Pastoral learning at Bellevue Hospital: A seminarian's apprenticeship

by Chloe Breyer in the August 30, 2000 issue

At the end of my first year at General Theological Seminary, in New York City, I spent eight weeks in clinical pastoral education at Bellevue Hospital. In case I thought that seminary was simply about mastering theology, General had arranged a summer's worth of practical education in pastoral care.

Being an assistant chaplain in a teeming New York hospital for mental and physical illnesses was the most emotionally challenging experience of that year. God's justice never seemed more confusing or the church more marginal.

Described by one of my professors as a "kind of spiritual EMT," a chaplain works differently than a parish priest. Historically, chaplains are appointed by states or private bodies as religious functionaries working at secular institutions such as schools, prisons, hospitals, or in the military. Chaplains rarely develop the long-term relationships that connect a priest to her parishioners. They are more like an emergency room staff—ready to sew up spiritual wounds and pass the patient along to primary-care providers. Clinical pastoral education for Episcopal seminarians resembled a medical internship. If we could cope with daily crises in hospitals, we might be able to handle the less frequent crises in a parish.

Clinical pastoral education, or CPE, is open to anyone wishing to learn about spiritual care, and it's required for everyone entering the Episcopal priesthood. In 1925 the first CPE program enrolled four seminary students for summer study at Westboro State Hospital in Massachusetts. CPE was the inspiration of Anton Boisen, a minister who had been hospitalized five years earlier for "catatonic schizophrenia" at Westboro. After he recovered, Boisen founded CPE to teach clergy to care for the sick and dying through firsthand experience.

Over 70 years later, Jewish, Christian, Islamic and Buddhist students seeking ordination in their own traditions enroll in the program nationwide. My classmates and I work in hospitals and hospices ranging from Christ Hospital in New Jersey, where Brad does 32-hour shifts once every eight days and performs many sacramental functions, to Columbia Presbyterian, where Mauricio takes part in a very structured program with preaching opportunities and strictly delineated pastoral responsibilities. I want to do my CPE at Bellevue Hospital because work in a large, ailing New York public hospital is guaranteed to be a “boot camp” experience. Also, our supervisor, Ernst Joseph, has been running CPE for 33 years; this would be his last program cycle before retirement. Joseph has chosen four of us from General, a Yale Divinity School student from the United Church of Christ, and a Benedictine monk who lives in Oregon.

Bellevue Hospital, located at First Avenue and 27th Street, lies within easy biking distance from General. Founded to serve “lunatics and paupers” in 1736, Bellevue is the oldest public hospital in the country. In films like *One Flew Over the Cuckoo’s Nest* and *The Snake Pit*, Bellevue is the archetypal insane asylum. But although New Yorkers tell tales about great aunts and dipsomaniacal uncles carried off to Bellevue, and the guides on Circle Line tour boats describe it as a mental institution, Bellevue is a general hospital.

For a seminarian, it’s hard to imagine a building that contains much more of “the world outside.” The locked psychiatric wards occupy only one small part of this 1,232-bed facility. In addition to the birthing center, medical and neurological ICUs, and dialysis clinic, Bellevue houses two libraries, a high-security prison, a fully accredited public school, a print shop, a Medicaid registration office, two chapels, a synagogue and one of the city’s best emergency rooms. The hospital also has a community board, a palliative care unit and a world-renowned psychiatric program for survivors of torture and hostage taking. Alcoholics Anonymous and Narcotics Anonymous groups meet there, and relatives of schizophrenic and depressed patients find support groups. Art therapy programs serve children and adults who suffer emotional disorders.

As a microcosm of New York, Bellevue contains the best and worst of life. At Bellevue I learned things I could have lived a long life without knowing. Surreal bits of information came my way. Catholic chaplains are wary of giving out rosary beads because patients have used them to display provocative gang colors. Bibles are no longer distributed in the locked psychiatric wards since patients sometimes use the

pages as toilet paper.

My notions of right and wrong were challenged too. Level one trauma centers like Bellevue depend on a steady stream of violent-crime victims to maintain the reputation of their ER residency programs. In psychological intake exams, desperate people give answers that will guarantee admission because they'd prefer an indefinite period in the psychiatric wards to the New York streets. I learn that prisoners sometimes commit crimes that will return them to jail because they cannot handle the uneasy burden of freedom.

I also saw selfless professionalism. Here were medical and social work professionals, often leaders in their fields, who had forgone more lucrative and prestigious places at well-endowed medical centers to help care for the poorest people in our society.

I often walked past rows of people waiting to register for Medicaid. Going into a patient's room, I was as likely to be asked for spare change as for a prayer. Sure, it would be great to speak with a chaplain, a patient says. But first, would I mind calling his daughter to come over from Brooklyn, and could I pay the $20 fee to turn on his TV, or better yet, call the public notary from medical records so he could send a letter to his bank and bail his son out of jail? I would turn away, guessing that our heart-to-heart on spiritual matters might have to wait. "By the way," the patient adds, as I try for a discreet exit line, "Could you get one of the nurses to pick up my bedpan? It's been sitting here since breakfast."

Over the intercom, I heard requests for interpreters of Spanish, French, Filipino and Cantonese. In addition to meeting the African-American homeless woman who just learned she is HIV positive, I might encounter a highly paid model recovering from a heroin overdose or a Wall Street lawyer hit by a bicycle courier. People from every class, race, ethnicity and nationality pass through Bellevue's halls. Upward and downward mobility, not to mention immobility, are all on display.

After receiving medical clearance and a brief orientation, our CPE group gathers with our supervisor in a small, sparsely furnished room on the ground floor next to the social work department. Having to choose between the air conditioner and being able to hear, we opt for a stuffy room. We try to ignore the broken answering machine that jangles at odd intervals during our meeting, and stop for a few minutes while two janitors assess the damage from a gaping leak in the ceiling.

Our instructor tells us a little about himself. After growing up in a strict Mennonite family, Chaplain Joseph went through an extended period of religious doubt and struggle. At college he studied history and theology, then spent several years teaching in the Middle East. Once home, he began working with the mentally ill. In the early 1960s he came to Bellevue as a CPE supervisor, and liked it so much that he decided to stay.

Chaplain Joseph is an unassuming, quiet figure who seems on good terms with much of the permanent staff—particularly the social work department. At the same time he's a little removed from the hospital mainstream. One psychiatric resident describes him as "that very nice-looking elderly gentleman." Chaplain Joseph's affable air and the way he walks—one hand tucked in the pocket of his short lab coat, name tag slightly askew—reminds me of the gardener in the Peter Sellers film *Being There*.

He appears unassuming, but we discover that very little slips by him. During our hour-and-a-half morning debriefings, we each recount our interactions with patients in reports called "verbatims." Chaplain Joseph's way of intensive listening, eyes closed, is sagelike.

Usually he waits for the rest of the group to respond, then offers acute observations about our motives or behavior that we would never have admitted to ourselves. Mary, my classmate from General, says he reminded her of the father in the prodigal son story. Like the parable figure, our chaplain has a magnanimity that extends undeserved forgiveness.

CPE is a group process, so other summer assistants are critical to the experience. From General, besides me and Mary, there is Bob, the only Native American in my class of 18.

In his late 30s, Bob is a tall man with a ponytail of long dark hair; he moves slowly, reads voraciously and speaks laconically. His father was an Episcopal pastor on the Pine Ridge Reservation in South Dakota, where Bob hopes to return with his wife and two small children. Our resident expert on the productivity of silence, he says little. But when he does speak, everyone listens. I'd been rather intimidated by Bob during the school year, but I appreciate his wry sense of humor and look forward to getting to know him.

Mary, a classmate from Louisiana, was once nominated salesperson of the year when she worked for Toyota in Detroit. Her “burning bush” moment at the altar rail in a church basement was a call to turn her life over to God, but the idea of priesthood evolved later, after she’d worked as a verger in a large Beverly Hills Episcopal church. Short, with black hair and dark eyes, Mary has enormous energy, doesn’t waste time and doesn’t suffer fools. She has a quick wit, and can drop everything for cheap opera tickets or a good bottle of champagne. I struggled all year to keep up with her in our Greek class.

The other two non-General members of the CPE group are Thomas, a divinity school student at Yale, and John, a Benedictine monk from an abbey in Oregon.

Thomas is very bright, earnest—and from the most scrupulously traditional Protestant background of anyone in the program. He often single-handedly defends his ministry at CPE by reference to the Bible. For all of General’s liturgical fundamentalism, few of us begin sentences with “The Bible says . . .” It is eye-opening to watch Thomas unapologetically defend his pastoral decisions on scriptural grounds, while the rest of us trip over each other to see situations in murkier shades of gray.

John, the 40-year-old Benedictine monk, plans to be ordained a priest. He has traveled around the world recruiting for his abbey’s Catholic seminary. Before joining the monastery, he studied music in Germany and released a CD of a choral work he had composed. Possibly because of his age, experience and decision to wear a collar, John assumes a unique air of authority in the hospital and among our group. He soon becomes the confidant of several policemen at Bellevue, is called into rooms and sought out for advice. John’s congenial, slightly reserved manner makes him more enigmatic than others in the group. Impressed by his religious vocation and captivating life story, I strive to put my best self forward whenever we talk.

I learned early that as chaplains-in-training we were not supposed to be instructors in morality. Allies in moral struggles or facilitators of conscience, perhaps, but not directors, or even teachers. This lesson became clear as I listened to my group’s verbatim accounts of conversations. Some accounts were more pastoral than others. For example, Bob’s story about his relationship with a homeless alcoholic in recovery, an expert panhandler who divulged to Bob all the tricks of his trade, sounded more “ministerial” to me than Thomas’s instructions to an addicted man that “God loved him and would expect more of him.” Though Thomas had doubtless

spoken the truth to this person, who turned himself into detox at Bellevue every few weeks for a temporary drying out, Thomas's verbatim created an uproar in the CPE room. It left me feeling terribly sorry for the poor man, whose low self-esteem could not have been boosted by a chaplain implying that God too was disgusted by his behavior. Chaplain Joseph commended Thomas for being "real" with his patient but stressed the difficulty of preaching morality from above—a practice that might work from the pulpit but was less effective on a ward. In contrast, the trust Bob had generated with his patient led the man to share detailed life stories.

My own experience told me that trying to play the guardian angel who dispels a patient's demons was not a productive use of a chaplain's energy. I was very proud of my progress with Colin, a Rastafarian from Brooklyn who wound up in the neurology ICU after being mugged. Colin had solicited my help in his struggle between his religious principles, which required peace and forgiveness, and his instinct for revenge. I'd thrown myself into the part he cast for me—supplying him with several biblical role models who were rewarded for prevailing over temptation. All went well until one afternoon. We were role-playing how Colin might react if someone called him with a tip on his mugger's identity. The phone rang. "Where the *hell* is my money? I told you that's *my* money! Where the hell is it?" Colin yelled into the receiver without stopping for breath.

Later he explained he was talking to his baby's mother, as if that justified the outburst. Colin added that he was relieved—he didn't have to worry anymore about violating his nonviolent principles because his brother had taken it upon himself to beat up the people whom he suspected of mugging Colin. Still, he hoped that I would return soon and read to him more about King David.

Despite evidence that placing myself in the position of a finger-wagging instiller of high principles didn't work, it was impossibly hard to avoid. I fell into this trap more than once, though it was painfully clear that imposing my own ideas of morally admirable behavior on a patient was fruitless unless the patient was searching for guidance.

Take Adam, a patient I met in the neurology ICU. The harder I tried not to impress my own values upon him, the more transparent my earnestness became. Adam, his medical chart said, had "jumped/been pushed?" from the window of a large Manhattan apartment during a party. A livid surgical scar bisected his shaved head; one eye was swollen shut, and a yellow-green rainbow of bruises arched across his

face, one arm and side. He could barely speak because of the tracheal tube in his neck. He breathed laboriously, and flailed around so much that he had to be forcibly restrained. Seeing Adam as a deranged patient who'd be sent up to 18E when his physical ailments healed, I approached gingerly and took his gesticulations and raspy calls for water as hallucinations.

I realized there might be more to Adam when I arrived at his bedside one day and found an elderly gentleman, Adam's uncle, leaning over the bed. He called out gently, "Adam, Adam, it's me. Your aunt and I have sorted out your apartment, we've turned off the gas and will come by to check your mail. Everything is taken care of, so don't you worry. It's all going to be fine." I was shocked at how my perceptions changed with this new framing. To see someone who knew Adam speak to him about homely matters, as though he could grasp the conversation, brought me up short. After that I sat longer, deciphering his scrawled notes about being afraid and wanting to see his uncle or wondering where he was. A conscious, rational person lay behind Adam's appearance and wildness. Usually, I'd carry on a short one-sided conversation about how everything was going to be OK. "Please, Adam, try to relax and don't try to get out of bed; I can't give you water right now because of your tracheal tube, but the nurse can bring some relief."

The real miracle came when Adam was transferred to rehabilitation. It took a few days to find him, and a weekend elapsed between visits. When I entered his room, Adam was sitting in a wheelchair by the sink, swabbing his face with wet paper towels. The swelling had abated and his bruises were fading. He looked up inquiringly.

"Hello," I said, "I'm an associate chaplain here. I've been visiting you upstairs. You look much, much better!"

"Ah yes," replied Adam in a slightly nasal tone, "my uncle told me about you. I understand you've been quite a faithful visitor," he continued, smiling wryly. "Thank you very much."

Adam is a financial analyst who lives on his own in Manhattan. He grew up in a large Roman Catholic family in small-town Louisiana and attended Princeton. He thought about being a doctor, but decided on business school. Adam is well read, well traveled and enjoys what he calls the good things of life—music, literature, food, drink and the company of good friends. The Roman Catholic faith of his childhood

disappeared during his first year of college, when he began to “understand the world as it really is.” Now, Adam says, the only time he believes in God is when he listens to Mozart. He respects people who are religious, but, honestly, the whole thing doesn’t much interest him.

During his hospital stay, Adam and I enjoy chatting. No doubt our shared middle-class backgrounds make it fun to socialize. I describe my interest in entrepreneurial public service programs and we compare undergraduate experiences. I ask about his preferred authors and he tells me about favorite New York restaurants and meals he’s enjoyed. Although Adam can be both arrogant and condescending, his dry wit makes for entertaining talk. He hasn’t, for example, been able to make the Bellevue psychiatrists understand that he doesn’t want “happy pills—just a small leg of lamb, *puh-leeze*.”

But Adam’s continually irreverent, occasionally condescending ribbing about religion touches a sensitive spot in me, and I wonder if socializing with Adam is inappropriate. I am supposed to be his chaplain, not his dinner guest. Shouldn’t I try to probe deeper matters, even if they are harder to discuss?

After all, despite Adam’s degrees and accomplishments, he is at Bellevue recovering from what I assume (with no proof) has been a suicide attempt. At the very least, Adam has behaved in a reckless fashion that, I believe, points to serious emotional problems. Although he has told me and everyone else in the hospital that he won’t discuss what happened the night he fell, it seems my duty to make sure that he acknowledges that something is missing from his life. I feel responsible for urging Adam to attend to his psychic wounds as well as the physical injury.

This will be my agenda with Adam, although I resolve to disguise it well as I know the dangers of imposing my views on patients. But there has to be something to show for our relationship. I will consider myself successful at chaplaincy if I succeed in leading Adam to admit his confusion.

One afternoon, Adam is explaining how amusing he finds the young residents who try to locate his pulse without success. “They can’t find anything because they hold both fingers on my plastic wristband,” he chortles. Adam deplores how seriously the psychiatrists underestimate his knowledge of their field and satirizes the transparency of their questions.

“When you have had the background and education that you and I have had, Chloe,” Adam confides, “you know a lot about how these things work.”

I smile and stay quiet, trying to turn our conversation to the issues on my agenda.

Adam continues talking, almost in a reverie, about his recommendations for improving Bellevue—basic things, like less noise and more courtesy. He understands that a public hospital probably can’t offer the amenities of a well-endowed private one. “But I’m really not used to this sort of atmosphere,” he explains, adding that when he has to stay home with a cold, an army of retainers is mobilized.

“Usually, I have everything, meals and all, delivered in. My assistant makes sure I have the work I need. This is really a new experience. My friends are amused.”

I see an opportunity. “So who are these ‘friends’ you keep talking about? Are they close friends?”

Adam replies vaguely that they are people who understand him—some from Princeton he kept up with over the years, more recent acquaintances from around the city.

Suddenly he is defensive. “If I really wanted to leave here, you know, I could. I would just call up my friends and they would come and get me right away. I know how to get things done. If I really wanted to get out of here, I could fly right out that window.”

I nod, and we sit in silence. Later that afternoon I realize the significance of his threat, and I am seriously alarmed.

“I’ve learned,” says Adam, switching subjects, “that I’m being prayed for from all over the map. People in all 50 states are praying for me, according to my aunt. A group of 40 women I don’t even know is praying for me. It’s very sweet, I think, don’t you? Endearing.”

I remember how worried his aunt was when she and her husband visited Adam in the ICU. She had asked me to anoint him with holy water, even though I wasn’t Roman Catholic. Suddenly Adam’s condescension angers me.

“Why are you glad they’re praying for you if don’t even believe in God?”

“Oh, I think it’s great that some people believe in religion,” Adam says airily. “I respect it very much. It’s just that I don’t think God exists for me. I don’t know very much about it. If push came to shove I think there’s about a 50-50 chance that God exists—so probably I do believe. But, I’ve told you already, religion doesn’t interest me that much. I enjoy talking about other things.”

I ignore the hint and keep probing. “So you don’t care if I pray for you or not?”

Slightly exasperated, Adam says, “You should pray for people without money, without any kind of education. Pray for those who get trampled by the world and don’t know to push back. They need your prayers. Me, I know how to push back a little bit. I know how to get things done. I’ve learned how to say ‘no’ or ‘not right now,’ or ‘no thank you very much’ or just ‘NO.’ It works.”

I back off. Has Adam imagined the first thing he’ll do when he leaves the hospital?

“I’m going to have a huge party and invite all my friends and everyone who helped me to recover,” Adam replies drily, looking past me out the window.

On the way to the elevator, I feel ambivalent. It does not occur to me that Adam was egging me on. I cannot let his comment go by. Just as the elevator door opens, I resolve to confront Adam right away. I turn back and knock on his door.

“Adam, I just thought I should let you know that I’ve thought about what you said about throwing a party, and it upsets me a little bit. I mean, isn’t that how you ended up coming here?”

The minute the words come out, I want to swallow them whole.

His back to me, Adam bursts out angrily, “I told you in the most diplomatic way I could that I did *not* want to talk about the accident. I don’t know what happened to me that night, and I’m not going to discuss it till I get better physically and am at home and will seek expert advice. I can take care of myself, thank you very much, and technically this is none of your business. You are out of your league. Good-bye.”

It turned out I did not destroy the fragile trust between Adam and me. I summoned the courage to return, he accepted my apology, and our usual conversation began. He complained that the nurses were unsympathetic when he insisted that visiting family was more important than “spending another half hour jumping around on a pogo stick in rehab.” I manage a smile when he jokes about his “infamous welcome-

home party” and invites me to attend with an oxygen mask and a stretcher, since I worry so much about his health. We remain on good terms until I leave Bellevue.

I am disappointed and alarmed that I did not resist the impulse to preach at him. By the time I bring it up with my CPE group, I anticipate Chaplain Joseph’s suggestion to hesitate before “rushing in where angels fear to tread.” I know the answer to his question about whether my wish to hear Adam confess dark doubts had more to do with Adam’s need or mine. But how could I—so proud of my open-mindedness and ability to embrace diversity—be perceived as “pushing the religion stuff a little too strongly,” as Adam scoffed. I had indeed “rushed in” to the life of someone who was perhaps spiritually wounded, but also perhaps mentally ill beyond my powers to assist. I *thought* I understood the concept of pastoral engagement in moral questions, but clearly not well enough to put it into effect.

Pastoral engagement remained mysterious. How could I get involved with a patient’s moral dilemma without, on the one hand, agreeing with everything he said, or on the other, imposing my views? The choice seemed to lie between relativism and closed-minded dogmatism. Although I never worked out a satisfactory answer to this puzzle in my own pastoral work, one of Mary’s experiences let me glimpse a solution.

Mary had taken time off from the neonatal ward to visit the obstretics unit. A nurse on the ward pointed out a young woman who had just had an abortion; her mother sat beside the bed. Mary went over to introduce herself and began talking with the patient, an African American in her early 20s.

The woman, called Tashi, wondered if she would be “forgiven” for what she’d done. Noticing the “confession” and “forgiveness” language, Mary inquired further.

The young woman and her mother had arrived at Bellevue a few days before, seeking an abortion for Tashi after the baby’s father disappeared. She and her mother feared the young woman wouldn’t be able to bring up her child alone. The mother was adamant on this point. At Bellevue, all had gone according to plan until they discovered, after the operation, that Tashi had been carrying twins.

“I don’t know,” Tashi told Mary tearfully. “Somehow when I heard that, it seemed like this was a gift. Something really special.”

Mary caught the inconsistency. Twins would have been twice the work and demanded twice the resources of a single baby—all the more reason for their choice, if Tashi and her mother really meant what they said about being too poor to raise a child. Now Tashi cried that, had she known she was carrying twins, she might have kept them.

Then Mary did something pastoral. She pursued her curiosity and asked the young woman if she could talk more about her feelings.

Again, Tashi said it was because twins felt like a gift, a special thing.

Mary suspected there was more to the story. From the overbearing attitude of the mother, she gathered there was heavy maternal pressure on Tashi to keep up appearances even within her own family, most of whom had no idea what had taken place. This must have weighed heavily in the hasty decision to seek an abortion—getting rid of the child was the tragic means of saving face and avoiding shame.

Not once, however, did the church's or Mary's personal opinion on the morality of abortion enter their conversation. "Right" or "wrong" was never mentioned. By inquiring with sensitivity, compassion and natural curiosity into Tashi's situation, Mary engaged the young woman and her mother in an honest conversation about the abortion, a conversation they probably would not dream of having with someone in the church. Mary heard Tashi express her sorrow in the language of Christian faith, and opened the way for the young woman to continue talking with a priest or pastor who might help her to move beyond regret. Listening to Mary, I thought that the tragedy was not so much the abortion itself, but that such a large decision had been made so hastily and with no outside guidance. The church was the last place Tashi and her mother felt they could turn.

Now the difference between a pastoral approach and other approaches to moral issues grew clearer. Mary had not been discussing an important "issue" in the abstract, she'd had a poignant conversation with Tashi. In a pastoral setting, Mary's own views or the church's views on the morality of abortion in principle were far less important for the young woman's life than uncovering Tashi's own feelings of remorse. Tashi was the one who would ultimately have to be reconciled to herself in order to move ahead. She alone would know how God's forgiveness would allow her to embrace her own life again. And Mary, the good chaplain, had shown Tashi that

this question was worth pursuing.

This article is adapted from the author's book about her first year of seminary, The Close *(Basic Books, 2000).*