

My Life As A Chaplain
Unitarian Universalist Fellowship of Montgomery, October 2, 2005
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This morning I am going to share with you some of my experiences as a chaplain resident last year at a hospital in Anderson, South Carolina. As it happens, I only had the opportunity to personally serve three Unitarian Universalists during my tenure, and in each case, the patient was stunned to learn that his or her chaplain was a UU. That's because there aren't many UUs in chaplaincy, though I am pleased that the number is going up.

We Unitarian Universalists aren't the kind of people who, by our personality or temperament, are inclined to call for our ministers in a medical emergency, let alone clergy from other faith groups. We tend to compartmentalize our lives, leaving to doctors what doctors do and to ministers what ministers do. According to one story, and this may not be true, a Catholic, a Jew and Unitarian Universalist were involved in an accident. As the medics went to each person, one called out, "I've got a Catholic here, go get a priest." Then another said, "This one is Jewish, go call a Rabbi." And finally, one medic cried out, "This guy is a Unitarian Universalist, somebody get a math teacher." As I said, that may not be true.

I want to take just a moment to explain in a little more detail the program I was in because it will also help you to understand more about how Unitarian-Universalists prepare women and men for ministry. All UU candidates for ministry are required to have 400 hours of experience working in an institutional setting as a chaplain. Most work in hospitals, but others work in retirement communities, prisons, the military and other settings.

In effect, it's a full-time job for 10 weeks which students pay the center for the privilege of doing. I met this requirement working over a summer break at Asbury Village, a continuing care retirement community outside of Washington with about 1500 residents, who ranged in status from independent living to skilled nursing.

Although not required by the UUA to become a minister, many candidates like me choose to do a year-long residency as a chaplain. It's not a perfect analogy, but it's like getting a bachelor's degree, or in my case, a seminary degree, and then choosing to study another year before taking on that first settled ministry.

This may be more than you need to know, but, I want you to know what I can and cannot do and what that means for our relationship. First, and perhaps most important, pastoral care with a small "p" is something we all do, or should be doing. Second, the kind of pastoral care in which I engage as your minister is not limited to hospital visitation. The intense training and experience I had over the past year, I hope, will show up in everything I do. It will show up in next week's sermon on Forgiveness. I hope after the New Year to engage in some adult programs for individuals and couples on the subject of family systems. UUs don't have a formal Marriage Encounter-type program as some other faith groups do. Still, I want to use my experiences to create something like that for our families here next spring. I want to get through the installation and then the holidays before I tackle something like that.

In addition to the hospital visits, I am expected to provide a certain level of counseling, and that's with a small "c" in contrast to what licensed psychologists or clinical social workers do. The general rule of thumb for ministers who are not trained therapists is that we should not see people more than three or four times before referring them to someone else. What I can do if you come to me as an individual, a couple or a

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family, is to help you get through a crisis period, let some of the steam out and de-escalate the tension, clarify the issues and help you find the right resources for continued help and then support you in that process.

Now, about hospital visits. I haven't had any here yet, and I suppose we all can be grateful that that need hasn't arisen. Yet, many of you have had hospital visits. I hear in Joys and Concerns and in the hallways after services that you have visited friends and family in hospitals and nursing homes. You may not naturally think to invite me on such visits, but I want to encourage you to do so. I remember one case I had in which a critical care patient who had been stable took a serious turn for the worst. The nurse called the patient's husband, who came right away. I greeted him and asked how I might help him, and his answer was to call his pastor, and then he gave me the pastor's name and number off the top of his head. That's my new gold-standard of pastoral care.

I may be able to help you feel more comfortable visiting others and the patient, particularly if she or he is more overtly religious than you, may appreciate my visit. More importantly, it is in such visits that we—you and I—form the kind of relationship that will help me minister to you when you are the one in need.

The vast majority of my experiences as a chaplain were positive. Most of the time, when people asked what church I was with, I said the hospital was my church and they let it go at that. I didn't say that out of any sense of embarrassment, but rather, to keep the conversation focused on the patient. Still, some persisted and I told them I was a Unitarian Universalist. Some shrugged, pretending to know when they had no clue what a UU was and others just said, Oh. I only had one patient, who happened to be Methodist minister, tell me—and these are his exact words—"I can help you to get over that."

I prayed with patients about a dozen times a day. Contrary to my training and what my colleagues did, I did not routinely ask people if they wanted to pray. I would look around for religious books or objects and listen for religious language to get a sense if the question might be welcome, which in fact was true on most of my visits.

I did not always begin my prayers with an invocation. Sometimes I would say, let us pray, and, after a moment of silence, simply start. One of things that caught me off guard at the beginning was the posture for prayer many assumed. When I begin a prayer, I typically put my head down and I may or may not fold my hands. For a lot of Baptists, Holiness and Pentecostals, the first thing they do is hold hands and form a circle and then one or more of them just starts talking to Jesus. When you're not used to that, it kinda throws you off stride.

When I used an invocation, I used God or Eternal Spirit. Of course, my image of God was significantly different than most of my patients. For me, invoking God is a way of closing out the outside world and, if I am alone, to enter into a time of reflection, or if I am praying with someone, to enter into a relationship with that person. I could do the same thing by ringing a bell or chanting OM. I chose to use God to create this spiritual boundary because that usually was the language of the person I was trying to help. I personally don't think I am praying "to" anything. I think of prayers as spiritual affirmations, things I say to build up my own courage or those with whom I am praying. So, my prayers have a lot of lines like, "Let us be grateful today for our family and friends. We pray that their love may be part of our healing strength." "We pray today for the courage to get through these difficult times." If I'm praying with a family for a non-

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responsive patient, I might say, “Let the love in this room guide us in our care for (insert name).”

Notice that these prayers invoke inner resources, which I believe are divine, rather than petition an external deity. When people specifically asked me to pray to Jesus Christ, I left off the last part and no one noticed. I have no trouble invoking the historical Jesus, as in, “Let us have the courage to forgive others as Jesus forgave his enemies.” Or “We pray that we may show the compassion to all who are suffering that Jesus showed.”

Instead of ending prayers with, In Jesus Christ’s name we pray, I always ended my prayers with Amen or Blessed Be, and no one ever noticed or complained. Some may feel that I was being dishonest or at least disingenuous with my patients. This misses two points. First, it’s not about me. Second, it’s not about the words. It’s about being present with people.

I’d like to pick up on that phrase “being present with people” because what I learned as a Chaplain that will be the most important to you in your daily lives—not just visiting people in hospitals—is how important it is, and how hard it is, to be with people where they are.

Our natural tendency with people in emotional or physical distress is to want to cheer them up, to give them hope, and to encourage them in whatever struggle they may be engaging. Now, please don’t take the following suggestions as all or nothing. There is a time and a place when it’s important to try to give people hope and encouragement. However, there also is a time and a place when we must try with our actions, our words, and our affect or emotions, to let people know that is OK to be angry or bitter or in pain.

I had a lot of patients who were experiencing pain, some fear and maybe anxiety - - plus whatever medications they were taking -- who shared with me how difficult it was when their family and friends burst into their rooms with flowers and balloons and candy expecting them to put on a big happy face. You can understand why that would be difficult for a lot of patients. What I’m saying now probably makes sense to most of you. What I want you to take away from this, though, is that we all sometimes give similar well-meaning but misplaced responses to people who may be going through really tough times at work, with a family member, or any variety of their own personal challenges. I’m sure everybody here can recognize what I’m saying because most of us have been on both ends of this—we do this to other people and others have done it to us.

This is a topic that I’ll return to from time to time. For today, I want to share what I learned as a chaplain that may help us to give a more appropriate response to people in pain—physical, spiritual or emotional. So, as I talk about patients, I want you to think not only of people you may be visiting in the hospital, but also about a partner, a child, a sibling or a friend who may be going through a difficult time.

As I said, our natural inclination is to try to raise a patient’s spirits and give her or him hope. We do that in part because that’s a good thing to want for anyone but also because we’re scared to death ourselves of going down into the depths of despair or fear or anger that a patient may be experiencing. Nobody wants to do that, including chaplains. As part of my training, though, I would sit around a table with four other residents discussing how we handled some of our visits. The most common critique we gave each other was that the other person really was just trying to avoid his or her own pain by trying to fix the patient’s problem.

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What does fixing a patient's problem sound like? Let's be grateful that you survived; I know you can get through this; we'll get through this together; I love you.

There's nothing inherently wrong with saying "I love you." Again, this is not an all or nothing thing. However, think for a moment about how these responses are different in substance and tone: I'm scared, too. You must be angry that your company won't give you any more time off. You must be very disappointed and hurt that your sister did not come to visit you.

The fallacy that we all fall prey to at times is thinking that naming something makes it worse, that saying "I'm scared, too" will increase the patient's anxiety. The reality is that that anxiety already is there, and saying it out loud releases it. There's a difference, too, between affirming someone's feelings and agreeing with what they are saying. Imagine a patient saying, "I'm really disappointed that my brother hasn't called me." To respond, "Your brother really is being insensitive" is to agree with the statement. To say, "It must really hurt to feel that your brother doesn't care for you." Is to affirm what the patient is feeling and gets down there and sits in that pain with the patient.

Well, I could go on and on giving you suggested responses. For today, though, here is a brief summary of what I learned as a chaplain. There is no perfect response. When in doubt, just be present and be silent. Never underestimate the power of touch, the touch on the hands or the cheek, the stroking of the arms or hair. And always remember, there is a difference between affirming people's feelings and agreeing with what they are saying.

This is hard stuff. I still come home from visits thinking I should have said something different. Every one of you has had experiences—some better than others—responding to people in need. From those experiences you have your own database of wisdom from which each of us can grow and learn. As a new minister, I want to affirm how important your collective wisdom is for my ministry. I also humbly suggest that I have some training and experiences that may help you help yourself or others. So, let's do this together. Let's help each other to help each other.

I said last week that Unitarian Universalism is about love, and not about doctrine. Doctrine is easy—you're told what to memorize and regurgitate and that's that. But loving each other is hard. That requires as much work from you as from me. There is no one here, though, who is not worth the effort.

May it always be so. Blessed Be.