removed, in a different position, so you can see things that others might not notice. And also the willingness to advocate and go ask those questions, or say, 'Hey, have you considered,' or 'I wonder if,' or 'I'm curious about.'
>
> (Interviewee) Yeah. And done in a way that they don't get defensive. So I can ask a question…. We probably have twenty hospital-based doctors, and I think to a person, if I ask them a question, they're willing to slow down and listen to me, because they know I … either need some information for my own medical knowledge so that I'm supporting an accurate understanding of [the patient's] health condition, or that I'm advocating for something that may have been missed. And I would only step in if I thought that it was something really important that needed to happen... They might let down their guard in a way they might not do with a nonchaplain.
>
> (Interviewer) So it sounds like you've also built trust with them."
>
> (Interviewee) And it took years."

This chaplain's story illustrates the significance of chaplains working within existing systems and structures and becoming part of the system, and it also includes examples of using the chaplain's natural aptitudes (an idea that is listed among the ideas in Table 3.9). These aptitudes often come with the territory for trained clergy: being nonjudgmental, being comfortable with "gray areas," being compassionate, possessing listening skills, being comfortable in settings where life and death topics are discussed, and wielding spiritual and moral authority. The chaplain quoted above took their impact seriously, built relationships and trust,

and asked questions that moved their interlocutor away from binary "this or that" thinking. They also describe using post-consult debriefs—a strong tool to use within a structured team environment.

Table 3.8. Individual practices: Use empathy and humanity

Subcategory	Interviewees' ideas
Show your humanity and highlight the humanity of others	● Show your humanity; "e.g., "I cried with the family of a 4-year-old with cancer, and it meant a lot to them." ● When staff is tempted to "other" patients or families, offer them snippets of stories that humanize those they are struggling with.
Practice empathy and make space for people's experiences	● Put yourself in the other person's shoes, then "witness" along with them, from that location. ● See people the way they want to be seen. ● If staff is hearing expressions of pain as aggression, make space for the patient to express pain and have it be interpreted as pain. ● Notice/witness what's going on in the room, including interpersonal dynamics and body language. ● Validate people's experience, and help them name grief when they are experiencing it. ● With the person who's experiencing it, bring up what you're witnessing. Don't pretend you don't see it; allow space for conversations around race. Don't add your assumptions to it, but instead ask "How was that for you?" ● Make space for people to grieve, even if their style is uncomfortable for you. ● Remember that people have difficult contexts, and troubles you don't know about.
Cultivate and bring a contemplative, person-oriented presence and a stance of bearing witness	● Move away from bottom-line thinking; use more qualitative and subjective ways of evaluating what's important for patients. ● Bring a thoughtful presence to the interaction; have a sense of "not knowing" and humility; be willing to communicate from within, grounded in a reflective/contemplative aspect. "It's not about checking off boxes." ● Don't always try to fix; always be willing to bear witness.

	• Just holding a person's story is an act of bearing witness. • Treat people holistically; e.g., the MD who took time to look at the person's whole life, not just the one symptom.

A Buddhist interviewee spoke of the ways their personal spiritual practices help them cultivate a stance of bearing witness, and work with their own implicit biases. I quote that story here in full:

> So much of my spiritual practice is coming into connection with the way things are, as they are, and seeing clearly the nature of our suffering, our pain, and to be able to meet it in the present moment. And through meeting it, it changes, or anything is possible, really. And I hold this belief (I mean, it feels like more than a belief) that we can all be free and be liberated from our suffering. Holding that perspective is a support for me … it feels very aligned with the work of being a chaplain, and being able to bear witness with people and encourage them to be able to see clearly…. [S]omeone doesn't have to have that same perspective. But to hold that, to know that no matter your circumstance, it's possible to sort of be okay, I feel like that nourishes me, or supports me to keep doing the work.
>
> And related to how race shows up around this are all the ways that we have our implicit bias or conditioning, or our reactivity to that, those are all manifestations of how we're not free. And so it feels like a fundamental part of the practice is to investigate and identify, wrestle with, these hidden parts of ourselves that silently govern us, and we're not aware that they're happening. Anyone can be free, and there's conditions that make it more difficult for certain people in certain ways, and so … holding both of those, that freedom is possible, and that yes, we also live in a difficult world….
>
> [Holding both of those ideas] feels grounded in reality, and not 'spiritual bypassing.' And holding that bigger piece, which I feel like can be a spiritual bypass of, like, 'We can all be free, everything is fine!' with a little bit of a balance of having reality, that is important.

This chaplain was pointing to a powerful balance between seeing what is, and seeing what can be. Believing or knowing that a good outcome is possible can be an anchor that allows a caregiver to look deeply at what is really happening, no matter how awful it is. It is a powerful combination, both for hurting people who are held within such a space, and

for the one holding the space. Fully acknowledging and coming to know the difficult things while also holding onto a buoy of hope, possibility, and potential. By cultivating such a stance, a chaplain can bear witness to the truth of what is happening, whatever it is, and hold that space in some expectation.

Prayer, meditation, worship, and other spiritual practices help chaplains stay anchored in their own deep convictions, which the chaplain quoted above called "the bigger piece," in their case the belief that "we can all be free and liberated from our suffering." My interviewees spoke of other anchoring beliefs that support them in the potentially hope-draining work of chaplaincy: knowing that God is merciful, knowing that each person is a beloved child of God, and knowing God will never let any person go.

Table 3.9. Individual practices: Use chaplains' assets

Category	Interviewees' ideas
Make use of chaplains' natural aptitudes, the settings they're privy to, and the authority that's given to them.	● Be creative, because the chaplaincy interaction is creative by nature; your assessment is like the moment before you make a brush stroke, or a gesture in a dance. ● Take your impact seriously; the work you do can feel like nothing, but you don't know the impact that can ripple out (butterfly effect). ● Invite reflection without shame. ● MDs sometimes tend toward binary thinking: "I did it right, I did it wrong"; chaplains are more comfortable with the gray areas and can ask gray-area questions that don't make people defensive, e.g., "Isn't it interesting that this Black family felt like they were kind of sidelined? I'm curious, do you think there was anything we could have done better?" ● Build up rapport so you can ask those questions; it can take years. (2) ● Sometimes, be direct; e.g., "Is there a role for us to be directive around things, when we can just call something out? I think we can do that."

Table 3.10. Individual practices: Use available time

Category	Interviewees' ideas
Take time with people, and use time that is available	● Find small windows of time, where possible, and use them to build rapport. Be present, and learn about the individual. ● Don't think you always have to find something to say. On the contrary, the deeper stance is to be present. ● Be willing to just hang out for a while. ● Take an extra beat to slow down and consider whether you're making assumptions. ● Take time to use the interpreter service and have a long visit, if that is what the person needs. ● Put in the time it takes to support a grieving family through their whole hospital experience; it might be hours. ● Take time to create safe space for vulnerable patients. If, in that space, you learn information that affects care, then communicate it to the medical staff. ● Take time to find out about cultural needs, foods, etc. ● Get creative, e.g., find time to bundle up that person who's been in the hospital for so long and get her outside to be in the sun for a few minutes.

Table 3.11. Individual practices: Keep learning

Category	Interviewees' ideas
Work on self-awareness and personal growth	● Be aware how you handle race, and your conflict style; e.g., do family-systems work, and know the roles that you tend to get pulled into. ● Work on seeing the world through more than your own lens. ● Pray that God will help you exercise your words in holiness. ● Push through the discomfort of making a mistake and being corrected. ● Be aware of your own biases when you see intense behavior, e.g., be mindful about what the media has told you about Black violence and crime. ● Be aware of your own tendency to "other," meaning to see a "them" instead of an "us." ● Be aware of biases that you might trigger when you walk into a patient's room; e.g., if you're dressed like a priest, or if you're Asian, or if you say you're from "pastoral care." Work to make it easy for people who are already vulnerable to receive care from you. ● Learn not to take things personally; e.g., with a family expressing grief in ways that don't match your culture, remember that they are not aiming their emotions at *you*.

Table 3.12. Individual practices: Other ideas

Subcategory	Interviewees' ideas
Set aside assumptions	● Look at each person as an individual; set aside assumptions. ● Listen to stories without bias. ● Don't use shortcuts based on your understanding of a person's race or ethnicity; check yourself, don't rely on stereotypes. "If you knew that I was Thai and came into the room offering Thai meditation, it would be very odd for me as a person." ● Don't assume that people are racist on purpose.
Find or create bridges between you and other people	● Look for ways in which the person's "awakened heart" is expressing itself, e.g., what you see in the room (image of Mother Mary, balloons, photos, the game on TV). Use it to make a bridge that will bring a connection. ● Connect human-to-human, e.g., the MD who lowers mask briefly, from across the room, and says "This is my face." ● Use humor.
Miscellaneous / contradictory advice	● Keep your defending-of-racism in check; e.g., don't go into the room and say "Hey, your nurses aren't being racist, they just don't understand you, they're good people." ● "A few times they will express concerns [about receiving worse care because of their race], and I will have to try to calm them back down and say 'No, nobody's going to do anything to you.'"

As shown in Tables 3.2 to 3.12, I heard many examples of how chaplains approach situations where race or ethnicity is a factor. Many of these practices and behaviors could support justice and healing for members of racialized groups.

3.3 Research conclusions

My interviewees said that they believe healthcare chaplains make a positive difference, in general, by bringing a spacious quality of time and a nonanxious presence, by bringing humanity into tense medical scenes, by creating and offering safe space, by providing spiritual support, and more. Benefits such as these are hard to quantify, because the recipients of a chaplain's care perceive the care, and its effects, subjectively. A chaplain's day might include lowering existential distress, facilitating grief work and end-of-life processing, providing empathetic active listening, reminding an anxious person of their own spiritual resources, offering prayers and guided meditations, navigating group dynamics, performing spiritual assessments to guide ongoing spiritual care, and more. These tasks do not lend themselves to numbers or to binary, either/or thinking.

My interviewees reported that they had witnessed or been part of various situations where race or ethnicity seemed to play a role. As summarized in Table 3.1 earlier in this chapter, they spoke of people from racialized groups being problematized and judged by staff, people in racialized groups mistrusting the medical system and the staff, non-English speakers not being as well cared for as English speakers, situations where deficits in the staff's cultural knowledge led to patients' spiritual needs not being met, situations where staff was on the receiving end of racism, and situations where Black patients' pain was

not taken seriously. I included and discussed one interviewee's story in detail, the story of bearing witness to the traumatic deaths of Black men whose bodies were not always treated with respect after they died. That chaplain's story shows how helpful it can be for a chaplain to operate inside the healthcare system while also being an outsider to the system, a balancing act that requires skill and spiritual strength. The story shows the chaplain wielding several kinds of authority, choosing strategic moments to advocate for patients, bringing humanity and dignity into sterile situations, and collaborating with a team. The story also shows the chaplain's experience of moral distress.

My interviewees offered many examples of how chaplains can make a positive difference in bias-affected situations, and I divided these examples into eighteen categories, as shown in Tables 3.2 to 3.12. The data points to a powerful combination of using the system, and using individual practices. Using the system means leveraging the processes and relationships that are available to chaplains in the institutions where they work: A chaplain can explore how advocacy and education can fit within the system, and they can support advocacy and education that already exist. Chaplains can collaborate with colleagues, both chaplains and others, for the benefit of members of racialized groups. Chaplains can bring in resources from the outside community to provide help for patients and their families within a healthcare system, and they can make use of their professional authority to call out instances of injustice within the system. Using individual practices means using the chaplain's own education and training, denominational endorsements and connections, life experiences, learned skills, and personal qualities (such as empathy, nonanxious presence, friendliness, and emotional intelligence) to advocate for justice. A

chaplain can look to their own spiritual practices and faith community for help in shifting their own implicit biases, and to support them in their anti-bias efforts.

By working within the system and using individual practices, chaplains can bear witness to suffering and stay present to difficult realities in ways that bring positive change.

3.4 Areas for future research and writing

The ways in which the spiritual beliefs and practices of chaplains help them avoid burnout would be a rich topic for further exploration. And beyond avoiding burnout, I wonder whether a chaplain's spiritual beliefs and practices act as a kind of engine that can help them transform the energy of distressing feelings (such as empathetic sadness, anger, and moral distress) into effective actions for justice. My interviewees provided deeply felt, and in some cases lengthy, responses to the question "How does your personal philosophy or theology support your work?," and it was an inspiration to speak with them about this area of their lives. I do not present these responses in this paper, except as they relate to my thesis (for example, the Buddhist interviewee whose spiritual practice helps them work with their own implicit biases).

Another rich topic for exploration would be the relative prominence of Black people in the examples of racism that my interviewees shared with me. I heard examples related to Muslim, Jewish, immigrant, non-English-speaking, Latino, Asian, Roma, and Black people, but with slightly more examples relating to Black people than to any other group; also, the examples I heard about Black people were the most troubling, as described in the section after Table 3.1. It is impossible to come to broad conclusions from my small

data set, which includes several uncontrolled variables, but a few hypotheses might be tested in a larger study: that in healthcare settings, racism toward Black people is more frequent than racism toward other racialized groups; that it is more noticeable; or that it is more frequently what comes to mind when one is asked about how race and ethnicity affect situations in the U.S.

The words "grief" and "family" also came up somewhat disproportionately in my interviews. Maybe this is because when a person is dying, family dynamics intensify and emotions run high. Staff can become rushed or tense (particularly in trauma-related deaths), which are conditions that can trigger implicit biases. As Table 3.1 shows, I heard three examples of a family's grieving style being problematized, in both Black and Hispanic families. (For example, loud, physically expressive grief being seen as threatening.) The ways in which the dynamics of grief intersect with racism in U.S. healthcare institutions would be a rich area for study.

Other areas for future research include studying the implicit biases of chaplains themselves, and studying the outcomes of interventions that chaplains use in situations where they witness (or witness the effects of) bias against people in racialized groups. Another area for study would be the spiritual, even mystical, experiences that chaplains sometimes report when they inhabit the space of trauma with a person who is suffering. What experiences of these sorts do chaplains have, how do chaplains interpret them, and how do these experiences contribute to the chaplain's caregiving and advocacy?

Introduction

The context for this theological reflection is the intersection between healthcare chaplaincy and healthcare bias. When asked, each of my interviewees was able to articulate how their own theology frames their work, and it seems clear that knowing where one stands, and why, is an important source of support for chaplains. Reflecting on my theology, one of many that could be developed, has helped me to frame my chaplaincy work within the greater work of God's Spirit moving on earth. I am a liberal Quaker, and while I am not aligned with the classical theism of early Quakers (for example their belief in an all-powerful, never-changing God who determines all external affairs),[59] I am convinced that goodness and love exist objectively, and that a divine Light shines within each person to illuminate this goodness and love. Early Quakers used the word "experimental" to describe their methods of attaining knowledge about God, and it is possible that they used this word deliberately to evoke the scientific experimental method. As scientific methods shifted in Europe in the mid-seventeenth century, "[T]he Quakers, in parallel, seemed to shift from a passive 'observational' relationship with theology, requiring the mediation of priests or the Bible, to a more interactive, dialogical relationship with the divine. This direct interaction with the divine was also, in principle,

[59] Stephen W. Angell, "God, Christ, and the Light," in *The Oxford Handbook of Quaker Studies*, Stephen W. Angell and Ben Pink Dandelion, eds. (2013; online edn, Oxford Academic, 16 Dec. 2013), 158–171, https://doi.org/10.1093/oxfordhb/9780199608676.013.0103.

available to everyone."[60] In this chapter, in a spirit of experimentation, I explore a theology of witness in which a chaplain's presence, observations, actions, and words can support justice in healthcare settings. When a chaplain advocates for individuals, or presses for systemic changes that increase justice in a healthcare institution, they are actively witnessing to the inherent value of each person they serve. I associate seeing the inherent value of each person with the Quaker idea of seeing "that of God" in everyone, a phrase that George Fox used.[61] Chaplains also bear witness to scenes of ambiguous, unresolvable suffering, which is a contemplative practice of presence.

Active witness

In some Christian contexts, a person's Christ-like actions function as the person's *witness*, meaning the evidence they present about Christ, or about a spiritual truth. This sort of witness is often intended to reveal Christ in the world, or to bring about the kingdom of God. John Dominic Crossan equates the kingdom of God with "the ruling style of God," which "imagines how the world would be if the biblical God actually sat on an imperial throne down here below. It dreams of an earth where the Holy One of justice and righteousness actually gets to establish—as we might say—the annual budget for the global economy."[62] Crossan proposes that Jesus saw the coming of God's kingdom in a radically different way than his own people did. Jesus did not preach or act as if the

[60] Jeffrey Dudiak and Laura Rediehs, "Quakers, Philosophy, and Truth," in *The Oxford Handbook of Quaker Studies*, https://doi.org/10.1093/oxfordhb/9780199608676.013.0351.

[61] For example, a search for the phrase "that of God in every man" in Fox's writing turns up eight instances in Earlham School of Religion's "Digital Quaker Collection."

[62] John Dominic Crossan, *The Greatest Prayer: Rediscovering the Revolutionary Message of The Lord's Prayer* (HarperCollins Publishers, NY: 2010), 78.

kingdom of God would be a culminating event brought about by the violent intervention of God. Instead, he saw the kingdom as an already present reality, one that he and his followers were cocreating by nonviolent collaboration with the will of God for justice and righteousness.[63] At the beginning of the Gospel of Mark, Jesus says "The kingdom of God has come near. Repent and believe the good news!" (Mark 1:15b NIV). Near the end of Mark, an armed crowd comes to arrest Jesus, and one of his followers responds with violence. But Jesus does not use violence and does not resist his arrest. Instead, he says "Am I leading a rebellion … that you have come out with swords and clubs to capture me?" (Mark 14:48). And between the beginning and the end of Mark, Jesus forgoes worldly status and power, instead spending his time healing the sick, preaching repentance and the forgiveness of sins, and restoring outcasts into community. He follows his calling to resist empire, without violence.

The extremely violent book of Revelation, in which the metaphorical winepress of God's wrath produces blood "rising as high as the horses' bridles for a distance of 1,600 stadia" (Rev 14:19-20), can actually be seen as a story about nonviolent resistance to power. In this reading, the violent events that occur during Babylon's fall are read as the inescapable consequences of unjust behavior, rather than the actions of an innately violent God. Exegeting Revelation from an African-American perspective, theologian Brian Blount sees the writer's counsel to "witness" as a call to act in opposition to unjust power structures; for Revelation's original audience, this power structure was the Roman empire. Revelation's writer uses the poetic, symbolic, catastrophic language of

[63] Ibid., 84, 88-91, 117.

apocalypse, which would be familiar to Revelation's readers (or listeners) from apocalyptic writing such as Daniel 7–12, and which they would understand as the language of resistance to oppressive power. The language of witness in Revelation, specifically language that describes the witness borne by Christ himself, can be read as a commendation of nonviolent resistance against an unjust empire.[64]

The resistance itself functions as a witness by exposing the injustice more clearly, maybe provoking necessary conflict that can lead to change. In the symbolic world of Revelation, the witness is carried out by opposing the dragon; in the literal world, the witness can be carried out by nonviolent direct action, as exemplified by Martin Luther King, Jr., and his followers. The witness reveals a truth that stands in opposition to the lie of empire, the lie that is being sold as truth. For Revelation's original audience, the lie being sold as truth was the idea that Caesar was the divine Lord, worthy of worship; for King and his followers, the lie was white supremacy and, as it might be phrased today, the idea that white bodies are more important than other bodies. King's truth included a belief in the apocalyptic inevitability of justice in human history, with nonviolent action as an advanced step in the slow, thoughtful process that he advocated and used: collecting facts, attempting negotiation, taking time for preparation and self-purification, and then, if necessary, using nonviolent direct action to "create such a crisis and foster such a tension that a community which has constantly refused to negotiate is forced to confront

[64] Brian K. Blount, "Reading Revelation Today: Witness As Active Resistance," in *Interpretation* 54, no. 4 (2000): 398–412, https://doi.org/10.1177/002096430005400406.

the issue."[65] All of this is an act of witness to a powerful, alternative truth: that "kingdoms" held together by unjust institutional policies will someday experience catastrophe and be replaced by the kingdom of God. "*This* is the revelation of Jesus Christ," writes Blount.[66]

A chaplain might live out this kind of active witness by speaking up on behalf of those who lack power in the healthcare system, asking questions of staff when an injustice seems to be underway, working to change processes that allow injustice, and taking other direct, thoughtful actions. This kind of witness supports the truth: that justice will someday prevail, and that each person has inherent value and must therefore be treated justly.

Contemplative witness

Sometimes, chaplains are called to stay present to ambiguity and suffering that they have no immediate power to change, and bearing witness in this way is a significant act. The theologian Shelly Rambo explores this sort of witness in her theology of trauma.[67] Trauma, whether it is acute, chronic, or complex, changes our world view and continues to affect us within that newly created world. Collective trauma changes society and how it works; for example, the collective trauma of 9/11 permanently changed airline travel in

[65] Martin Luther King, Jr., "Letter from the Birmingham jail," in *Why We Can't Wait*, ed. Martin Luther King, Jr. (New York, NY: Harper & Row Publishers, 1963), 81.

[66] Blount, 410.

[67] Shelly Rambo, *Spirit and Trauma: A Theology of Remaining*. 1st ed. (Louisville, Ky.: Westminster John Knox Press, 2010).

the U.S.[68] The world view of those affected by trauma never returns to exactly what it was before the trauma. Trauma lingers from the past into the present, and even from one generation into the next. As Rev. Michael McBride puts it, "Our bodies carry the history of our ancestors, of generational trauma and moral injury."[69] In exploring a theology of trauma, Rambo writes that life after an acute trauma is not the same as death, but it is not completely free from death. Christian theology and practice sometimes focus on the extremes, death and life (Good Friday and Easter Sunday), but Rambo focuses on what she calls the "middle" space, where death and loss intermingle with life, hope, and healing. A person who resists an unjust "truth" by actively bearing witness to a powerful alternative truth understands the message that they are proclaiming, but a witness to the ambiguous middle space of trauma sees truths that resist articulation and might not match the dominant logic—truths that are sensed and even experienced, but not clearly understood. Likewise, a chaplain does not have to clearly understand a patient's personal or generational trauma to bear witness to it with love.

Rambo sees this kind of witness in John 20, where Mary Magdalene witnesses Jesus walking around near his tomb. It is three days after Jesus' death, an event that can be viewed as a collective trauma for those who knew and loved him. In this story, Mary is often interpreted as a flawed witness, in that she is confused, does not recognize Jesus, and does not understand what is happening. But Rambo reads this as a story about a

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[68] Françoise Mathieu. *The Compassion Fatigue Workbook: Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization*. Routledge Psychosocial Stress Series, 42. (New York, NY: Routledge, 2015).

[69] McBride, 440.

typical human being bearing witness to the space of trauma. It is a snapshot of the messy, painful process of unrehearsed witness, and it occurs on the mixed terrain where death and life are not clearly delineated. Jesus is there but not there; Mary's senses are confused; she hears Jesus but cannot place where he is. She sees him but is not allowed to touch him. His response to her in John 20:17 affirms that he is standing right in front of her, but the situation is perplexing: is he really there? If she tried to touch him, would she feel anything? And what does it mean that he will "ascend" to his Father? Is he a ghost? Mary has entered into the disorientation that trauma brings, and she is witnessing an "unlocatable truth."[70] Trauma moves in and out of focus, and truths about the trauma are faced and then ignored—sometimes purposely, for example to promote a certain narrative, or to keep certain persons in power.[71] The power of Mary's participation here is that she is *here*. Jesus tells her to report her experience to the male disciples, which she does (vv. 17-18), making her the first witness to the resurrection of Jesus in the Gospel of John. The story does not describe the male disciples having any reaction at all to Mary's world-changing news, and it is only when they see Jesus for themselves that they believe what she has already told them. Bearing witness can be invisible work.

Witness, in Rambo's formulation, is "a tenuous orientation to suffering that presses central theological claims about death and life in and against themselves."[72] Mary's

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[70] Rambo, *Spirit and Trauma*, 90.

[71] Ibid., 37–41.

[72] Rambo, *Spirit and Trauma*, 42.

theology is put to the test and undone; likewise, a chaplain who bears witness to traumatic truths might struggle with the limits of their own theology.

In this middle space, a practical question is "What does redemption look like when viewed from here?" The prerequisite question is "What is *here*?" The theologian Walter Burghardt describes contemplation as the work of taking "a long, loving look at the real."[73] When holding such a stance, we are not forcing solutions or a linear progression of events, but entering into the space of trauma with some ability to tolerate unsettled feelings and unresolved questions. The physical, social, spiritual, and existential suffering of many hospital patients is located in this space. Rambo calls the Spirit of God that operates in this space the "middle Spirit." What is this Spirit's agenda, and what does it look like when a chaplain aligns herself with this Spirit in bearing witness to suffering? The purpose of remaining in this middle place is not to join, glorify, or triumph over suffering. Rather, the purpose is to truly see and acknowledge the suffering, expressing compassion by offering deep listening and a nonanxious presence. It involves resisting the urge to run away, change the subject, give advice, claim to understand, or offer spiritual platitudes. Rambo writes that for those who are conscious of racism, history is not a record of discrete past events, but "the unaddressed harm that lives on."[74] As in Isabel Wilkerson's metaphor of being residents in an old house in need of repair,[75] we live

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[73] Vinita Hampton Wright, "A Long, Loving Look at the Real," on IgnatianSpirituality.com, n.d., , accessed August 6, 2021, https://www.ignatianspirituality.com/a-long-loving-look-at-the-real/.

[74] Tom Paxon, review of *Resurrecting Wounds: Living in the Afterlife of Trauma*, by Shelly Rambo, *Friends Journal* (January 2019), accessed August 4, 2021, friendsjournal.org/book/resurrecting-wounds-living-in-the-afterlife-of-trauma/.

[75] Wilkerson, 15-17.

within the fallout of past events, and to see and acknowledge those events is to take a first step in addressing their effects on the present. We can interpret the effects of the past (for example, the ways that racism continues to affect healthcare and health outcomes) as arrows that point to the wound. We work to uncover these wounds in hope of bringing rebuilding and repair.[76]

As we continue to take a long, loving look at the real, can we also expect to see arrows that point toward this rebuilding and repair? If so, how does it happen? God does not intervene in every situation where we might think that a benevolent, omnipotent God would intervene, and so we wrestle with theodicy. The theologian Charles Hartshorne points out that there are two ways to interpret God's omnipotence: it can mean that God controls every detail of the world, or it can mean that God has a power that surpasses all other powers. He writes:

> "I incline to say that the word [omnipotence] itself had better be dropped. God has power uniquely excellent in quality and scope, in no respect inferior to any coherently conceivable power. In power, as in all properties, God is exalted beyond legitimate criticism or fault finding. In this power I believe. But it is not power to have totally unfree or 'absolutely controlled' creatures. For that is nonsense."[77]

Of the argument that suffering happens because of free will, which God allows so that humans can freely choose to love Him, Hartshorne points out that many of the world's ills have no connection to human choice.[78] Alfred North Whitehead, the other founder of

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[76] Rambo, *Resurrecting Wounds*, 71-73

[77] Charles Hartshorne, *Omnipotence and Other Theological Mistakes* (Albany: State University of New York, 1984). 26.

[78] Ibid., 13.

process theology, saw the attribution of coercive power to God as idolatry, writing that "the fashioning of God in the image of the Egyptian, Persian, and Roman rulers, was retained. The church gave unto God the attributes which belonged exclusively to Caesar."[79] In contrast, process theology emphasizes God's love and relationality; according to theologian Marjorie Suchocki, God is "the Supremely Related One."[80] God is linked with our past and our future, and God's process is linked with our process. God participates in our world, suffering with those who suffer, and limited by what limits *us*—the past, the nature of creation, human nature, and maybe other things as well. But within the limitations that circumstances set on future possibilities, God affects our world by continuously envisioning a future in which all things are harmonized into God's love. God tracks along with us, communicating these new possibilities to us as our actions and decisions change things, and as new circumstances arise. The system is in constant flux. While actions (including unjust ones) do bring their own eventual consequences, there is no predetermined future, and no one way forward that all creation must follow. Even past influences that are omitted from the present because they are decided against (either by subjective decisions, or because they are objectively incompatible with the present) are part of the present, by way of their having been decided against. Process theology, then, implies that remnants of both the recent and distant past are with us in every moment. As Suchocki puts it, "...stories that are told are haunted at their edges by the intimations of

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[79] Alfred North Whitehead, *Process and Reality: An Essay in Cosmology*, corrected edition, Gifford Lectures, 1927-28, ed. David Ray Griffin and Donald W. Sherburne (New York: Free Press, 1978), 342.

[80] Marjorie Suchocki, " *God, Christ, Church: A Practical Guide to Process Theology*. New rev. ed. (New York: Crossroad, 1989), 33.

those elements left out."[81] The white-curated story of racism in the U.S., for example, is haunted by elements that have been sidelined or left out.

Process theology supports the idea that God is changed by the events of the world, including the suffering and dislocation that trauma brings. In process theology, we are interconnected with each other and with God, and our fates are linked. The African concept of *ubuntu*, or *botho*, is compatible with process theology, because it identifies interdependence as a defining feature of humanity. In describing *ubuntu*, Desmond Tutu writes that "[w]e say, 'A person is a person through other persons.' It is not 'I think therefore I am.' It says rather: 'I am human because I belong. I participate, I share.'"[82] The proof of my existence is not that I think, but that I am held in a web of connectivity with other humans. Process theology posits that God is an integral part of this web, affecting and affected by the least vibration along any strand of the web. The past, too, is part of the web. God desires redemption and repair not only for our sakes, but for God's own sake. We are in this together.

"Making a way out of no way" (or "making a way out of nothing," or "making do") is a concept that resonates with many womanists and womanist theologians, including Dolores Williams, Katie Cannon, and Monica A. Coleman. God "makes a way out of no way" by providing a vision of new possibilities, and for womanists in particular, a vision that reveals survival resources for African-American women. In many situations, the past

[81] Suchocki, 243, 244.

[82] Desmond Tutu, *No Future Without Forgiveness*, 1st ed. (New York: Doubleday, 1999), 29.

does not contain a way forward, and so these God-provided possibilities are unforeseen. Where there was no way, there is a way.[83] As the Quaker saying goes, "Way will open."

Putting these ideas together with Rambo's, one might say that in the "middle" space, where completed crimes are still with us, and where new life is emerging along with the seeds of further crimes, there is often no way forward—yet God's middle Spirit reveals unforeseen possibilities. Consciously locating ourselves in this paradoxical middle space when we encounter it, as best we can with our own limitations, is a powerful way to collaborate with the movement of God's healing Spirit. In this space, we bear compassionate witness, we wait for way to open, and we trust in the alternative truth that sustains us.

Jesus calls his disciples to this sort of witness-bearing when they accompany him to Gethsemane on the night before his execution, as told in Mark 14:32-43. Mark shows us a distressingly human Jesus, one who stays present to his own suffering and the suffering of others. Unlike Jesus as presented in the Gospel of John, who does not pray to be saved from execution but instead declares that his death is the reason God sent him (John 12:27-28), Mark's Jesus prays for a reprieve, an ordinary human thing to do. He begins to be "deeply distressed and troubled," then tells Peter, James, and John that his soul is "overwhelmed with sorrow to the point of death" (Mark 14:33-34). The Jesus who prays in Gethsemane understands how it feels to anticipate physical violence, and Emerson B.

[83] Monica A. Coleman, *Making a Way Out of No Way: A Womanist Theology* (Minneapolis, MN: Fortress Press, 2008), Kindle loc 548-568.

Powery points out that this makes him the Jesus whom "African Americans epitomize."[84] This is a Jesus who is familiar not just with physical torment, but with the psychological torment of expecting physical torment. This Jesus cries, bleeds, is taunted and flogged, and is hung on pieces of wood—an event that has been compared, both physically and symbolically, to the thousands of lynchings of Black people that have occurred in the U.S.[85] The disciples are asked to bear witness not only to this kind of suffering, as Jesus undergoes it, but they are also asked to stay present to a radical alternative truth, as taught and exemplified by Jesus: that Jesus' "kingdom" is not a worldly kingdom, but an upside-down kingdom where "[a]nyone who wants to be first must be the very last, and the servant of all" (Mark 9:35).

Jesus suffers in solidarity with us, and he calls God "Father," an intimate term that implies trust. But the Father does not do as Jesus asks here, and when Jesus is dying on the cross, he cries out "My God, my God, why have you forsaken me?" (Mark 15:34b). It is powerful that even Jesus feels forsaken, and even Jesus asks the "Why?" question: Mark's Jesus is intimately connected to all those who suffer, and to all those who cry out with questions. Much of this echoes the physical, emotional, and existential suffering that patients and their loved ones sometimes experience in hospital settings. When we bear witness to this kind of suffering, it is as if we are bearing witness to the suffering of Christ himself in his "distressing disguise," as Teresa of Calcutta expressed it. Teresa

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[84] Emerson B. Powery, "The Gospel of Mark," in *True to Our Native Land: An African American New Testament Commentary*, ed. Brian K. Blount et al. (Minneapolis: Fortress, 2007), 148.

[85] James H. Cone, *The Cross and the Lynching Tree* (Maryknoll, N.Y.: Orbis Books, 2011).

explained that celebrating the Eucharist each morning with her sisters trained her in this practice: "If we recognize [Jesus] under the appearance of bread, we will have no difficulty recognizing him in the disguise of the suffering poor," she said.[86]

By asking his disciples to accompany him to Gethsemane and stay near him, Jesus indicates that their presence has the power to affect his experience—*God's* experience! As we witness this story by reflecting on it, we are invited to bear witness to the pain, disappointment, and unanswered prayer within the story, and to aspects of Jesus that are distressingly human. We are invited to bear witness to Jesus himself as he shines through every person we encounter. With the disciples, we are invited to stay awake during Jesus' emotional agony and to pray, even when prayers are not answered. And we are reassured that when we fall asleep or run away, we have good company in Jesus' disciples. Grace abounds for us, as it did for them.

Relevance to my own chaplaincy work

To witness can mean to take action that testifies to, and acts in support of, an alternate truth—a truth that stands in opposition to the unjust "truths" put forward by powerful institutions. To bear contemplative witness is the flip side of this coin. Trauma and grief come and go from our consciousness, and we often turn our attention away from what causes us pain or challenges our world view. But whether we can maintain our stance of contemplative witness or not, the Spirit is fully present, always witnessing to inchoate life as it emerges. For me, this assurance of God's presence is comforting and inspiring, given

[86] Brandon Vogt, "Jesus in His Most Distressing Disguise," *Word on Fire*, September 5, 2014, accessed December 2, 2022, https://www.wordonfire.org/articles/jesus-in-his-most-distressing-disguise/.

how hard it can be to witness complex or painful truths, and how easy it is to be pessimistic about the emergence of new life in the presence of death.

Process theology, along with the idea of the Spirit's witness to the liminal, post-trauma terrain that lies between death and life, fits with the Quaker emphasis on continuing revelation, the belief that insight from God continues to become available to us. For many Quakers, fresh insight is at least as valid as insight gleaned from scripture, and continuing revelation is much more than simply a light by which we interpret scripture.[87] We are called to pay attention, waiting and watching for whatever God's Light will reveal, a stance I try to take during unprogrammed Quaker waiting worship. Like the world, which is refilled with God-inspired possibilities as time moves forward moment by moment, the terrain of unresolved suffering is alive and in motion, each moment filled with God. We live on the thin edge where the past disappears into the present, and I believe that this edge is where we meet the Spirit of God and receive insight about what steps to take next. As the Quaker writer Thomas Kelly puts it, "[c]ontinuously renewed immediacy, not receding memory of the Divine Touch, lies at the basis of religious living."[88] In places of suffering and grief, God can seem absent, and so it is helpful for me to have a theology

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[87] The relationship between continuing revelation and scripture has been a thorny issue in Quaker history. Theology across the main branches of the modern Religious Society of Friends ranges from conservative evangelical to nontheist. My branch, which is at the far liberal end of spectrum, leaves the significance of scripture up to the individual; scripture holds no inherent authority whatsoever in our group decisions.

Evangelical Quakers, on the other hand, subscribe to the 1887 Richmond Declaration of Faith, which includes the following statement: "It has ever been, and still is, the belief of the Society of Friends that the Holy Scriptures of the Old and New Testament were given by inspiration of God; that, therefore, there can be no appeal from them to any other authority whatsoever." The statement implies that, according to the authors, those who appeal to an authority such as experience, reason, tradition, or the inward Light over scripture are not part of the Society of Friends.

[88] Thomas Kelly, *A Testament of Devotion* (New York: HarperCollins Publishers, 1941), 5.

that posits ways in which God is present and providing insight, no matter how I feel in the moment—not so I can convince anyone else of God's presence, but for my own sake. My theology strengthens my ability to stay present, and it informs my prayers and spiritual practices. On the flip side, my theology also encourages me to grow in my ability and willingness to witness to injustice by taking direct action.

Recommendations from my interviewees

Healthcare chaplains operate both inside and outside of "the system," and they can make use of this unique position to advocate for people who are harmed by bias. The chaplains I interviewed spoke of coming alongside patients, families, and staff to bear witness to their suffering, which sometimes results in a parallel process in which the chaplain experiences an echo of the suffering person's disorientation and pain. My interviewees gave me examples that I separated into eighteen categories of potentially helpful interventions and practices. The examples are listed and discussed in Chapter 3, clustered into recommendations for how chaplains can work within the system, and how chaplains can use individual practices. In summary, my interviewees spoke of working within the system in the following ways to do good in situations where bias causes harm:

- Collaborate with staff and help them out; collaborate with chaplain colleagues.
- Push for helpful changes and support diversity within the institution.
- Learn how to navigate the system and make use of its rules and processes on behalf of others.
- Actively advocate for people experiencing harmful bias. When it will not further harm the person involved, speak up. Use whatever means the system provides.
- Informally educate fellow staff members, with discretion and kindness.

- Call in the resources of the wider community to meet people's spiritual and cultural needs; for example, many mosques can step in on short notice to provide appropriate care and burial for a Muslim who dies without a pre-arrangement.
- Use the race-healing resources of your own faith tradition; for example, liturgies and denominational training.
- Protect staff from racism, and acknowledge it when it happens.
- When working with a team, integrate anti-bias queries into post-consult debriefs.

In summary, my interviewees spoke about using the following individual practices to do good in situations where bias is causing harm:

- Continuously work on self-awareness and personal growth; cultivate cultural humility.
- Show your humanity, and highlight the humanity of others.
- Practice empathy, and take time to create safe space for other people to share their experiences.
- Cultivate and bring a contemplative, person-oriented presence. Cultivate a stance of bearing witness.
- Make use of your natural aptitudes as someone who's drawn to chaplaincy; for example, your ability to see nuances in a situation rather than needing yes/no answers; your ability to care for people's spiritual, emotional, and relational selves.

- Make use of the settings that a chaplain is privy to, and the various kinds of authority that a chaplain can wield: professional, denominational, moral, spiritual, reputation-based, traditional, assumed.
- Set aside assumptions and learn what vulnerable people actually need, not what you think they need.
- Find, or create, bridges between yourself and other people.

Other recommendations

In this section I go into more detail about a few of the recommendations summarized above, and a few that my interviewees did not mention.

Develop a personal theology

I infer from my interviews that having a personal theology or philosophy, or strong spiritual convictions, is a great help to chaplains in sustaining their work. This might be particularly true for those who bear compassionate witness to the harms that bias causes, and who strive to bring justice in the context of their everyday tasks. In the previous chapter, I developed a theology that helps me to frame my own chaplaincy work within the greater work of God's Spirit moving on earth, which deepens my sense of purpose, but many other theologies can be developed.

Avoid burnout

A 2018 study found that when it comes to chaplain burnout, most variation among chaplains can be explained by a combination of secondary traumatic stress (which

contributes to burnout), mindful self-care and compassion satisfaction (which mitigate against burnout), and demographic and organizational factors (which can either contribute to, or mitigate against, burnout). Compassion satisfaction, meaning the intrinsic emotional reward that comes from caring for people, is strongly protective against burnout, as is having a sense of purpose in one's work:

> When chaplains feel a sense of joy and purpose, and have their needs met as conceptualized in the Maslow hierarchy, they can buffer the impact of compassion fatigue (secondary traumatic stress and Burnout). This supports prior findings that being satisfied and finding meaning in their work can be a protective factor against stress and Burnout.[89]

Practicing mindful self-care, deepening one's sense of purpose, and experiencing compassion satisfaction seem essential for anyone who hopes to sustain anti-bias work within a caregiving profession.

Use stress debriefings

Chaplains in healthcare settings provide spiritual and emotional support not only for patients, but also for staff, and they sometimes provide in-service trainings and staff debriefings. After a stressful or traumatic event, a chaplain might check in with the staff members who were involved, providing space for them to tell their stories. Chaplains also facilitate group processes, such as critical-incident stress debriefings, in which storytelling is a key component. Most people have a psychological need to tell their story, sometimes repeatedly, after harm has been done. Sharing your story in a group setting,

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[89] Jason T. Hotchkiss and Ruth Lesher, "Factors Predicting Burnout among Chaplains: Compassion Satisfaction, Organizational Factors, and the Mediators of Mindful Self-Care and Secondary Traumatic Stress," in *Journal of Pastoral Care & Counseling* 72, no. 2 (2018): 93–94. https://doi.org/10.1177/1542305018780655.

and listening to the stories of others, allows information to be exchanged thoroughly, and on an emotional as well as mental level.[90] A chaplain's attention and focus validate people's need to process their thoughts and emotions, and a chaplain can normalize people's stress reactions, letting them know that their headache, lack of focus, or feelings of regret, for example, are not unusual after a trauma.

Perhaps chaplains also can, or in some places do, help with group processing around racial and ethnic tensions among staff members. John Paul Lederach describes "lenses" through which we can examine a conflict, and he cautions that the lens showing the urgent, presenting episode is often the only one used, without any examination of the broader context and history.[91] Some nonwhite peacemakers have expressed frustration about white people who address only the presenting episodes of racial conflicts, ignoring the deeper and more hurtful systemic and historical injustices that made the episode possible, or even inevitable.[92] Facilitating group processes that examine the underlying context and patterns of racial harms in a healthcare institution would be a large, important project, one that I am not in a position to undertake. But when doing staff debriefings, maybe chaplains like me can learn to acknowledge and address the undercurrents of history and deep harm that lie behind some episodes.

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[90] Kay Pranis, "The Little Book of Circle Processes," in *The Big Book of Restorative Justice: Four Classic Justice & Peacebuilding Books in One Volume*, revised ed., Howard Zehr, et al. (New York, NY: Good Books, 2015), 321.

[91] John Paul Lederach, *The Little Book of Conflict Transformation* (Intercourse, PA: Good Books Press, 2003), 10-13.

[92] Robert Yazzie, *Colorizing Restorative Justice: Voicing Our Realities*, ed. Edward Charles Valandra, First ed. (St. Paul, Minnesota: Living Justice Press, 2020); the theme of white peacemakers ignoring the historical and systemic aspects of racial and ethnic conflict occurs frequently in the book's essays.

Use storytelling and the arts

One of my interviewees mentioned using storytelling to "pull up the empathy" in staff who use shortcuts to evaluate people's character and motives, saying "I think advocacy and storytelling, in subtle and overt ways, are some of the biggest tools that we use." The interviewee gave an example of using storytelling to humanize a deceased patient's family members for the staff, helping them to understand why it was important in this case for several extra family members to be able to view the body. Small, strategic, discreet pieces of storytelling can happen in person, or in a patient's chart notes, as a way to promote better care for the patient.

Narrative theology, like the stress debriefing process, takes seriously the idea that storytelling has an impact. Various pro-slavery narratives became popular in the seventeenth and eighteenth centuries; for example, polygenic narratives described Black people as being a different species than white people, with physically and socially inferior characteristics, while monogenic narratives described Black people as having become inferior to whites over time, through environmental and social pressures.[93] Those who claimed a Biblical basis for slavery saw Black people as the descendants of Noah's son Ham, one of three brothers from whom "the whole earth was populated" (Gen 9:19 CEB). Ham viewed Noah's nakedness when Noah was drunk, so Noah cursed Canaan, Ham's son, saying "Cursed be Canaan: the lowest servant he will be for his brothers" (Gen 9:21–25). In a pro-slavery readings of this text in the U.S., Blacks were meant to serve whites by God's decree. These narratives, along with narratives about Blacks being

[93] Washington, 34.

less susceptible to pain than whites, more muscular, and therefore better suited to hard physical labor in hot, humid climates such as the American South, gave enslavers powerful ways to silence detractors, and silence any twinges of conscience that they themselves might have had.

False narratives that support injustice need to be debunked, and the narratives of those who are negatively affected by racism need to be written, published, believed, and seen as arrows that point to the wound. For example, narratives that nonwhite women tell about having their pain and illness minimized by physicians shine an important light on the workings of implicit bias in the healthcare system.[94] A continuous flow of new narratives, and new theologies, is needed. Remaining with God's "middle" Spirit, staying present to the space that is located (metaphorically) between the crucifixion and the resurrection, is about witnessing and testifying to the ongoingness of suffering,[95] and this testimony can be delivered within any genre. In 2018, the photographer MaryLynne Wrye spent a summer as an artist-in-residence with a group that laundered blankets for refugees in the Moria camp on Lesvos, before the camp was destroyed by fire.[96] MaryLynne told me about young Christian missionaries who had nothing to offer but Bibles. They were not "cleared" by their organization to do anything of practical help, even help someone put up a tent.[97] It is a grim and frustrating picture of a theology that clings to an impoverished

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[94] Matthew, 144.

[95] Rambo, *Spirit and Trauma*, 144.

[96] MaryLynne Wrye's photo project about Moria is at https://www.marylynnewrye.com/olive-grove, accessed December 1, 2022.

[97] Personal communication with the artist, 2019.

narrative about the meaning of salvation, skipping over the confusing terrain of Holy Saturday and going straight to salvation in the afterlife. MaryLynne's contemplative photos from inside the camp are an example of witness—entering the confusing in-between space of daily life within Moria, taking a long and thoughtful look at painful realities, and bringing the story out to the rest of us, so that we might be inspired to act.

Chaplains can use any artistic medium to create new narratives about old truths, as many writers have done with words, including James Baldwin, George Takei, Toni Morrison, Sherman Alexei, Ocean Vuong, and many of the writers quoted in this paper. Art is a powerful way to bring stories out from within walls, and the arts give us ways to express and understand what is difficult to articulate using clinical descriptions.

Conducting and publishing research about chaplaincy, for example as I am doing in this paper, is another way to use storytelling in advocacy work. (Transforming Chaplaincy, www.transformchaplaincy.org, provides training and resources for chaplains interested in doing research.) While none of my interviewees emphasized storytelling, they each told me stories, and their stories inspired all the recommendations in this chapter. Whether chaplains are using individual practices, or using the relationships and processes of the system, they are always receiving other people's stories, as listeners and witnesses. The advocacy that my interviewees described to me was informed by the stories that they heard and saw unfolding around them.

The recommendations that I gleaned from my interviewees can be fit into a story, of sorts, that moves from individual growth to system-related growth. If viewed this way,

my interviewees' advice for personal, spiritual, and professional growth for chaplains who care about justice for racialized groups of people would be something like this: First, begin to see your own personal biases, and seek education about how to handle them (as might happen in CPE, or in a process of spiritual formation, or as described in the "Implicit bias" section of Chapter 2 of this paper). Begin, and continue, a life-long commitment to cultural humility. Learn from the wisdom and training that your own faith tradition offers about racism, and develop personal practices that support you in implementing this learning. And finally, develop ways to work within the system while keeping one foot *outside* the system, so as to be able to bear effective witness to injustices that occur and advocate for those who are harmed.

CONCLUSION

In the United States, racialized groups of people have worse health outcomes, and receive worse healthcare, than non-racialized groups. Much research has been done on these discrepancies and their causes, as I discuss in Chapter 2. As a hospital chaplain, I sometimes witness these discrepancies, and I also learn about them from my colleagues. My hope for justice in this area motivates the original research that I present in Chapter 3, the theology that I develop in Chapter 4, and the chaplaincy recommendations that I present in Chapter 5. My overall claim in this paper is that chaplains can make a positive difference in the area of bias toward racialized groups within the U.S. healthcare system, and such bias as it shows up within the sicknesses of people who enter the healthcare system. What made this idea seem plausible to me in the first place is the nature of chaplaincy itself—the background and training that many chaplains have, the theologies that support them in their emotionally expensive work, the tasks they perform, and the skills and sensibilities that these tasks require.

The religious, spiritual, and ethical grounding of chaplains prepares them to care about issues of justice. Many of them have long been thinking about, and trying to mitigate, the problem of bias. Most professional healthcare chaplains are ordained or otherwise endorsed by an approved body, such as a faith community, that holds them to a set of ethical standards. Chaplains are encouraged to reflect on and articulate their own theologies and statements of service in CPE, in seminary, and in their faith communities. To become board-certified by the Association of Professional Chaplains (APC), chaplains

must explain how they support the well-being of those receiving their care, and what they mean by "well-being." They must also explain how they support ethical decision-making in their workplaces, describe the ethical theories that inform their spiritual practices, and agree to abide by the APC Code of Ethics. CPE training programs include anti-racism and self-awareness training, and CPE is required for board certification. All this is to say that healthcare chaplains are generally inclined to care about justice, are supported by their communities and their personal theologies in doing so, and in many cases have received relevant education and training.

The tasks and tools of chaplaincy are well-suited to anti-bias work. For example, many chaplains conduct stress debriefings with staff after particularly traumatic events, and chaplains create and conduct in-service trainings for staff. These debriefings and trainings can be vehicles for anti-bias work among staff, as can hospital ethics-committee meetings, in which chaplains sometimes participate. In some situations, the chaplain acts as the ethics expert in the room, and a healthcare chaplain's job description often tasks them with advocating for patients, families, and staff, which can easily include advocacy around issues of justice and equity. Because patient advocacy and ethical expertise are part of the job, and because most chaplains receive training in subjects like anti-racism, chaplains are likely to care about these tasks. They have on-the-job support and training, colleagues who are also tasked with these things, and (one hopes) positive feedback when they do it well. In some cases, anti-bias work can be part of formal work goals, and success in this area can further professional ambitions.

My research bears out the idea that chaplains can make a difference in the area of race-based bias in healthcare. I interviewed eight people who have worked as healthcare chaplains in the U.S., and my interviewees confirmed that many chaplains perceive bias in healthcare, are concerned about it, and believe they can contribute to the healing process of those harmed by it. Several chaplains whom I interviewed for my research indicated that they, or their team, are actively working to mitigate racial and ethnic bias in their hospitals. My interviewees spoke of using the tools and tasks of chaplaincy to do anti-bias work; several spoke about using both formal and informal debriefing sessions to educate hospital staff about the cultural needs of patients, to gently question staff about the assumptions they make about patients, or to intervene when a family member was being rushed to make end-of-life decisions, where race or ethnicity seemed to be a factor in the interaction. A theme that emerged from my research is that chaplains are located *inside* the healthcare system as colleagues to the medical staff, but *outside* the healthcare system as faith-community leaders with moral, ethical, and spiritual authority. It is a unique vantage point that chaplains can use, along with the typical tasks of chaplaincy, to mitigate some of the effects of race-based bias. My interviewees gave examples of working within the system by collaborating with colleagues, changing the system, directly advocating for those harmed by bias, educating others about bias, seeking help from outside communities, and leveraging the system's processes on behalf of others. My interviewees gave examples of personal practices such highlighting the humanity of others, practicing empathy, cultivating a contemplative presence, using creativity, building rapport with medical colleagues, taking plenty of time with those you minister

to, educating yourself, working on personal growth and self-awareness, and setting aside assumptions.

In my research, I also heard several beautifully articulated theologies and philosophies that support the work of chaplaincy and the work of bringing justice through the vehicle of chaplaincy, and several of my interviewees expressed a deep, sober joyfulness as they spoke about their work. Having a supportive theological or philosophical framework that anchors one's work in a transcendent reality can provide energy and insight. In Chapter 4, I describe a process theology in which the Spirit experiences the space of trauma along with us, invites us to bear both active and contemplative witness to injustice, and offers us a continuously renewed stream of possibilities by reimagining, moment by moment as circumstances change, how an outcome that instantiates God's love can be reached from the current moment. Many other theologies and philosophies can be developed to support the work of mitigating the harms done by bias in healthcare—for example, the idea that the flow of Spirit is toward justice; that Allah rewards those who care for the poor; that one's practice of karma yoga requires action on behalf of the marginalized; that one reaps what one sows and therefore should work to sow justice; that we are called to help others find freedom from suffering; that to align oneself with the marginalized is to align oneself with Spirit, or with positive ethics, or with one's true self, or with one's Higher Power. My belief is that God is loving, that God experiences suffering along with us, and that if a goal or task fits into God's hope for the world, then the formidable momentum of God's Spirit is behind the work and will inform it. For me, this belief supports the idea that healthcare chaplains can be agents of healing some of the harms caused by bias, because

the Spirit's power adds weight to the chaplain's own small efforts. Br. David Stiendl-Rast once told the poet David Whyte that the antidote to exhaustion is not necessarily rest, but wholeheartedness.[98] My hope is that the facts, stories, ideas, and recommendations in this paper will support wholehearted collaboration with the life-giving possibilities that God continuously renews for our world.

[98] David Whyte, *Crossing the Unknown Sea: Work as a Pilgrimage of Identity* (New York: Riverhead Books, 2001), 132.

APPENDIX A: IRB APPROVAL

Below is the 8-page research approval that I received in January 2022 from the Earlham College Institutional Review Board (IRB). Included are the consent forms that each of my interviewees signed (the "Earlham College Human Subjects Consent Form" and the "Earlham College Recording Consent Form"), along with the approved interview script.

This research has been approved by the IRB at Earlham College.
IRB#: 2122-e013

Rachael D. Reavis
Associate Professor of Psychology
IRB Convener

EARLHAM COLLEGE
Expedited Review Application

All questions on this form must be answered completely. If a question does not apply to your research project, please indicate this by typing "N/A" in the answer area.

Projects with student Principal Investigators should be sent to the IRB by the faculty sponsor.
Sending such an email indicates faculty approval and advising of the proposed research. Applications submitted by students will be returned without review.

Principle Investigator(s): Katarina Stenstedt, ESR student, MA in Religion

Phone #: (c) 510-339-0179 or (h) 510-333-4145 Email(s): kstenstedt@gmail.com

Additional Investigator(s): None

Faculty Sponsor Name and Email (for student PIs): Jim Higginbotham, higgija@earlham.edu

Department: Earlham School of Religion

Title of Project: Chaplains' Perceptions of Healthcare Bias

Source of Non-Earlham Funding for Research (if any): None

Anticipated start and completion dates: Feb. 1, 2022 to July 31, 2022

Do you intend to use campus email lists (student, faculty, staff, employee) to send a request to complete the survey? No.

If yes, have you spoken to the Director of Institutional Research? Please enter the date you spoke to her and a summary of your conversation: N/A
(Please be aware that there are strict guidelines that must be followed to send research surveys out via institution email lists, and it must be approved by the Institutional Effectiveness Office, which can be reached at institutionaleffectiveness@earlham.edu. If you do not get approval, you may NOT send your survey out via those email lists. See http://bit.ly/CampusSurveyPolicy for more information.)

Do not proceed if you intend to use a campus email list and have not sought approval from the Institutional Effectiveness Office.

A. Research Overview
1. State the purpose/objective/aims of your research.

Revised August 2020

To understand how U.S.-based healthcare chaplains perceive race-based and ethnicity-based bias in the institutions where they work, and to develop recommendations for how chaplains can deepen their anti-bias and anti-racism work in U.S. healthcare institutions.

2. **If relevant, include your major hypotheses.**
   Many healthcare chaplains in the U.S. are aware of the harmful effects of race-based and ethnicity-based bias in the institutions where they work, and many see themselves playing a role in preventing or lessening the harm caused by this bias. These chaplains would benefit from learning the thought processes of like-minded colleagues, and from the development of recommendations based on anti-bias interventions used by other chaplains.

B. Research Procedures

1. **Describe in detail the activities in which participants will participate, including any equipment that will be used. The IRB should be able to imagine every step the participant goes through.**
   In a one-on-one conversation, the participants will answer questions that I ask them about their chaplaincy experiences.

2. **Describe the amount of any biospecimens you are collecting and the mode of collection.**
   N/A

3. **Specify the length of time each participant will be involved.**
   About 30 minutes, and no more than 45 minutes.

4. **How are you obtaining informed consent from your participants? Specify if you are obtaining broad consent**. I am not obtaining broad consent. I will ask each participant to sign informed-consent and recording-consent forms. If I am not in direct contact with a participant, I will ask them to print and sign the forms, then scan or photograph them and send me the images. If they prefer, I will mail printouts of the forms to the participants.

5. **If you believe that consent is not required, if you plan to obtain consent without using a consent form (e.g., verbal consent by illiterate adults), or if you would like to waive informed consent, describe your justification.**
   N/A

6. **If you plan to use incomplete disclosure (withholding more information than your hypotheses in order to conduct an unbiased study), explain how you will debrief participants (e.g., written debriefing document, script for verbal debriefing).**
   N/A

7. **If you plan to use deception (misleading participants about the purpose of or procedures in a study), provide your rationale for using it.**
   N/A

8. **If you plan to use deception or incomplete disclosure (withholding more information than your hypotheses in order to conduct an unbiased study), explain how you will debrief participants (e.g., written debriefing document, script for verbal debriefing).**
   N/A

9. **How will you assure that participants are not coerced, in any way, to participate?**

My informed-consent form asks participants to confirm that they are over 18 states that participation is voluntary; participants can skip any question or withdraw from participation at any time. I will not recruit any participant who might feel a sense of obligation toward me—for example, someone for whom I wrote a recommendation.

C. Participant Information

1. **State the source of the participant population and how they will be recruited. Include any information about the use of incentives, if relevant.**
   I will recruit ten chaplains who have worked in healthcare in the U.S. I will not recruit any current CPE students, or anyone whose chaplaincy experience does not extend beyond the clinical hours they completed for CPE. I will not offer any incentives.

   To select chaplains to recruit, I have compiled a list of more than forty chaplains, some known to me, some not, who represent a mixture of races, ethnicities, faith traditions, and age. I will use a random-number generator to select chaplains to recruit, continuing until I have recruited at least ten chaplains who agree to participate.

2. **State the total number of participants.**
   Ten.

D. Potential Harms and Benefits

1. **State any potential harms to your participants.**
   I do not anticipate any risks associated with participation in this study, beyond those encountered in everyday life.

2. **Describe your methods for minimizing the risk of any potential harm. If you are conducting in-person research, you must explain in detail how you will prevent the spread of the coronavirus that causes COVID-19. Also explain why a distance approach (via Zoom, phone calls, or online) is not possible for your study.**
   I anticipate doing most of my interviews using Zoom or the phone, and I will give all participants the option of doing our interview that way. For indoor in-person interviews, I will require full-vaccination proof (and show my own proof), require masks, and maintain a six-foot distance. For outdoor in-person interviews, I will require full-vaccination proof, meet in an uncrowded place, and maintain distance.

3. **State any anticipated benefits to your participants.**
   I am an experienced spiritual director and chaplain, and I anticipate that my participants will find it clarifying to talk with me about their experiences and thoughts about healthcare bias. Also, my research will add to the body of knowledge about the importance of chaplaincy in U.S. healthcare institutions, which benefits all chaplains, because chaplains often need to justify the expense of their employment. My research will also contribute to the development of recommendations as to how chaplains can bring positive changes in the institutions where they work.

4. **State any anticipated benefits to society-at-large or others (e.g., your academic field). Benefits to the self are not included in this section.**
   By adding to the body of knowledge about healthcare bias, and by exploring anti-bias interventions that some chaplains use, my research will support chaplains and perhaps other health-care professionals in working for justice in U.S. healthcare institutions.

E. Data Storage/Sharing

Only answer one set of questions.

For projects where data is protected/anonymous (must be used for biospecimen research)

1. **Describe your methods for protecting the identity of individual participants.**
   I will not name any participant in my published work, I will obscure identifying details that they share about themselves or others, and I will fictionalize the details of vignettes that might identify them or others.

2. **Describe your plans for keeping and disposal of the original data in a way that keeps the data private.**
   I will keep original data on a personal computer, including a personal back-up hard drive, and in an Otter.ai location to which only I have access. I will keep participant names and contact information in a Google spreadsheet to which only I have access. I do not have plans to dispose of this data.

3. **Describe how biospecimens are labeled and how documentation matching them to participants is secure.**
   N/A

4. **Describe how biospecimens will be stored after collection, for what length of time, and procedures for destruction.**
   N/A

For projects where participant identities are shared (not appropriate for biospecimen research)

1. **Explain how you will ascertain whether or not participants agree to share their identity and procedures to be followed if a participant does not want her/his identity shared.**
   N/A

2. **Indicate how individual data will be shared and stored (e.g., location, length of time, format, etc.).**
   N/A

F. Additional Documents

All documents should be submitted as one additional file (Word or PDF) in the same email as a complete IRB form.

The following documents are in the "AdditionalDocs" file:

1. **Informed consent document**
2. **Recording consent document**
3. **Interview script (questions to be asked**

Earlham College Human Subjects Consent Form

Chaplains' Perceptions of Healthcare Bias

Researcher: Katarina Stenstedt, kstenstedt@gmail.com, text: 510-333-4145
Research faculty sponsor and thesis reader:
Jim Higginbotham, Associate Dean and Professor of Pastoral Care and Counseling, Earlham School of Religion, higgija@earlham.edu
Thesis advisor: Lonnie Valentine, Professor of Peace and Justice Studies, Earlham School of Religion, valenlo@earlham.edu

Earlham College, Earlham School of Religion (ESR)

This document is designed to inform you about the research project described below. Your signature at the bottom of this document indicates that you are at least 18 years of age, have had all questions answered, and agree to participate in the research described.

What is the topic of this research project? This research is about whether, and how, chaplains perceive race-based and ethnicity-based bias in U.S. healthcare institutions.

Why are you studying this? To understand how chaplains perceive healthcare bias, and to develop recommendations.

What will I be asked to do and how long will it take? You will participate in a one-on-one interview with the researcher, which will take 45 minutes or less. The interview will take place over the phone, on Zoom, or in person. The researcher will ask you questions about your experiences as a chaplain.

Are there any risks if I participate? There are no anticipated risks associated with participation in this study, beyond those encountered in everyday life.

Revised August 2020

Are there any benefits if I participate? Your participation in this research will add to the body of knowledge about the importance of healthcare chaplaincy and contribute to the development of recommendations as to how chaplains can bring positive changes in the institutions where they work.

What will happen with the answers I provide? Your data may be required to be made publicly available in order to publish knowledge gained as a result of this study, which means it could be used in future research without additional consent. No report or data that is made available to the public will include your name or any other individual information by which you could be identified.

Do I have to do participate? No. Your participation is entirely voluntary. You have the right to skip any questions and to discontinue your participation in this research without consequence. Participating in this study does not mean that you are giving up any of your legal rights.

What if I have questions about this research? You have the right to ask questions and receive a summary of the results. If you have questions about how you have been treated, please contact the convener of Earlham College's IRB at irb@earlham.edu.

Can I keep this document? Yes. You can print it yourself, or the researcher will mail you a printed copy if requested.

Are there other important things I should know before participating? Yes. The researcher is responsible for keeping your informational confidential. Individual information, including interview transcripts, will be kept on a personal computer and in an Otter.ai location to which only the researcher has access. If you want to know more about research protections, see http://bit.ly/Protection_English.

_____ _____

Participant Signature *Date*

Revised August 2020

Earlham College Recording Consent Form

Chaplains' Perceptions of Healthcare Bias

Researcher: Katarina Stenstedt, kstenstedt@gmail.com, text: 510-333-4145
Research faculty sponsor and thesis reader:
Jim Higginbotham, Associate Dean and Professor of Pastoral Care and Counseling, Earlham School of Religion, higgija@earlham.edu
Thesis advisor: Lonnie Valentine, Professor of Peace and Justice Studies, Earlham School of Religion, valenlo@earlham.edu

Earlham College, Earlham School of Religion (ESR)

As part of this research project, audio recording may occur. It is not possible to participate in this research project without consenting to this recording. The recordings may be used for future research, or excerpted for a talk or paper. To protect your individual identity, your name will not be used, and no excerpt will be used that includes identifying details about you or others. The recordings and their transcripts will be stored on a personal computer and in an Otter.ai location, both of which can only be accessed by the researcher.

If you consent the above type of recording during this research, please sign and date below.

_____ _____

Participant Signature *Date*

Revised August 2020

Interview script

[The researcher will begin the interview by reading the introductory statement below, and will then ask the listed questions. The researcher will ask follow-up questions when relevant.]

Introductory statement
Researchers have studied the effects of race-based and ethnicity-based biases in U.S. healthcare institutions, and my questions for you are about this possible bias—for example, situations where a patient's race or ethnicity might affect the quality of care that they receive, or might affect their subjective experience of receiving care. I'm investigating whether, and how, chaplains perceive this kind of bias in healthcare institutions.

Questions to be asked

1. How do you identify your race and ethnicity?
2. What is your faith tradition?
3. How long have you worked as a chaplain, and in what contexts?
4. What are one or two ways you would say healthcare chaplains make a positive difference in healthcare settings?
5. In your chaplaincy work, have you witnessed or been part of situations where race or ethnicity seemed to play a role in an interaction between healthcare staff and a patient or the patient's loved ones? Could you give examples?
6. Have patients or their loved ones ever told you they have race-based or ethnicity-based concerns about their healthcare? Could you give examples?
7. Are you familiar with the idea of implicit bias, and if so, do you think it plays in the healthcare institution(s) where you work? If so, could you give examples?
8. How do healthcare chaplains make a positive difference when it comes to race-based or ethnicity-based bias in their workplaces?
9. What practices can chaplains use to improve situations where bias is, or could be, causing harm?
10. How does your personal philosophy or theology support your work?
11. Is there anything else you'd like to tell me?

For clarity's sake, I removed most filler words and phrases such as "you know," "like," and "yeah" from these quotations.

Race and ethnicity

In response to the question "How do you identify your race and ethnicity?," interviewees gave the answers shown in the table below.

Table B.1. Self-identified race and ethnicity of interviewees

Summary	Complete answer
Black African-American	"I identify as Black, African-American."
Human Argentinian Eastern-European	"They wouldn't give me always that little checkbox on forms, you know, the ethnicity or race…. I will probably say that I'm multiracial, I have a lot of blood from here and there. And my mother is Argentinian, very Argentinian, descended from Spanish, and my father came from Eastern Europe. And I grew up in a very diverse city, in Argentina, in Buenos Aires with people from all kinds of backgrounds and religions…. "So … if I had to, [I'd say] I'm a human being. I kind of refuse to say I'm white, red, yellow, blue, or black. I'm a human. And we come in different colors and shapes."
Latino Hispanic	"I typically identify as Latino Hispanic, although … when options are limited, I'll sometimes put white. There'll be like race: Black, white, Asian type of thing, and then ethnicity: Hispanic or non-Hispanic type of thing. So it just kind of depends, but mostly I identify as Latino or Hispanic."

Caucasian/white Euro-American	"If I'm checking boxes, I would check a Caucasian box, a white box…. Euro-American would be another way to describe myself. Ethnicity is a hard one, in that so much of that in my mind's eye is about culture as well. And so, being married to somebody who's Jewish, I feel like there's more to me than, you know…. You could see me as a suburban, white, fairly high socioeconomic cisgendered female, but who identifies as coming from the Christian tradition, but is married to somebody who's Jewish and from a more Middle Eastern background. So those are the things that go into my mind when I think about race and ethnicity. But if I'm checking one box only, that's Caucasian slash white."
Asian-American	"I'm an Asian-American, but I grew up in the United States. I went on sabbatical over to Asia, but here I'm just American. So I feel some of my ethnicity is contingent on context. A little bit, or how, I sort of imagine myself. Also, I grew up on the East Coast. I have friends who are Asian-American on the West Coast, and I feel there's a slightly different experience, just because there's so many more Asians there. Both in a positive, and possibly negative, way."
White Jewish	"White and Jewish."
Thai Mexican Scottish-English Norwegian	"So it's a little bit of two things. A little bit of many. My ethnic background: I'm half Thai. So that's my biggest slice. My next biggest slice is I'm Mexican, which I actually didn't know about until very recently. Like, oh, cool, why was that hidden, but oh cool. So, very relieved and kind of interpersonally disappointed, but I'm very relieved to learn that. So I'm mostly Thai, part Mexican, and then the other ones are part Scottish-English and Norwegian, and I think that's basically how my roots all line up together, so I'm together. "In terms of my experience of affinity and where I exist in the world, I've spent a lot of time being immersed in white American culture. I think that's where I've adapted to be most competent. It's kind of the ways of thinking that I've integrated. So with that, I personally experience this sense of *distance* or *loss* when it comes to my own personal race. And the way I tried to

	reconnect was largely academic, because I was in a very academic setting when I figured out that there was a problem in my soul. So I learned to reengage with my ethnic background, not through family, because that's just difficult. Pretty inaccessible. But reengaged through study, learning about culture, learning about history, learning about the nuances of the literal way I speak language now. And religion, religion is a point of research and rediscovering myself. So that's how I identify, and that's also how I relate to my sense of race."
White European-American	"I'm a European American, a white person."

Chaplaincy experience

In response to the question "How long have you worked as a chaplain, and in what contexts?," interviewees gave the answers shown in the table below.

Table B.2. Self-identified length of time working as a chaplain, and contexts

Summary	Complete answer
Eight months hospice chaplaincy (post-CPE)	"About somewhere between a year and a half to two years? I'm on a break right now because I, near the end of July, kind of a burnout took my health totally down. So for the first year and eight months or so I was in a hospital CPE context, and then I was in a hospice context. So out of education, hospice has been my main context, and now I teach piano lessons. It's a nice way of offering care, it's very perspective-giving."
About one year hospital chaplaincy	"So I have worked professionally now since September. Yeah, maybe like five months, but including CPE it's been about a year and a half. I was a volunteer chaplain for like three years part time in a hospital before I did CPE."

About five and a half years hospital chaplaincy	"Five years, maybe five and a half. My first unit of CPE was at ___. And then in downtown ___. And then, I don't know if you need to know the name of the center, but it was technically ___. And then I did my one-year residency at ___. So that was four units there. And then I spent four more years, so three years as a staff chaplain at University of ___ medical center, the downtown campus, and then the sister campus school hospital, called ___, campus for the last year."
About eight years hospital chaplaincy	"I started volunteering as a chaplain at ___ Hospital in 2006. So that would be fourteen, fifteen years ago. And I finished Seminary in 2011. So I was ordained and had been serving as a hospital chaplain in 2009. So I actually did an internship at ___ in 2009, where I was, you know, it was a formal chaplaincy, not just a volunteer, and then residency in 2013. So I would say, if you asked me at a cocktail party, 'Are you a chaplain?,' from 2013 and beyond I would've identified as a chaplain, so that's eight years. And then in my current position for six and a half years."
About eight years military and healthcare chaplaincy	"I have worked as a chaplain for about eight years now. That was under the military. So I was a military chaplain, a hospital chaplain, and now a hospice chaplain."
About ten years hospital chaplaincy	"Well, I actually haven't been active. I taught at ___ for about eight years. And so when I was there, I wasn't a chaplain, and I really haven't been, but I was a chaplain in Philadelphia doing CPE and also working at the hospital for about ten years in Philadelphia. At a tertiary care hospital in downtown Philly."
About thirteen years hospital chaplaincy	"A little over ten years at my current hospital, and my training began in '09. So I've been working in the same hospital system the entire time. I worked at ___; there's five campuses in this system. And I worked at ___ and ___ and ___ and ___, the ___ part of the system, for most of the years and during my training, and then around 2013, I exclusively worked at ___, and that's where I am still."

About twenty-five years hospital chaplaincy	"I have been doing this for already, let me go back to the kids. I have six…. So probably, at least around twenty, twenty-five years. I have been most of that time at ___, then that became ___, and now it's ___. At one point, immediately after finishing my CPE, I went to ___ hospital in San Jose. And then … I left ___, and I became the sole chaplain at ___. And then I was recruited to return to ___."

For a discussion of interview responses directly related to my thesis topic, see the sections "Situations impacted by race or ethnicity" (page 41) and "How chaplains can make a positive difference" (page 51) in the analysis portion of Chapter 3.

Chaplain contributions, in general

Interviewees gave various answers in response to Question 4, "What are one or two ways you would say healthcare chaplains make a positive difference in healthcare settings?" The table below shows representative quotes.

Table C.1. How chaplains make a positive difference in healthcare settings

Summary	Representative quotes
Chaplains bring humanity.	● "We bring humanity into a place that often feels cold and sterile." ● "There's something important about keeping humanity alive [in conversations about death among hospice staff], even though it is a little bit more uncomfortable [than the technical aspects of things]." ● "[One thing we bring is] just common humanity, that people feel seen, known, loved, appreciated, less alone when somebody takes the time to talk to them beyond their medical condition…." ● "Our care is beneficial to the whole of the patient, allowing there to be relief for the patient's many different aspects, so they can experience relief on many different levels, more holistically. The spiritual side can play a part in their healing process."

Chaplains bring a sense of safety and comfort for patients and staff.	• "We are a safe space for patients who are experiencing psychological, emotional, and spiritual pain that's contributing to their physical pain." • "I've witnessed and comforted staff during employee deaths…. Sometimes a chaplain coming in, it's like hey, it's okay, I'm here at the job, and it's okay for you to take fifteen minutes or ten minutes to talk about this, and then go back to your job." • "At the hospice site where I worked, we'd have some sort of grounding [or] positive kind of message-thing at the beginning of each interdisciplinary team meeting…. I didn't realize how important it was until I started wanting to hear my teammate do it more. It was a huge comfort."
Chaplains bring time, and a certain quality of presence.	• "Being there at the moment of crisis. Someone may receive bad news or they receive a poor prognosis, or a change in diagnosis, … or just maybe go into a long hospitalization, just all these different aspects of things like loss, and death. [It's] the chaplain *being* there." • "The position of chaplain is often given some flexibility to not check things off checklists. And then being able to be there with somebody and not have checklist vibes, I think that's really good. [A]nother way I would say that, is being present for the person. I think that's really valuable." • "The kind of time that's spent with the patients is … something that they may not get from other healthcare providers, like nursing staff, or social workers." • "There's nobody else in the hospital who has time to be with a patient who is in distress or struggling in a horrible moment when their mother's dying, or, you know … nurses have other patients, even the ICU nurses now, we're in crisis standards of care. So they're taking care of more people than normal." • "We provide the gift of time…. There's lots of staff and nurses and other support folks who kind of act as chaplains too, but often have other things to take care of.

	And so I feel like we can provide more spacious presence for patients." ● "We have the luxury to spend more time with the patient than any nurse, or anybody else. So we can learn many things from the patient that are beneficial for the care team…. Cultural stuff. All kinds of things." That last quote also speaks to chaplains making a positive difference by acting as liaisons between patients, families, and staff.
Chaplains meet spiritual needs.	● "Chaplains are the people who can be by the bedside to listen, to support and encourage and pray with people. There's nobody else in the hospital who's going to ask you 'Would a prayer be a comfort right now?' Unless a religious staff person does, and sometimes they do, and that's pretty special. But the person you can count on to ask that question is a chaplain." ● "This week, we had a Cambodian Buddhist patient who went on comfort care. And the husband told me what temple they went to so I could call the temple to see if monks could come and chant with her, and they could. So I was able to get the CNO to make an allowance in our visitor policy so that these three people from the temple could come and bless her and chant for her…. This is an incredibly important thing that we can do."

Chaplains bring cultural and religious awareness, and chaplains can educate staff.	● "We can make the care team aware of cultural or religious issues that they may not be aware of; for example a group for which you have to check with the elders before having a transfusion, or needing a female nurse to care for a female Muslim patient who is not comfortable with male nurses." ● "Hospital chaplains are often the go-to people to learn about a different culture…. So we, for example, had a Roma patient, and the hospital waiting room was filling to overflowing with Roma people from up and down the West Coast who were coming here to be a witness and to honor the man in the ICU. And so we printed information about Roma culture for the ICU staff and helped everybody in the hospital come up with solutions for this many visitors…. Chaplains helped everybody understand what was going on, and how to behave appropriately."
Chaplains can improve health outcomes, and they make positive contributions to the business side of healthcare.	● "My mind goes to money first, because you have to make a case for your status. But I'd say patient care outcomes are a lot better when chaplaincy is involved. People feel seen in the midst of a medical system that can often identify them by their medical record number or their disease, or maybe their name, but very rarely about who they are, who they love, and what makes them tick and what their joys are. So, quality outcomes." ● "Many times chaplains are the ones who stop the lawsuit from taking place, or something like that, and people are very thankful.… We are the ones who were able to convince somebody to take this or that medicine, because it was very important…."

How chaplains view implicit bias

Question 7: Are you familiar with the idea of implicit bias, and if so, do you think it plays in the healthcare institution(s) where you work? If so, could you give examples?

The table below shows representative quotes.

Table C.2. How chaplains view implicit bias in healthcare institutions

General idea	Representative quotes
Chaplains do not always see examples of implicit bias.	● "I feel like I don't have examples of seeing this. I watch people get equitable treatment."
We all have it, and we don't know how it's affecting things.	● "Definitely, [implicit bias] plays a role in how I do care. Our racial conditioning is so ingrained within us. And so yeah, I think it can't be separated from anyone. I think it shows up in how people go into the room of someone of a different race, how they comport their body, or what sort of interactions they have, or who has to lead the interaction. It's pervasive everywhere. It goes beyond any institution, right?"
Chaplains are well-suited to anti-bias work, and they often have training in this area.	● [Chaplains] come from a culture that is accepting of gray areas. Medical culture is very binary, you're either in or you're out, you've either got the condition or you don't, the treatment worked, or it didn't. And physicians have this perfectionist thing where they just have to know it's right. And if they didn't get it right, there's big shame. Whereas chaplains can have the like, 'Oh, isn't it interesting that this Black family felt like they were kind of sidelined? Was there something we could have done better? I'm curious, do you think there was anything we could have done better?' … I feel like when I ask those questions, they're well received, and people will actually slow down and say, 'Yeah, I didn't like how that felt.' Whereas I think if there were another, if it was physician to physician, they'd be like, '....I did my best, you do your best. Why are you asking me this? Are you judging me?' Nonbinary thinking is really important in chaplaincy." ● "No institution is perfect, but my denomination tries really hard to educate, in the formation process, on cultural biases…. With so much programming going on, I can't help but try really hard to be as humble and culturally

	aware as I can be. So chaplains have that kind of background; almost every denomination has some form of implicit bias training and cultural awareness training. So there's definitely an importance to having people who have training. Now does it have to be chaplains? Maybe not. But I think we're the most likely to be told, Hey, step back, make sure you're not making assumptions, check out questions you might have, take an extra beat to slow down."
The work on seeing our own biases and helping others to see theirs can be done gently, and with kindness and humor.	● I know [a Black chaplain who] asks pointed questions, but she does it with a real smile and kindness that helps people say, 'Oh, there might have been more to that, I could have slowed down and asked some more questions, or maybe I shouldn't have leapt to that assumption.'" ● "[Getting rid of implicit bias] seems unrealistic, but at the same time, I think there's different ways to navigate it and recognize when it comes out, and have a sense of kindness and humor in pointing it out. I don't know about the blaming stuff, because that doesn't really change people that much." ● "I learned once from somebody who was Wiccan and told me she was a witch, and I catlike kind of jumped back, although I'm in the San Francisco Bay area…. I didn't know what to do, because the lady asked me to leave the room, she said go away, go away, go away, you're a priest…. So I [made a relevant joke about my last name] And then she laughed. You know, we started talking."

Anti-bias training can be helpful.	● "I'm absolutely aware of [implicit bias]. I'm one of those people who took that test and went 'Oh!' I think it does play a role because we're human.... We do lovely training on all of this stuff so that it doesn't impact people's health care. I watch the people in my hospital system do everything they can do to have it *not* impact people's healthcare. And I really, really appreciate that. I haven't had people, for example transgender patients, tell me that their hospital stay included shaming, ignoring, sidelining. I haven't had that experience."
It is challenging to *experience* biased treatment, and to work with one's own implicit biases.	● "If I'm perceiving implicit bias against me, and I'm a caregiver, I will likely not acknowledge it, because I'm giving care. And that's some weight that it puts on me." ● "There are little helpful moments, like during evaluations and stuff, where somebody will name a reaction that they perceive from me, and that'll let me know what I'm not seeing, because my eyes are inside my head. So the work can be done. I don't think it can be done in isolation very easily." ● "If you're doing race work in a way that's comfortable and soothing, I don't think that's quite right. I think it's supposed to be challenging, or else your implicit biases are not becoming explicit biases."
Implicit bias sometimes comes out in the form of assumptions about shared norms.	● "I do think [implicit bias plays a role].... like sometimes I've heard staff say, 'Oh, why is all that family there in the waiting area; why did they bring kids here? What's wrong with them, it's like 8pm, 9pm at night, 10pm, they should be at home…..' And then I thought about it; these are usually Hispanic or African-American families that they're saying this about … some of that is that they're very family-oriented, and also maybe they don't have babysitting…. They're trying to support their loved one, or their cousin, or their brother or sister that's here; it's not just like, *nothing.* It seemed like there was like a cultural clash there."

	• There was an African-American family with a sister or a mother that got really upset, and they were kind of raising their voices, and they were at the front nurse's station … they felt like the nurse was not respecting them by updating them or sharing with them, but just kind of ignoring them in the room…. I felt like I had to be able to say [to the family], 'Hey, is this what's going on, is this what you're thinking about?' And then mediate with the staff and the family, and then I think they felt heard and felt like … things are going to get better, and we don't want this nurse anymore. "But afterwards, when I was with the nurses, it was interesting. There were some white nurses, some Asian nurses. And I said, 'Well, for example, I'm Latino, and sometimes people might be speaking loudly or passionately, but they're not yelling or being threatening ... but some people might prefer to be more subdued or detached.' And they were like, 'Yes, [subdued and detached] is the way to be respectful! *That's* the way it should be done….' It was almost like a test in, 'Do we have some implicit bias here?,' and then it was a resounding 'Yes!'"
Bias can be helpful; for example, bias can help you connect with people who need care, because you understand that they experience a lot of bias.	• "Sometimes you see somebody and just have an instant connection to them. And it's kind of not fair, but you just instantly care about somebody and want to be helpful toward them. So the reality is, sometimes for really superficial reasons, or reasons that show up on the surface that you really don't know about, you, it helps somebody, and that's cool. For me, that kind of implicit bias comes out around, especially, trans or nonbinary people, where I think oh my gosh, I've got to care for this person or nobody else will. Which is not true, but that's how it shows up."

APPENDIX D: STRAWBERRY CREEK MINUTE ON RACISM

Minute on Engagement to Uproot and Dismantle Racism in Strawberry Creek Friends Meeting

Strawberry Creek Monthly Meeting of the Religious Society of Friends acknowledges the centrality, depth, and pervasiveness of systemic racism in the United States. Continuing revelations of history, experience, and conscience challenge Friends to live up to the Light, increasing awareness of how we, our communities, and our institutions perpetuate the structure of racism. We must help one another discern what Spirit calls us to do individually and corporately. We utterly reject the racial status quo. People are suffering and dying daily as a result of systemic racial bias within and across institutions and economic structures, which reproduces inequity and discrimination for "people of color" and unearned advantage for "others". We call upon ourselves as Friends to illuminate, uproot, and dismantle white privilege because it is used to maintain white dominance. Systemic racism creates a barrier to living fully into our deepest Quaker values as reflected in all of our testimonies. We seek to bring about a truly inclusive, compassionate, diverse Religious Society of Friends through which our individual lives speak to our collective belonging to one another and Creation. We commit to the work of healing and transforming to make foundational change in our Meeting. We commit equally to the work of dismantling the political and economic structures of racism and opening to acceptance of real beauty in human difference.

Approved 2/9/20
Strawberry Creek Friends Meeting
Berkeley, California

Discrepancies in health outcomes and healthcare

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