Secretary of Education through the Department of Education. Such recognition enables the ACPE, Inc., and/or its programs and students to participate in federal programs such as the International Student Visitor Program, the veterans' educational benefits program, Medicare Pass-Through reimbursement funding, and in some cases the federal student loan deferment program. Recognition by the U.S. Department of Education requires regular and rigorous review of the agency and its standards and processes for accreditation.

10. P.A. Clark, M. Drain, and M.P. Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal on Quality and Safety* 29, no. 12 (2003): 662.

11. National Hospice and Palliative Care Organization, *Guidelines for Spiritual Care in Hospice*, 5.

12. T.P. Daaleman and L. VandeCreek, "Placing Religion and Spirituality in End-of-Life Care," *Journal of the American Medical Association* 284 (2000): 2515.

13. Other important centers of research on quality in pastoral care include the Department of Religion, Health and Human Values at Rush University Medical Center, the Department of Pastoral Care and Education of the University of Pennsylvania Health System, and the Department of Chaplain Services at the Mayo Clinic.

14. A.J. Weaver, K.J. Flannelly, and C. Liu, "Chaplaincy Research: Its Value, Its Quality and Its Future," *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 16.

Ethical Grounding for a Profession of Hospital Chaplaincy

BY MARGARET E. MOHRMANN

Hospital chaplains do not have a monopoly on the spiritual care of patients, just as teachers do not have a monopoly on teaching. Spiritual care of the ill and dying—compassionate and thoughtful attention to a patient's explanations of suffering, yearnings for transcendence, constructions of meaning, expressions of faith or loss of it, reliance on prayer or ritual, bafflement, fear, hope, or any of the many other possible manifestations of spirituality in crisis—has long been within the domain of good nurses and good doctors. Nevertheless, spiritual care is the primary and arguably the sole focus of chaplains' work, and just as we recognize a teaching profession even though "nonprofessionals" also teach, we can justifiably recognize hospital chaplaincy as a profession that specializes in spiritual care of patients—and then turn to the task of specifying the defining criteria for the profession, including its ethical grounding and governing tenets.

As chaplains acknowledge, physicians, nurses, and other clinicians may—and often do—offer patients "spiritual" care that attends to the deep questions of meaning, purpose, and connection to others that arise during a serious illness. (Although some patients may frame their questions in religious terms, it should be noted that "religious" is not a synonym for "spiritual," but rather describes a sizable subset within the category of the spiritual.) The difference between chaplains and other clinicians is that chaplains are specialists in spiritual care; it is what they do, rather than part of what they do.

Chaplains tend to distinguish themselves and their work from clinicians who also offer spiritual care by referring to what they do as "pastoral" care. But for this distinction to represent a salient difference, it will have to be explained. One way of understanding the distinction would be to regard spiritual care as only vaguely or incidentally (if not tendentiously) religious, whereas pastoral care hones in on the specific religiousness of the patient. This understanding would highlight a potential difficulty lurking for an avowedly "interfaith" profession in its use of the term "pastoral," a word closely tied to the Christian tradition's fondness for shepherd imagery.

Alternatively, is the spiritual care provided by clinicians a form of screening only, perhaps with some empathic connection added, and are chaplains then the professionals equipped to take the conversation further, into realms of assessment and some analogous sort of therapy? Adept practitioners of ancient moral philosophies, such as Stoicism and Epicureanism, understood and often referred to their teaching as therapy. They seem to have considered their therapeutic task to be identification (diagnosis) of the student/patient's specific "disease"—his particular erring thoughts and bad habits—followed by provision of appropriate bracing, life-altering theories and methods intended to redirect and heal the supplicant.[1] If chaplaincy seeks to be something more or other than a form of palliation, then an analysis of the ways in which the practice is and is not intended to be therapeutic may be useful for elucidating professional goals and methods. It is also the case that a language of therapy will affect, for good and for ill, the communication bridge of translation and interpretation that is sometimes necessary when justifying the presence of clerical professionals within a secular health care institution.

Thus, one fundamental challenge for the nascent profession of chaplaincy is to assert that which not only defines but also distinguishes the kind of care provided by trained and

Margaret E. Mohrmann, "Ethical Grounding for a Profession of Hospital Chaplaincy," *Hastings Center Report* 38, no. 6 (2008): 18-23.

certified chaplains. Theologian John Cobb's admonition is relevant here:

> The pastor's task is to be present with and to "hear" the sufferer, to let the parishioner know that expressing fear, anger, and loneliness is acceptable. I do not dispute the validity of this approach, which in many cases is no doubt the best one possible.
>
> The question of why can be appropriately understood and dealt with psychologically, but to treat it only that way fails to take the questioner with full seriousness as a human being. A pastor who has not reflected about the question, who has nothing to say, has a truncated ministry.[2]

Cobb is referring here to a clergyperson's response to a parishioner asking difficult questions about God in the face of suffering—questions also likely to be encountered by hospital chaplains. He distinguishes between psychologically significant methods of presence and acceptance and the more specifically pastoral task of reflective response to the questions themselves. He thereby provides a way of expressing the distinction between, on the one hand, the "spiritual" care that may also be offered by other clinicians, and on the other, chaplains' professional "pastoral" care. The implication is that chaplains' claim to offer "pastoral" care entails an obligation to provide care with substantive content, reflecting their professional education and training—care that includes but goes beyond the comfort of a listening ear.

Chaplains are obligated to provide care with substantive content, reflecting their professional education and training—care that includes but goes beyond the comfort of a listening ear.

Defining what hospital chaplains do—and whether "pastoral" is an appropriate adjective for the sort of care they give—is one fundamental task inherent in becoming a recognized profession. The move toward "professionalizing" also brings with it the need for professional ethics. This requirement raises not only the question of what the specific ethical tenets of chaplaincy are or should be, but also a more basic question about what constitutes its theoretical grounding: How and on what basis should professional ethics for hospital chaplaincy be conceptualized? In what follows, I consider a few approaches to answering this basic question, none of which is likely to be the winning response and each of which likely should have a place in a fully formulated chaplaincy ethic.

Chaplaincy Ethics as a Form of Medical Ethics

Is a professional ethic for hospital chaplaincy better understood as a theological-religious ethic for a particular kind of health care professional, or as a health care ethic for a particular kind of theological-religious-pastoral professional? The multiple alternative terms employed in that question point out a complication attributable to the interfaith designation of chaplaincy. The interfaith commitment constrains any reliance by the profession on the settled ethical frameworks of specific religious traditions and suggests that chaplaincy must look beyond the religious stances of its practitioners to consider how the practice itself, located in and defined by the provision of medical care, shapes and even determines the profession's ethical obligations.

This issue, however, brings up a significant distinction between chaplains and other health care professionals. Doctors, nurses, pharmacists, and respiratory therapists are each part of a single profession. Nurses, with rare exceptions, are nurses only; the nursing profession is their one source of *professional* obligation. Hospital chaplains, on the other hand, are members of two professions: They are ordained or otherwise officially recognized as trained leaders by their faith traditions (a requirement for board certification as a hospital chaplain), and are thus members of the clerical profession. They are also members of this newly forming profession of hospital chaplaincy, which is seeking to establish itself as something other than a variant wholly subsumed within the clergy. Hospital chaplains then have differing, and potentially conflicting, moral obligations entailed by their adherence to two relatively distinct professions—an issue I explore further only after setting out ways in which chaplaincy ethics and medical ethics may coincide.

What are the similarities between the ethics characteristic of faith traditions and the professional ethical understandings that govern nurses, physicians, and clinical therapists of various sorts? Clearly each formulation is identifiably *ethics*, since each is concerned with, among other things, how we conduct ourselves, interact with one another, and care for those dependent on us. When situated within the health care setting, each insists on the primacy of the patient. Medical ethics tends to ground the patient's central status in general principles of respect for persons and in more specific, relationship-generated obligations of care for others' well-being. Theological or religious ethics tends to base similar principles and

obligations on claims about common humanity, with or without reference to a creator-god, and on (divine) injunctions to love others. But the two ethical frameworks are agreed on much that might be called an ethic of caring for patients, the practice that forms the large area of overlap in the work of these professions.

Another way in which these versions of professional ethics, and others, are similar is in the matter of multiple fidelity commitments. Both clinicians and chaplains have personal obligations—to self, family, and friends—that at times rival the call to attend to patients. Chaplains and health care professionals alike have moral obligations toward the institution of which they are a part, and these, too, may at times conflict with other professional commitments.

But obligations *within* each profession may also conflict. Physicians may find that their commitment to the care of a patient conflicts with important duties to train future doctors or to carry out research likely to be of benefit to others. Good and compelling imperatives to educate and to create new knowledge do not simply fade away upon hearing of the primacy of the patient's need. Part of a physician's professional ethical obligation is to find the morally appropriate balance among his or her commitments in each situation. Chaplains, too, have obligations to their profession of chaplaincy—including the education of future practitioners—that may on occasion interfere with optimal care of the patient. Both clinical and clerical professionals find themselves in the position of deciding between the need of the trainee to gain experience and the need of the patient for the most experienced caregiver. It does not help either profession to have a code of ethics that speaks only of the primacy of the patient without regard to how this necessary balance is to be recognized and managed morally.

Some health care professionals struggle with whether their work is or should be governed primarily by the ethical codes of their profession or by their "personal" ethic, which is often based on religious beliefs. Current controversies surrounding conscientious objection to providing certain legal medical treatments indicate that professional ethical assertions and practitioner behaviors do not track together in every instance.

However, this marks a point at which the problem of multiple fidelity commitments diverges for chaplains, whose position within two professions complicates the issue further. Regardless of the interfaith aspirations and intentions of the profession of chaplaincy, its practitioners are situated—not only by personal belief, but by prior training and professional initiation—within a specific faith tradition that compels their allegiance. The conflict between chaplains' professional obligations to patients and their professional obligations to their own faith tradition is not equivalent to the conflict of professional and personal ethics characteristic of clinician dilemmas. For clinicians, there are arguments available to justify the primacy of the professional commitment or, on the other hand, to recognize exceptions to that primacy. For the chaplain, however, who or what adjudicates between commitments to two professional codes? How should a chaplain—who upon entering a tradition-specific clerical profession promised to witness faithfully and overtly to the existence of God, understood in specific, tradition-determined ways—balance that professional obligation with what appear to be generally accepted obligations of interfaith chaplaincy not to so witness to one's patients?[3]

I have no doubt that most, if not all, chaplains and hospital teaching programs have managed to resolve this potential conflict. If they have not, they are not likely to be serving as chaplains or surviving as programs. My point is not that the conflicts are unresolvable, but that this matter of dual professional allegiances must be explicitly considered when drawing up a professional ethic for hospital chaplains, in terms of what is being asked of those who profess chaplaincy in relation to their other professional commitments, and in terms of what constitutes an authentic description of chaplaincy ethics.

This fundamental question about the various moral responsibilities of chaplains raises a related question—to whom are chaplains responsible?—and leads us to consider a second way of conceptualizing the ethics of hospital chaplaincy.

Chaplaincy Ethics as an Ethic of Accountability

Whatever the relation of chaplaincy ethics to medical ethics (or, for that matter, to business ethics, which seems to have more to do with medicine than ever before), there is a real need for a shared ethical language within the health care enterprise. The best candidate for a common idiom is likely to be some version of the language of responsibility, of accountability. An ethic of accountability for a profession entails that the profession should be able to give an account of:

> 1) what its professionals do—which requires criteria that define the field and distinguish it from others;
>
> 2) whether they do it well, and how—which requires modes of evaluation, requiring explicit descriptions of what counts as "doing it well" that can serve as the profession's standards of quality; and
>
> 3) whether they could do it better, and how—which requires mechanisms for enforcement of standards and improvement of quality.

Thus, for the nascent profession of hospital chaplaincy, the moral requirement of accountability encompasses both an obligation to set standards of practice (and then to monitor and enforce them) and an obligation to participate in efforts directed at quality improvement.

The focus on accountability does not remove but may help us maneuver the chaplain's conflicting fidelity commitments. It seems clear that, for chaplaincy as well as for medicine, accountability is most particularly owed to patients. Even if patients are not the ones to whom chaplains must give their account, they are nevertheless the ones to whom and for whom chaplains are responsible, and the ones whose vulnerability

demands high standards of professional activity and constant efforts toward higher quality work.

This matter of setting standards, monitoring and enforcing them, and working to improve the quality of chaplain interventions generates consternation and resistance in some chaplains, who understandably find it difficult to imagine ways of categorizing and judging their work that do not outrageously distort it. It is one thing to measure the prompt delivery of accurate doses of appropriate medications, quite another to gauge the quality or the effect of a chaplain's discussion of spiritual matters at the bedside—and the unmodified imposition of methods used for assessing the former may well not do justice to the latter.

On the other hand, programs for clinical pastoral education (CPE) have long considered themselves able to make judgments about their trainees on the basis of such nonquantifiable characteristics as their "presence" with patients, responsiveness to the needs and views of patients and colleagues, willingness to change and grow within their work, ability to refrain from preaching to patients or staff, and some degree of adherence to the interfaith commitments of chaplaincy. There are processes already in place for professional board certification of hospital chaplains and supervisors of chaplaincy training, and for accreditation of CPE programs. In other words, standards of practice for hospital chaplains clearly exist, even if they need some modification. These standards can be evaluated, codified, and adopted, and they can then form the basis for trajectories of quality improvement.

Chaplains should be candid about what they do that can be done as well by someone else, what they generally do better than others, and what can be done well only by them.

That said, an ethic of accountability would press the profession of chaplaincy to ask itself, What else? Beyond these traits that make for a good chaplain at the bedside—openness and responsiveness, perhaps also gentleness, calm, and an aversion to preaching—what else may be the responsibility of chaplains in a health care setting? There is certainly the issue, revealed by Cobb's injunction to pastors, of some yet-to-be-delineated obligation to provide care with substantive content. But aside from these aspects of direct bedside interaction, what are the moral implications for the profession of the fact that chaplains' work happens in a hospital, or hospice, or other setting in which medical care is being delivered?

Chaplain and theological educator Martha Jacobs has said that chaplains, rather than espousing theology, should be asking the kinds of questions that theology raises. Her cogent claim brings to mind Paul Tillich's expansive definition of a theologian as not necessarily a theist, a believer, but as someone whose primary focus is on matters of ultimate concern. The kinds of questions theology raises are about matters of ultimate concern, and I would argue that medicine needs often to be reminded that such matters are always present in the work of health care, whether recognized or not, whether couched in transcendent language or not. Chaplains bear responsibility not for answering or solving them, but for keeping them visible, recognized, no longer ignored.

Sociologist Daniel Chambliss has identified the hospital as a site of thorough-going routinization, one important consequence of which is that moral issues often go unnoticed. He writes, "The great ethical danger, I think, is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing a decision at all."[4]

The same may be said of recognizing and responding to spiritual issues in the health care setting. Such issues pervade serious illness, childbirth, disability, dying, and the difficult decisions that so often attend them, and they are indeed matters of ultimate concern for most people, regardless of their religious affiliation or belief. In the midst of the routines of the setting, health care professionals and even patients may fail to recognize that questions of lasting spiritual significance are at stake in daily, recurring, predictable events that typify the hospital. Chaplains are the professionals obligated to respond to these questions when they arise, but they are also responsible for seeing that the issues are noticed in the first place and then taken seriously. The fact that the work of health care is shot through with spiritual significance, for recipients and providers alike, needs to be held up to the light daily, spoken of openly, acknowledged, wrestled with, celebrated, and mourned—and this is surely the responsibility of the chaplains, the "spiritual professionals" in the hospital.

Philosopher Margaret Urban Walker asserts that ethicists in the health care setting should be regarded less as expert engineers, offering technical problem-solving approaches to moral dilemmas, than as skilled architects, creating "moral space" within which those who work with the sick and the dying can freely air both their certainties and their bafflement, and discern together ways of proceeding morally in the face of irreducible ambiguities and conflicting commitments.[5] The development of such spaces—locations and opportunities within the hospital for interprofessional conversations about what matters morally—can potentially convert the entire enterprise into one truly moral space in which the inevitable

ethical dilemmas of medicine are consistently acknowledged and are dealt with inclusively, early, and well.

Taking Walker's lead, I suggest that chaplains see themselves as professionals responsible for creating "sacred space" within the hospital, space in which it can be openly acknowledged that holy things are happening, things that are "set apart"—the fundamental meaning of "holy"—things that matter spiritually to everyone involved. A hospital chapel is only the most obvious example of sacred space (although the effect of its existence on the institution's self-understanding should not be underestimated or, for that matter, overvalued). Patients' bedrooms and family waiting rooms surely also qualify, but we need to be reminded of that. And we look to chaplains to denominate even more spaces as sacred—operating rooms, nurses' stations, clinics—by taking them seriously as places where important spiritual transactions are occurring and by calling the rest of us to do likewise. The ultimate goal would be recognition, by the institution as a whole, that the entire health care enterprise—now including board rooms, kitchens, record rooms, and communication centers as well—is sacred space, full of infinite meaning.

A commitment to reclaim the sacredness of the place where human suffering, frailty, and hope come for help, and where help of various kinds and efficacy is provided, may entail a further commitment for chaplains to be courageous participants in and critics of their hospital's organizational structures and ethics—to be an effective voice at the table where the decisions about space, money, and their uses are being made. Might this also be a standard for chaplaincy practice, a measure of quality that can be improved?

Whatever the answer to that question, the idea of sacred space puts the accountability of the chaplain squarely within the "pastoral" aspect of the profession that distinguishes it from other professions engaged in the care of the sick and dying. Therefore, it is time to turn to a model for ethics that may seem to be most surely suited to the work of chaplains as the ministers they are.

Chaplaincy Ethics as an Ethic of Ministry

To minister is to serve; an ethic of ministry is, therefore, an ethic of service. Although "ministry," like "pastoral," is a term that bears the weight of one particular religious tradition, it is nevertheless a word that chaplains of all faiths can claim as an appropriate tag for the patient-centered services they offer. In what follows, "ministry" could be replaced with "service" and "minister" with "servant," but the latter term brings its own baggage—some of which plays into problems with ministry/service discussed below. Like the other approaches explored in this essay, an ethic of ministry keeps the needs of the patient—the one being served—at the forefront. And, like an ethic of accountability, it also diminishes, without eliminating, the strength of moral obligations that do not directly involve the patient's welfare.

A ministerial ethic may seem the most "natural" candidate for a professional ethic for chaplaincy, but there are problems with it that require the corrective lenses of other ethical approaches, especially that of justice. I have already alluded to the difficulty entailed by the profession's interfaith designation as it limits chaplaincy's ability to call on the ethical understandings of specific religious traditions—which are, however, likely to be the source for individual chaplains' senses of their ethics of ministry. In addition, perhaps the most important thing to be said about any ethic of ministry is that it is potentially dangerous, both to the servant and the served.

There are apt lessons in this regard to be found within the decades-long debate over the feminist "ethic of care." The correctives offered by more recent entries in that discussion highlight two salient dangers for ethical frameworks centered on caring, and both dangers seem equally applicable to an ethic centered on ministry. The first concern has to do with the power of the servant over the served, a sort of "imperialism of empathy" in which the actual needs and desires of the one cared for may be ignored or overwhelmed by the caregiver's interpretation of what service is called for. For example, the depth and seriousness of a patient's questions about personal responsibility in relation to illness may be swept aside by a chaplain's certainty that self-blame is spiritually toxic; a patient's desire to prepare spiritually for death may be overridden by a chaplain whose focus is on healing and hope for an earthly future. In those who choose to care for others, the rescue impulse is often quite strong and can distract attention from what is actually going on in an encounter. In the context of medical care, where the vulnerability of patients and the dominance of caregivers is already manifest and largely inescapable, a responsible ethic of ministry will include safeguards—or, at least, warnings—against a well-intentioned but powerful and potentially heedless urge to help.

The second concern arising from consideration of an ethic of care can be construed as the reverse of the first. Without clear boundaries in place, it is possible for the needs of the one cared for to take precedence over any needs of the caregiver—for the served to so dominate the servant that ministry becomes a form of bondage. Persons, including chaplains, who are involved in the direct care of the sick are vulnerable, for example, to the patient who claims to derive comfort from the ministrations of only one particular caregiver, engendering in that clinician a feeling of obligation that may keep him or her in the hospital well beyond reasonable work hours. As mentioned previously, the work of health care is characterized by conflicts among fidelity commitments for all its various professionals. Physicians, nurses, and chaplains alike are pulled simultaneously by their obligations to patients, to the hospital, to their trainees, to their colleagues, and to the creation of new knowledge. They also experience conflicts between these multiple work-related duties and the duties of their nonprofessional lives—their commitments to self, family, and friends. A responsible ethic of ministry will include explicit attention to the chaplain's welfare and the limits of the work's demands.[6]

This matter of setting limits also raises the issue of professional boundaries, already mentioned in terms of the profession's need to distinguish the care it gives from the sort of spir-

itual care offered by other health care providers. To clarify and promote recognition of such boundaries, chaplains should be candid about what they do that can be done by someone else as well as it is done by chaplains, what they do that is generally done better by chaplains, and what they do that can be done well only by chaplains. Further, chaplains must consider what should not be done by chaplains. For example, it is not unusual for an experienced chaplain, well versed in the language and practices of the hospital, to act as the interpreter of unintelligible or minimalist medical explanations to patients and families. Is this an appropriate role? Are chaplains trained to carry out this task—and should they be? Should it be a standard of practice?

There are other questions, of similar practical relevance, that should be asked: Should chaplains serve as cultural brokers? As mediators and conflict resolution facilitators? The process of defining chaplaincy as a profession calls for setting limits, even if broad, on what counts as appropriate professional work for chaplains. Setting these limits must precede the establishment of standards for the performance of that work, and it can only then be followed by consideration of quality improvement.

There are obviously more questions than answers in this discussion, questions that are rightly answered only by the chaplains forming this profession. However, it does seem that any professional ethic for chaplaincy must contain a thoughtful consideration and explanation of the particular ethical obligations entailed by the health care context of chaplaincy, not only because of the central status and vulnerability of patients, but also because of the intensity of commitment and the confusion that characterize the work of health care providers. It must include careful attention to the demands, dangers, and limitations inherent in a moral practice of ministry, justifying the practice and safeguarding both the practitioners and their patients. And it must delineate and justify the responsibilities of chaplains, transforming their multiple lines of accountability into an ethical framework for chaplaincy as responsible health care ministry.

1. M.N. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton, N.J.: Princeton University Press, 1994).

2. J.B. Cobb, Jr., "The Problem of Evil and the Task of Ministry," in *Encountering Evil: Live Options in Theodicy*, second ed., ed. S.T. Davis (Louisville, Ky.: Westminster John Knox Press, 2001), 181.

3. There are now interfaith seminaries in the United States, some of whose students enroll in order to become hospital chaplains. It remains to be seen whether the educational content of their professional vocational preparation is sufficiently robust to constitute its own tradition, especially if "interfaith" includes both theist and nontheist faiths, and to engender allegiances that produce the sorts of conflicts I refer to here. That is, the hypothetical conflict of a deeply theist chaplain asked to avoid talk of God with a nonreligious patient could be mirrored in that of a thoroughly "interfaith" chaplain confronted by a deeply traditionally religious patient who desires specific practices and references to a very particular God.

4. D.F. Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago, Ill.: University of Chicago Press, 1996), 59.

5. M.U. Walker, "Keeping Moral Space Open: New Images of Ethics Consulting," *Hastings Center Report* 23, no. 2 (1993): 33-40.

6. In many medical centers, chaplain trainees are categorized as medical house staff, subject to the same limitations on work hours that apply to interns and residents. In some medical departments, the constraints on house staff time have led to significantly increased demands on the time of junior faculty, a development that the profession of chaplaincy should certainly try to avoid as it works to protect the well-being and the time of both its members and its aspirants.

Lost in Translation: *The Chaplain's Role in Health Care*

BY RAYMOND DE VRIES, NANCY BERLINGER, AND WENDY CADGE

Chaplains often describe their work in health care as "translation" between the world of the patient and the world of hospital medicine. Translators usually work with texts, interpreters with words. However, when chaplains use this metaphor, it describes something other than a discrete task associated with the meaning of words. While medical professionals focus on patients' medical conditions, chaplains seek to read the whole person, asking questions about what people's lives are like outside of the hospital, what they care about most, and where they find joy and support in the world. Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns. Some chaplains are skilled at translating patients' experiences and sources of meaning in real time, allowing medical teams to better understand the person they are treating. "Translation" is also defined as metamorphosis. Chaplains

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