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A STUDY OF CHRISTIAN EDUCATION IN THE CHURCH-RELATED HOSPITAL

A Thesis

Presented to

the Faculty of the Department of Religious Education

Asbury Theological Seminary

In Partial Fulfillment

of the Requirements for the Degree

Master of Religious Education

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by

Phyllis Pauline Wright

June 1958

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CHAPTER I

THE PROBLEM AND DEFINITION OF TERMS USED

For many years the church has had a program of education in its Sunday Schools, Vacation Bible Schools, Bible studies, missionary circles, and other groups, but only in recent years has the interest in a Christian education program in its hospitals been growing rapidly.

I. THE PROBLEM

Statement of the problem. It was the purpose of this study (a) to determine what kind of a program of Christian education now exists in the church-related hospital, (b) to determine the attitude of the administration and chaplains of these hospitals and of the church itself toward the Christian education program which presently exists in its own hospitals, and (c) gather suggestions from these chaplains for future developments in such hospital programs.

Importance of the study. In spite of the general recognition of those who work with the sick that there are often spiritual needs in times of illness relatively little has been done by way of setting up standards for this ministry beyond immediate counseling. It is recognized also that there are those who will accept and some who will even seek spiritual help and guidance because of their

illness. Some have little or no Bible knowledge, no church affiliation or back-ground and are in need of teaching in addition to immediate counseling. This study was attempted to obtain the reactions of certain key persons who each stand in a unique relationship to the Christian education program in their hospitals. The church stands in her position as the religious body related to the hospitals, the administration in its place as governing body of the hospital, and the chaplain as the one responsible for the organizing and carrying out of the Christian education program in the hospital.

Limitations of the study. There are certain limitations inherent in a study carried out by the questionnaire method. A questionnaire should be fairly brief in order that the persons to whom it is sent will take the time to answer and return it. Though this questionnaire was checked by several persons before it was used in the study, apprently some of the questions did not convey the intended meaning to the one answering them. In some instances medical personnel were answering questions involving Christian education terminology with which they were unfamiliar. Some questionnaires were returned only partially answered. Eighty-three questionnaires were returned out of the 168 which were distributed.

II. DEFINITIONS OF TERMS USED

Religious education. Throughout the report of this investigation the term "religious education" is used to denote any positive reaction to a spiritual need in response to instruction. This is using "education" in the broad sense that in any instance in which learning takes place, there is education.

Christian education. The term "Christian education" can be used interchangeably with "religious education" in this report since all of the hospitals from which questionnaires were returned were related to a denomination of the Christian faith.

Church-related hospital. The hospitals which were included in this investigation as "church-related" were taken from an annual listing by the American Hospital Association and include those listed as church-owned, church-operated, and church-related.

Religious worker. In this report the term "religious worker" is used to denote any one ministering specifically and only to the spiritual needs of the patients or staff members in a hospital.

III. ORGANIZATION OF REMAINDER OF THESIS

Since it is a generally accepted premise in any

undertaking to "start from where you are" an attempt was made first to survey the literature written on the subject. Then the question was studied to discover the attitude of the church toward religious education in hospitals both from the answers to the questionaires and from the literature, because it is the church which furnishes and trains the ministers and chaplains and provides the literature to be used in the program. The second division of this report shows the views of the administrations of the hospitals who initiate and control religious programs in their institutions. The third viewpoint is that of the chaplain himself. It is he who organizes the religious education program and for the main part, executes it. Lastly, on the foundation of these viewpoints certain conclusions are drawn.

CHAPTER II

RESUME OF HISTORY AND PRESENT STATUS OF PROBLEM

Much attention has been focused recently on the counseling phase of the religious workers' ministry in the hospital. There have also been a few short courses established for special training for hospital chaplains. In spite of this, one chaplain indicated to me that he was not able to find any standards for a curriculum for his teaching and several of the publishing houses said they did not have anything written pertaining to this subject, "Christian Education In the Church-Related Hospital."

I. REVIEW OF THE LITERATURE

Much has been written in regard to the emotional and spiritual needs of the sick, the importance of sympathy and understanding of these needs on the part of those who work with and minister to them, and the art of counseling with them. Westberg points out that "The nurse is with the patients at a time when the very foundations of their lives are being shaken."[1] He further describes illness as "this is a lonely experience and the patient pleads for

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[1]Granger Westberg, Nurse, Pastor, and Patient (Rock Island, Illinois: Augustana Press, 1955), p. 13.

friendship and understanding."[2] He shows how a nurse can conduct a spiritually therapeutic conversation with individual patients in her daily contacts. This certainly points out the necessity for some religious education in the nurse's training.

A group to whom our hospitals minister that needs special spiritual attention is the physically handicapped. Anna B. Hayes says:

> It is hard for a whole, healthy person, however understanding, to realize the full measure of bitterness that may attend a physical handicap even in an adult.... The handicapped child, not yet mature enough to be philosopical, stands in far greater need for the best help available.[3]

She continues with the thought that the handicapped child often feels a hunger for spiritual things and greatly needs reassurance and spiritual security. These people often have much time to think and recognize their need.

An annual report of Fairview Hospital, Minneapolis, Minnesota, had for its cover photo a picture of a chaplain, a nurse, and a doctor, with the quotation from Plato, "As you ought not to attempt to cure the eyes without the head or the head without the body, so neither ought you to attempt to cure the body without the soul."

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[2]*Ibid.*, p. 19.

[3]Anna H. Hayes, "Helping the Handicapped Child," (Chicago: International Council of Religious Education), p. 1. (Mimeographed from National Parent-Teacher, December, 1948.)

In a commencement address to nurses Rev. Albert P. Shirkey of Mt. Vernon Place Methodist Church in Washington, D. C. said:

> The one thing that you must never forget as a nurse is the fact that people are not just bodies, but they are complete, whole personalities that simply cannot be divided; and unless you take this into consideration, you will never be able to minister to ill people.[4]

He continues, "When life gets out of adjustment physically, a person is out of adjustment all over.... Not only will you find this individual mentally upset, you will also find this person spiritually upset."[5]

Among the things listed as things that he thinks a nurse should carry into the sick room are a radiant countenance, the peace of mind that means quiet poise, and a strong and unbroken faith in God.[6]

In several articles nurses, doctors, and chaplains agreed that a genuine Christian atmosphere in all departments of the church-related hospital is not only of great value but is practically a necessity. The Board of Hospitals and Homes of the Methodist Church has printed a four page leaflet on "The Importance of a Chapel in Every Methodist Hospital and Home." In this it is stated that, "It is as

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[4]Albert P. Shirkey, "The Art of Being a Nurse" (Commencement address to nurses, Chicago: Board of Hospitals and Homes of the Methodist Church), p. 2 (Mimeographed.)

[5]*Ibid.*, p. 3.

[6]*Ibid.*, pp. 5,6.

necessary that the Christian atmosphere dominate the institution as it is that rest, medical care, protection, and guidance be afforded its occupants."

Dr. Andrew Elia, who is both an assistant professor in Boston University School of Medicine and a visiting professor of Psychology and Clinical Training at Andover Newton Theological School, says that in his lifetime he has witnessed an increasing recognition by both of these groups of the need for medicine and religion to become allies. Distinguished physicians are turning to men of religion to help where medical science alone is not sufficient.[7] He places the responsibility of emotional and spiritual preparation of the patient for hospitalization as well as the responsibility for factual instruction on the physician. He quotes his colleague at Massachusetts Memorial Hospitals, Dr. Krumbhaar, as saying:

> Every physician sees patients who....become self centered, querulous, and difficult. He also sees people who make illness or tragedy the means of gaining in understanding, unselfishness, and love for others. Few physicians perhaps realize that they themselves are often the ones who determine which of these courses a patient will follow. He must help them to develop spiritually not in spite of but because of the illness.[8]

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[7]Andrew D. Elia, M. D., "Spiritual Needs in the Care of the Patient," Bulletin, American Protestant Hospital Association, XVIII-3 (July, 1954), p. 5.

[8]Dr. Douglas G. Krumbhaar, "Physician Without Physic," New England Journal of Medicine, June 4, 1953, cited by Andrew D. Elia, M. D., op. cit., p. 6.

By pointing out the patient's need for sympathy and understanding Dr. Elia shows the importance of a spiritual atmosphere in every department of the hospital. He further shows that this spirit can be manifested by all of the hospital personnel doing the extra little things beyond the bare duties in patient care. The chaplain is placed in the center of this spiritual atmosphere as a source of inspiration and integration for the whole program.[9]

Richard Young, Director of the Department of Pastoral Care of Bowman Gray School of Medicine, tells how the church actively opposed the progress of medical science as far back as the sixth century beginning a breach between the two. Recognizing that in this present generation medical science is pointing out the need for a total approach to the total person he asks, "Is not the church obligated to re-emphasize its ministry of healing and to prepare its pastors for more intelligent cooperation with the medical profession?"[10]

He suggested that because of the pastor's contacts with his congregation in church activities and in pastoral calls he may have a finer perspective of a patient's personality patterns and emotional drives than the doctor. The sharing of these with the doctor may vitally affect the

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[9]Elia, op. cit., p. 6.

[10]Richard K. Young, The Pastor's Hospital Ministry (Nashville, Tennessee: Broadman Press, 1954), pp. 5, 6.

recovery of the patient. The pastor can also greatly assist the patient in the adjustment of going home especially in case of long convalescence or handicap.[11]

He further shows that the value of this cooperation has long been recognized but only recently have the two professions joined in a systematic, recorded study. The Art of Ministering to the Sick by Richard C. Cabot and Russell L. Dicks has become a classic in this connection.

But nearly all of the writers emphasize that there is an area which belongs strictly to the doctor, an area that belongs to the pastor, and an area where they overlap. Each must respect the area of the other in order that the total ministry be most effective.[12]

Clesson W. Richardson, who has acted in both capacities, says, "The doctor acts as assistant to the Great Physician, the chaplain as assistant to the Great Shepherd."[13] He recognizes that man is a body-mind-soul complex that requires both of these ministries. Therefore the chaplain fills a necessary place on the hospital team. Chaplain Richardson gives some instances illustrating how the chaplain in this shepherd relationship has aided the doctor. He

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[11] Ibid., pp. 24, 25. [12] Ibid., pp. 29, 30.

[13] Dr. Clesson W. Richardson, Chaplain, "The Chaplain's Contribution to the Practice of Medicine", Bulletin, American Protestant Hospital Association, XVIII-3 (July, 1954), pp. 1, 3, 4.

mentions one patient who was scheduled for surgery but began to seriously question "whether she really ought not to cancel the operation and trust in the Lord for healing." The chaplain met this problem with:

> A discourse on how God has progressively revealed His resources of healing to present day doctors,... an earnest prayer with her asking that God might make it very plain to her about the proposed surgery, and left her to continue in prayer for guidance.... She had surgery and an uneventful recovery with no more doubts.[14]

Other cases which he mentioned included working with a psychiatrist, a surgical patient whose recovery was slow because of a guilt complex, a grandmother who needed to be convinced that her life could still be useful to others. "These shepherds tend their sheep by day and night" in many situations such as visitation before surgery, having their favorite hymn played over the public address system at the daily chapel hour, introducing newcomers to the area to the pastor of their choice, helping children and their parents make the adjustments necessary to hospital procedures, sponsoring an informal Twenty-third Psalm Club in which the initiation is the correct rendering of the shepherd's psalm, ministering to the bereaved family, and establishing good lisison between the patient with cancer, his doctor, and his family. The obstetrical department presents its own problems such as the mother of a deformed child or

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[14]*Ibid.*

a terrifying monster, family problems of the mother, and the unwed mother.

He gives one example in which there was a great deal of Christian teaching needed and possible. The hospital chaplain had established a friendly rapport in previous contacts with ten year old Jon who was wasting away with an incurable disease. Jon's background was one of an evil and vicious influence. The chaplain tried to convey the loving concern which he felt to Jon. Jon seemed to have some idea of right and wrong but the chaplain had to teach him to want to be a good boy and to ask Jesus to forgive him for being a bad boy. When the chaplain sang "Jesus Loves Me" Jon appropriated the phrase, "Little ones to Him belong" for himself. The chaplain gave him the New Testament for which he asked, read Matthew 18:1-5 to him, and explained about Jesus loving little children, that Jesus is not far away but is right here knocking at his door, (Revelation 3:20). Jon spoke up, "I want to open the door, but I don't know how." The chaplain continued this teaching by directing Jon in a prayer of asking Jesus to show him how to open the door.[15]

Chaplain Richardson sums up the doctor-chaplain relationship thus:

> The doctor's work, of necessity, deals with temporary matters, while ours, by God's grace, deals with matters of eternity. The doctor has a passion to see

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[15] *Ibid.*

> healing, the chaplain has a passion to see right relationships with God. Speaking as one who has functioned as a doctor in this and other lands, may I affirm my sincere conviction that the spiritual awards that come to a chaplain cannot be excelled by any that can come to a doctor. God grant that we may ever measure up to the opportunities that come to us as assistants to the Great Shepherd in our respective hospitals.[16]

Westberg believes that the chaplain needs to take time to get to know the patient as a person. He says, "Recent studies have clearly shown that a chaplain ought to see a few patients, more intensively, rather than all patients superficially." The quick superficial visit of the chaplain is compared to a doctor only having time to stop at the door to say "hello".[17]

Russell Dicks points out the importance of a spiritual ministry in times of illness because this is a time of crisis when the issues of life and its uncertainty are brought clearly into focus. At this time "beliefs are tested and often found wanting."[18] The person who is a practicing Catholic, Protestant, or Jew has a clergyman and a belief in prayer, Scripture, or Sacrament to help to meet this need. But for those who do not have this background, Dicks says, "...other methods must be found. It is my belief

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[16] Ibid.

[17] Granger Westberg, Nurse, Pastor, and Patient (Rock Island, Illinois: Augustana Press, 1955), p. 71.

[18] Russell L. Dicks, B. D., Who Is My Patient? (New York: The Mac Millan Company, 1943), p. 20.

that often such help must come not from the clergyman but from the nurse and doctor if it is to come at all."[19] He cites three specific cases in which the patients were each receiving excellent medical and nursing care, and yet had needs beyond this. He suggests that, "By the nature of her work the nurse is in the best position to observe these necessities and if she does not deal with them herself she can call them to the attention of some one else."[20] Because she spends a considerable amount of time with the patient in carrying out her nursing procedures she can meet a need in listening as he talks. She may suggest to him that she will call his clergyman or another one if he seems reticent to talk to that one. Or she may take one into the room casually introducing him as "Rev. Mr. . . who was in the hospital" or as "Rev. Mr. . . that I wanted to have speak to you." Then the clergyman starts with her authority.[21] Young stresses the importance of a good relationship between pastor and nurse calling cooperation from the nursing staff necessary for the minister to work effectively. The pastor's part is to ask for the nurse's permission to visit the patient and for any observations of the patient's condition

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[19] Ibid., p. 21. [20] Ibid., pp. 32,33.

[21] Ibid., pp. 77-84.

which would assist him in his ministry to the patient.[22] In order that the nurse might recognize the patient's need of a spiritual ministry even before he requests it Dicks brings to her attention signs and special times of this need. He warns that the spiritual needs of the patient are complicated and often masquerade as something else. He lists general signs as asking for a Bible, clergyman, or prayer; guilt feelings; loneliness; apprehension or fear; and negative signs such as strong resentment toward church, religion, or clergy. There are conditions peculiar to illness which cause stress in which the clergyman can be especially helpful. The patient facing surgery nearly always thinks of death in one way or another. In the loneliness of a long convalescence the patient needs human fellowship in its own right as well as to stimulate and direct Divine fellowship. Many patients need special help in facing the future with a physical handicap after their illness. He says, "The physician is limited in dealing with this problem professionally because he is so close to the patient and is often associated with, if not definitely held responsible for, the handicap in the patient's minds." The clergyman can bring the "perspective of religion" to help the patient accept the handicap and adjust to it. This perspective is defined as "the thought

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[22]Richard K. Young, The Pastor's Hospital Ministry (Nashville, Tennessee: Broadman Press, 1954), pp. 26-28.

of life five years, etc. from now", "a unique virtue of religion." Facing death may be a special stress but religion transcends both life and death. In summing up the ministry of the doctor and the clergyman in these times of stress he says, "The basic interest of medical science is the prolongation of life; the basic interest of religion is the quality and meaning of life irrespective of its length."[23]

Young lists the general basic needs of the patient in two categories:

> The critically ill patient needs the companionship of his minister and a strengthened faith which will increase his will to live. In chronic illness the patient desires a genuine understanding of his plight; he needs to reach some sort of adjustment to the burden of the illness and to recognize the opportunities within the illness; he needs some hope and companionship; and he needs also to be assured that some bitterness and frustration are to be expected."[24]

More specifically he mentions areas where the pastor should not fail to minister in a few types of patients. The basic problem of the preoperative patient is fear. This fear may be based on ignorance of procedures, on uncertainty, on necessary adjustments after the surgery, or on taking an anesthetic. The ministry here is one largely of support. In the immediate postoperative period the patient is concerned with the immediate discomforts and fighting for life and needs

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[23]Dicks, op. cit., pp. 34-51.

[24]Young, op. cit., p. 60.

the ministry of companionship. As the postoperative period moves into convalescence the patient is concerned about future adjustments and needs the ministry of counseling. The problems of the convalescent are varied, including an attitude of giving up, a sense of being isolated, loneliness, boredom, pain, fear of dependency on others, or the economic problem. The convalescent needs a strong faith in God. Spiritual faith is often greatly strained when physical strength is suddenly cut off. The ministry here is to strengthen or rebuild a spiritual faith. The convalescent sometimes needs a ministry of sympathy, but it must not be a sentimental, shallow sympathy, rather the kind that calls for action. This is a time when more extended counseling can be carried out.[25] The extent depends, of course, on the length of hospitalization but in general would be shorter than the contact in the pastor's study. Therapeutic efforts should proceed as rapidly as possible. A spiritual climate should be created that would melt the barriers within the patient and between patient and counselor.

In speaking of the art of listening in counseling patients Dicks says:

> If given the chance, the patient will carry us to his religious needs, and often times through his discovering them they are ministered to and his hopes strengthened but nonetheless our part is significant

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[25] *Ibid.*, pp. 94-105.

> in this process....Listening is the ability of one person to encourage and give another person the opportunity to talk."[26]

Qualifications of the listener are a willingness to trust God, an ability to be non-judicial, to be spiritually healthy, and to really care for the person enough to take time. In this technique the chief instrument, the question, is used to express one's interest in the patient, to encourage him to talk, to hold him to the subject, and to probe. The listening is terminated with reassurance given in the form of a positive statement and given briefly, simply, sincerely, but not too soon. This is effective in proportion to the authority which the person has with the patient. Reassurance is also gained through prayer.[27]

Young characterizes the art of listening as "the resource most frequently used in the pastor's hospital ministry", yet "the most difficult technique to impart to the would-be counselor," and "a powerful instrument for good or harm according to the skill with which it is practiced."[28] He warns:

> On routine visits the pastor has no ethical right to use any technique that will cause the individual to reveal material that he did not intend to share. Many times it is a temptation to 'pull out' with the listening method, material one knows is underneath,

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[26]Dicks, op. cit., pp. 87,8. [27]Ibid., pp. 92-106.

[28]Richard K. Young, The Pastor's Hospital Ministry (Nashville, Tennessee: Broadman Press, 1954), pp. 69-71.

> but nothing is ever gained by the method unless the individual willingly enters into an experience of trusted sharing.[29]

"Does God send suffering?" will be met sometime by nearly any one who ministers to the sick. Dicks called suffering a chief instrument in the building of souls for fellowship with God. He answers this question:

> God does not send specific suffering; He does send suffering in general. That is, God wills suffering as an experience in the world, as an instrument with a purpose. The creative way to deal with experience is upon the basis of: What can I do with this opportunity? It is the task of each of us to discover the desire of God for himself; to search for the meaning behind every experience.[30]

Things which Young lists as the pastor's resources for his hospital ministry are the influences embodied in his traditional role of pastor, the ministry of listening, the Bible, prayer, and the conscious use of the voice to create an atmosphere of peace and quiet. "The pastor's role as a representative of God occupies the central place in the healing methodology of his ministry to the sick." The Bible, too, has traditionally been known for its inexhaustible resources of comfort and strength for those facing crises in life. But for maximum effectiveness it should be used with a specific purpose for each case. It is comparatively easy to find in it examples of experiences similar to that of the patient to help him to gain perspective. If

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[29] *Ibid.*, p. 71. [30] Dicks, *op. cit.*, p. 149.

the pastor has committed certain passages to memory he can quote a few appropriate verses to a critically ill patient. The patient's interpretation of a passage may reveal his deeper, underlying needs. In any case, Young believes the patient ought to be given the opportunity to make a choice of a Scriptural passage. This assures that the Scripture will be a familiar one. He suggests that when a Scripture verse is to be left with a patient it makes it more personal to jot it down on a scratch pad from his pocket than to pass out printed material.[31] Westberg tells of the following instances in which nurses enter into this ministry. In some Mennonite hospitals it is customary for each of the entire personnel to go individually, following morning chapel service, to a patient's room, introduce himself, and ask the patient's permission to read a short portion of Scripture. In certain Deaconess hospitals in Germany on the wall of each patient's room is a calendar which has a Scripture verse for each day. As the nurse greets the patient each morning she reads the verse for the day.[32] Westberg and Dicks have both listed suggested Scripture portions for hospital ministry which are given in the appendix to this study.

"Prayer, intelligently employed is another potent

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[31]Young, *op. cit.*, pp. 61-66.

[32]Granger, Westberg, *Nurse, Pastor, and Patient* (Rock Island, Illinois: Augustana Press, 1955), p. 47.

therapeutic resource in the hospital ministry." He believes that there is no "pat" formula as to when one should use prayer and when not but rather the pastor must constantly seek the mind of Christ for this. This depends much on the needs of the patient but also on the situation and on the experience and knowledge of the patient. When the patient has requested the pastor's visit they usually welcome a prayer. When the patient feels the need of confession, a prayer laying the whole matter before God to take away the guilt can be a potent therapeutic resource. In the supportive ministry with those facing surgery, the acutely ill, those facing death, or the bereaved, he uses intercessory prayer to call for spiritual comfort, encouragement, and strength. He further says, "Prayer also serves a teaching purpose as one ministers in the sickroom; that is, it teaches the patient to get beyond the immediate situation.."[33] Dicks says:

> Prayer makes us sure of ourselves because the self becomes submerged in God, doubts give way to confidence, discouragement to hope, because we submerge our minds in the mind of God as we pray. Prayer does not change God's mind or will for us but it brings us into line with His mind and will: it helps us to play our part, and to trust the Eternal Father.[34]

The responsibility of prayer with the patient will sometimes fall on the nurse. Patients may ask the nurse for

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33Young, op. cit., pp. 66-67.

34Russel L. Dicks, Who Is My Patient? (New York: The Mac Millan Company, 1943), p. 113.

prayer when they would not want a pastor or at a time when a pastor would not be readily available.[35]

Since illness affects the whole person the patient may be more sensitive, irritable, hostile, or suspicious than usual. Therefore the initial contact in visitation is extremely important. At this time a working relationship between patient and pastor may either be established or prevented.[36] Following is a composite list of simple rules from those who have done visitation.

1. In general do not go into any room where the door is closed without first finding out from the nurse or family the circumstances existing behind it.

2. Observe special signs such as "No Visiting" or "Isolation" that are hanging on the door. They are there for a definite reason; find out the reason and respect it.

3. When a light is on over the door wait until the nurse takes care of the patient's needs.

4. Do not touch the patient's bed or apparatus and equipment attached to it.

5. While entering the room quickly size up the situation as to indications of the patient's condition, evidence of previous visitors, etc.

6. Let the patient take the lead in shaking hands,

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[35] Ibid. [36] Young, op. cit., p. 55.

and then returning the pressure with like strength.

7. Take a position in line with the patient's vision so he is not required to move around in bed.

8. Beware of letting the visit become a pathological conference. Don't share your own or other's hospital experiences with the patient.

9. Be relaxed. Don't carry tensions from one patient to another.

10. Keep the visit short, even counseling sessions should rarely be over forty-five minutes.

11. Leave when the patient's meal is delivered.

12. In a small ward, speak to all of the patients.

13. "Don't whisper or speak in low tones to a nurse, to a member of the family or to any one else in the sick-room or near it, if there is the slightest chance that the patient will see you or hear you."[37]

14. Don't use medical terms, that is, don't pose as a psuedo-medical man. Represent Christ.

15. Cooperate with other members of the healing team. It is good etiquette to check at the nurses' desk before visiting.

16. Times suggested for visitation are not before eleven A.M. but before lunch, after lunch but before general

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[37] Richard C. Cabot, M.D., and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: The Mac Millan Company, 1945), p. 26.

visiting hours, or after afternoon visiting hours but before the evening meal. This will help to avoid being interrupted by other visitors.

In using prayer in the sickroom Young suggests that it be fairly short, be in a conversational tone, lift the individual up to God, give the patient's spiritual need as he himself recognizes it, and that the patient be helped to pray.[38]

In speaking on The Relationship Between Hospital and Church" Rev. Ray Anderson reminds us of the spiritual inheritance of the healing ministry recorded by Luke, the New Testament doctor:

> St. Luke 8:38,39: "The man from whom the demonds had gone begged that he might be with Him; but he sent him away, saying, Return to your home, and declare how much God has done for you. And he went away, proclaiming throughout the whole city how much Jesus had done for him." And again: St. Luke 17:15-19: "Then one of them, when he saw that he was healed, turned back, praising God with a loud voice: and he fell on his face at Jesus' feet, giving him thanks. Now he was a Samaritan. Then said Jesus, Were not ten cleansed? Where are the nine? Was no one found to return and give praise to God except this foreigner? And he said to him, Rise and go your way; your faith hath made you whole."[39]

Ambroise Pare, a sixteenth century surgeon, left the principle of his life and practice of God and man working to-

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[38]Young, op. cit., p. 68.

[39]Rev. Ray Anderson, D.D., "The Guiding Principle of Ambroise Pare (The Relationship Between Hospital and Church)," Bulletin, American Protestant Hospital Association, XIX-3 (July, 1955), p. 6.

gether in the healing ministry in the words inscribed on his statue, "I dressed the wound, God healed the patient." Anderson suggests that the task of our church-related hospitals today is to follow Jesus' example by sending the patients back to their homes and churches "to praise God for what has happened." The chaplain or pastor should have helped them to find "a new direction in their soul to carry them into a new life in Christ and the church."[40]

Ritz Heerman, then president of the American Hospital Association, left his challenge to the 1954 American Protestant Hospital Association Convention by recalling Jesus' words in Luke 10:25-37:

> "And behold, a certain lawyer stood up and tempted him, saying, Master, what shall I do to inherit eternal life? He said unto him, what is written in the law? How readest thou? And he answering said, Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy strength, and with all thy mind; and thy neighbor as thyself."

When Jesus was asked, "Who is my neighbor?" he gave the story of the Samaritan who stopped to care for the sick man. Heerman then says, "This is our calling, the care of the sick. ...We must never lose the spiritual inheritance which gives our chosen field a special richness."[41]

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[40]*Ibid.*

[41]Ritz E. Heerman, In his address to the 1954 Convention of the Protestant Hospital Association, *Bulletin, American Protestant Hospital Association*, XVIII-2 (April, 1954), p. 1.

Even as the healing ministry has a spiritual inheritance in Jesus' example the modern hospital movement has an inheritance of spiritual consecration. For a thousand years or more the hospitals of Europe were maintained as charity institutions to care for the sick and injured poor who had no other refuge or relatives to care for them. These unfortunate ones were cared for by members of religious orders as an act of religious devotion in the spirit of the Good Samaritan. Three-quarters of a century ago the hospitals in this country presented a similar picture. Sisters in the Catholic hospitals and Deaconesses in the Protestant hospitals cared for the sick poor, cooked, did the janitor work, and all that needed to be done. There were no paid employees.[42] Westberg gives the origin of the typical hospital in an average American community as a time of some acute need fifty to one hundred years ago when a church basement or parsonage was pressed into use for emergency care by people who were inspired by the Master to do something tangible about the need.[43] This close tie between healing and the church has been severed. But recently it is being rediscovered that those pioneers were motivated by the spirit of Christ "who healed the sick because

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[42] William C. Perdew, "The Church Hospital As An Employer," Bulletin, American Protestant Hospital Association, XIX-4 (October, 1955), p. 2.

[43] Granger Westberg, Nurse, Pastor, and Patient (Rock Island, Illinois: Augustana Press, 1955), p. 78.

He could not resist ministering to the whole man in order to bring about the abundant life."[44] Basic religious concepts of the Protestants do not require that one withdraw from the world to be religious. Rather Protestants believe that religion should be practically expressed in all of the relationships of daily life. Therefore they believe that Protestant hospitals may have paid employees who are still doing their job in this spirit of spiritual devotion and consecration.[45]

Frank Tripp, executive secretary of Southern Baptist hospitals states his idea of the ministry of the church-related hospital as follows: "The hospital offers the best possibility for Christian witnessing because in itself it provides witnessing in three ways: preaching, teaching, and healing."[46] He says this in the light that the cnurch is measured by the number of people that it can reach and the hospital is its one agency in which there are more people concentrated and available to the message.[47] One student nurse at New Orleans Southern Baptist Hospital gave her reason for being there by quoting her favorite Scripture verse, "I am come that they might have life, and that they

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[44]*Ibid.*, p. 79. [45]Perdew, *op. cit.*, p. 3.

[46]Frank Tripp D.D. "A Christian Atmosphere in the Church-Related Hospital in Employee Relations," *Bulletin American Protestant Hospital Association*, XVIII-2 (April, 1954), p. 5.

[47]*Ibid.*

might have it more abundantly."[48]

Young lists the following five motives for the hospital ministry of Southern Baptists:

> (1) to give medical care to the poor, (2) to carry out the healing ministry of Jesus, (3) to provide a Christian atmosphere for the sick, (4) to train godly young women in the field of nursing and to furnish an avenue of service to doctors and nurses who feel the Christian call, and (5) to enlarge its program of evangelism.[49]

As the church-related hospitals live up to these motives surely they are, as Young calls them, "among the most useful instruments for home mission work which the denomination possesses."[50]

In addition to this ministry of the hospital staff the patient can often times be reached and helped spiritually through literature written especially for him. Dicks has not only written for those who minister to the sick, but he has written also for those who are sick. In his book, Meditations for the Sick, he recommends relaxation as an aid to recovery. In order to really relax the patient should lose his consciousness of himself and his trouble. But he must fill his mind with other things.[51] When the pastor visits

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[48]Don Minton, "A Nurse's Training Starts at Home, "Home Life, IX-4 (April, 1955), p. 30.

[49]Richard K. Young, The Pastor's Hospital Ministry (Nashville, Tennessee: Broadman Press, 1954), p. 15.

[50]Ibid., p. 127.

[51]Russell L. Dicks, Meditations for the Sick (Chicago: Willett, Clark, and Company, 1937), p. 2.

the sick, he, as an individual, is interested in the patient and how he is getting along. But as a pastor, a representative of religion and of Christ, he is interested in leading the patient from himself to a far better relationship with Christ. If he voices a prayer at the bedside, it will, no doubt, be for recovery of health for the patient but beyond that for a peace and poise which is of the Eternal.[52]

J. Otis Young gave as a standard for Methodist hospitals that they have Christian books, leaflets, and other reading material within reach of every patient and visitor. Religious pictures and symbols should be on the wall of every patient's room, in the halls, offices, and waiting rooms. To give a Christian witness the church-related hospital ought to provide a place for private worship in a chapel not used for other purposes and to make adequate provision for pastoral care for each patient.[53] Chaplain Draheim does not want the patient's room "cluttered up with religious 'props'" but wants the patient to find in his room "a good religious picture, a Bible, and a prayer book in good condition."[54] At another time he elaborated a little

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[52] *Ibid.*, p. 82.

[53] J. Otis Young, "What Our Church Expects of Her Hospitals" (Paper presented at the Convention of National Association of Methodist Hospitals and Homes, St. Louis, Missouri, February 8, 1956).

[54] Lester W. Draheim, "A Christian Atmosphere in the Church-Related Hospital In Patient Relations, "*Bulletin, American Protestant Hospital Association*, XVIII-2 (April, 1954), p. 5.

on this standard. The Bible or a New Testament with Psalms which should be at each bedside should not be large enough to be cumbersome for the patient to handle. He also suggests that a daily devotional book be available to each patient and that tracts may well be used with moderation by the chaplain for distribution.[55]

Of the tracts written especially for the sick the series, "Comfort and Strength," has come to attention the most frequently. Included in this series are: (1) leaflets for specific occasions such as "Your Big Moment" for the patient who is being prepared for surgery, "So You're a New Patient", and one for Thanksgiving; (2) leaflets on special topics such as "You're Closer to Prayer Than You Think"; and (3) leaflets to meet special needs of the patient such as fears, giving up, tensions, unbelief, and crying out in despair, "Why did this happen to me?" These are four-page leaflets that are simple, attractive, well written, and easy to read. Some tell the story of how other patients in similar circumstances have allowed Christ to help them in order that the reader may gain understanding of his own problem through identification. Others simply present the claims and invitations of the Bible and of Christ to meet

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[55]Rev. L. W. Draheim, "Full-Time Chaplain in the Hospital," _Bulletin, American Protestant Hospital Association_, XIX-4 (October, 1955), p. 4.

the patient's needs.[56]

II. STANDARDS FOR THE CHAPLAIN

The study turned next to find what qualifications had been set up for the one who is to administer the spiritual work. Several denominations, organizations, and institutions have manuals or at least lists of these. One of these pamphlets states:

> This statement deals with qualifications and training of the chaplain, with his appointment, with his basic relationships in his work, and with other administrative questions. It does not attempt to erect standards for the details of his day by day work, but merely to mark out the areas of his proper functioning.[57]

Dr. Elia says "The chaplain's present role is not well defined."[58] The reason for this is because the hospital has not always recognized the need and called the chaplain. Rather he has been sent in and supported by an outside agency which believed he had value to the hospital. This value lay in his ability to meet a special need of the patient which does not come within the realm of either physician or psy-

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[56]Rev. Harold Peters Schultz (ed.), "Comfort and Strength" tract series, (St. Louis, Missouri: Evangelical and Reformed Church Federation).

[57]_Standards for Chaplaincy Service in Institutions_ (Commission on Ministry in Institutions, New York: Federal Council of the Churches of Christ in America), p. 1.

[58]Andrew D. Elia, "Spiritual Needs in the Care of the Patient," _Bulletin, American Protestant Hospital Association_, XVIII-3 (July, 1954), p. 7.

chiatrist and thus contribute to the total care of the patient.[59] An answer to the question, "What should be his real role?" was sought by putting together these statements of various groups. This was approached first through the avenues of "why" should there be a chaplain administering a spiritual program and "who" should this chaplain be. Nearly all say or at least suggest that the hospital chaplain is first of all a minister of the Gospel and a pastor to the people under his care. In this capacity his purpose would be to deepen the spiritual life of believers, to lead others into a living fellowship with God through Jesus, and to bring comfort and hope to the distressed.

The standards which these groups have suggested mark out a big job which would require more than an ordinary person. The qualifications which they have suggested for this extraordinary person are here divided into formal, personal, and spiritual qualifications. These in the following category, which are called formal qualifications, are the ones having to do with his education and fields of interest.

1. College and theological school degrees from approved schools.

2. Ordination and denominational endorsement with evidence of the current approval of that denomination and pastoral experience.

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[59] *Ibid.*

3. Specialized training in a clinical course of counseling, a course of orientation in hospital procedures, or in-service training under another chaplain.

4. An interest in psychology, counseling, and research is the best kind of ministry to people in hospitals.

5. A desire to be constantly learning through study, observation, and experience.

6. Be familiar with church and denominational history and philosophy.

7. Have a thorough enough acquaintance with the history and content of the Bible to find passages easily and quickly.

Suggested as desirable were these personal characteristics

1. Physically well and strong.

2. Have a cheerful, friendly, genial personality, well adjusted with a capacity to give and take.

3. Have a stable tempeament with ability to be relaxed not showing hurry or worry.

4. Be, by nature, a leader yet have the unfeigned humility and modesty in his position to put himself in the background.

5. Be attentive and courteous with a complete sincerity.

6. Be prompt, regular, dependable, readily available, and cooperative, mindful of rebuffs but never resentful.

7. Have a determination to become acceptable and proficient in his field.

8. Have a concern for the hospital's reputation in its professional services, its religious influence, and its teaching standards.

Very important in describing the one who is to be the center of the religious program would be his own spiritual qualifications. These qualities which must necessarily characterize that one are summarized thus:

1. He must be spiritually minded, firm in the faith, consecrated to Christ, continuing in the study of God's Word, and growing in his personal spiritual experience.

2. Because of a definite sense of Divine calling to this work, he has a desire to express his love and devotion to Christ by ministering in His name to those who are in hospitals.

3. He must have an uninhibited readiness in prayer.

4. He must be able to recognize the patient's spiritual needs and have the conviction that spiritual help may have a direct influence on their healing.

5. While he is loyal to the denomination of the hospital, his ministry is often to those of many denominations and must therefore be interdenominational.

All of these groups had somewhat to say about how the chaplain should be appointed and how his work should be set up in relation to other departments. Those who mentioned his appointment specifically recommended that it be by the institutional authorities with the consent of or nominated

by the appropriate church group. In relation to the other departments he should:

1. Be a department head with full sway in the formation of policy in the department and the privilege of attending department head meetings.

2. Be loyal to the policies of the hospital and gear his ministry to the overall program of the hospital.

3. Be responsible to the administrator and to the religious activities committee of the board of trustees, if there is one.

4. Have a trustee to represent him on the board to defend his actions or to initiate new projects which need the consent of the board.

5. Initiate such cooperative relationships with other departments and other members of the hospital staff as are possible without sacrificing religious principles.

6. Be included in the doctor's plans for his patients.

7. Be on the teaching staff.

While the chaplain is associated with the hospital he still retains his ministerial relationship with his denomination. As a clergyman he abides by the same professional ethics that he would in a church. That is to say he will compromise no point of doctrine or morality, he will not reveal confidences, and he will attend such church meetings, conferences, and conventions as will be helpful to him or will promote the chaplaincy program in the denomination.

His church officials may reasonably expect him to furnish them with necessary reports of his work. In turn he may expect them to furnish him with certain supplementary items such as special literature or specially consecrated items, but he retains the right of selection of the proffered materials. Some groups suggest that the chaplain wear wome identifying insignia even though their ministers do not routinely wear special clerical garments. The Board of Hospitals and Homes of the Methodist Church suggest that patients would often times invite him to their rooms if they recognized his status.[60] Others do not prescribe any special dress.

Also included in "how" to have a chaplaincy program is how shall it be supported. The groups who mentioned support said it should come from the hospital and should be commensurate with that of ministers in the church pastorate and professional members of the hospital staff with equal training and skill. This would provide, too, for advancement in salary with increased competency in skill. In addition to salary it was recommended that the hospital furnish him with two other funds. An operating budget will cover such things as materials for religious education and special holidays.

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[60] Suggestions for Qualifications of Chaplains in Methodist Hospitals (approved by Board of Hospitals and Homes of the Methodist Church, 1954), p. 4.

Beyond this situations arise in which the chaplain needs a discretionary fund to meet needs of a confidential nature.

How many chaplains are needed to adequately carry on a program of Christian education in the hospital? This must necessarily vary with the type of hospital and the type of patients to which it is ministering as does the program itself. A suggested standard would be one full time chaplain of the major faith group for the first 150 patients with an additional chaplain for each additional 500 patients of that same faith group. Other faith groups should be represented by a chaplain of their group for 250 patients or a part time chaplain for less patients.[61]

In order that the chaplain carry out an effective program of Christian education he needs adequate quarters and equipment. Foremost he needs a private office which he can use for study, for interviewing and counseling and where he can keep confidential records. This office ought to be easily accessible to those coming from within the hospital and to those coming in from the outside. There ought, also, to be a chapel used exclusively for religious purposes and open at all times for patients, visitors, and staff for prayer, meditation, and worship. Young also suggests a good intercommunication system to each bed and residence in

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[61]*Standards for Chaplaincy Service in Institutions* (Commission on Ministry in Institutions, New York: Federal Council of the Churches of Christ in America), pp. 6,7.

or near the hospital because of emergency calls at night.[62]

After considering why there should be a chaplain, who this chaplain should be in terms of his qualifications, how he should be appointed, how he should stand in relation to the hospital and to his denomination, how he should be supported, how many chaplains are needed for an adequate Christian education program, and where his quarters and equipment are, the next avenue of approach was, "What shall be the nature of his work in the hospital?" Since the realization of the need for such a program with a chaplain at the center of it is still in the growing stage, he must first sell himself to the staff. In order that his ministry may be an integral part of the healing ministry of the hospital he must coordinate his work with that of his collegues and oftentimes serve as a liaison between the doctor and the patient. His work has been summed up in the following words:

> A clergyman in an institution attempts, so far as possible, to recreate the conditions of parish or local church life, that is, to perform as many of the ministerial functions as are relevant to the institutional situation, for patients, and, as he may be called upon, for staff and other employees.[63]

By the nature of the group to whom he is ministering he personally has the responsibility of organizing and supervising

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[62]Richard K. Young, _The Pastor's Hospital Ministry_ (Nashville, Tennessee: Broadman Press, 1954), p. 129.

[63]_Op. cit._

the whole spiritual program and carrying out most of it. This program can be broken down into parts according to the several groups of people with whom he works. His ministry to the primary group, the patients, and to their loved ones is basically the same type of ministrations as in a church pastorate, but differs distinctly from it in some of the details. He provides worship services in the chapel but also in the wards, with the permission of the doctor, and at the bedsides. His congregation is available, via the intercommunication system daily and at many hours of the day. It may consist of several denominations and faiths necessitating care to avoid offence to any of them and to avoid any proselyting. In the chapel special care must be exercised for the comfort of the worshippers.

He must be prepared either to administer ministerial acts such as the rites and sacraments or to call the patient's own pastor for these as the patient may desire. His pastoral duties begin with visitation but his list of parishioners is constantly changing and he must have some system, varying with the hospital, of meeting them and their needs in a short time before their discharge from the hospital. Times of special physical need call for alertness on the chaplain's part as the greater part of his time is spent in dealing with the individual in visitation and counseling. These times often open up opportunities for a spiritual ministry to those who would not otherwise recognize a need for it.

They may be referred to the pastor of their preference in their home community and thus the chaplain's ministry is extended to the community and continued. This introduces another important facet in this big job, that of a liaison between the patients and their home church and clergyman. Articles written by two different chaplains stated that when the patient is a regular member of a church his own clergyman ought to be notified and allowed to minister to the patient if he desires.[64] Besides this individual ministry the chaplain ought also to arrange for group worship for other faith groups when they are large enough to warrant it. While indiscriminate visiting for religious ministry is discouraged, the chaplain may well approve religious ministry and distribution of selected literature by qualified workers and ministers. Relatives of the patients often go to the chaplain with pleas for reassurance and interpretation of the illness or of hospital routines. This gives him the opportunity of showing concern and understanding to them as well as to the patient himself.

A second group connected with the hospital to whom the chaplain ministers is the student nurses. Many of these, too, are away from their home church and need a pastor. They

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[64]L. W. Draheim, "Full-Time Chaplain in the Hospital," Bulletin, American Protestant Hospital Association, XIX-4 (October, 1955), p. 4; and James E. Flinchbaugh, "Within Hospital Walls," National Council Outlook, (July, 1956), p. 21.

need to be encouraged and helped to find a new church home and one close at hand where they feel free to ask for help with spiritual problems. Besides the general chapel services to which all patients and hospital personnel are welcome he may conduct chapel services for the student nurses at an hour which especially fits their schedule. It is recommended that he be used as advisor on religious activities for the school of nursing in Southern Baptist hospitals.[65] He is their pastor, counselor; advisor; teacher, and co-worker inasmuch as the student nurses' talents can be used in chapel services.

Probably the group in the hospital which is least touched by the chaplain's ministry is the employees. They should understand that he is there willing to be a personal counselor to them at any time. But they can be instrumental in getting his program integrated into the overall program of the hospital by understanding his purpose and program and then by observing and reporting to him cases where he may be of spiritual help. As an interpreter of the philosophy and policies of the church-related hospital to employees he promotes understanding and happiness.

Beyond the hospital the chaplain is perhaps the most

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[65]"Recommendations for the Southern Baptist Hospital Chaplaincy" adopted by Southern Baptist Hospital Chaplains; and Administrators' Convention, February, 1953 cited by Richard K. Young, The Pastor's Hospital Ministry (Nashville, Tennessee: Broadman Press, 1954), p. 130.

likely person to have the opportunity to promote understanding between the hospital and the denomination, the hospital and individual churches and their clergy, and the hospital and the community.

Christian education must always be an integral part of Christianity and the church. Therefore the pastor must always deal with this function. In the church he delegates most of the teaching to others, but in the hospital the chaplain does all the teaching. His teaching to the patients may be in the obvious form of Bible classes, but more often is incorporated in his visitation and counseling. Both as an additional program and an auxiliary to his work with the patients he carries on an educational ministry to other groups within the hospital. In order to aid the chaplain in making his spiritual ministry a vital, integral part of the whole healing ministry of the hospital these other groups, which include nurses, doctors, medical students, theological students who are working under the chaplain, and even some pastors from the community, must first feel a personal interest in the spiritual ministry and then an interest in extending it to the patients. In classes to these groups the chaplain will aim first of all to get them to see their own needs and have them met, secondly to show them his aims and methods in ministering to the patients, then to arouse in them a desire to cooperate in this ministry. Lastly, he will teach them some of the signs of spiritual need in the patient,

how they can observe and report the needs to him, and some basic techniques of counseling which they can use at the moment when a patient opens up a need to them and can use to reach those who reject the chaplain because of his professional status but will accept counsel from the one who had already won their confidence by ministering to them physically. If any other persons or groups are carrying on religious education within the hospital it must be on approval of and under the direction of the chaplain. This then is what the literature marks out as the "real role of the chaplain."

III. SPECIAL CHAPLAINCY TRAINING

Richard Young says, "It is imperative that denominational hospitals have chaplains trained to work with the medical profession."[66] He quotes J. F. Murrell, administrator of the Miami Baptist Hospital in Oklahoma, thus:

> Baptists will use their hospitals to greater spiritual ends when they institute a program for training men for the highly specialized task of ministering to the sick. Theological training, as furnished by our seminaries, is essential as a background, but it is not enough. A clinical training program for this work is vitally needed, for only when we have men especially trained for this task will they fit into the hospital routine and be welcomed by the physicians and nurses, because they work along sound lines and cooperate with them and do not work independently of them.[67]

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[66]Young, op. cit., p. 16.

[67]J. F. Murrell, cited by Young, *op. cit.*, p. 16.

Because of Austin Philip Guile's vision of this necessity and his labors in this field at Andovar Newton Theological School the hospital chaplaincy was recognized as a specialty by the "establishment of the first chair in any theological school in the country, the Guiles Chair of Psychology and Clinical Training" at that school.[68] Other seminaries and hospitals, seeing this need, have instituted courses for this study. No special study of these courses was made as this seemed to be a side issue relevant only to the extent that such training is available. This fact was established from literature which was included with answers to the questionnaires sent out. A list, which is by no means exhaustive, of courses for this specialized training is included in the appendix. Also some hospitals sponsor two or three day workshops in pastoral care. The methods of study in these courses varied including lectures, seminar discussions, attendance at medical and surgical clinics, actual counseling with verbatim reports, special reading with book reports, studies on special topics, and individual interviews with chaplains, psychiatrists, or directors of the course. Topics studied ranged from orientation into hospital organization and procedures, the art of counseling,

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[68]Andrew D. Elia, M. D., "Spiritual Needs in the Care of the Patient," Bulletin, American Protestant Hospital Association, XVIII-3 (July, 1954), p. 5.

the mechanics of hospital visitation, the relationship of the chaplain to various individuals and groups in the hospital, the application of clinical findings to the pastorate, and others.

IV. PREVIOUS INVESTIGATIONS

The American Protestant Hospital Association, through its Commission to Study Religious Work in Protestant Hospitals, has made studies of the ways in which a religious ministry to patients was carried out in various hospitals of the country. The most recent one of these which came to the attention of this investigator, "Religious Work in Protestant Hospitals, Standards and Reports-1945"[69] is the one treated here. This study was carried out by sending questionnaires to various Protestant hospitals of the country. Earlier studies made by that Commission, "Report of the Religious Work in Protestant Hospitals-1941" and The Report on the Commission to Study Religious Work in Protestant Hospitals-1943," were mentioned in it.

The 1945 study reveals a trend toward the "Standards" which were adopted by the American Protestant Hospital

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[69] Religious Work in Protestant Hospitals, Standards and Reports - 1945. A study made by the Commission to Study Religious Work in Protestant Hospitals, American Protestant Hospital Association, compiled by Rev. Harold Peters Schultz. New York: Federal Council of Churches of Christ in America.

Association in 1940 and revised after the 1945 study. This trend was evidenced in a large increase in the number of chaplains employed in Protestant hospitals between 1941 and 1945, in increased cooperation between the hospitals and churches in religious ministry, and in an increased number of hospitals providing a private office for the chaplain. Some of the less encouraging findings of the 1945 study were that the number of chaplains with special clinical training did not keep pace with the increased number employed and that only a small number of the courses taught to student nurses dealt with the spiritual aspects of their ministry to the sick. The need for still more cooperation between clergy, physicians, and hospital personnel was revealed especially by the answers concerning visiting clergy coming into the hospital. Very few of the visiting clergy cleared with the nurses or doctors to find out the patient's condition or need before visiting. The question, "What religious literature is distributed to your patients?" brought out a definite need for more literature written specifically for the sick or dying, and for more care in the selection of the literature which was being passed out. The fact was established that in most cases the hospitals which had made more provision for a spiritual ministry, usually with a full time chaplain, were stronger at the above mentioned "weak links" than were those which made little or no provision.

The report was concluded with "Recommendations to the American Protestant Hospital Association". The needs for a full-time chaplain, for specially written literature, and for better clergy-physician relationship were touched upon in these recommendations. The "Standards for Work of the Chaplain in the General Hospital", which this commission officially approved, lists suggestions under the following topics: (1) the training of the chaplain; (2) the chaplain shall be responsible to the administrator of the hospital; (3) the chaplain shall cooperate with the other personnel of the hospital; (4) the chaplains shall have a rational plan for selecting the patients he calls upon; (5) records of the chaplain; (6) the appointment of a chaplain; (7) worship in the hospital; and (8) it is written, "Man shall not live by bread alone." Very little was mentioned in them about his actual work or his opportunities for Christian teaching.

The study revealed a growing interest and an improvement in an adequate provision for a spiritual ministry by the church-related hospital but showed a long way left to go.

In this report as in the other literature reviewed only a little has been said about the possibilities that exist for a program of Christian teaching in the church-related hospital. For the religious worker to teach courses to nurses or student nurses was a fairly common practice but

apparently the content of those courses varied with the worker. The possibility of a program of Christian teaching with other groups was barely mentioned with nothing said about content or quantity.

V. PRESENT STATUS OF THE PROBLEM

The existence of the great number of church-related hospitals that we have today is proof that the church has believed that its commission was threefold: teaching, preaching, and healing. But in many instances it has detached these from each other and relegated each to its own institution. That the hospitals are recognizing their need for this is shown in the way they are making a place for a chaplain to head the preaching ministry and more recently giving him a teaching ministry also. The medical profession too, is recently heralding "the total approach to the total person" and thus recognizing the need for a spiritual aspect in the healing profession. Without a trained religious worker in the hospital, the nurse and doctor are confronted with the spiritual problems of the patient. Neither is trained to meet them. Young says, "The opportunity which exists in this generation to enter into a total ministry to the total person is the greatest which the church has faced since Jesus set the example."[70]

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[70]Young, *op. cit.*, p. 5.

In the light of this, is not the church obligated to co-operate in this total approach by preparing its pastors for this particular ministry?

With this recognition and increasing interest on the part of those concerned, this program of a combined ministry is growing. The emphasis thus far has been on the counseling phase of the chaplain's work. Those who would add the other third of the threefold ministry, teaching, must experiment with what to teach, when, and how. Little has been written on this other than varied suggestions and general principles.

CHAPTER III

METHOD USED AND GROUPS STUDIED

The problem as stated in Chapter I was to determine the kinds of programs of Christian education now existing in church-related hospitals, determine the attitude of those in certain key positions toward those programs, and to gain suggestions for future developments in this field. It was necessary to limit the field by confining the investigation to some selected group that would be representative.

I. METHOD OF PROCEDURE

Methods considered for obtaining the information were personal interviews and questionnaires. Too great an amount of time and expense would be involved to attempt very many interviews. The questionnaire seemed to provide the best means of obtaining necessary data.

Because the information desired covered a very broad area it would not have been difficult to list many questions. But the number of replies would probably vary inversely with the number of questions. Therefore an attempt was made to ask for information that would be readily available to the person answering the questions and to so word the questionnaire that the replies would demand the least possible amount of effort. Check mark and completion type of questions

seemed to be the answer to this. The questionnaire was further shortened by grouping the questions under major headings. It was hoped that this subject was new and sufficiently pertinent to create sufficient interest to counterbalance the length of the questionnaire.

In order that the questions might be relevant and significant an interview was arranged with a chaplain in a hospital. Next the question sheet was submitted to two experts in religious education for criticism. Then the final questionnaire was compiled beginning with a short explanation of the purpose of it and the proposed study.

II. SOURCES OF DATA

Since it is a generally accepted fact that a particular group should be canvassed as completely as possible if the results are to produce significant information, it was intended to include all of the church-related hospitals in a given area. Names and addresses of these and their administrators were obtained from the annual listing of hospitals by the American Hospital Association in a special issue of their monthly magazine.[1] This magazine also contained a map dividing the country into nine districts. Three adjacent districts; four, five, and six shown in

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[1] Hospitals, The Journal of the American Hospital Association, Part II, (June 1956).

Figure 1; were chosen. A mailing list was made including, insofar as possible, all of the Protestant hospitals which were listed as church-owned, church-operated, and church-related. Questionnaires were then sent to the administrators of these hospitals with the request that they be filled out by the person in charge of religious education and returned. Out of the 168 which were mailed out, 83 or 49.4% were returned. This was considered an average response and a large enough percentage to gather trends of thought and actions.

FIGURE I

DISTRICTS OF THE UNITED STATES AS DIVIDED BY

THE AMERICAN HOSPITAL ASSOCIATION[2]

1. New England
2. Middle Atlantic
3. South Atlantic
4. East North Central
5. East South Central
6. West North Central
7. West South Central
8. Mountain
9. Pacific

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[2] *Ibid.*

CHAPTER IV

THE ATTITUDE OF THE CHURCH

In Chapter II the church's attitude toward the Christian education program in its hospitals was reviewed as revealed in articles and bulletins by various groups telling what they expect and require; in the literature which they have written especially for hospital use, and in their provision for specialized training for the hospital chaplaincy. This chapter attemps to catch the attitude of the church toward its Christian education program in church-related hospitals by its practical working in the hospitals as reflected in the answers to the questionnaires.

Among the questions were: Are the churches supplying other religious workers where there is no chaplain? What type of religious ministry is being carried on in these hospitals? Does this ministry vary according to denomination or because of some other factor? Are the churches providing for a spiritual ministry to all groups within hospitals, or only to certain groups?

It was found that theoretically the church has set down requirements for high personal and spiritual qualifications for a chaplain to head this program. They asked that this chaplain's motives be a sense of Divine calling or a desire to express his love and devotion to Christ by ministering in His name to those in hospitals. They set

fairly high requirements for accredited college and seminary training with some pastoral experience and prefer that the chaplain have some specialized chaplaincy training. This interest in the specialized training began only in recent years but has been growing rapidly and has resulted in clinical pastoral training courses. Some of these have been set up by theological seminaries; some are sponsored by the Institute of Pastoral Care, Incorporated,[1] a nonsectarian educational foundation; and some are sponsored jointly by these two. These courses provide the chaplain practical experience in counselling with the sick. But the church expects him to be at the hub from which the Christian atmosphere radiates and permeates the whole hospital via all possible avenues, through counseling and otherwise.

There is perhaps more need for the church to actively show its concern by furnishing religious workers for the hospitals with no chaplains. Of the 83 hospitals responding to the questionnaire, 28 or 34% had no chaplain. In seven or 25% of these 28 there were staff members trained for religious work, and in three of the seven and two others there were religious workers from outside groups. In two hospitals there was a chaplain-of-the-week program. In

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[1]Institute of Pastoral Care Incorporated, Massachusetts General Hospital, Boston 14, Massachusetts.

four church-related hospitals apparently no arrangements were made for any spiritual ministry. They all welcomed the patient's own clergyman and sixteen endeavored to list the patients according to local church or denomination for visiting clergymen, or for use in notifying pastors to call on patients of their own membership or those of their own denomination. In seventeen hospitals the church had no sort of organized program to reach the patient or employee who is without any church connection.

There is also need for the church to furnish helpers for hospital chaplains. Of the 56 hospitals with chaplains who responded fourteen of them had outside religious workers coming in to assist or augment the chaplain's work. In eight of the fourteen these helpers were under the chaplain's direct supervision. They included one group of students, one minister, church groups, and individuals from the hospital auxiliary, loçal churches, and Gideon auxiliary.

Of the thirty chaplains who listed suggestions for the improvement of religious education in their hospitals three said they had recently added personnel and eleven indicated a need for more personnel. In only two of these cases were there any outside religious workers assisting chaplains. One of the eleven specified a director of Christian education, four specified chaplains, and the others said their need was for added personnel. Could not

the church furnish both the specially trained personnel and volunteers to augment their work?

These workers whom the churches have sent have used various avenues of approach for their spiritual ministry. They come in contact with the patients in the course of their hospital duties; thus they are readily available for spiritual counseling. In addition to this they had a planned spiritual program which included either a weekly chapel service or daily devotional period or both in each of the hospitals where they were rendering service. Other plans which were mentioned in this group were playing religious records over the public address system each evening, having prayers on cards on the meal trays, and personal witnessing to individual patients as they ministered to their physical needs. Groups coming into these hospitals which were without a chaplain conducted a religious service in the chapel, hallways or sang and read Scripture in the wards. One questionnaire reported that most of the local churches had a visiting committee.

One of the hospitals reported using a chaplain-of-the-week program to acquaint the ministers of the community with its services during its first months of operation. In another instance the chaplain-of-the-week program was carried out by the ministerial board of the city. These ministers, acting as chaplains, would have a point of contact

with all the patients but would have very little opportunity for any type of continued influence or teaching. Hospitals which made no other provision for a spiritual ministry had various ways of notifying the local clergymen, such as: listing the patients by churches, filing patients' names by denomination in a file for the ministers, sending a card to the ministers for each admission, phoning them for critical patients, and allowing the ministers to check the registry. Some of these pastors made regular routine visits, others come only when notified but in most of the cases their visits were limited to the members of their local church or of their denomination. These visits were usually regular pastoral calls in which the pastor made such use of Bible reading, prayer, and devotional literature as was fitting to the occasion and in which he was ever alert for any need of further counseling. This type of ministry, of course, affords much opportunity for follow up. In one of these hospitals ministers taught a class for student nurses but the questionnaire answer did not indicate the content of the teaching.

Hospitals with chaplains also welcomed the local pastors but usually to call only on their own members or personal friends. In one of these hospitals a minister came in to teach a course for student nurses. The ministry of other religious workers showed a somewhat different

trend where there was a chaplain. The need here was to assist the chaplain and to augment his work. Most of those whose work was not under his supervision reported their findings to him or worked in other areas. Some of these acted as assistants to the chaplain in making first calls and referring patients with special needs to the chaplain, in interviewing patients to find those desiring communion, and in distributing religious literature. One volunteer just works with the new mothers. In one hospital staff nurses conduct devotional period with patients as a part of regular P. M. care. A group of students carried on a special ministry of singing once a week on the geriatrics ward and in another hospital the chaplain used groups from church organizations in conducting worship periods.

One of the services which was distinctively Christian education was teaching a Sunday School class for children. But as this activity was mentioned by only three of the eighty-three hospitals reporting it would seem that this is more of a challenging possibility for the future than a fact of the present. Two of these were in children's hospitals in connection with a general hospital and quite likely included children who were long term patients.

Only twelve of the hospitals without a chaplain reported any kind of chapel or devotional service for patients and of these seven have staff members trained for religious work. One of these hospitals has a chaplain-of-the-week

program. Still another is affiliated with all of the Protestant churches in its area and these ministers are responsible for the weekly chapel service. There seems to be a positive correlation between the hospitals that do not have any type of worship service and the hospitals that apparently have no one on their staff trained for religious work. In only one case was it stated that the churches of the community were responsible for chapel services where there was no trained staff member.

Distribution of religious literature, a part of the spiritual program which is educational, is dependent on the church. This literature comes either from denominational or other Christian publishing houses. Seventy-six of the hospitals with chaplains stated that they purchased new all of the religious literature which they used, while twelve purchased part of it and had the rest donated. Two hospitals used no religious literature. One hospital stated that their literature was sent by their state denominational social service department for free distribution to patients and visitors. Additional ways in which the churches helped to supply literature were religious folders to be placed on trays and providing tracts for the chaplains. In one case the church furnished copies of the book, _Nurse, Pastor, and Patient_ by Westberg,[2] for the

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[2]Granger Westberg, _Nurse, Pastor, and Patient_ (Rock Island, Illinois: Augustant Press, 1955).

student nurses. This book gives the nurse valuable instruction on when and how to counsel patients. There was only one hospital reporting which did not indicate that Bibles were available to the patients and many of them mentioned that the Giseons had provided them. Ten hospitals did not indicate that devotional literature was available to the patients. General devotional and prayer books were the most commonly listed literature, then tracts and denominational papers. Very few of these seemed to be written especially for the sick. It would seem that providing literature written for patients constitutes a challenge to the church.

Other ways in which the church identified itself with the religious education program of the hospital were listed. These included furnishing speakers for the chapel services, inviting the hospital chaplain to speak to various church groups concerning his work, giving financial support to the hospital program, and the appointment of a conference religious work supervisory committee. One hospital reported that it was affiliated with a denominational college for a degree course in nursing and another denomination furnished a full time deaconness for the hospital.

The study did not seem to reveal any particular differences in the religious education work being done by the different denominations. There were 14 denominations represented in the 83 replies and several of them had only

one or two hospitals, which was not a sufficient number to show trends.

Student nurses are the second large group within the hospital who are often away from their home church and need the ministry of the church. Of fifty-three hospitals with student nurses only twelve reported that they had their own denominational group for the girls in the hospital. Nearby churches would, no doubt, welcome these students, but their working hours are very often such that they need a special hour for meeting to fit their schedules. Nurses' Christian Fellowship groups met in nineteen or 37% of these. There were only nine of the groups of student nurses that did not have a worship or chapel service and five that had only an occasional service. Only three of the ten hospitals without chaplains that had student nurses had any provision for chapel services for them. One of these reported that such services were conducted by the pastors of the community.

There was special ministry to other employees except in two instances where the chaplain provided worship services for them. In thirty-six of the hospitals the chaplains said they were counselors to the employees showing there was a ministry available even though many of the employees were living at home and had their regular church connections.

CHAPTER V

THE ATTITUDE OF THE ADMINISTRATION

Next was explored the extent to which the administrations of these church-related hospitals encouraged and aided a Christian education program in their hospitals. The administration, being directly in charge, can encourage, keep out, or merely allow a religious education program in the hospital.

It appears that the American Protestant Hospital Association is not only theoretically but actively interested in extending religious work in hospitals. This group, which is representative of administrators and chaplains of Protestant church-related hospitals, set up "Standards for the Work of the Chaplain in the General Hospital."

In many instances the interest of the administration in a spiritual program is first evidenced by the fact that a chaplain has been employed to be in charge of such a program. Of the eighty-three hospitals ansering the questionnaires fifty-five had a chaplain. These were divided into thirteen with only a part-time chaplain, thirty-six with one, and six with more than one full time chaplain. There was a positive relationship between the size of the hospital and the employment of a chaplain. All of the twenty-eight hospitals with two hundred or more beds had a chaplain and

only four of these were part-time. Of the twenty-seven hospitals with between 100 and 199 beds nineteen had a chaplain and only four of these were part-time. In the twenty-eight smallest hospitals, those with less than one hundred beds, only eight had chaplains and five of these were part-time. Hospitals with one full-time chaplain ranged in size from twenty-six to fourteen hundred beds. In the survey, hospitals with only a part-time chaplain ranged in size from thirty-two to three hundred beds and those with more than one full time chaplain ranged from 235 beds to 665.

Inasmuch as twenty-six of the chaplains answered that they had taken special clinical training courses ranging in length from four months to two years hospital administrations must be seeing the value of such training. They had either employed a chaplain who had this training or as in one case at least, had allowed him time for it after they employed him. Though the two studies did not cover the same group of hospitals perhaps it is significant that in the previous study in 1945 only eight per cent of the religious workers had had any supervised clinical training as compared with the forty-seven per cent now. The interest in having a chaplain, of course, is much older than in him having special training. The answers, "always", "many", "several", "years", that the hospital has had a chaplain

program show that some administrations have long felt the chaplaincy to be a necessary part of a church-related hospital.[1] In contrast to that, seventeen hospitals or thirty-five per cent of those who gave definite answers had started their chaplain's program in the last five years. Eleven had started the program between five and ten years ago. Only twelve had had a chaplain's program for over twenty years. A seventy bed hospital reported that they had always had a chaplain; a 346-bed hospital had only a chaplain for a year and a 350-bed hospital for two years. This variation in the time when the interest in the chaplaincy first began must have been due to the individual administrations since it did not correlate with either the size of the hospital or the denominations.

The administration of the hospital is responsible for the status of the chaplain in the hospital. By making him a department head it is shown to staff and patients that they consider the work of his department equal in importance and on a professional level with the other departments of the hospital. Thus the chaplains in thirty-seven or sixty-seven per cent of the hospitals answering go about their work with the authority of the administration behind them. In one

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[1] Religious Work in Protestant Hospitals, Standards and Reports - 1945. A study made by the Commission to Study Religious Work in Protestant Hospitals, American Protestant Hospital Association, compiled by Rev. Harold Peters Schultz. New York: Federal Council of Churches of Christ in America.

of the hospitals the administrator answered that he was also the chaplain, but that a full-time, fully accredited chaplain had been called to begin his duties soon. This administrator felt that his two-fold responsibility hampered him in developing the chaplaincy program including religious education, which he felt to be necessary. In ten of the hospitals the chaplain was considered only as a part of the staff but apparently not important enough to have a separate department, and seven of these ten had had a chaplaincy program for over ten years. In one hospital, he was a board member and in another he was given only the same privileges as any other minister who came to call.

Closely linked with the status which is given to the chaplain in the hospital, and a key to how he is accepted professionally by the administration and other staff members, is the amount of medical information which is placed with him. It was encouraging to note that in thirty-two of the hospitals, the chaplain was given access to the medical records which put him professionally on the level with the medical staff. From the viewpoint of the clinically trained chaplain particularly this is often a great asset to his work. The previous investigation of 1945 reported that the medical records were available to the religious worker in 54% of the hospitals which is not significantly lower than the 58% in the present study.[2] In contrast to this,

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[2] Ibid.

medical information was accessible to the chaplain only the same as to any other minister in seventeen of the hospitals, and through the doctor in one of the hospitals. Nurses, who are allowed to give only a very little medical information, were given as the chaplain's access to this information in three of the hospitals. However, thirty-nine gave the contact through nurses as a secondary source. This places a responsibility on the nurse to oabserve signs of spiritual need even as she observes signs of physical and medical need in her patients. In turn the administration has the responsibility of teaching her to observe all such signs of need.

It was stated that in thirty-one of the hospitals there was no set policy as to whether the chaplain should work in cooperation with the medical staff or independent of it. Only four said that there was a set policy of cooperation. In these four cases as department heads the chaplains had access to medical records. The chaplain was a counselor to the other employees in forty of the hospitals but consultation was usually initiated by the employee himself, since the administration requested it in only three of the hospitals. This attitude of the administration leaves the chaplain more free to work with the other employees in caring for the patients rather than being over them.

An area of the chaplain's work where he needs and

very often gets the help of the administration is in making the contact with the patient. The patient is asked his religious preference at the time of admission in eighty of the hospitals with or without chaplains. In many of these the patient was informed that there was a chaplain and the chaplain was notified of the admission. Thus the patient could see that the chaplain had the endorsement of the administration. In forty-eight of the hospitals the patient was notified at the time of admission. In thirty-two hospitals this information was given in special literature for this purpose. Of the samples returned with the questionnaires some were prepared by the hospital and some by the chaplain. Only two of the hospitals assumed that the patient would know about the chaplain without being told. In one case the chaplain announced it by visitation, and in another they were notified by the nurse. The hospitals used various ways to inform chaplains of the admissions. In fifty of the hospitals the admission office was responsible but did it by various ways such as giving the patient a copy of the admission slip, by phone, by a denominational file, and through the medical library. The chaplain had to take the first step in contacting the patients by visitation in only four of the hospitals.

In order that he may carry on a rounded program of religious education the chaplain must have some facilities with which to work. One of the most common and essential

things is a chapel for worship services, meditation, or group meetings. Fifty-five of the hospitals had chapels but they were not identical with the ones that had chaplains. In fifteen or twenty-seven per cent of those with chapels there was also a public address system of some sort to bring the worship or devotional services to those who could not go to the chapel. There were several indications that in other hospitals this was a definite need.

When the administration will use the chaplain in the educational program with the student nurses, medical students, or with other religious workers, it affords him the opportunity to lay some ground work for religious work with the patients, and is at the same time religious education for the student. The most familiar part of the educational program in the hospital is the student nurse program. Although this is most often thought of as scientific education, thirty-one of the fifty-three hospitals with both a chaplain and student nurses report that they are using the chaplain to add the spiritual to professional training. Inasmuch as the chaplain is usually responsible to the administrator the courses taught by the chaplain reflect the attitude of the administrator to some extent, at least. However, in some cases the chaplain is allowed free choice of courses to teach.

The growing trend of hospital administrations to hire chaplains who have had special clinical training

has resulted in hospital administrations working with theological schools to provide clinical training. In nine of the hospitals with chaplains, student religious workers were coming in and in each case attended classes taught by the chaplain. In seven of the hospitals this was a course sponsored jointly by the hospital and theological school, council for clinical training, or Institute of Pastoral Care. The classes in the other two hospitals were taught by the chaplain without a connection with a theological school. In one hospital the chaplain was giving an occasional lecture to medical students.

In the fourteen hospitals in which outside religious workers were ministering, the chaplain was supervising the work in eight of the hospitals. The attitude of desiring trained religious workers was further reflected in nine hospitals which did not permit outside religious workers other than ministers and they usually only to call on their own church members or patients of their own denomination.

If there is to be a Christian education program in the hospital without a chaplain the responsibility falls on the administration to make the arrangements with pastors for visitation, for worship services, for religious literature, and for any religious education for the student nurses. The nineteen of the hospitals without chaplains there was a systematic way of notifying the ministers of

admission of their parishoners or patients of their denomination. In ten hospitals postal cards were mailed to the pastors, in three the pastors were communicated with by telephone, and in six there was a denominational file or list for the use of the pastors. There were three hospitals which depended on the ministers finding the patients by making regular rounds of visitation. In two of them there was a chaplain-of-the-week program. Four hospitals reported that they notified the ministers only when a patient requested it.

Hospitals having chapel services, religious literature available and classes for student nurses, have already been considered from the view point of the church. They also reflect the attitude of the hospital administration.

In cases where administrators answered the questionnaires several of them directly expressed favorable attitudes toward religious education programs in their hospitals by giving an evaluation of their program or suggestions for improvement of it.

An attitude of complacency or indifference was revealed by such statements as, "the pastors of the community visit their patients quite frequently and are always willing to come", "the patients seem to appreciate it", and "the system is very satisfactory". These answers were from the administrators of six hospitals of less than one hundred beds with either no chaplain or a part time one. The

administrator of a 225-bed hospital with a chaplain indicated that they felt their program to be successful. Reflecting a different attitude, another administrator gave the impression of not being in sympathy with any aggressive Christian education program by saying that their chaplaincy program was directed to the patients only to the extent that they requested it. He observed that most of the patients who were receiving planned and elective health care were spiritually prepared and adjusted but the emergency and critical cases needed more intensive spiritual care. In contrast to these, other answers revealed that administrators are concerned about further developing their religious programs. One simply listed "full time chaplain" as a suggestion for improvement in his hospital, another called a chaplaincy program "one of our dreams" which he felt sure would come to pass, and a third indicated plans for development when they moved into their new building. The administrator of a forty-bed hospital with a chaplain said they were planning a new hospital and would be able to work out a religious education program, which he believed was essential in every hospital. Another need was voiced from a small Mennonite hospital, which had sisters on the staff but no chaplain, that every employee have an interest in the souls of others. They expressed need of a program to develop such concern. Another small hospital without a

chaplain distributes a folder to patients telling them that the staff is concerned in helping people both physically and spiritually, explaining their program, and offering to help the patients in any way possible.

Attitudes varying all the way from prevention, permission, to active encouragement and aid to Christian education programs in their hospitals were reflected. The Church cannot give assistance to the program and the chaplain cannot carry out any program without the permission of the administrative body of the hospital.

CHAPTER VI

THE ATTITUDE OF THE CHAPLAIN

The attitude of the church is reflected in the way it gives assistance to the religious program in its hospitals and the attitude of the hospital administration is evidenced in the way it gives permission, encouragement, and aid to the program. The attitude of the chaplain is revealed in the way he carries out the program. In Chapter II the question, "What should be the chaplain's real role?" was discussed from several angles. This chapter reports how the chaplains on the job are carrying out their role and the new roles which they are learning through experimenting with new procedures of their own.

The first interest which is manifested in any work is that of acquiring the proper training for it whether that be general or specific, in school or on the job. In the case of the chaplains included in this study twenty-six showed professional interest by acquiring a specialized clinical training beyond the basic requirement of theological training. There were four others who answered that they had had specialized training but did not answer where or how and two of them said that they had attended institutes and workshops. Their training varied from four week refresher courses to two year courses for qualifying the chaplain to train others.

Specialized training was acquired in general hospitals, university hospitals, church-related hospitals, mental hospitals, medical schools, the army, seminaries, and other places. In contrast to this there was one who answered that his seventy-one years of of preaching was the best training to be had. His evaluation of the success of his program was, "nothing helps like common sense and experience."

In the matter of chaplain-patient contacts one chaplain said that the nurses often called his attention to particular patients that needed his help. Then as a possible improvement in his religious education program he suggested a better system of training the employees to observe and report to him patients in need of spiritual help. Several chaplains returned samples of literature which was given to patients to inform them of the chaplain's services. Most of these were written by the chaplain to meet the particular situation. One chaplain used a series of three beginning with the small folder, "The Hospital has a Chaplain," put in each room when it is prepared for a new patient; then a sheet, "The Hospital has a Chapel service," put on each Saturday evening dinner tray to invite the patients to the Sunday chapel service; and a small, fourteen page booklet, "Prayers for Hospital Days," which he has written and distributes as he visits. Other

hospitals have purchased many copies of this prayer book for their use. Among the samples was a four page leaflet with a message from the chaplain printed in the form of a personal letter on the front page, several prayers applicable to specific situations common to hospital patients and an announcement of chapel services and references to Scripture passages especially relevant to hospital experiences. Others contained a brief message from the chaplain, a prayer or two, an announcement of the time and place of religious services, with perhaps a picture of the chapel, the hospital, or the chaplain. Another chaplain possessing the gift of writing poetry included several of his own devotional poems which various circles of churches of his denomination had had printed. For patient-chaplain contact patients were informed that they could ask the nurse, telephone the chaplain, or go to his office. One chaplain had a card given to patients when they were admitted that they could fill out and return to him requesting a visit. Another had a returnable form for them to fill out requesting him to notify their own pastor or a minister of their denomination. Several others indicated that they notify the patient's own pastor for him either routinely or by request.

In evaluating his program one chaplain reported that the doctors and nurses have always welcomed the chaplain's help at times of death or other difficult times for the

patient or family. That others shared this appreciation was indicated when twenty-five of the hospitals said that the chaplain was always called in cases of death. In seventeen questionnaires the answers varied from usually, not always, to sometimes and three stated that chaplains were called only by request. Another said the patient's own clergyman was called and if he were not available the chaplain went.

Patients of all religious groups were ministered to by the chaplain in nearly all of the hospitals responding. In three of the hospitals the chaplain answered that he visited only those of his own denomination. However, in one of these there were eight chaplains of different denominations each ministering to his own people and in another other ministers were notified by card or telephone call. There were four hospitals in which the chaplain ministered to all Protestants. One chaplain, who sees the Roman Catholic patients only on request, says that this happens more frequently than one would suppose. Out of the forty-seven chaplains who ministered to all religious groups there were four mentioned as ministering to Roman Catholics. In one instance the chaplain attributed part of the success of his program to the fact that the constituency, patients, and staff were all of the same religious background making it easy for his preaching and his visitation to complement each other. The part-time chaplain of an interdenominational

hospital, who was appointed by the city Council of Churches, visited those who requested it, those to whom he was referred, the non-affiliated, and all Episcopalians. A twenty-six bed hospital without a chapel holds religious services every Sunday afternoon in the corridors so that all the patients can hear.

In any hospital there are certain individuals or specific situations that call for special spiritual attention. Besides these there often are particular groups to which the chaplain can render a special spiritual ministry. The chaplain of one hospital which has a special crippled children's wing in which the patients often stay for many weeks or are readmitted at intervals characterizes the Sunday School class for these children as "most rewarding" in that it gave Bible training to many who had not received it before. Eighteen of the chaplains said that they had a special ministry to children, three had Sunday School classes, and a fourth had a "Twenty-third Psalm Club". This club was unique in that the chaplain had been on the foreign mission field for a time and could clarify the meaning of the Psalm in the light of his experiences in the Orient.

Maternity patients were another group which were receiving special attention in twenty of the hospitals. The "Comfort and Strength" tract series, "A New Member of the Family", written especially for new mothers, a

congratulatory folder, and a meditation on motherhood were distributed to the new mothers. Another chaplain sends the date, sex, and names of new babies to the mother's own pastor to be put in church publications. One of these who already distributed special literature had in his planning for the future some lectures by the chaplain to new mothers and fathers. The chaplain who had written his own prayer book included a "Prayer Before Childbirth" written by a mother of three young children.

There were twenty-two of the chaplains who answered that they had a special ministry to long term patients. Hymn sings on the geriatrics ward, a prayer for the chronically ill printed in the folder which the patients received at the time of admission, and continued call backs were the only things mentioned. Three chaplains stated that their ministry was the same to all. The blanks left on the questionnaires from the other twenty-nine hospitals indicate that they have no special ministry to any of those groups.

Pre-operative patients and psychiatric patients were groups to which a special ministry was being given. There were two chaplains who mentioned their special visits to patients the night before their surgery and one who said he was the only minister allowed on the psychiatric ward.

The extent to which the other employees would go to the chaplain for counseling depended on the extent to

which he encouraged them to do so. Forty-four of the chaplains reported that they counseled with hospital employees and called their relationship to the employee counselor, pastor, friend, or a combination of these. In two of the hospitals they were considered as pastor inasmuch as they held services for the employees, one chaplain weekly and the other monthly. In one hospital the chaplain met all employees in an initial interview.

Then there is religious education in its more formal sense. That there was a fairly commonly accepted religious program in the nursing schools was evidenced by the fact that such a program was set up in thirty-one of the forty-three hospitals having student nurses and a chaplain. The variety of subjects taught would indicate that the choice of these was left to the individual chaplain. Of the thirty-eight courses listed ten were in Bible and in five hospitals Bible was the only course taught. Courses in religion accounted for eleven more and courses relating the spiritual ministry to nursing for four more of the hospitals. Other included one course on emotional problems, one on psychology and religion, two on ethics, one on nursing ethics, three on orientation and adjustment, one on psychosomatics, one on family relationships, and one on marriage. In two hospitals there were occasional lectures rather than a regularly scheduled class. There were three chaplains who felt that the teaching function was of

sufficient importance and success to include it in evaluating the whole religious education program in their hospitals. In two of these cases the Bible was the only course taught and in the other Comparative Religions was the only one. Suggestions for improvement were given by a chaplain who was teaching only Bible but suggesting a broader course of study and another who was teaching Bible and psychology and suggesting more classes. A chaplain who had a weekly vesper service for student nurses saw the need for a more extensive program with courses in Bible and religion.

Besides meeting the students in the classroom chaplains in thirty-one of the hospitals held chapel services daily, weekly, occasionally or on special days for the students. In thirty hospitals the chaplain was considered as a pastor to students and in ten hospitals he was accessible to them for counseling. These religious services, also, were considered important to the success of the program. Attendance at nurses' chapel services was credited with both filling a personal need and helping the nurse to minister to the patients more effectively. In one case a very extensive program, with the student nurses was conducted in an annual Religious Focus Week, developing their special talents, and recommending church attendance and membership. In another it was stated that the Sunday service for nurses was well received and atten-

ded but the religious program for student nurses was necessarily limited because they were kept so busy otherwise. In a hospital which had only been church-related for two years the chaplain felt that the lack of response to a voluntary weekly vesper service indicated that it was not too effective and he was thinking of some other approach to the student nurses. Others, too, considered this an important enough avenue to be thinking of improvements such as a separate, small meditation chapel in the nurses' home; better integration of the chaplaincy program with the nursing service; and a student council to work with the chaplain in outlining more activities such as a group Bible class and a chorus.

This teaching program had some growing edges, also. There were nine of the hospitals which had student religious workers coming into the hospital for clinical training courses. The establishment of such a program has already been credited to the administration but the curriculum of this program would more likely be credited to the chaplain or indirectly to the church through its theological schools. The answers to what kind of clinical training program was set up for these students were so caried and vague as to be hardly significant. The question on the nature of their work in the hospital was more revealing, showing a similarity between the programs of the nine hospitals with visitation common to eight of these. This

pastoral visitation included calling on selected patients and writing reports of the interviews in one case and being supervised in three others. In two of the hospitals these students worked as orderlies while becoming acquainted with the hospital environment and routine before starting visitation. In three cases the chaplain indicated that the students worked along with him in such other activities as interviews, his office work, and chapel services.

Another possibility for extending the religious education program is that of drawing the doctors into the overall program. That this has reached the planning stage was indicated by its mention in suggestions for improvement of the religious education program. One chaplain suggested originating a class for internes and residents while another said that he was working toward a "more direct individual and group approach to internes." He stated his purpose in the hospital as not primarily for religious education but more to express Christian concern by attitude and service. Others listed as suggestions, a closer working relationship with the doctors to step up the doctor-chaplain work, and a better integration of the chaplaincy program with other services, especially medical services. The former two suggestions were from larger hospitals where there was probably a more thorough and complete interne and resident program. In that situation it would perhaps be easier for the chaplain to initiate such classes.

A class was being taught to medical students or釘 internse in only one of the hospitals and this was only by an occasional lecture.

Perhaps the most obvious and commonly accepted work of the chaplain is his work in visitation and conducting worship services. To the question: "Does the chaplain use his time primarily to reach the many patients or to reach only a few with greater needs?" twenty-five chaplains said that they tried to see all of the admissions, eleven said they selected by some means the patients on whom they called. But fourteen answered that they used a combination of the two methods. Some chaplains explained that they made an initial contact with as many as possible of the patients and then tried to concentrate on helping those whom they felt needed and would benefit the most from further continued counseling. Besides this initial visit to the patient the chaplain used requests from the patient or family and referrals from doctors or other staff members in the screening process. There were three chaplains who were already doing some counseling with selected patients and saw the need for more and suggested this for a future improvement in hospital practice. One of these expressed desire for more help so that he could start initial interviews with all the patients and do more therapeutic counseling, and another who was seeing only selected patients felt that time was his limitation. This visitation work of the

chaplain was considered sufficiently important by two of the chaplains to be mentioned in evaluating the whole program. One answer was by a part time chaplain whose main work was apparently a "room to room visiting program" in a hospital which had recently been enlarged to two hundred beds. He felt that this visitation was well received by most of the patients and staff but was planning on an expanded program in the larger hospital. The other of these, who was seeing all of the patients and then concentrating on a few, credited this bedside counselling with resulting in many of the patients being helped in a spiritual way. He observed further that it had been a source of great inspiration to him.

After finding out with whom the chaplain spent his time the investigation turned to the nature of the interview in visiting patients. In answer to the question, "What use does the chaplain make of Scriptures, prayer, other devotional literature?" there were several who simply used a check mark or some other means to indicate an affirmative answer. The other answers varied so greatly that it was difficult to group them. The chaplains in fourteen of the hospitals answered that they used Scripture as the particular occasion warranted, ten chaplains used it frequently, two used it only occasionally, six only when requested, and fourteen merely answered affirmatively. A chaplain who said he tried to minister to the spiritual

needs of all from the very young to the old mentioned his use of Scripture as contributing to the success of his total program. He used selected Bible verses and prayed with pre-operative patients who were fearful, read their own favorite passage to elderly patients, and had the Twenty-third Psalm Club for the younger ones.

Prayer was used more than Scripture. The chaplains in sixteen of the hospitals said that they used prayer as the particular occasion warranted, in twelve it was frequently used, in four only when requested, and in seventeen regularly.

Considerably fewer hospitals gave any details of how they used devotional literature but twenty-four answered that they did so. While no one answered "no" to the use of Scripture or prayer, there were two who said they did not use other devotional literature. In contrast to this four said they always used it. Only four chaplains used it as the occasion warranted. Three used it frequently, five used it only as requested, and four only occasionally. In two cases the chaplains thought that this devotional literature was an important enough part of their work to warrant more extensive use of it. One of these felt a need for better literature and the other wanted to better organize his distribution of it. Another chaplain considered devotional literature valuable enough to attribute part of the success of his total program to

his distribution of devotional books written by himself and others.

The amount of devotional and other religious literature which is available to the patients and the amount of it which is donated has been discussed as reflective of the church's attitude. The chaplain should have the privilege of screening the donated material and rejecting any which he does not wish to use. The type of literature distributed or available to patients reflects the chaplain's attitude. In thirty-seven of the hospitals there were devotional books or prayer books available, and in thirteen tracts and denominational papers. Also listed were the 'Comfort and Strength" tracts, _Religion and Health_, _Health and Strength_, and devotional booklets which two chaplains had written for their own use. This literature came from a great number of publishing houses with several chaplains using material from the publishing house of the same denomination as that which maintained the hospital and several, not. There were eleven who were using literature from several publishing houses.

One does not ordinarily think of hospital patients being able to attend church services, but 75% of the hospitals responding to this questionnaire have found some time, place, or way to provide this opportunity for those who desire it. Among the patients there are always those who regularly attend worship services and miss them

greatly when they cannot attend, some because they desire a religious ministry at that time, and others because it helps to pass the time more quickly. Usually there are some ambulatory and wheel-chair patients able to attend a service in the chapel who appreciate the opportunity of participating in it. In thirty-four of the hospitals worship services are conducted in the chapel and thirteen of these reach bed-patients through public address systems. Two hospitals conduct worship services over the public address systems only. Three provide services only on special days such as Christmas or other religious holidays, and two conduct services only in a special ward or part of the hospital.

The ingenuity of the chaplains was seen in the variety of services conducted. In forty-one hospitals there were, as nearly as could be counted, 132 services conducted per week. These ranged from a five minute devotional service or prayers broadcast daily over the public address system to a regular Sunday morning worship service. In twenty-three of these hospitals there was more than one service per week up to as many as one every week day and two on Sundays. Weekly services were conducted in fourteen more hospitals. Two of those surveyed planned to have services in the future when they can provide a chapel or communication system, and another listed daily chapel services for all employees and ambulatory

patients. There were seven chaplains who listed in their suggestions for improvement building a new chapel, or enlarging or relocating the ones they had to make them better fit their needs, and five who wanted a public address system to take the services to the bedsides. One chaplain suggested a Bible study in the chapel as a possibility for the future. Still another chaplain suggested a specified time for a devotional period with individual departments. Thus chaplains are seeing enough value in worship services to warrant their planning for more of them. Three other chaplains mentioned worship services in writing concerning the success of their present program of Christian education. Religious services other than worship services which were mentioned as extra services of the chaplain were bedside, communion and in three cases, an occasional marriage ceremony, baptism, and funeral.

The answers to the question, "What other services does the chaplain render to patients, not ordinarily rendered by chaplains?" one chaplain suggested that he could use additional help so that he might do more therapeutic counseling, listing his other services as programs for patient entertainment and library. Should these things be taking the time of a clinically trained chaplain? Services such as letter writing, making phone calls, and purchasing items were mentioned by three others and social service by two others. The important function of representing the hospital

in the churches of the state was given by one chaplain but it had been mentioned by three others under other ways in which the church identifies itself with the religious education program of the hospital.

The statements of evaluation of the religious education program of each hospital revealed a great variety of comments and ideas. A great many seemed to imply that their programs were successful and one simply stated that his was successful in that it met the needs of the patients there and offered no further comment. There were two hospitals that felt their program had not been as effective as they would have liked because of certain restrictions. One of these had employed a full time chaplain to remedy their situation. "There is a long way to go to be really successful," "planning to incorporate more things soon," and "much to be desired," characterized new chaplaincy programs in three hospitals. In three others the chaplains were new and did not feel qualified to evaluate the program. Favorable comments from past patients and expression of appreciation from patients, other employees, and staff members proved to several chaplains that the work was worthwhile.

A warm Christian atmosphere in the whole hospital was a contributing factor to the success of the program to one chaplain and proof of its success to another. One chaplain worded it thus: "We have no other purpose than functioning

as a channel of the Lord. While we serve the physical, it is always related to spiritual and eternal dimensions." Another said that it is often perceptible that patients do grow spiritually during their stay in the hospital and believed much of it, at least, to be due to the religious ministry of the hospital. In another hospital Sallman's "Head of Christ" hangs on the wall of each room creating Christian atmosphere.

Some of the answers dealt with the matter of cooperative relationship with planning groups and committees both in the hospitals and the communities. One chaplain suggested that to identify the chaplaincy program in a hospital with religious education was a "bit beside the point" and another one answered that when a patient expresses a desire for religious education he refers him to a pastor. Another chaplain said religious education is a must in present day patient care. Still another chaplain called it a very important service to the patients. Other comments were: "I'm not at all sure that we do a great deal of religious education," "up to this moment I had not thought of it as religious education," and, "Religious education, which our institution should have."

Thus the chaplains are carrying out very diversified programs of Christian education in the church-related hospital.

CHAPTER VII

SUMMARY AND CONCLUSIONS

In this study it was found that theoretically the ideal church-related hospital is one in which the spiritual program is completely integrated with the healing and educational programs. Thus the whole person--body, mind, and soul--is ministered to effectively. In practice this spiritual program must be many sided to meet the needs of all groups within the hospital. It must be flexible in order to fit the situations peculiar to hospitals, must be intricately interwoven with that of the other departments in the hospital to make it a total ministry to the total person. If this cooperation extends beyond the hospital, the ministry of the hospital may more easily fit into the patient's life outside.

Basically the three main groups discussed in this report must be in agreement to establish an effective spiritual program in the hospital. Permission for it comes from the administrative body, assistance with it comes from the church, and the execution of it from the chaplain.

The study indicated that a growing number of people are seeing the value of and the need for a spiritual program in the church-related hospital. This was shown by the number of hospitals which had recently started or

enlarged their chaplaincy program; by the fact that hospitals, theological schools, and other groups are making available courses in clinical training for chaplains; and by the number of chaplains who are taking advantage of these courses, institutes, and workshops.

It was also indicated that while many are not, there are several chaplains, administrations, and church people who are definitely thinking of this spiritual program in terms of an opportunity for Christian education and one of these even to the point of suggesting a director of religious education in his hospital.

Areas in which only a few chaplains were working but others were thinking in terms of possibilities for improvement were in this study considered to be areas in which this ministry is growing. Internes, resident doctors, student nurses, and other employees were mentioned by different chaplains as groups to which they could not only teach religion, but could teach them to observe and report the signs of spiritual need of patients.

There were several of the church-related hospitals without chaplains and with no organized spiritual program to reach the patients or employees who have no church connections. In several hospitals there was no worship service held for those who desire it, and no devotional literature available for those who like to read.

Churches furnished teachers for Sunday School classes

for children in a few hospitals. There are many more hospitals with child patients who could benefit from such a service.

There still seems to be little literature written especially for the sick.

Some administrations were permitting chaplains to begin their work with administrative endorsement and authority by making them department heads and thus giving them professional status; by helping in making the initial chaplain-patient contact; giving the chaplain access to the medical records for his information and guidance.

Most of the hospitals need a definite policy as to how closely the chaplain was to work with the medical staff and other employees.

Here, too, the educational function of the chaplain is limited. The administrations are wanting to use him to teach but there seems to be no curriculum set up for this and no standard by which to go. There are possibilities of establishing limited training periods for religious workers who would come in to the hospital as volunteer teachers.

The chaplains would, no doubt, be the first to admit that there are yet many possibilities for an enlarged religious education ministry for them. But since they are the group which is most closely associated with the spiritual ministry in the hospital they see these possibilities

before others do and begin to work toward their realization. There did not seem to be any outstanding opportunities in a single area but rather many smaller places where individual chaplains could reenforce their own program. Many did feel the limitation of time and help.

The responsibility of a standard curriculum for Christian education in hospitals is faced by the chaplain.

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APPENDIX

A. SUGGESTED RESOURCES FOR PASTOR AND PATIENT

1. "The Use of the Bible," as given by Russell L. Dicks in his book, Who Is My Patient?

a. for the person who is a regular Bible reader but who is restless, apprehensive, and discouraged.

Psalm 23	Mark 4:26-29	John 14:27
Psalm 90:1-4	Matthew 6:25-34	John 15:1-9
Psalm 91	Matthew 11:28-30	John 16:33
Psalm 121	John 14:1-4	I Corinthians 13
		Hebrews 12

b. for the person suffering from guilt feelings, who seeks comfort, but knows little about the Bible. The patient should be encouraged to think on these and perhaps to memorize some.

Psalm 23	Matthew 7:7-8	Luke 15:11-24
Psalm 121	Matthew 11:27-30	John 4:14
Psalm 51:2-3	Matthew 18:21-35	John 6:35
Psalm 130	Luke 11:5-13	John 10:11
Matthew 5:21-24	Luke 15:1-7	

c. for the person who is dying, who may or may not know a great deal about the Bible, but who is dying in peace. The task here is to strengthen or support that peace.

Psalm 23	Mark 4:26-32	Romans 8:28
Psalm 90:1-4	John 14:1-7	Romans 8:31-35
Psalm 91	John 14:25-27	Romans 8:37-39
Psalm 121	Romans 8:14-19	Revelation 21:1-4
Matthew 5:1-16	Romans 8:22-25	

2. Suggested Scriptures which were listed by Granger Westberg in his book, Nurse, Pastor, and Patient.

Deuteronomy 31:6	Psalm 42:11	John 15:11
Psalm 4:8	Psalm 46:1	John 16:33
Psalm 23:1	Psalm 55:22	II Corinthians 12:9
Psalm 27:1	Psalm 121:1-3	I Peter 5:7
Psalm 27:14	Matthew 11:28	I John 4:18
Psalm 34:4	John 14:27	

3. Our religious heritage according to Russell L. Dicks in Meditations for the Sick.

a. Scripture

The Eternity of God	Psalm 90:1, 2, 4
God as my Fortress	Psalm 91:1-4
Confidence in God	Psalm 23
Courage	Matthew 5:14-16
My Strength Cometh from God	Psalm 121
Ask and Receive	Matthew 7:7,8; Luke 11:9,10

Unto the Weary and Contrite	Matthew 11:28-30
Release from Worry	Matthew 6:25-27
Eternal Life	John 11:25-26
Peace and Quietness	John 14:27, 16:33
God's Gift	John 4:14, 6:35, 10:11

b. Hymns of the Church

When Morning Gilds the Sky, Anonymous, from the German
Love Divine, All Loves Excelling, Charles Wesley
Holy, Holy, Holy, Reginald Heber
Fairest Lord Jesus, Anonymous, from the German
Day is Dying in the West, Mary A. Lathbury
O Little Town of Bethlehem, Phillips Brooks
O God Our Help in Ages Past, Isaac Watts
In Heavenly Love Abiding, Anna Laetitia Waring

B. PLACES WHERE SPECIAL CHAPLAINCY TRAINING IS GIVEN

Alexandria Baptist Hospital, Alexandria, Louisiana.
Asbury Theological Seminary, Wilmore, Kentucky, and Eastern
    State Hospital, Lexington, Kentucky.
Bellevue Hospital, New Jersey.
Bethany Seminary.
Cook County Hospital, Chicago, Illinois.
Drake University Divinity School, Des Moines, Iowa, and
    Iowa Methodist Hospital, Des Moines, Iowa.
Elgin State Hospital.
Episcopal Hospital, Philadelphia, Pennsylvania.
Garrett Theological School.
Graystone Park, New Jersey.
Independence Mental Hospital.
Institute of Pastoral Care Incorporated, Massachusetts
    General Hospital, Boston 14, Massachusetts.
    Affiliated with:
        Andover Newton Theological School.
        Boston University School of Theology.
        Episcopal Theological School.
        Harvard Divinity School.
    Courses given in:
        Augustana Hospital, Chicago 14, Illinois.
        Boston City Hospital, Boston 18, Massachusetts.
        Massachusetts Memorial Hospitals, Boston 18,
            Massachusetts.
        Emanuel Hospital, Portland 12, Oregon.
        Massachusetts General Hospital, Boston 14,
            Massachusetts.
        Miami Valley Hospital, Dayton 9, Ohio.
        Minneapolis General Hospital, Minneapolis, Minnesota.
        Homer G. Phillips City Hospital, St. Louis, 13,
            Missouri.
        University Hospital, Ann Arbor, Michigan.
        Boston State Hospital, Boston 23, Massachusetts.
        Colorado Psychopathic Hospital, Denver, Colorado,
            with Iliff School of Theology.
        Cleveland Receiving Hospital, Cleveland 15, Ohio.
        Gowanda State Homeopathic Hospital, Helmuth,
            New York.
        Harrisburg State Hospital, Harrisburg, Pennsylvania.
        Massachusetts Mental Health Center, Boston, 15
            Massachusetts.
        Westboro State Hospital, Westboro, Massachusetts.
        Worcester State Hospital, Worcester, Massachusetts.
        Juvenile Hall, 2802 Sherwood Lane, San Diego,
            California.
Manteno State Hospital, Manteno, Illinois.

Memorial Baptist Hospital, Houston, Texas.
Mendota State Hospital, Madison, Wisconsin.
New Orleans Baptist Theological Seminary, with New Orleans Baptist Hospital.
North Carolina Baptist Hospital, Winston Salem, North Carolina, with Bowman-Gray Medical School, Winston Salem, North Carolina.
North Park Seminary, 3225 Foster Avenue, Chicago, Illinois, with Swedish Covenant Hospital, Foster at California Avenues, Chicago, Illinois.
St. Lukes, Milwaukee, Wisconsin.
University of Chicago.
Veterans Hospital, Ann Arbor, Michigan.
Wesley Hospital, Chicago, Illinois.
Willmar State Hospital, Willmar, Minnesota.
Workshops and Institutes (2 or 3 day)
- Lutheran Hospital of Bemidji, Minnesota and Bemidji Ministerial Association.
- Southern Baptist Hospital and New Orleans Baptist Theological Seminary, New Orleans, Louisiana.

C. QUESTIONNAIRE WHICH WAS SENT OUT

Name of Hospital ________________ Location ____________
Administrator or Chaplain ______________________________

I am a medical technologist employed part-time in a hospital while I am preparing for the foreign mission field at Asbury Theological Seminary. Since I am greatly interested in both the medical and the religious education work in the hospital, I have chosen for my Master of Religious Education degree thesis, "A Study of Christian Education in the Church-Related Hospital." I would be very grateful if you would help me by filling out the following questionnaire or by giving it to the person in charge of religious education in your hospital to fill out. Please return this in the stamped envelope enclosed.

Very truly yours,
Phyllis Wright

Religious Education in your Hospital

I. General Information:
Number of beds in hospital ______________
Number of employees __________
Number of student nurses ________
Does the hospital have a chapel? ______
With what denomination is hospital affiliated? ___
Owned by? ________ Operated by? ________
How does hospital find out patients' religious preference? ______________________
Approximately what percentage of patients admitted desire religious ministry? ______________

II. Hospitals without chaplains answer this section:
What plan does hospital follow in spiritual ministry to patients? ______________
If ministers from outside the hospital come in, how are they notified? ______________
What do they do in the hospital? ____________
Administer to all denominations? ____________
Only own denomination? ______________
If other religious workers, are they hospital auxiliary? _____ local church (what denomination(s))? __
______________ students (from what institution)? __
______________ others?)specify) ____________
What is the nature of their religious work in hospital? ______________
Is religious literature available to patients? ____
Bibles? __________ Other? (specify) __________

Are there any classes in religion for student
nurses?_____; medical student?_____; other?___
Is there a chapel service?_____ If so, when?______

III. Hospitals with a chaplain answer this section:
Is chaplain full time?_____; more than one?_______;
part time?_____; how many hours?_______
Has chaplain had special clinical training?_______
If so, where?_____________; how long?_______
How long has hospital had chaplain program?_______

Relation to patients:
How is chaplain notified of patients?_______
How are patients told that chaplain is available?
____
How do patients themselves contact chaplain?___
Is the chaplain usually called in cases of
death?__________
Does the chaplain visit all religious groups?__
_____; just own denomination?_______
Does chaplain have any special ministry to
children?_______; to maternity patients?___
________; to long term patients?___________
____
What other services does chaplain render to
patients (not ordinarily rendered by chaplain?
____

Relation to staff:
Is chaplain's status in hospital as part of staff?
department head?______attend department head
meetings?_______________
How closely does chaplain work with medical staff?
independent?____; in cooperation with?_____
Is there a set policy?___________
How much medical information is accessible to
chaplain? same as any minister?_____; access
to medical records?_______; contact through
nurses?_______________
Does chaplain counsel with hospital employees?
_______ If so, to what extent?_______
What is chaplain's relationship to employees?____

Teaching program of chaplain:
If nursing school:
What is chaplain's relation to student nurses,
as pastor?________; as counselor?_________
Is he accessible for problems?___________
Does he hold religious services?___________
Does chaplain teach in nursing school?______ If
so, what _______________________

Is there a Nurses' Christian Fellowship (branch of Intervarsity Christian Fellowship?_______; other religious organization? (specify)______

If medical students or internes:
Does chaplain teach a class for them?_________
If so, what? ______________________________

If out side student religious workers coming in:
Is there a clinical training program for them? _______ If so, what? ______________________
On what basis are these students acceptable?__
____
What is the nature of their work in the hospital? ____________________________

If other outside religious workers coming in:
Are they hospital auxiliary?_____; local church (which denomination(s))?______; volunteers? ______________________________________
Does chaplain supervise their activities?_____

Methods used by chaplain (answer if possible);
Does chaplain use time primarily to reach the many patients?____; or to reach only a few with greater needs?______________________________
What use does chaplain make of:
Scriptures? ______________________________
Prayer? __________________________________
Other devotional literature? _______________
Is the literature donated? ____; purchased new___; from what publishing house? _________________
Are Bibles available to patients?______; Is other devotional literature? ___________________
What kind ? ______________________________
Does the chaplain conduct worship service to hospital? ____If so, when?______; conducted in chapel?________; over public address system? ________; other? (specify) _______________

In what ways, other than answers already given, does the church identify itself with the religious education program of the hospital? _______________
____
____

What suggestions do you have for the improvement of religious education in your hospital?___________
____

Would you write a short paragraph concerning the success of your religious education program?