HealthCare Chaplaincy
Finding Meaning ✦ Bringing Comfort

By Its Fruits: The Science of Health Care Chaplaincy
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HealthCare Chaplaincy, with the generous support of the John Templeton Foundation, introduces *Practical Bearings*, a series of bibliographies and critical reviews of the important books, articles and other publications on the theory and practice of pastoral care.

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I.   Rationale

This series will present a variety of current thought and suggested practice bearing on what might be broadly characterized as the science of modern health care chaplaincy. A basic premise underlying this series is that pastoral care in health care can, and should, and needs to make increasingly predictable and evidence based contributions to the holistic care of those who are suffering, and their care givers. Because the published thought in pastoral care pertaining to these issues is limited, material will be drawn from sources outside the profession. While the relevance of some of the titles may seem questionable, we will attempt to make the relevance clear in each review. Finally, this series is emphatically not an attempt to remove the art or mystery from professional pastoral care or in any way minimize their importance. However, it does posit that pastoral care must adopt and adapt relevant scientific thought and method to maximize its benefit to those it serves.

II.   3-5 Best Books

As aforementioned, the overall literature in this field is in its infancy. With the exception of VandeCreek & Lucas, the books presented here are not directly about outcome based chaplaincy; rather, they present important components of what should go into the thinking about, and the planning for, that practice.

VandeCreek, L., & Lucas, A. (2001). *The Discipline for Pastoral Care Giving*. Binghamton: Haworth Press.

Summary

Co-author Chaplain Arthur Lucas, the former Director of Pastoral Care and CPE Supervisor at Barnes-Jewish Hospital in St. Louis, is credited with developing this system for the delivery of pastoral care to patients. As documented in the book, the system is characterized by an assessment, a patient profile and a plan of care with expected outcomes, interventions and measurement of how well the outcomes were achieved. The idea of outcomes that are measurable and for which the chaplain is accountable probably represents the most dramatic departure from the traditional delivery models for pastoral care, in which structure of this kind is considered problematic, if not heretical. However, this system almost mirrors the outlines of nursing standards of practice insomuch that communications and referrals are improved across interdisciplinary lines. The book, itself, is composed of an introductory chapter, which outlines the system followed by different Barnes chaplains, thus demonstrating how the system plays out within their particular clinical specialty, or within the teaching of clinical pastoral education.

Comment

This volume is the only book to date devoted entirely to presenting a system for "outcome oriented chaplaincy." It is a must-read book for anyone practicing, or in training to practice, pastoral care in a health care setting today. The material is clear and straight forward. Chaplain Lucas' system summation in the introductory chapter is done nicely, while the following chapters vary somewhat in quality, as expected from a book of different authors. They generally present good case material, which allows the reader to see the system in action. A couple chapters on the use of the system in CPE highlight the usefulness of this system as a training method and a patient care delivery model. This system is not as prescriptive as it may first appear. While it proposes an outline for service delivery; when done well, it actually enables creativity in the pastoral relationship rather than constricting it. This system also enables monitoring of service delivery for quality improvement purposes as more and more institutions are requiring.

Frampton, S., Charmel, P., & Gilpin, L. (2003). *Putting Patients First: Designing and Practicing Patient-Centered Care*. San Francisco: Jossey-Bass.

Summary

Patient-centered care has now become a central outcome of health care in the United States; emphasizing respect, collaboration and holistic care. It is the philosophical approach behind the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which every general hospital is now required to administer and publicly report its results. Since 1978, the Planetree Group has been applying it to every aspect of its care, from how doctors talk to patients, to how the lobby is designed. Planetree is a non-profit membership organization working with hospitals and health centers to develop and implement patient-centered care in healing environments. Edited

by three of Planetree's principle architects, this volume lays out a vision for patient-centered care that is actually alive and functioning throughout the country. All chapter authors have practical experience in their particular area. The book is divided into two basic sections: *Nine Elements of Patient-Centered Care* and *Future Directions for Patient-Centered Care*. The pervasive influence and presence of spirituality in this care model is quite apparent and quite consonant with the practice of pastoral care.

Comment

Arguably, no one does patient-centered care better than Planetree. They have proven that a hospital can fully involve patients and families in their own care, while making staff happy, and making money. For pastoral care providers, this model demonstrates that focusing on the care of the spirits of patients, family members and staff, does not have to be an afterthought; rather, it can be the centerpiece of a care model. In that vein, the chapter on religious and spiritual care may be the least interesting to chaplains because it tells them what they already know. This book presents, not guesses about what might be done, but results of what has been done, and done successfully. It is filled with ideas that chaplains can advocate for in their institutions, ideas that embody the values of pastoral care. While spirituality is everywhere in this model, it is sometimes so ubiquitous that it is hard to define and take hold of. That is, it is often everywhere, and no where, which is a valuable example for chaplains engaged in discussion of the role of spirituality in their own institutions.

Providing Culturally and Linguistically Competent Healthcare (2006). Oakbrook, IL: Joint Commission Resources.

Summary

This volume is the output of a research process at the Joint Commission that reviews the benefits, business case and barriers associated with cultural competence. Cultural and linguistic competence is "the ability of healthcare providers and institutions to deliver effective services to racially, ethnically, and culturally diverse patient populations. It is one of the primary drivers of quality in health care today.

A large part of the book is devoted to the provision of language and translation services to patients in hospitals, which while interesting, is not directly relevant to the practice of pastoral care. However, it should be noted that "Culturally" coming before "Linguistically" in the title is intentional. Cultural sensitivity and competence should be a major skill set of the professional chaplain. These are areas in which the professional chaplain can make significant contributions. Since Joint Commission Resources is a subsidiary of the Joint Commission and not the Joint Commission itself, this volume does not have the force of regulation. However, it still carries significant weight with healthcare administrators. Due to the involvement of the Rev. Sue Wintz, BCC as an editor of this volume, there is specific and significant mention of chaplains and their role in this important outcome of care.

Comment

Cultural competence, because of its tie to patient safety, has gone from a "nice to have" to a "must have" for every healthcare institution. The Joint Commission will also soon come out with a standard for this area of care on which there has been professional pastoral care input. As this volume advocates, chaplains are often looked to as the "culture brokers" for the institution. They become the subject matter experts in both staff training, formation of institutional policy, and care of individual patients and families. Given this role, chaplains become familiar with the issues involved and have a plan for how they might contribute to these important outcomes in the context of the cultural mix of their particular institution. This volume provides significant help with that task. One important caution is to pay attention, not only to the cultural mix of the patient population, but to the cultures of the staff as well and any cultural interactions between the two groups

Fitchett, G. (1993) *Assessing Spiritual Need: A Guide for Caregivers*. **Minneapolis, Minnesota: Augsburg/Fortress Press.**

Summary

George Fitchett presents a model for spiritual assessment that he and his colleagues developed, as illustrated with case studies. This "7X7" model has become a classic from which many other models are derived. He reviews three other models and provides a framework for evaluating them. The framework includes the model's concept of spirituality, norms and authority, and assessment context and process. The models include Paul Pruyser's *The Minister as Diagnostician,* Elizabeth McSherry's work at the Veterans Administration, and the model of the North American Nursing Diagnostic Association. This book addresses many of the questions pastoral caregivers have raised about this timely and enduring topic and provides an informed and balanced approach for making decisions about spiritual assessment models and tools.

Comment

Good assessment needs to be the cornerstone on which all of pastoral care delivery is built. It drives the plan of care, interventions, and outcomes. It surfaces the facts that communicate to other disciplines what chaplaincy does. As a side note, it is important to distinguish spiritual screening, which any staff person can do, and spiritual assessment, which should be the prerogative of the professional chaplain. Many chaplains have avoided doing assessment because professional pastoral care does not have a standard method. All chaplains need to realize that what is most important is to have a system that becomes standard for them and for their colleagues in a given institution so that other disciplines come to understand what they are doing.

III.   Other books

VandeCreek, L. (2002). *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No*. **Binghamton: Haworth Press.**

One of the many services that Larry VandeCreek rendered for professional chaplaincy was to gather a group of thought leaders to write about the pros and cons of chaplaincy becoming more scientific. Since outcome oriented chaplaincy is by its nature, scientific. Additionally, very chaplain needs to understand what "scientific" means in the context of chaplaincy, what it will do for us, and some of the down sides we need to recognize and avoid.

Nursing: Scope and Standard of Practice (2004). Silver Spring, MD: American Nurses Association.

As chaplains move toward standards of practice as a mechanism for demonstrating outcomes, spending even one hour reading the comparable documents for the profession of nursing gives us a template for how this is done, and how simple the process actually is.

George, M.L. (2002). *Lean Six Sigma: Combining Six Sigma Qualities with Lean Speed*. New York: McGraw Hill.

Continuous Quality Improvement is here to stay, and with the Joint Commission firmly in the lead, Lean Six Sigma as presented in this volume, is the Cadillac of quality improvement systems. While it is not necessary for chaplains to understand all of the intricacies of Six Sigma as presented here, or be able to implement it, many of the terms and much of the process is part of the environment in most healthcare institutions. Chaplains would do well to understand this approach to management, if they are to fully participate in the life of their institutions and to contribute to the desired outcomes rather than being further marginalized.

Studer, Q. (2003). *Hardwiring Excellence: Purpose, Wothwhile Work, Making a Difference*. Gulf Breeze, FL: Fire Starter Publishing.

Quint Studer, an important management consultant, presents a system that has successfully helped institutions consistently attain virtually perfect patient satisfaction ratings and retain virtually all of their employees. Although the system will likely seem "routine-ized" and therefore stilted to chaplains, understanding a program whose influence is being felt throughout US health care as a solution to one of the primary desired outcomes- patient satisfaction, will assist chaplains.

Bowker, J. (1975). *Problems of Suffering in Religions of the World*. Cambridge: Cambridge University Press.

The author's primary thesis is that explaining suffering and integrating it into a given belief system is the greatest challenge to all of the religious belief systems in the world. Suffering challenges the believer who needs and wants to have an all-powerful deity or higher power and one who, at the same time, is all powerful. All religions spend a great deal of effort explaining how suffering can exist in this context. This is a very dense and

challenging book, but one that explores in depth a central challenge and desired outcomes for professional chaplains.

Kuhn, T. (1962). *The Structure of Scientific Revolutions*. **Chicago, IL: University of Chicago Press.**

"Paradigm shift" is a vastly overused and misunderstood concept. Long ago, Thomas Kuhn gave us the classic text that explains in clear language how ideas and paradigms change in a scientific environment like the one we all live in. This text will help anyone understand how and why change happens and why it does not happen.

Articles

The articles below describe different aspects of the science of pastoral care today including evidence for its efficacy, methods, demonstration of need and delivery models.

VandeCreek, L., & Burton, L. (2001). Professional Chaplaincy: Its Role and Importance in Healthcare. *Journal of Pastoral Care & Counseling, 55(1)*, 81-98.

Summary

This paper describes the role and significance of spiritual care and is the first joint statement on this subject prepared by five of the major healthcare chaplaincy organizations in North America representing over 10,000 members. As a consensus paper, it represents the perspectives of these bodies on the spiritual care they provide for the benefit of individuals, healthcare organizations and communities. Throughout this paper, *spirituality* is inclusive of *religion; spiritual care* includes *pastoral care.*

[Click to read the articles](#)

Comment

This article, known in professional chaplaincy as the "White Paper' remains the only official description of professional chaplaincy ever authored by the profession, itself. While now in need of updating, it remains an essential teaching tool to help explain to health care administrators and others what professional chaplains do and how they are trained. It should be read by any administrator who supervises pastoral care or is thinking about starting pastoral care services.

Iler, W., Obershain, D., & Camac, M., (2001). The Impact of Daily Visits from Chaplains on Patients with Chronic Obstructive Pulmonary Disease (COPD): A Pilot Study. *Chaplaincy Today, 17 (1)*, 5-11.

Summary

This study presents empirical data showing the relationship between daily visits from the chaplain and several variables including anxiety, length of stay, and willingness to recommend the hospital to others. Generally, the chaplain visits seemed to influence these variables in desirable directions when compared to a group of patients who did not receive a visit from a chaplain. In sum, this study demonstrates qualitatively some possible benefits of visits from a chaplain.

Comment

The article is unique on several fronts. First, it is arguably the only published example of a controlled trial of chaplaincy interventions that demonstrates how pastoral care visits can affect some significant outcomes, including anxiety and length of stay. Further, the outcomes are demonstrated without resorting to a rigid protocol of interventions suggesting that it is only necessary for a chaplain to "do their thing" in order to get results. Second, this is a testament to the fact that a single chaplain, alone in a community hospital, without a lot of support, can plan, carry out and publish significant research.

Wintz, S, Outcome Oriented Chaplaincy- An Overview

Summary

In her Power Point Presentation, Sue Wintz, one of the principle trainers in Outcome Oriented Chaplaincy (The Discipline), presents a set of training slides that spell out in some detail the steps in actualizing the practice of OOC. Included are two extended case examples, suggestions for interacting with the multidisciplinary team and hints for "getting going." Wintz's intent is to give a starting point for individual chaplains or groups who wish to adopt some variant of this system.

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Comment

Sue Wintz is the most experienced trainer in Outcome Oriented Chaplaincy active today. She outlines a very logical and clear process for adopting this method. An essential caveat to bear in mind is that this system does not need to be swallowed whole. That is, it is not essential to know it completely before beginning to use it. The experience of others is that the best way is simply to start and work into the system through periodic case review.

Fitchett, G., et al. (2004). Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients. *International Journal of Psychiatry in Medicine. 34(2)*, 179-196.

Summary

The aim of this study was to examine the prevalence of religious struggle in three groups of medical patients- diabetic outpatients, congestive heart failure outpatients and oncology inpatients. Half of the total sample reported no religious struggle, while 15% reported moderate or high levels. Younger patients, CHF patients, and patients with positive religious coping tended to have higher levels of religious struggle. Religious struggle was also associated with emotional distress in all groups.

Comment

As chaplains begin to contemplate outcomes for chaplaincy, one of the first questions is, Which outcome? Certainly, some of the frequently used outcomes like patient satisfaction apply. However, what outcomes are unique to pastoral care? George Fitchett and his group present us with "religious struggle," which is roughly defined as the combination of heavy reliance on religious coping resources and failure of those resources to function in a given situation. Their paper begins to explore the prevalence of this issue in several medical populations.

Fitchett, G., & Risk, J. Screening for Spiritual Risk. *Journal of Pastoral Care & Counseling. In Press.*

Summary

For years George Fitchett has been the leading authority on spiritual assessment and screening. The article describes a brief screening protocol for use identifying patients who may be experiencing religious/spiritual struggle, as well as patients who would like a visit from a chaplain. They describe the results of a pilot study in which non-chaplain healthcare colleagues administered the screening protocol to patients on admission. The protocol identified 7% of the patients as possibly experiencing struggle. The protocol generated a very low rate of false positives and a somewhat higher rater of false negatives.

Comment

Increasingly, pastoral care in healthcare settings is focused on need for care rather than desire for care. For chaplains to demonstrate outcomes that contribute to healing, they have to demonstrate need. Until now, there has been no screening protocol for pastoral care. The screening protocol from Fitchett and colleagues provides an extremely simple, effective and easily taught method to identify patients with religious struggle. It can easily be inserted into any nursing or admitting assessment.

Balboni, T. A. et al. (2007). Religiousness and Spiritual Support among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life. *Journal of Clinical Oncology, 25(5)*, 555-560.

Summary

In a sample of 230 advanced cancer patients, 88% considered religion to be a least somewhat important in their coping. Nearly half (47%) reported that their spiritual needs

were minimally or not at all supported by the religious community, and 72% reported that their spiritual needs were supported minimally or not at all by the medical system. Spiritual support by religious communities or the medical system was significantly associated with patient quality of life (p=.0003).

Comment

In building the case to administrators and others that tending to spiritual and religious need is not just a nice thing to do but a necessary part of holistic care, it is essential to demonstrate need. This well documented study by a highly reputable team of researchers demonstrates that religious/spiritual needs are central to the coping of this population and that those needs are not being met- even by the religious community. Thus, this study provides crucial evidence for the presence of professional chaplains.

Handzo, G., & Koenig, H. (2004). "Spiritual care: whose job is it anyway?" *Southern Medical Journal, 97(12)*, 1242-1244.

Summary

The authors, a chaplain and a physician, respectively, set out a description of the relative roles of chaplains and physicians in providing spiritual care. The physician's role is defined as the spiritual care specialist whose job is to screen for spiritual/religious need and attend to those that may be within the physician's training. The chaplain's role is defined as the spiritual care specialists, whom like all other specialists in the medical system, is tasked to respond to referrals in cases where religious/spiritual need is considered significant.

[Click to read the Article](#)

Comment

One of the major questions for professional pastoral care is how its role interrelates with, but is different from, the roles of other professions. Significant concern exists in the pastoral care community that other disciplines are hijacking the role of chaplain. At the same time, it is acknowledged that all disciplines have some role in spiritual care. Using a generalist-specialist model familiar to every health care professional, this article clearly deals with some of the important issues in this area in a way that would apply to other disciplines as well.

Puchalski, C., Lunsford, B., Harris, M., & Miller, R. (2006).) Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model. *The Cancer Journal, 1295*, 398-416.

Summary

This article by an interdisciplinary team of care givers describes a system for spiritual care in which each member of the team has partial responsibility for that care. The role of each discipline is carefully documented in the context of a case study. A system for

taking a spiritual history is also described in detail along with barriers to providing spiritual care.

Comment

Dr. Puchalski continues to be one of the leading proponents of the inclusion of spiritual care in health care and the chaplain as the spiritual care professional. This article represents a well written and thorough example of how a health care team that includes a chaplain can work together to provide spiritual care to patients and families. The article would be an effective teaching tool for teams who are working to enhance their assessment and treatment of spiritual/religious issues.

Cadge, W., PhD, Freese, J., PhD, & Christakis, N. A., PhD. (2008). The Provision of Hospital Chaplaincy in the United States: A National Overview. *Southern Medical Journal, 101(6)*, 626-630.

Summary

This study investigates (1) the extent of chaplaincy service availability in US hospitals between 1980 and 2003; (2) the predictors of having chaplaincy services in 1993 and 2003; and (3) the change in the magnitude of these predictors between years. Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over that period. Hospital size, location and church affiliation were central factors influencing the presence of chaplaincy services.

Comment

Another question often asked chaplains advocating for pastoral care is what do others do? Cadge and her colleagues have given us a rough parameter to measure the market penetration of chaplaincy. While this is a helpful study representing new knowledge, please note the measurement question asked is somewhat non-specific and open to interpretation. Also, while the study measures the presence or absence of pastoral care, it cannot account for increase or decrease in the quantity or quality of pastoral care within a given institution. Therefore, one needs to be careful in describing what this data actually means.

Flannelly, K., Handzo, G., Smith, W., & Weaver, A. (2005). A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles. *The Journal of Pastoral Care & Counseling, 59(1-2),* 87-96.

Summary

A random sample of hospital administrators throughout the United States was surveyed about their views on the importance of eleven chaplain roles and functions. All eleven roles were considered relatively important, although administrators of hospitals that do not have pastoral care departments gave lower ratings, overall. Meeting the emotional needs of patients and relatives were seen as chaplains' most important roles, whereas

performing religious rituals and conducting religious services were seen as least important.

Comment

Again, as chaplains are choosing outcomes as part of their planning, they should be choosing outcomes that are consonant with the goals and objectives their administrators have for them. Too often, chaplains do not align their goals with the goals of their institutions and then wonder why they are not supported. This large random survey that elicited responses from all fifty states gives support to eleven roles for chaplains. Notably, emotional care of patients and families, particularly care of the dying, were endorsed as important by an overwhelming majority of administrators while religious services were not nearly as well supported.

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Critical Analysis
By Its Fruits: The Science of Health Care Chaplaincy

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The recommendations by Handzo and Wintz to assess chaplaincy outcomes are part of a larger endeavor by other health care professionals to evaluate the effects of their protocols and practices.[1] Handzo's own advocacy for outcome based chaplaincy is clearly connected to his ongoing support for social scientific research--and of scientific inquiry itself--as a means to the end of a better chaplaincy: "Science can work in the service of ministry, especially in the current era of healthcare in which numbers drive administrative decision making."[2] Along with the late Dr. Andrew Weaver, Handzo holds that scientific study of religion may reveal its practical bearings: "The effect of faith or religious practice on people's lives can be described by science, irrespective of one's faith claims."[3]

In its striving to measure the effects of chaplaincy, Handzo's endeavor bears a family resemblance to the earlier efforts of the American pragmatists to assess things religious by their fruits.[4] Their call for outcome based chaplaincy is commensurable with the

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[1] E.g., Paul Fenn and Alistair McGuire, "Valuation as measurement: an economist's approach to rendering health care outcomes commensurable," in *Health Outcomes: Biological, Social, and Economic Perspectives,* ed. Helen Macbeth (Oxford: Oxford University Press, 1996).

[2] George Handzo and Kevin Flannelly, **"**An Opportunity to Participate in Chaplaincy Research," *PlainViews* 2, no. 2 (1995). See also George Handzo, "Bridging diversity: President's address to the 2004 APC conference," *Chaplaincy Today* 20, no. 2 (2004): 31-35 and George Handzo, "Science and ministry: Confusion and reality," *Journal of HealthCare Chaplaincy* 12, no. 1, 2 (2002): 73-79.

[3] Andrew J. Weaver and George Handzo, "Research, Cancer, and God," *Lutheran Partners* 18, no. 4 (July/August 2002).

[4] William James, *The Variety of Religious Experience* (New York: Viking/Penguin Press, 1982); see also *A Pluralistic Universe* (Cambridge, MA: Harvard University Press, 1977) wherein James lays a rationale for the social scientific study of all religious beliefs and practices: "Let empiricism become associated with religion, as hitherto, through some misunderstanding, it has been associated with irreligion" (142).

broader pragmatic inquiry into the practical bearings of all ideas[5] and for the purposive nature of all inquiry.[6] That is, like those calling for structuring assessments of chaplaincy practices around the ways in which they achieve particular goals, these pragmatists also focused on the "so what" question of a variety of ideas and practices.

In *Pragmatic Theology: Negotiating the Intersection of an American Philosophy of Religion and Public Theology,* Victor Anderson describes the particularly religious bearings of American pragmatism.[7] Throughout this work, Anderson examines a wide variety of understandings for the ways in which religious belief may and must be translated into publically understandable, if not empirically verifiable, argument. In describing the Chicago School of Theology that held some sway in the 1920s and 30s,

Anderson asserts: "For these thinkers, in order for religion to be intelligible . . . the study of religion must be congruent with the criteria of intelligibility . . . operative in other fields of study."[8] In a like manner, proponents of outcome based chaplaincy maintain those outcomes must be intelligible to other health care professionals.

Again, Anderson notes the strong response of theologians such as H. Richard Niebuhr that, "[the Chicago School's] use of value in religion [its utility in securing human well-being and the justification of human values] was methodologically disastrous for theology. For the justification of theological claims proceeds as inferences from knowledge claims in other disciplines and not as an inference of religious insight or religious life itself."[9] In a like manner, there may be those who aver that the valuation of chaplaincy outcomes by any criteria outside the worldview of chaplains themselves may be beyond the pale of chaplaincy.

On the other hand, the work of practical theologians such as Johannes van der Ven,[10] and the ongoing research reported in *The Journal of Empirical Theology,*[11] exemplify how the effects of religious practices such as those of chaplains may be measured without violating their integrity or purposes.

Throughout his career as a neo-pragmatic philosopher, Richard J. Bernstein has proposed ways that social-scientific research may be reconceived so that it serves human needs;[12] ways to resolve tensions around the objectivity and relativity of such research;[13] and problems and possibilities of common meanings in differing human

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[5] See William James, "Pragmatism: Lecture Two," in *The Writings of William James: A Comprehensive Edition,* ed. John C. McDermott, (Chicago.: University of Chicago Press, 1977), 379, and Charles Sanders Peirce, "How to Make our Ideas Clear" in ed. James Hoopes, *Peirce on Signs: Writings on the Semiotic* (Chapel Hill: University of North Carolina Press, 1991), 169.

[6] John E. Smith, *Purpose and Thought: The Meaning of Pragmatism* (New Haven, CT: Yale University Press, 1978).

[7] Victor Anderson, *Pragmatic Theology: Negotiating the Intersection of an American Philosophy of Religion and Public Theology* (Albany: SUNY Press, 1999).

[8] Ibid., 59.

[9] Ibid., 84.

[10] E.g., Johannes van der Ven, *Practical Theology: An Empirical Approach* (Leuven, Belgium: Peeters, 1993).

[11] *The Journal of Empirical Theology* (Nijmegen, the Netherlands: Brill) at http: //www.brill.nl/jet.

[12] Richard J. Bernstein, *The Restructuring of Social and Political Theory* (Philadelphia: University of Pennsylvania Press, 1978).

[13] Richard J. Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis* (Philadelphia: University of Pennsylvania Press, 1983).

endeavors.[14] In *The Restructuring of Social and Political Theory,* Bernstein cites Max Weber's referencing Leo Tolstoy's question: "What is the meaning of science?"

> Tolstoy has given the simplest answer with the words: "Science is meaningless because it gives no answer to our question, the only question important for us, 'What shall we do and how shall we live?'"

That is to ask: can social scientific studies that measure the outcomes of chaplaincy answer questions about what practices chaplains should engage in and what protocols they should establish? Some may think not. However, the citation continues, "That science does not give an answer to this is indisputable. The only question that remains is the sense in which science gives 'no' answer, and whether or not science might yet be of some use to the one who puts the question correctly."[15]

The corpus of Bernstein's works suggest that there are, indeed, good ways to put science to use to help all persons--including health care professionals such as chaplains--discern what to do and how to orient themselves. Accordingly, there is reason to suggest that the enterprise of Handzo, Wintz--and others--to employ social scientific reasoning for the sake of profession of chaplaincy may produce good fruits.

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[14] Richard J. Bernstein, "Incommensurability and Otherness Revisited" in *The New Constellation: The Ethical-Political Horizons of Modernity/Post-Modernity* (Cambridge, MA: MIT Press, 1992).

[15] Max Weber, "Science as a Vocation," from *Max Weber: Essays in Sociology*, ed. H. H. Gerth and C. Wright Mills (New York: Oxford University Press, 1946), 143 in *The Restructuring of Social and Political Theory* (Philadelphia: University of Pennsylvania Press, 1978), 47.