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The Role of the Hospital Chaplain

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INTRODUCTION

While an exhaustive history of chaplaincy work and the role of the chaplain in medical and mental institutions may not be necessary in dealing with this subject, it may be appropriate and helpful to look at some of the old ideas and how they are undergoing rapid changes.

Until rather recently, it was held by many in theological and other circles that as long as a man was ordained he was adequately trained to be a minister in a hospital whether as a full or part time chaplain or a pastor calling on his own parishioners. In fact, all that was really expected of him was that he offer comfort and solace—especially to the dying—help the patients with "spiritual problems" and leave anything deeper or more complicated to the physician—the general practitioner, the surgeon, the psychiatrist—or to a social worker or psychologist.

There was a common misconception among many denominations (perhaps all denominations) that a hospital was a fine place to put a "pastor out to pasture." His best, most productive and vigorous days were over and perhaps, just prior to retirement, and even in retirement if he still had some life and ambition in him, he could serve in a hospital as a "chaplain spreading comfort and cheer."

Certainly much good and worthwhile work was done by men in such situations but this concept of the chaplain served only to emphasize the dichotomy which existed for so long in dealing with the physically or mentally ill. The physician treated the body, the chaplain the soul, and if

necessary, the psychiatrist treated the mind—actually resulting in a trichotomy approach. This approach unfortunately continues to prevail (in theory and practice) in large segments of medicine and religion even today.

However, there is a growing awareness of the interrelatedness of man's body, mind and spirit in both medical and theological circles. It is of this concept—this enlightened approach to the hospital ministry—that I wish to speak.

MY ROLE AS A HOSPITAL CHAPLAIN

First of all I am a pastor concerned with the spiritual welfare of those to whom I minister as a part of the therapeutic team. Working as a chaplain in a State University medical center, a general hospital setting, I often minister not only to patients, but to relatives and to staff and to any others who may come seeking help.

In other words, the chaplain is a clergyman who may be called upon to get involved in every possible kind of helping relationship and one never quite knows by what kind of situation he may be confronted next.

Today, in the age of specialization in all areas of human endeavor, the effective hospital chaplain is also a "specialist." I shall speak of the kind of clinical training there is available for the chaplain later in this presentation.

He must be equipped to meet every type of situation in his encounter with patients, relatives and staff members. I find that I am constantly involved in a multiplicity of relationships although my basic ministry is directed toward patients.

Serving as the first and only full-time Protestant chaplain in a large medical center, I have had to arbitrarily limit my scope of work in order that I may make the most effective use of my time. I shall attempt to describe my role as I view it after nearly four years of service in this place.

Patient

My primary duties are, of course, ministering to patients. With the growing awareness that illness is not an isolated entity and that a patient's emotional and spiritual well-being has a great deal to do with his physical well-being, his recovery from illness or surgery, there is also a growing appreciation for the so-called "team approach" to patient care.

The well-staffed hospital today includes a clinically trained chaplain who provides that dimension of care of the patient no one else can furnish. The chaplain is not a psychologist or social worker but his work may of necessity combine some aspects of these. He is basically a minister—with all that term implies in total care of patients.

In order to function as a chaplain I must utilize all the understanding and "techniques" I can muster. In approaching any patient I have an advantage over other staff members because I bring no needle, nor thermometer or such paraphernalia; neither do I diagnose nor do I prescribe medications.

I come to the patient freely allowing him to speak to me or not as he wishes. I am not there to chide nor scold even though the patient should express anger, hostility, resentment at anyone—God, family, church, physician, nurses, yes, also chaplain or any other clergy. I strive to permit the patient freedom of expression and accept his feelings. I listen to him to learn all I can. I seek for meaning in

his words and in his silences. I permit him to verbalize so that his feelings may be brought out into the open and his emotions shared by one who can minister to his emotional and spiritual needs.

Often a patient will express his feelings of guilt, believing his illness or injury and subsequent suffering are brought on by some "sin." Frequently he can point to a specific cause for his immediate dilemma or crisis and must speak of it. As chaplain, I feel qualified to help the patient explore the reason he feels as he does. If he is truly guilty of a sin of commission or omission I try slowly to bring him to a manner of dealing with it. If he desires God's forgiveness I show him it is available for the asking when able to accept it. If his feelings of guilt are out of proportion to factual evidence at hand, we work on that.

I endeavor to be supportive but not too hasty in reassurance. Acceptance of the patient's feelings, his anxiety, his loneliness, his hopelessness is of major importance. The chaplain symbolizes hope. He can foster faith in God, in physicians, in surgeons, in nursing care—so that the healing processes are able to proceed less impeded or hindered by gnawing anxiety and depression. All possible resources must be harnessed to fight illness and bring about the proper atmosphere or milieu for healing of disease and surgical wounds and catastrophic injuries.

When a patient is facing a terminal illness, the role of the chaplain is again important for he is the individual who can most effectually assist in mobilizing religious resources needed to face the ultimate reality of dying. The chaplain proceeds as far as possible at the pace of the patient "walking through the valley of the shadow of death" with him.

Often patients facing death but who have "not been told everything" by

the physician, will freely tell the chaplain he is aware of his terminal condition.

Utilizing his own faith and knowledge of patient and Scripture, the chaplain assists the dying patient to face death with as much faith and hope and peace as he can muster—the chaplain often making up somewhat for the patient's own lack of faith.

Relatives

The chaplain is frequently able to be of assistance to the relatives of patients, particularly in the case of pediatric patients. Anxiety and concern can create problems on the part of relatives relating to their hospitalized loved ones. The chaplain may do much to alleviate these fears, thus also assisting the patient and the staff.

In the case of severe and terminal illness the contribution of the chaplain to the comfort and solace of anxious and grieving relatives is often inestimable. It may be more valuable than the medical aid given the patient.

Nurses

Nurses and aids as a rule spend more time with patients than do physicians and surgeons. Consequently, if they are alert to the emotional and spiritual needs of their charges, they serve as excellent sources of meaningful referrals to the chaplain.

In making such referrals, nurses often show that they have become concerned for the patient, at times to the point of identifying with him. The chaplain may be of significant assistance to nurses caught up in such problems, particularly in cases of terminal illness and death itself.

Ward nursing team conferences involving the chaplain are of great value in further learning all that it is possible to know and can be of mutual benefit to nursing personnel and chaplain, as well as ultimately to the pa-

tient. When relatives of the patient are distressed, the chaplain may be of assistance in alleviating their anxiety and removing some of the burden from the nurse.

Physicians and Surgeons

Physicians and surgeons are becoming increasingly aware of the value the chaplain can be administering to their patients. When the physician is willing to share with the chaplain his concerns for his patient's well-being, he adds another dimension of patient care involving the whole-man approach. Furthermore, the doctor can then know he does not carry the full burden of concern for the patient.

The chaplain can be instrumental in informing the medical man of anxieties or concerns which his patient may be suffering and of which the doctor may not be aware. Occasionally a patient may express his feeling of inability to communicate with the physician—that he is not being told all he would like to know—and the chaplain is often in a position to interpret the problem.

Where relatives may be especially anxious and difficult to work with, the chaplain can be of help to the physician. In cases of approaching terminality and death itself, the chaplain stands ready to support and comfort the bereaved. Thus he can join the physician in this stressful situation and again be of assistance as another member of the team shouldering some of the physician's burdens after he has worked to save the patient's life.

CLINICAL PASTORAL TRAINING

The Clinical Pastoral Training movement got under way nearly 40 years ago with the stimulation of interested men such as Dr. Richard C. Cabot of Boston. In the early 1920's he made a specific proposal that every seminarian be required to spend a year

in a clinical setting, learning about people from *people*, not from books.

Clinical training got under way in 1925 at the state hospital in Worcester, Mass., and as the clinical training idea spread, most centers were in mental hospitals at first. A number of reasons lay behind this early development including the fact of the relatively greater length of mental patient's confinement so that the seminarian or pastor could get to know him well; also the dynamics of personality are quite revealing in mental illness.

However, many centers are now located in general hospitals where students are provided with considerable experience in crisis situations. The students relate to others on the staff and share in the total management of patients so that all aspects of their care are viewed and as adequate treatment as possible provided. This approach to total patient care requires adequate communication between various disciplines and calls for a sympathetic understanding of the capabilities and limitations, the strengths and weaknesses, of each other's role and work.

To implement this kind of interdisciplinary relationship, physicians of various specialties as well as other medical, nursing and administrative people are invited to participate in seminars with the student chaplains. Each presents his own field in language intelligible to the theologically and lay-oriented students, who in turn pose questions brought to mind by their own experiences—perhaps with patients upon whom they are currently calling.

This makes for dialogue between students and seminar leader providing the setting for further communication during the training program. Long range results are highly beneficial on both hands. Physicians gain a new appreciation and respect

for the calibre and capacity of the clergy. The theologians likewise are given new insights and admiration for the dedication, knowledge and skill of the medical men and other specialists.

Training and communication of this nature occurs during the summer as well as other times during the year in 110 clinical training centers throughout the nation under the direction of two interdenominational organizations: the Institute of Pastoral Care, Inc., and the Council for Clinical Training. Other training opportunities are being afforded by denominational groups such as the Lutherans and the Southern Baptists. These centers are primarily located in general and mental hospitals. Also included in this number are several correctional facilities as well as state schools. Taking advantage of these training opportunities are theological students in various stages of their education and ordained clergymen who feel the need for greater understanding of people in need and for greater capacity to work with people in depth. Not only do they usually become better pastoral counselors, but their preaching usually takes on new dynamics of understanding and communication.

These full-time residency clinical training programs are usually three months in length, although increasing numbers of six-week courses are being offered. One year residency and internship opportunities are also being afforded to clergymen interested in becoming professional chaplains.

Seminaries of all major denominations throughout the nation are increasingly aware of the importance of clinical pastoral training as an essential part of the education of candidates for the ministry. Such a period of training is a requirement in some seminaries. A great many seminaries incorporate several hours a week of clinical "orientation or experience" in

a local hospital as a part of a course in pastoral care. This experience may be under the direction of a chaplain supervisor, a duty chaplain in residence at the hospital, or the seminary professor of pastoral care or his assistant. It is designed to give the theologian an opportunity to gain field experience in putting into practice the learned principles of pastoral care. It sometimes serves to whet his appetite for more extensive and intensive clerical training.

I know of no such large-scale interest on the part of medical and nursing schools to have their students exposed to the philosophy and work of the clergy who are also interested in the total well-being of people. With the exception of church-related medical and nursing schools (where it can be assumed there is some confrontation of the students with the emotional-spiritual needs of patients) how can the students of other medical schools be better informed as to community resources to meet the needs of patients beyond the purely physical?

Perhaps the A.M.A. will have some influence in the development of programs in the medical schools of our nation wherein students will be given opportunities to learn how other members of the "healing team" function and their contributions to the total care of patients. Perhaps in the not-too-distant future there may be developed interdisciplinary programs involving theological seminaries and medical schools in addition to those that are already largely doing such work because of their denominational affiliations.

We who are involved in clinical pastoral education are trying to learn about people from people as Dr. Richard Cabot pleaded that we in the ministry would do some day. Now we plead not only that physicians recognize increasingly the place and role of

the ministry in dealing with patients, but also that medical schools provide facilities and require that their students learn about people—more than just their physiological makeup. They, too, need a deeper understanding of what really "makes people tick" and that people are individuals.

WHAT I EXPECT OF THE PHYSICIAN IN TOTAL PATIENT CARE

I expect the physician to be aware of the emotional, psychological and spiritual needs of his patients—to look at them as people with these dimensions as well as the physiological—to recognize the psychosomatic factors in illness.

I expect to be recognized—not merely tolerated, but accepted—as a valid member of the healing or therapeutic team, for I am a specialist in my area of total patient care. A clinically trained hospital chaplain must have at least four years of college, three or four years of theological seminary, at least three years in the parish ministry, and at least two quarters of intense clinical training as previously outlined.

I expect the physician to be willing to involve me, the chaplain, in the care of his patient in order that a greater measure of his total needs may be met and to call me or see that I am called when necessary.

I would like the physician to keep the channels of communications open between him and me so that we may frankly discuss ethical and moral and other problems without either of us becoming defensive about them.

While someone has so aptly pointed out the basic interest of medical science is the prolongation of life, and the basic interest of religion is the quality and meaning of life irrespective of its length, I expect the physician also to be concerned about the qualitative aspects of the life of his patient.