Designated Humans: Health Care Chaplains, Baseball, and the Beyond

Danielle Spencer

Robert L. Klitzman. ***Doctor, Will You Pray for Me?: Medicine, Chaplains, and Healing the Whole Person.*** New York: Oxford University Press, 2024. 324 pp. Hardcover, $35.00.

Robert Klitzman's 2024 *Doctor, Will You Pray for Me?: Medicine, Chaplains, and Healing the Whole Person* begins with two personal stories. Klitzman, a psychiatrist and bioethicist, recalls one of the first people he treated during his medical internship: a young woman, dying of breast cancer, who had a card of Jesus taped to the wall of her hospital room. Aware of her "terror and psychic pain" yet not having received any training in addressing spirituality, Klitzman wondered whether to call a priest for her; when he asked, however, his supervising resident responded with disparaging incredulity. The lesson for Klitzman was that "in the world of scientific medicine, even broaching this subject was out of bounds," though he confides that to this day he regrets his silence, which has "continued to haunt, embarrass, and disturb" him.[1] Indeed, while the woman's distress rightfully has primacy in the story, Klitzman, too, suffered—a sadly characteristic punctum of clinical training in which the caring young physician faces "an amputation of the concept of humanity with which medicine does its job."[2] He confronted what Max Weber describes as medicine's "technical mastery," which comes at the expense of asking whether—and when—a life is worth living.[3] Weber quotes Tolstoy: "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?'"[4]

While inuring oneself against anguish and uncertainty is part of his expected formation as a doctor, Klitzman, to his credit, has continued to broach and investigate questions of human suffering and meaning-making and their relevance to health care. Of particular note among his extensive body of work, his 2008 *When Doctors Become Patients* examines doctors' loss of their "sense of invincibility" wrought by illness and patient-hood, bringing lived experience of vulnerability and mortality into explicit dialogue with professional identity.[5] And in *Doctor, Will You Pray for Me?*, the second primary story framing the book is Klitzman's own experience of trauma following the death of his sister on 9/11. As he movingly recounts, that is when he became acutely aware of the severe somatic and emotional effects of shock and

Spencer, Danielle. 2025. "Designated Humans: Health Care Chaplains, Baseball, and the Beyond." ***Literature and Medicine*** **43(2): 588–603. https://muse.jhu.edu/pub/1/article/991648**

grief, struggling with existential and spiritual dimensions of life and loss. Such complementarity of suffering between health care providers and ill persons sets a humble and inviting premise, that we are all engaged in a shared struggle, facing common questions: What lies beyond the known? What is the role of faith? How can we acknowledge the "limits of science" (29)? In the face of uncertainty, how might we help one another to find and construct meaning?

Doctor, Will You Pray for Me? explores the role of health care chaplains in this project. Its portrayal of the field is rich and compelling, supporting Klitzman's argument that chaplains often play a valuable role in the search for meaning, purpose, hope, and significance. Organized into topical chapters, these stories demonstrate that chaplains help religious and non-religious individuals—ill persons, family members, health care practitioners—to face disease and mortality, navigate medical decision-making, pose spiritual questions, cope with workplace stress, address mental health and quality-of-life concerns, connect material and existential domains, and improve communication, among other benefits. The book also offers insight into the current and evolving state of the profession, including the degree to which chaplains are connected (or not) to specific religious institutions and faiths and their role vis-à-vis medical bureaucracy. It paints a multifaceted portrait, and will be of lively interest to any reader invested in the many dimensions of health care.

In addition, the book reflects the long-running tension between medicine and that which lies outside its apparent bounds. Even Flexnerian biomedicine, broadly held to have instantiated a near-exclusive emphasis on the scientific method in U.S. medical schools at the dawn of the twentieth century, began with Abraham Flexner's *proviso* that the scientific "instrumental minimum" is "instrumentally inadequate." As physicians "deal with other, more subtle elements," he noted, "one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience."[6] Despite this acknowledgement, the present-day medical curriculum—still largely formed by Flexner's scientific model—must, per accreditation standards, be defined in "outcome-based terms that allow the assessment of medical students' progress in developing the competencies that the profession and the public expect of a physician," with the familiar injunction that learning objectives be "specific, observable, and measurable."[7] The *other, more subtle elements*, such as Klitzman's genuine care for a dying young woman, do not necessarily fit such requirements. Similarly, the MD-accrediting Liaison Committee on Medical Education stipulates that

medical schools encourage applicants to obtain a "broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences," yet leaves the details unspecified.[8] Such exposure remains largely unobserved and unmeasured, echoing Flexner's nod to a *varied and enlarging cultural experience*.

Spirituality encounters a similar aporia; as Klitzman notes, The Joint Commission on health care accreditation mandates that hospitals must assess spiritual beliefs, but does not specify who should perform the assessment, with which skills and methods, or to what effect, thus sidestepping the measurement quandary (31). Hospital chaplains are at the nexus of this tension, as faith—alongside existential suffering, the eternal, joy, loss, ecstasy—confounds instrumental efforts to measure and track, while chaplains still must often, to varying extents, justify their work within the current biomedical system. This system seeks to quantify in service of determinate goals, reflecting what Weber described as the "rationalization and intellectualization" as a form of "disenchantment of the world."[9] Indeed, per Hebrews 11:1, religious faith itself is *the substance of things hoped for, the evidence of things not seen*, while "evidence-based" standards demand to make things seen, observable, and legible according to a specific set of desirable outcomes.

"Outcome Oriented Chaplaincy" (OOC) approaches have sought to reconcile the often undefinable aspects of spiritual care with the worldly aims of medical care. For example, George Fitchett and Allison Delaney's "Opportunity for Catholic Health Care: The Evidence-Based Spiritual Care Paradigm" tracks chaplaincy's effects on "patient satisfaction," communicating the "efficiency" of such efforts as a means of affirming that "the care we are providing is the best care that can be offered." Their study finds that for people with congestive heart failure, higher scores for religious/spiritual struggle are correlated with "greater emotional distress, poorer physical functioning, poorer adherence to important health behavior (not smoking, for example) and more hospital days," while those with higher inner-peace scores have elevated survival rates, better "adherence," and fewer hospitalizations.[10] Which begs the question—efficiency in service of *which* outcomes? This is an explicitly Catholic framework, yet what of . . . sanctification? Salvation? Are these not the ultimate ends for many of the faithful, rather than mere "satisfaction"? What of the inherent value of human struggle, presence, relationality?

This is the rub with instrumental evaluation, which requires, as Annelieke Damen et al. describe, that we "translate visions of the good into manageable outcomes that allow for empirical exploration,"

and has been the subject of lively debate within the field of pastoral care.[11] For example, hospital chaplain Steve Nolan contends that "the values that underpin OOC are the values of the managerialist culture, market-led values, and while they may be the real-world imperative of the much altered context in which we work, we embrace them at the risk of converting the people we care for into statistical quotients the more efficiently to process their conditions according to statistically proven schedules of effective interventions. This may work for therapies of the body, but it is highly questionable when it comes to caring for the soul."[12] We can imagine such managerialist questionnaires: *How would you rate your spiritual salvation on a scale of 1–10? Does the promise of eternal life leave you feeling very dissatisfied, dissatisfied, neutral, satisfied, or very satisfied?*

Doctor, Will You Pray for Me? acknowledges these ongoing tensions, and its own methodology reflects them as well. On the one hand, the project takes a grounded theory approach, coding interviews with a diverse range of hospital chaplains in the United States, as well as drawing upon research study interviews of clinicians and those seeking care; yet as Klitzman foregrounds, narrative itself is a meaning-making enterprise, and the emphasis is on extensively quoting such stories as a means of portraying a *varied and enlarging cultural experience*, to use Flexner's phrase. Klitzman explores the limits of measurement when it comes to pastoral care, while also proposing that "quantitative scales can potentially provide key objective, systematic, and concrete evidence of the field's impact and effectiveness and are worth pursuing" (253).

Here is the crux of the quandary: How to describe a role such as chaplaincy well enough to argue for its value, without constraining it—with strict definitions and efficacy measures—such that its essence is extinguished? This dilemma echoes a perennial challenge at the heart of Klitzman's field of bioethics, which seeks to bridge biomedicine and ethics. It is a tension that Arthur Frank helpfully frames in terms of Habermas's distinction between *lifeworld*, formed of social interaction and shared cultural knowledge, based on communicative action seeking mutual understanding; and *system*—such as a bureaucracy—based on strategic action, and seeking self-advantage. In Habermas's analysis, lifeworlds are necessary for systems, yet systems erode lifeworlds, and as Frank describes, bioethics stands in the middle "as an honorably contradictory enterprise: working within systems to defend lifeworlds against those systems, while recognizing that lifeworlds need systems."[13] Contemporary hospital pastoral care, too, stands in the middle between the lifeworld—one human present to another at the bedside, frequently

facing mortality and its attendant existential mysteries of the eternal—and a biomedical system often requiring "objective, systematic, and concrete evidence" of the efficacy of such presence.

Klitzman's response is to offer "narratives of success" (255)—and, intriguingly, the portrait of chaplaincy that emerges is, considering the topic, relatively light on religion itself, suggesting that this role has often come to stand in for what we might call humanism. It occupies a space that preserves some distance from the medico-scientific doctrine of measurement and judgment as well as from the strict religious doctrine of measurement and judgment. Tellingly, the book invokes a steady stream of words and phrases gesturing towards that which lies beyond materialist boundaries: *supernatural*, *unknown*, *mystery*, *existential*, *beyond labels*, *pastoral imagination*, *confusion*, *magic*, *sublime*, *metaphysical*, *fourth dimension*, *dark matter*, *spirit*, *heart*, *presence*, *sacred*, *uncontrollable*, *soul*. Emotion plays a crucial role, with terms such as *awe*, *confusion*, *enchantment*, *hope*, *care*, *love*, and *goodwill* alongside description of acts such as *listening* and *dialogue*. And while there is a recurrent emphasis on "meaning-making," whether the meaning is faith-based or not becomes seemingly less important. Religion is often denatured of explicit doctrine—there is discussion of "secular chaplaincy" (51); "atheologians" (48); the notion of God likened to a "placeholder" (74). Chaplains here are more concerned with quality of life than "religion and spirituality per se" (42), and there is a focus on "nones"—those not identifying with a specific religion, yet still describing themselves as spiritual. Chaplains are depicted as less connected with organized religion (92) and "less doctrinaire" than other clergy (196).

The shift in emphasis away from religious doctrine is in keeping with Michel Foucault's description of Christian pastoral power as having moved from religious institutions and a paternalistic responsibility for members' eternal salvation to secular institutions—including hospitals—serving more "worldly aims."[14] Of course Christianity is but one religion among many; however, this analysis helps to explain the adoption of formerly clerical responsibilities associated with a variety of faith traditions by medical practitioners. Indeed, while the scope of Klitzman's study is health care chaplaincy, in recent decades there have been various campaigns for clinicians themselves to utilize instruments assessing spiritual matters in addition to chaplains. One of the primary examples is the ©FICA Spiritual History Tool, evaluating:

- Faith, belief, meaning;
- Importance and influence;
- Community;
- Address/action in care.[15]

In this rubric, too, spirituality has often come to be understood quite expansively, from affiliation with organized religions to encompassing "a broad range of views on one's place in the universe." Among many goals, including better understanding people's values and connecting them with spiritual resources, the "clinical significance" of the FICA assessment is framed in worldly pathological terms: "by understanding the hopes and fears of the patient, the health care team member can *diagnose* and then attempt to address spiritual distress."[16]

There are numerous tools of this type. Here are four such frameworks:

- FAITH: Faith/spiritual beliefs; Application; Influence/importance; Talk/terminal events planning; Help (designed for use by UK physicians).[17]
- HOPE: sources of Hope, strength, comfort, meaning, peace, love and connection; the role of Organized religion for the patient; Personal spirituality and practices; Effects on medical care and end-of-life decisions (designed for U.S. family physicians).[18]
- BELIEF: Belief systems; Ethics/values; Lifestyle; Involvement in a spiritual community; Education; Future events (designed for general practitioner physicians to use in pediatrics).[19]
- SPIRITual History: Spiritual belief system; Personal spirituality, Integration with spiritual community; Ritualized practices and restrictions; Implications for medical care; Terminal events (developed for physicians).[20]

Here the words representing the ineffable—*faith*, *hope*, *belief*, *spirit*—are assigned double-duty as acronyms denoting distinct checklist line-items, a legerdemain characteristic of biomedicine's indefatigable measurement drive. Many such infinity-totalizing instruments purport to equip practitioners "with evidence-based strategies to ensure that [patients'] spiritual needs are met," to be followed by a "prescribed spiritual distress management plan," as Timiya Nolan and colleagues describe.[21]

Another example is the JAREL Spiritual Well-Being Scale, the acronym formed by the first names of its creators, who employed grounded theory to develop a definition of spiritual well-being as "a

sense of harmonious interconnectedness between self, others/nature, and Ultimate Other which exists throughout and beyond time and space . . . achieved through a dynamic and integrative growth process which leads to a realization of the ultimate purpose and meaning of life" (!). Here, too, the resultant "data" from their 21-question assessment survey (e.g. #8: "I believe in a supreme power: Strongly Agree / Moderately Agree / Agree / Disagree / Moderately Disagree / Strongly Disagree") is said to support clinical "diagnoses and interventions."[22] The promotion of spiritual assessments like these fulfills the managerialist questionnaires we were imagining, and echoes OOC's justification of spiritual care within a secular clinical framework. As Jeffrey Bishop puts it, in such a "biopsychosociospiritual" model, religion is readmitted to medicine only insofar as it supports goals of social functioning and is "'purified' of any specifically theological content."[23]

An additional characteristic of this swing away from explicit religious doctrine is the subordination of religious judgment, even when spiritual care remains within the purview of chaplains. After all, analysis would likely reveal a strong positive correlation between facing eternal damnation and incidence of ☹ selection on the Wong-Baker FACES® Pain Rating Scale. Accordingly, in *Doctor, Will You Pray for Me?*, chaplains discuss individuals' distress over their actions—for example, having killed innocents in war and struggling with guilt and fear of divine retribution—as a consequence of "moral injury . . . from a religious upbringing" rather than ethical accountability or eschatological consequences (65). Similarly, the RCOPE inventory of religious coping asks respondents to rank statements such as "Decided that God was punishing me for my sins" on a Likert scale; as Bishop points out, it "takes for granted that this belief gets in the way of the return to normal social function."[24] (In addition to this "Punishing God Reappraisal" query, there is also a "Demonic Reappraisal" section; believing the devil made you do it is apparently another negative coping measure.) Moreover, alongside such tenets of divine judgment of individual action, many religions judge only their own doctrines to be true, and reject those of other religions—which can be tricky to square with a spirit of heterogeneous inclusivity. As Frank points out in his review of Michael and Tracy Balboni's *Hostility to Hospitality: Spirituality and Professional Socialization Within Medicine*, their "hard case" advocating full structural inclusion of spirituality alongside medicine runs up against "what Weber called the ethics of conviction, the basis of religious particularism, [which] is not open to pluralism."[25]

If we do seek to nurture pluralism in health care, that favors an inclusive and nonjudgmental approach that often welcomes multiple perspectives, as long as it appears to do good. Frank, for his part, is sympathetic to this sort of "soft case" for spiritual care, which characterizes Klitzman's thesis as well—that it fills an important need, is of benefit, and should be supported. Alongside this argument, however, what emerges quite poignantly from *Doctor, Will You Pray for Me?* is the value of a role that is not only less doctrinaire than institutional religion (to the point of stepping outside of religious judgment and particularism), but also less doctrinaire than biomedical doctors (stepping outside of medical judgment and particularism), with the capacity to "see people beyond labels" and "stand outside the medical system per se" as something of a counterweight (188, 199). If God is, according to one of the chaplains quoted in the book, "any number of things that we want God to be" (74), a key advantage of chaplains is that they are any number of things that we want *them* to be, "including not having an agenda and being the one person on the health care team who can simply be with the patient as a caring human being without a concern for outcomes," as George Handzo explains.[26] It is a delicate dance to describe the role of chaplaincy so that it can be better understood and supported, without letting the labels or metrics stick too firmly, lest the work be denatured of its essence—but all the more reason to try.

Yet speaking of labels, what of Klitzman's own title? It expresses a direct religious appeal to doctors, while the book explores the role of chaplains. Does this shift suggest that spiritual needs should be acknowledged by health care providers, yet not fully incorporated? Is biomedicine simply too distinct from the holistic illness experience and the existential abyss? And is the focus on chaplains a tacit suggestion that reconciling such different forms of care may well be an integrationist fantasy?

Given these quandaries, we must consider connections between chaplaincy and other reform efforts such as narrative medicine, particularly when they are closely aligned. For example, an essential quality of chaplains is listening; one of Klitzman's interviewees quotes Yeats to characterize the injunction to "make our minds, so like still water, that beings gather about us that they may see their own images" (57). Similarly, in her conception of narrative medicine, Rita Charon invokes Henry James's doctor Sir Luke Strett in *The Wings of the Dove* to describe the ideal posture of listening for a physician: "So crystal-clean the great empty cup of attention that he set between them on the

table."[27] Moreover, Klitzman's emphasis on narrative meaning-making as an intrinsic human need that can be supported in the face of illness is another premise aligned with narrative medicine, which trains clinicians in narrative skills to better "recognize, absorb, interpret, and be moved by the stories of illness," as Charon defines it.[28] Alongside this emphasis, too, narrative medicine elevates the importance of narrative and interpretation for *all* involved in health care.[29] And common to Klitzman's portrait of chaplaincy and to narrative medicine, which foregrounds the effects of close-reading literature, is the centrality of narrative. Indeed, the domains of spirituality and literature often exhibit similar traits, including (at least in some cases) an inherent uncertainty. As linguistic anthropologist Shirley Brice Heath notes: "What religion and good fiction have in common is that the answers aren't there, there isn't closure. The language of literary works gives forth something different with each reading. But unpredictability doesn't mean total relativism. Instead it highlights the persistence with which writers keep coming back to fundamental problems."[30]

Speaking of coming back to fundamental problems, however, this orientation towards the unknown is always at risk of being absorbed by the uncertainty-averse technocratic machine. And in this sense there are further parallels between this portrait of chaplaincy and other medical reform movements. In Klitzman's "Moving to the Future" chapter, one chaplain suggests that "spirituality is just one way of trying to help doctors be humanistic" (235). Such efforts can arguably be placed alongside initiatives to improve "clinical empathy," which, as John Coulehan et al. declaim, "requires systematic practice to achieve mastery," suggesting that what is being mastered is more so the *performance* of empathy, administered as a dosage of "words that work" seeking specific effects. Indeed, their study concludes that "the effective use of [physician] empathy promotes diagnostic accuracy, therapeutic adherence, and patient satisfaction, while remaining time-efficient,"[31] echoing the OOC studies' finding that spiritual care produces better clinical outcomes, patient compliance, and satisfaction.

While reform approaches differ, the challenge of reclaiming, guarding, and honoring human connection in the clinical space is a project that chaplaincy shares with such fields as narrative medicine, literature and medicine, and the health humanities more broadly—all of which grapple with their own measurement and instrumentalization dilemmas. Given the parallels, should we not seek alliances? In a similar spirit, Frank points to a range of "secular re-enchantment projects," suggesting that "maybe the humanizing of medicine requires

multiple complementary visions that are each small, more intimately specific to patients' needs and clinicians' capacities. By being diffuse, such visions of change are always-already pluralist. Their strength lies in the flexibility of having no solid institutional structures backing them but also constraining them."[32] Such pluralism can and should leave space for scholars, activists, ill persons, clinicians, chaplains, social workers, patient advocates, and the many other crucial roles within and around health care to work together to preserve our lifeworlds, even as we reap the benefits of extraordinary scientific knowledge and systems of effective practice.

After all, we face a mounting imperative to recall our humanity and interconnection and to fight for their continued importance within the powerful organizational structures we have created. For example, in *Doctor, Will You Pray for Me?*, doctors' understanding of those under their care often requires a specification to include their very personhood, as when Klitzman notes that "patients appreciate . . . when their doctor perceives them *as individuals*, not as anonymous and interchangeable. Physicians should of course have technical expertise in their field, but knowing about their patients *as human beings* can help as well—whether the patient is facing existential, spiritual, or religious crises, and is religious or spiritual or not. These domains are important parts of patients' social histories; and therefore of doctors getting to know their patients *as people*" (234; emphasis added). If in the course of one passage the term "patients" requires exhortations to include three distinct qualifications—*as individuals*, *as human beings*, *as people*—hardly unusual parlance amongst clinicians—then we can understand humanity as structurally extrinsic to the fungible machine-repair essence of passive patient-hood, a supplementary benefit that is appreciated but not required.

By the same token, we can understand humanity as often paradoxically extraneous to doctor-hood, so frequently tragically estranged and displaced from the profession's essential core, as evidenced by Klitzman's account of his thwarted instinct to offer a dying young woman spiritual assistance. Returning to the wounded healer trope addressed in his *When Doctors Become Patients*, one of the oft-proposed lessons of such experiences is that physicians have "learned how to respond to illness as professionals (based on medical science), but not as human beings (based on genuine empathy)"—and becoming ill oneself tends to elicit a more human response.[33] In this domain there is a frequent refrain that accounts by ill doctors "remind health professionals and wider society that we are all human," as Wilson et al. put it.[34] Such

experiences encapsulate a recurrent theme within physician writing: the urge to demonstrate that there is in fact a "person behind the surgical mask," as surgeon Paul Ruggieri describes.[35] It is the reverse of the speculative fiction plot twist in which a presumably human character is discovered to be a robot, zombie, clone, or the like, as here the interchangeable mask or white coat of the professional role is figuratively pulled aside to reveal—surprise!—a unique human being.[36] Why the need for such repetition of these revelations if there is not a structural elision of humanity in this professional role?

Indeed, the attenuation of humanity seems to apply to those seeking care as well as to physicians and other health care providers. In *Healers: Extraordinary Clinicians At Work*, David Schenck and Larry Churchill discuss this reciprocity and the goal of mutual recognition, to "have come full circle, from the practitioner recognizing the patient as a person inhabiting a life-world in crisis that is far larger than the person found in the medical system, to the patient recognizing the physician as a person inhabiting a life-world far larger than the clinician found within the medical system." As they describe, "this is what both patients and practitioners long for. It is the deep wellspring of their mutual healing."[37] Yes—but this is not a new *cri de coeur* by any means.[38] After all, Weber was writing in the mid-twentieth century, and we have been sounding these alarms about the alienation of modernity and seeking such healing across different sectors of society for quite some time. Health care is an arena that poses these tensions with particular acuity, as it juxtaposes tremendous scientism, bureaucracy, and economic forces with experiences of extreme vulnerability and profound existential quandaries.

Since we seem to keep calling for a recuperation of our humanity, we are at the point where we may as well have a DH in health care, as in baseball's Designated Hitter; in this case, a Designated Human. Just as the baseball DH subs in to bat for the pitcher, this human can step in to help their fellow humans regard themselves and others first and foremost as human, whatever that means to us. As Schenck and Churchill point out, "every clinician's success in recognizing the fuller world of the patient, and in turn being recognized as a human being by the patient, is a major achievement in a biomedical system that is as brutal for clinicians as it is for patients."[39] This DH, which must be truly empowered, is less likely to be subsumed by particular professional requirements, and thus can be tagged in to help us search for meaning, drawing from literature, spirituality, science, philosophy, ethics, history, and the connections between them; from community;

from the breadth of human endeavor, compassion, action, imagination. This heterodox DH role must foster dialogue and derive its value precisely *because* it is not beholden to any specific doctrine or outcome metrics. For regardless of which professional, disciplinary, or personal-identity team one plays for, the question of how we seek meaning is an ongoing dialogical and interpretive process.

Moreover, just as the baseball DH has been the topic of impassioned debate in the U.S. concerning the skills each player should possess and the integrity of the sport—as one writer commented when it was introduced to the National League in 1973, "probably not since the Roman Catholic Church switched from Latin to English Masses has any break with tradition caused more vigorous argument in this country"[40]—this one will prompt lively discussion concerning the skills various roles should rightly possess on the field of medicine, such as whether doctors should be expected to respond to ill persons' spiritual needs. Just as the baseball DH exposes the extent to which a secular pastime is imbued with spiritual sentiment—as another journalist noted, "the designated-hitter rule has caused a schism in baseball's religion, as serious a breach in the dogma as an argument over the soul. I mean, can a designated hitter go to heaven?"[41]—it will evince the importance of existential matters in clinical practice. And just as the baseball DH raises questions of how we evaluate the game—from an exclusive sabermetrics emphasis on a set of statistical variables to considering such goals as preserving the beauty of the sport, player morale, fan loyalty, inspiration, "human interest" stories, and so forth—the analogy will invite scrutiny of the systematization of medicine, including what is encompassed by or excluded from its metrics, and what kind of meaning and relationality we are seeking in health care.

After all, the imperative to address these issues and forge ties between different leagues of our experience will only keep increasing as we accelerate into an age of ever-more-powerful systems and generative AI that, alongside many benefits, often threaten to erode our lifeworlds. To quote poet Robert Hayden: "We must go on struggling to be human, / though monsters of abstraction / police and threaten us."[42] Perhaps calling it like it is—the unveiled absurdity of a Designated Human, almost on a par with "patient-centered care"—will prompt meaningful change to our systems' priorities rather than simply filling in the gaps, as health care chaplains are said to do.[43]

In the meantime, however, filling in the gaps is about joining together, a worthy focus shared by chaplaincy and other humanizing roles and reform efforts. Indeed, in discussing disenchantment, Weber

notes that "the ultimate and most sublime values have retreated from public life either into the transcendental realm of mystic life or into the brotherliness of direct and personal human relations."[44] Which returns us to the topic of how we try to find meaning in the unbounded territory of existential struggle, including the question of what happens when we die. What would have supported Klitzman, as a deeply caring intern, to help that young woman face mortality? As he describes, "chaplains assist patients and families wrestle, however they do so, with these unfathomable issues" (152). "Fathom" derives from Old English for outstretched arms, or embrace—it is the distance of an arm span—which becomes a term for grasping and understanding. What this rich portrait of chaplaincy demonstrates is that our process of understanding and seeking meaning in the mystery of our existence is about direct and personal human relations; it is about connecting with one another, however we do so.

NOTES

1. Klitzman, *Doctor, Will You Pray for Me?*, 4. Further references will be cited parenthetically in the text.
2. Damasio, *Descartes' Error*, 255.
3. Weber, "Science," 144.
4. Weber, "Science," 143.
5. Klitzman, *When Doctors Become Patients*, 34.
6. Flexner, *Medical Education*, 26.
7. Association of American Medical Colleges and American Medical Association, "LCME Standards."
8. Association of American Medical Colleges and American Medical Association, "LCME Standards"; see also Boudreau and Abraham, "Humanities," 325.
9. Weber, "Science," 155.
10. Fitchett and Delaney, "Opportunity," 12, 14.
11. Damen, et al., "Can Outcome Research," 146.
12. Nolan, "Re-Evaluating," 58.
13. Frank, "Dialogue," 48.
14. Foucault, "Subject and Power," 784.
15. Puchalski, "FICA."
16. Henry and Gilley, "Spiritual Assessment"; emphasis added
17. Neely and Minford, "FAITH."
18. Anandarajah and Hight, "Spirituality and Medical Practice."
19. McEvoy, "An Added Dimension."
20. Maugans, "Spiritual History."
21. Nolan, et al., "Assessing," 7.
22. Hungelmann, et al., "Focus," 262–63, 266. For an overview and assessment of such spiritual assessment instruments, see Lucchetti, Bassi, and Lucchetti, "Taking Spiritual History"; Nolan, et al., "Assessing," 12; Nissen, et al., "Spiritual Needs Assessment"; Bishop, *Anticipatory Corpse*, 241–46. For a current international catalogue of nearly 200 spiritual assessment tools of various types, see Research Group of Spiritual Care, "Catalogue."

23. Bishop, "Biopsychosociospiritual Medicine," 255–56.
24. Bishop, *Anticipatory Corpse*, 243–44.
25. Frank, "Does Medicine," 126; see also Balboni and Balboni, *Hostility to Hospitality*.
26. Handzo, "Process," 22.
27. Charon, *Narrative Medicine*, 133.
28. Charon, *Narrative Medicine*, vii; see also Charon, et al., *Principles and Practice*.
29. Spencer, "Narrative Medicine." See also Spencer, *Metagnosis*, 44.
30. Franzen, "Perchance," 49.
31. Coulehan et al., "Let Me See," 221.
32. Frank, "Does Medicine," 128.
33. Klitzman, *When Doctors Become Patients*, 164.
34. Wilson, Millard, and Sabroe, "Physician Narratives of Illness," 21; see also Spencer and Frank, "Illness Narratives," 132–34.
35. Ruggieri, *Confessions*, xv.
36. Spencer, "Wizards, Masks, and Metagnosis," 205; see also Spencer, *Metagnosis*, 175–87.
37. Schenck and Churchill, *Healers*, 158.
38. Relatedly, for an analysis of recurrent calls for reform likened to "carousel ponies circling around repeatedly in medical education," see Whitehead, Hodges, and Austin, "Captives," 765.
39. Schenck and Churchill, *Healers*, 166.
40. Leggett, "Lights Go on Again," 26. Within Major League Baseball in the U.S., the American League adopted the DH rule in 1973, while the National League did so only in 2022; the nearly half-century split fanned the flames of perpetual debate—including between my parents. See Spencer, "Loading."
41. Murray, "It's About Time," E1.
42. Hayden, *Collected Poems*, 98.
43. See for example Klitzman, *Doctor, Will You Pray for Me?*, 19.
44. Weber, "Science," 155.

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