UNIT 5

Chapter 3
The Healthcare Chaplain

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The word career is a divisive word.
It's a word that divides the normal life from business or professional life

— Grace Paley (1922-2007), American writer, poet, political activist[1]

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…lead a life worthy of your calling, for you have been called by God.
Be humble and gentle.
Be patient with each other,
making allowance for each other's faults because of your love.
Always keep yourselves united in the Holy Spirit,
and bind yourselves together with peace.

— Apostle Paul (Ephesians 4:1-3, NLT)

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Like others in the field of healthcare, the Chaplain functions in the realm where care—medical, social, mental and spiritual care—is provided for patients/residents. But the Chaplain is also involved in the world outside that particular sphere. Often the Chaplain senses the tension between these two "compartments" of his/her life. At times it is a difficult task to keep one compartment from running over and diluting the other. Often the distinction between each of them may become blurry as one may tend to flow out of the other.

This difficulty provides a helpful way for looking at the healthcare Chaplain. The Chaplain needs to minister and serve in the field of healthcare, but also live and relate to that which has nothing to do with the medical disciplines. The healthcare Chaplain has a *professional* life and a *personal* life.

Professional Life

The healthcare Chaplain functions as part of the healthcare team. S/he must not only be able to intermingle with the other healthcare professionals, but also needs to interrelate and interact with them. The sphere of healthcare brings together well-qualified people from many disciplines. The Chaplain needs to interface with them as a healthcare professional who can be trusted and who understands his/her role in relationship to others in providing patient or resident care. Much is involved in the background, experience,

[1] Paley's worldview may not be shared by HCMA, but her comment about our normal life versus our professional life is worth thinking about as we develop our role as a pastoral caregiver in the healthcare setting.

training, and life of a healthcare Chaplain to enable him/her to be an effective professional in providing competent chaplaincy care.

Qualifications

The ideal applicant to HCMA would have the following: college degree, seminary degree, ordination, a minimum of two years pastoral experience in a local church, good references and reputation, some pastoral counseling skills, people-oriented personality, and a vital walk and relationship with God. There are many more prerequisites that could be added to the list, but this is simply a thumbnail sketch. Leadership in HCMA would like to add such things as "having had a major surgery," but that would not be realistic.

The qualifications for a healthcare Chaplain are high because healthcare chaplaincy is a specialized ministry in a specialized setting and it has many professional demands. Also, the Chaplain is working shoulder-to-shoulder with well-qualified and highly educated professionals. Thus, HCMA needs Chaplains who are not only qualified spiritually, but also academically and professionally. This is one reason why HCMA has an extended application and screening process, followed by four units (1,600 hours) of extensive and intensive clinical pastoral education, and a 1,600-hour internship following the training for those seeking to become a Board Certification Chaplain (BCC). This is not to say that HCMA devalues the life and ministry experience of an older applicant, for that experience is weighed carefully.

Having a full-time church ministry background is very valuable for being a healthcare Chaplain. It allows him/her to have experienced the difficulties and challenges of providing pastoral care to a local congregation, many of them going through various kinds of suffering. It provides him/her a wealth of knowledge as to how to minister one-to-one. In addition, it forms the basis for a community from which the Lord can raise up faithful prayer and financial supporters.

Understandably, some personalities are more suited to healthcare chaplaincy than others. An optimistic type person will certainly fill the role better than a negative type person. Being an outgoing person provides great advantages because the Chaplain never stops meeting new people. People find a calm, reassuring person, who is also a good listener, easy to confide in and comforting to be around. One can never be an effective Chaplain unless s/he genuinely loves people. If one suffers from long-standing, unresolved emotional issues, or some form of psychosis, his or her ministry will obviously be hindered. The healthcare Chaplain also needs to be one who can be flexible, willing to accept interruptions, and called upon at any moment to deal with a crisis. In addition, s/he must be one who can accept and minister to a person without necessarily agreeing with his/her belief system or worldview.

God has entrusted each believer with at least one spiritual gift (cf. 1 Peter 4:10). A spiritual gift is a God-given ability for service and ministry. The lists of these spiritual gifts are given in Romans 12, 1 Corinthians 12, and Ephesians 4. Often these spiritual gifts will seem to dovetail with our natural abilities and personality traits, but not necessarily. Certainly, some spiritual gifts are more appropriate to the chaplaincy than others. This is considered closely during the application and training process to become a healthcare Chaplain. At least the following spiritual gifts would have a direct application to healthcare chaplaincy: mercy, service, pastor, evangelist, discernment, exhortation, and faith.

Calling

Being an HCMA Chaplain is not simply about taking a job or even filling a ministry opening or slot. It should be about following a heart cry that the Lord has implanted within us. It should spring from a love for God and a compassion for people. A heart yearning to comfort the suffering must be at the basis of this calling. One needs to sense in his or her inner being God's direction to this specialized ministry. S/he needs to know from experience that the Lord has brought encouragement and comfort to the sick through his/her ministry to them. Others need to have witnessed the effectiveness of that pastoral care ministry. In addition, s/he needs to know that there is no joy and satisfaction like being used of the Lord to touch the lives of the suffering, dying and grieving. In essence, there must be a personal "divine call" to this blessed ministry.

Preparation

Under the section on qualifications, some aspects of preparation were briefly mentioned. In addition to one's formal education—from grade school clear through graduate school—there are the on-going lessons of one's life experiences. Often it seems that the academics form only a base (though an absolutely vital foundation). It is usually personal life experiences that God uses to give direction. Knowing the comfort of the Lord in a personal time of affliction often enables a Chaplain to minister to others as God has ministered to him/her (cf. 2 Corinthians 1:3-4). The Lord then takes that experience and directs one toward the sick and suffering. So, as one is pastoring, for example, s/he finds that hospital visitation is something s/he enjoys. Others give positive feedback and affirmation of his/her spiritual gifts for chaplaincy care, especially at the bedside.

The Lord brings together all the academic training, life and ministry experiences, joy for chaplaincy care, and the affirmation of certain spiritual gifts. He does this in order to prepare us for ministry as a Chaplain. Then He directs us to HCMA and we are clinically trained so that we can make the transition from Pastor to

Chaplain most effectively.

Transition from Pastor to Chaplain

Moving from the pastorate to the healthcare chaplaincy is a bigger change than first meets the eye. Other than using some of the same spiritual gifts, there is hardly any other likeness. It is not unusual for this transition not to be fully anticipated by the experienced Pastor. It can catch the new Trainee by surprise and sometimes may even add an element of stress, if not fear.

So, how does the role of the Chaplain differ from the role of a local Pastor? In the pastorate, one usually has a set salary, perhaps a parsonage, plus other financial benefits. As an HCMA Chaplain, one must often raise his/her own financial support with perhaps no benefits supplied by the healthcare organization, except the privilege of ministry. In addition, when one is serving with a faith mission like HCMA, one has many prayer and financial supporters who expect to receive regular prayer/newsletters and personal notes. It is a never-ending responsibility. Furthermore, if one is to "stay afloat," the basis of support needs to be ever increasing.

Even if we do have a salary as a healthcare Chaplain, the source of that income is from a secular organization rather than from the religious community. And those to whom a Chaplain must report and be accountable to are sometimes not believers, which is quite different than that of a Pastor.

The clients to whom the Pastor and Chaplain minister are quite a contrast. The Pastor tends to know who makes up the congregation and, if active in the church, they are generally believers. The patients/residents at the healthcare facility change on a regular basis. They are either new admits or are being discharged and the census changes every day. Generally speaking, many patients/residents are unbelievers and may not have a Pastor of their own.

Overall, the Pastor moves and works with people who are believers, are of like theological orientation, or who are at least supportive of the Christian message, principles, morals, and life style. The Chaplain operates in a pluralistic setting, working with people from every background, religion, life style, and conviction (or lack thereof) that one can imagine. Some of those served may be agnostic, indifferent or even antagonistic to religious faith. The Chaplain is viewed as unique and often ministers all alone except for the Spirit of God standing with him or her.

Most Pastors, like Chaplains, officiate at funerals. However, one healthcare Chaplain was known to average about one hundred funerals per year, which is probably more than the average Pastor is involved with at his/her church. Generally, the funerals conducted by Pastors are for people the Pastor was acquainted

with and who were believers. The Chaplain is often asked to have a funeral or memorial service for strangers who are unbelievers or whose spiritual condition was uncertain at best.

Occasionally, a Pastor will be thrown into a crisis situation in a hospital emergency room (ER) or intensive care unit (ICU) for one of the parishioners. By contrast, almost every day a Chaplain can be called upon to intervene in ER and ICU crisis situations. Usually s/he may have never met these people before. As strangers, and often with a different worldview, they may either receive the Chaplain warmly or with great hesitation.

Even visits to patients/residents in their rooms are different for the Pastor and the Chaplain. The Pastor goes to the healthcare facility to see a specific patient/resident or two to whom s/he either has a connection as spiritual leader (Pastor) or an acquaintance with someone the patient/resident knows. The Pastor usually knows the patient/resident s/he is visiting very well, or at least well enough to build that immediate bridge of rapport. The Pastor is often aware of where the person is spiritually. In contrast, the Chaplain tends to visit strangers all day long. All the Chaplain knows, generally, is the patient's/resident's name, age, admitting diagnosis, and perhaps the religious preference. (Many Chaplains do not even have that much help from a daily census report.) Rapport must be built during each visit. The spiritual needs must be discerned by listening and observing. Appropriate spiritual/pastoral/chaplaincy care usually must be provided by the Chaplain in a very small window of time. Added to this ministry dilemma is the trend for the length of a patient's stay in the hospital becoming shorter and shorter. So the Chaplain often has no potential for a follow up visit, like a pastor may have with those s/he visits.

The Pastor is often sitting in his/her office. The Chaplain is most often away from his/her office—on his/her feet most of the day visiting patients/residents and their families. Sometimes Pastors cannot be reached when someone wants to speak with him/her. But Chaplains usually carry their cell phones (a few still have beepers) and are expected to respond immediately any time of the day or week. When the Chaplain must be away, s/he must arrange for on-call coverage.

Another difference is the fact that Chaplains minister in an ecumenical setting. They must often share chaplaincy care responsibilities with other clergypersons from other faith traditions. They are typically involved in nurturing the total religious community, encouraging pastoral responsibility, and providing a climate for professional growth regardless of creed.

Being aware that there is a transition from Pastor to Chaplain is the first step in making the change. The second step is to be teachable and willing to listen to and observe those who are experienced as healthcare Chaplains. Such a spirit, God will bless.

Relationship to the Opposite Sex

We will cover the subject of ministry boundaries more fully later in the chaplaincy training program, but it is important to bring up a few issues here.

The biggest error in this area—of possible mistakes or temptations in relationship to the opposite sex—is to be convinced of one's invincibility. This attitude may be communicated by statements or thoughts like, "I'm stronger than that guy who got trapped," or, "I'm too old for that kind of 'stuff.'" The first safeguard, then, is to remember that everyone must be careful in this area (cf. 1 Corinthians 10:12-13).

When counseling someone in the Chaplain's office, keep the door at least part way open, unless there is a window in the door. When visiting a patient/resident who is the only one in a room, be sure the door is not closed. As a professional Chaplain, we need to have the reputation of always being above board in all our dealings with people.

Caring Chaplains often need to touch others. It is a much needed expression of compassion and care. However, touching too much can be a hindrance to ministry, can cause others to become suspicious, and may add another possibility of temptation or misunderstanding. When appropriate, a touch to the hand or

shoulder may be welcomed. An arm around a person's shoulders from the side is considered by many as the "proper" Chaplain hug. Full body embraces should never be the habit of a Chaplain. Even so, there will be times when someone will hug the Chaplain out of thanks, grief, or a moment's need for assurance. But keep in mind the fact that people are particularly vulnerable at a time of crisis or grief. It is immoral for a Chaplain to take advantage, in any way, of a person in that state. Even though s/he might not refuse, because of the situation (e.g., being in a state of shock), it may be inappropriate to give the person a big hug.

The Chaplain needs to know that there will be natural attraction to some members of the opposite sex. This is the way people are built as human beings. Physical attractiveness and a "spark" of connection with certain personalities may be more appealing with some than others. Knowing this will be true enables one to be prepared to befriend the person, but to also be on guard about encouraging that which is inappropriate. Here one should be careful not to give compliments that go over the line. Being a friend to all is also a safeguard. Being exclusive with one individual, or spending too much time with one person, can be dangerous. A Chaplain could imply that his/her beeper call was for an emergency when in fact it was for "a private counseling session." If such were the case, the Chaplain's ethics have already been compromised and his/her testimony and ministry are in serious jeopardy. The Chaplain in such a situation should promptly seek spiritual counsel.

When entering a room, a Chaplain needs to be alert to potential boundary issues. If the door is closed, the best idea is to come back later or ask a nurse to go in to see if a visit would be appropriate. The next best thing to do would be to knock and state who we are and the purpose of our visit—*before* entering the room. If, then, when we enter the room, the curtain is pulled, be sure not to go around the curtain until we have asked if all is fine for a visit from us. If the person is not covered appropriately for a visit when we do go around the curtain, then leave the room immediately and talk with the head nurse, right then, and explain what happened.

In society today, and because of our testimony as a Chaplain, we need to be extremely careful about this matter of relationship to the opposite sex. If we have even a doubt about something in this area, "Don't do it!"

The Professional Look

Every HCMA Chaplain should adhere to the highest standards of neatness, grooming, and dress. That is a given. But when referring to the professional look, there is much more in mind then mere physical appearance.

The attitude of an HCMA Chaplain will either break or make his/her ministry. This is the instrument that all will "read" to discern the Chaplain's real heartbeat. One of the first readings watched for in a Chaplain will be whether s/he respects all equally or shows some partiality. Does the Chaplain show the same respect for a housekeeper as s/he does for a well-known neurosurgeon? Does the Chaplain show the same respect for someone with a different worldview as s/he does for a fellow believer? Again, the staff and patients/residents will want to know if the Chaplain is real, genuine, authentic. Is s/he always "in the clouds" or is s/he a person with emotions, hardships, and non-ministry interests? Can someone speak to the Chaplain about ordinary things, like news, sports, or family events? Is s/he available and approachable? Is s/he dependable, consistent, and effective? Is s/he an embarrassment to other professionals or a valued member of the healthcare team? Is s/he a team player or a lone ranger? The HCMA Chaplain needs to combine a quiet confidence with a true servant's heart.

Being a diplomat is part of the professional look. This means that the Chaplain will stand at times between opposing parties, views, and desires. S/he will "negotiate" for understanding, some more time if needed, or a peaceful resolution and restoration of relationships if possible. Furthermore, this means that the healthcare administration can always depend on its Chaplain to respond wisely, appropriately, and with dignity. The Chaplain should never be thought of as taking advantage of a situation, or of promoting in any

way that which would counter the best public relations for the healthcare facility. The presence of the Chaplain should always be thought of as that which brings peace and calmness to any situation.

Above all else, the professional look of an HCMA Chaplain should be that of integrity. Webster's Dictionary says that integrity is an unimpaired condition, soundness, firm adherence to a code, especially moral values, and a state of incorruptibility. This means, then, that the HCMA Chaplain is to be Christ-like in every aspect of his/her life and ministry. It should be said about him/her, as was said about one HCMA Chaplain by an unbelieving physician: "That is what Christ must have been like when He was here." An exemplary life is what it takes. That means the correct proportion of time is being spent in healthcare ministry, support raising, personal growth, church involvement, family time, and outside interests. All these areas must be above reproach. It involves all motives, thoughts, words, actions, looks, touches, and responses.

Personal Life

In dealing with the professional life of the HCMA Chaplain, the material overlapped into the personal life. This could not be avoided in the sense that a Chaplain is a person first of all, and the various aspects of his or her life cannot always be neatly compartmentalized or divided. There is a natural flow back and forth between the professional and personal life. However, at this point the focus will be on what is generally thought of as a Chaplain's personal life.

Spiritual Life

As in all forms of ministry, the Chaplain's personal walk with God must be maintained if s/he is to be adequate for the task. The healthcare Chaplain is continually, hour upon hour, giving and giving. Often, after a day of ministry to people in pain, heartbreak, crisis, death and grief, the Chaplain is drained and literally spent. Who is going to now give back to the Chaplain so s/he is refreshed, restored, and renewed for the challenges and opportunities of the next day's demands? Family is usually not going to be adequate, nor is time in front of the TV. Only the Lord is sufficient to pour back into the Chaplain the spiritual resources needed to sustain him/her. Time in His presence is a must each day.

Another source of spiritual input into the Chaplain's life is his/her local church. The teaching of the Word of God, fellowship with other believers, and the supportiveness of prayer in one's own congregation are vital for a balanced and growing spiritual life as a Chaplain. Fitting in as a "regular member" is another essential if one is to receive that which is needed personally and for ministry as a Chaplain. Although there are exceptions, generally speaking, the HCMA Chaplain is encouraged not to take on heavy responsibility at his/her local church because of the demands of the chaplaincy and of raising support. However, this should not be taken as an excuse for lack of attendance or involvement at one's church.

"Loose cannons" are always a worry. This is true also of the Chaplain who lacks in appropriate accountability. Often healthcare administrators do not understand or know what the Chaplain really does or does not do. Therefore, sometimes one's church leadership can provide the needed accountability. However, if the church is large, that may not be possible or realistic. Thus, one should seek a small group of Pastors, other Chaplains, or Christian leaders in the community to be the group to whom s/he is accountable. Meeting at least once a month with this group for a report and prayer would prove not only to be wise but of great blessing and encouragement.

Home Life

The chaplaincy is a thrilling, rewarding, challenging, fruitful and exciting ministry. It does not take long for it to "get into our blood." Soon we are "thinking, eating and sleeping" the chaplaincy. To be so needed is intoxicating. The rewards are immediate and satisfying. The challenges never cease and they demand all the resources of our training, background, abilities and gifts. Sometimes it is absolutely

electrifying. We never knew we could love ministry and work so much. And it is all about helping others, reflecting the compassion of Christ, and sharing His message of hope and good news!

"Oops—that's right—I have a spouse and family!" Family can be easily pushed aside because of "the importance and urgency" of the ministry. It is a danger for which the Chaplain must be prepared. The constant cry of human need within the healthcare setting can make us a stranger to our family. Time with our family has to be guarded. This is not merely referring to *quality* of time, but also *quantity* of time. Our spouse and family need us home most evenings and weekends. Even if we are guarding that family time, there will be unexpected times when the beeper will sound and we will have to go to the healthcare facility. If this begins to happen too often, we will need to get qualified local Pastors to share some on-call time so we can have the time needed with our family.

Our spouse is our greatest resource and blessing, other than the Lord Himself. Do not neglect or take for granted that precious person the Lord has given us. Plan something fun and relaxing to do together each week. Take off our ministerial Chaplain's hat and again be the young-hearted, goofy, and full-of-fun person our spouse fell in love with when we first dated. Over dinner each evening, share with our spouse and kids (if at home) the highlights of our day so they feel more like participants than observers of our ministry. At various times, have our family over to the healthcare facility to help us in some aspect of the work, like a special seminar, or guiding Christmas Carolers around the healthcare facility's corridors.

Community

Wherever a Chaplain goes in his/her own community, s/he will be viewed, referred to, and greeted as "the Chaplain." It does not matter whether s/he is dressed in professional attire or sport clothes. Always being known and addressed as the Chaplain is simply part of the territory. However, this fact should cause the Chaplain to realize, whether s/he desires it or not, that s/he is a public figure!

Because we really cannot take off our Chaplain's hat, the life of a Chaplain is always on display. Thus, a Chaplain must recognize that s/he is never free from representing the Lord, the healthcare organization, and HCMA. This does not have to be awkward, although sometimes it is tiresome not to go anonymously anywhere in our community. It calls for a consistent life and a constant reminder that Christ-likeness is not only necessary at the healthcare facility, but is a way of life, by His grace.

The community will also look to the healthcare Chaplain as a resource person. People from the greater community will learn of our reputation and come for counsel, assistance, or a handout. Our position will automatically make us an expert on death and dying, grief, euthanasia, and many other subjects related to healthcare chaplaincy. We will have opportunities to speak to civic groups and give seminars at churches on visitation. We perhaps will be asked to give the opening prayer at an interdenominational gathering. We will be called to conduct a funeral for someone we have never met. But in all of these additional demands there is usually a way to graciously say "no" if our schedule is too full, or to say "yes" and to use the opportunity to reflect the Lord Jesus Christ and bring glory to God.

Supporters

Prayer and financial supporters are the Chaplain's lifeline. If one neglects them, the pillars of his/her ministry will deteriorate and eventually his/her chaplaincy will collapse. These faithful praying and giving friends need us as their "Chaplain-Missionary" to send them regular prayer/newsletters. It is not too much for them to expect that of us. They deserve such a communication at least once a quarter from us. It would be even better if they were hearing from us on a monthly basis. And remember, they will be looking most of all for our personal note especially written to them at the bottom of our prayer/newsletter or on a card.

One of the means of accountability that is built into a faith ministry is the constant need "to report" to one's supporters. They expect an update and they desire to know how to pray specifically for us and our ministry. Be diligent to send these letters and endeavor to increase our mailing list each year.

In addition to letters and cards, supporters love to receive a phone call from "their Chaplain." Best of all, of course, is a personal visit. They, too, are merely people and they need assurance that they are an essential part of our ministry and are truly appreciated. Do not neglect those who will diligently pray for us, but at present are unable to participate with us in a financial way. They will be warriors with us in our spiritual battles and it is in the spiritual realm that the Chaplain ministers. God will hear the faithful intercession of one of His servants who prays for us each day. There is no more humbling experience, and at the same time greater joy, than to be told by some dear saint that s/he remembers us in prayer each day. Pray that the Lord will give us many such devoted prayer partners!

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Chapter Assignments

1. After reading Appendix A on "Agendas and the Chaplaincy," and spending sufficient time in Bible study, reflection and prayer about spiritual care agendas, write a two-page essay on your feelings and thoughts concerning agendas a Chaplain may tend to push. Include any agendas you might tend to set in motion (consciously or unconsciously) while engaged in chaplaincy care, and how you can prevent them from distracting you from focusing on the spiritual needs (agendas) of the patient/resident.

2. Read a book on chaplaincy care, write a one-page summary, and then discuss your insights with the Teaching Chaplain.

3. Spend several minutes in Bible study, reflection and prayer about chaplaincy care within the healthcare setting versus pastoral care within the church setting. Write a two-page essay on how you are changing your approach to chaplaincy care for patients/residents as a Chaplain now, from your typical approach as a Pastor or lay minister.

4. Answer the following questions in writing after spending time in Bible study, prayer and reflection on each one. Discuss your responses with the Teaching Chaplain:

    a. To whom are you answerable? Is there accountability for your personal life and professional ministry with someone other than your Teaching Chaplain? List those to whom you are accountable, how you came to be accountable, how this accountability takes place, and explain how it impacts your life and ministry.

    b. What has been the role of your spouse in your ministry up to this point? What do you see as your spouse's role in your ministry as a Chaplain? Ask your spouse to define this role and record the response. Describe any differences of opinion the two of you may have about it.

    c. What is your financial situation? Are you in debt? To what degree will your indebtedness affect your work as a Chaplain? Detail how you plan to resolve any financial obligations you have not met yet, and what provisions you have made for taking care of unexpected financial emergencies.

5. Interaction with your Teaching Chaplain. Write out your response to each of the following scenarios and then discuss each one with your Teaching Chaplain.

    a. A patient/resident tells you that he has rung for a nurse several times but s/he does not come. What should you do?

    b. When is it right to tell a patient that there are other patients in the hospital that are a lot worse off than s/he is?

    c. What requirements would you establish for a person who wanted to assist you in visiting patients/residents?

d. How would you turn down someone who wants to help visit patients/residents as a Chaplain Assistant, but you feel the person is unsuitable for the role?

e. A doctor walks in while you are visiting a patient/resident. Should you leave, stay, or ask if s/he minds if you pray before s/he takes over?

f. A patient/resident tells you that sometimes he hears voices. What should you do?

g. How should you end a public prayer when there are those present who resent using the name of Jesus?

h. How do you respond to a Pentecostal patient/resident who tells you that it is necessary to speak in tongues to be baptized with the Holy Spirit?

i. A patient tells you that she was hospitalized because her husband beat her badly. She asks if she should leave him. What should you say?

j. How would you respond to a patient/resident who tells you that he is angry with God?

6. Study the "Endocrine System" in the *Medical Terminology Manual* in order to become familiar with these common medical terms and surgical procedures.

7. Make rounds and debrief with the Teaching Chaplain.

8. Write a verbatim of a patient/resident visit. Schedule a peer group review team to evaluate it. Discuss your learning issues with your Teaching Chaplain.

Chapter Resources

The following annotated bibliography is not intended to be exhaustive in its content, nor does it contain all the latest resources. HCMA does not endorse all of the ideas expressed in all of the resources listed here. Some of the sources are given simply to expose the Trainee to a variety of viewpoints on the subject. It is expected that even in places of disagreement that we will reflect upon and think critically regarding our own views rather than simply dismissing views that run counter to our own.

Anderson, Robert G., and Mary A. Fukuyama, eds. *Ministry in the Spiritual and Cultural Diversity of Healthcare: Increasing the Competency of Chaplains*. New York: Haworth Pastoral, 2004.

This book identifies concrete methods for improving the provision of pastoral care to culturally and religiously diverse patients and/or residents. Experts from both inside and outside the profession—with established records in cross-cultural work and experience with religious diversity—discuss in detail the multicultural revolution that has challenged the traditional health care delivery system. With this timely resource, you will be able to respond to the requests and desires of patients and their loved ones with compassion and consideration for their cultural and spiritual backgrounds. It explores the challenges for the spiritual care professional in health care to address the emotional, cultural, and spiritual needs of a patient without assumption, bias, or discomfort for either person. In addition to advice, recommendations, and real-world examples and case studies, this valuable resource provides a guide for chaplaincy supervisors to use when training chaplain students to impart such unprejudiced care. The book is devoted to establishing chaplains who are clinically trained and certified to contribute to the increasingly pluralistic and global health care context with assorted religious, spiritual, and cultural values, beliefs, and practices.

Arbuckle, Gerald A. *Healthcare Ministry: Refounding the Mission in Tumultuous Times*. Collegeville, MN: Liturgical, 2000.

Never before have healthcare institutions faced a more chaotic and threatening environment. Rising costs, aging populations, and a lack of medical insurance have forced healthcare in the Western world to undergo a tumultuous change. The Christian healthcare ministry has added problems. With increasingly complex medical-ethical challenges and the continuing struggle to maintain financial viability while insisting on a preferential option for the poor, there is an urgent need for Christian healthcare to refound itself. It must continually re-invent radically

new ways to bring Christ's healing gifts to people in need. In *Healthcare Ministry*, Gerald Arbuckle examines this refounding and offers examples of how it can be done in creative ways.

Arnold, William. *Introduction to Pastoral Care*. Philadelphia: Westminster, 1982.
This basic work integrates theology and pastoral care in a practical and useful way. Citing actual experiences, with questions for personal reflection, this much-needed study brings about a new awareness of the ministry of pastoral care.

Autton, Norman. *Pastoral Care in Hospitals*. London: S.P.C.K., 1968.

Burton, Laurel Arthur, ed. *Making Chaplaincy Work: Practical Approaches*. New York: Haworth, 1988.
With compassion and commitment, practicing chaplains draw on a wide range of professional experiences and discuss principles, themes, and guidelines that have enhanced their ministries. These practical and successful approaches are aimed at helping others face the daily professional challenges of healthcare chaplaincy. The issues and responsibilities of chaplaincy work with a variety of patient populations—AIDS sufferers, long-term care patients, stroke victims, and the terminally ill—are thoroughly explored. Contributors provide creative and innovative methods of meeting the needs of hospital patients and their families as well as health care personnel, such as implementing a volunteer clergy program and establishing a surgical reporting plan.

Bush, Joseph E., Jr. *Gentle Shepherding: Pastoral Ethics and Leadership*. Atlanta, GA: Chalice, 2006.
Named "One of the Top Ten Books for Parish Clergy" for the year 2006 by the Academy of Parish Clergy. *Gentle Shepherding* offers a rare balance in an introduction to pastoral ethics, one that identifies deeply with the pastoral vocation and brings it into conversation with a developed body of ethical theory. The goal of the book is to equip seminarians and pastors with conceptual resources for clarifying moral responsibility in the practice of ministry. This responsibility includes three levels: the minister as a moral agent in offering care; the minister as a moral enabler in encouraging virtue in others; and the minister as a moral leader in facilitating congregational life and witness in society. Helping ministers and seminarians to think anew about their responsibilities and the moral quandaries in pastoral practice, *Gentle Shepherding* integrates theory with practice, providing case material for further reflection and discussion and at least one case study or exercise associated with each chapter.

Butler, Sarah A. *Caring Ministry: A Contemplative Approach to Pastoral Care*. New York: Continuum, 1999.
The Caring Ministry program was developed by the Pastoral Care Team at St. John at Episcopal Cathedral in Denver, Colorado, to train lay people in basic pastoral skills. Its premise is that there is no better way to cultivate a receptive posture toward others than by praticing listening to God. The Caring Ministry Approach thus combines basic pastoral skills and guildelines along with an emphasis on being grounded in prayer. It invites both clergy and lay ministers to deepen the well of relationship with God as a means to developing a caring, listening heart. The text weds expertise with reflection and draws up the rich stories and lessons from Scripture that add the spark of wisdom and grace to psychological programs. It is particularly suited for use in church-based pastoral care programs.

Cobb, Mark. *The Hospital Chaplain's Handbook: A Manual of Good Practice*. Norwich: Canterberry, 2005.
A recent national survey found many serious problems within hospital chaplaincy work with chaplains often feeling marginalised by other staff or failing to understand their role. This practical and informative guide is therefore both timely and will meet an urgent need. Aimed both at newly appointed and experienced chaplains, it aims to be a primary resource offering continuing guidance on: the role of chaplaincy in the NHS today; the spiritual dimension of illness, injury and health care; ward etiquette, assessing needs, working with other health care professionals; working in specialist areas: maternity, paediatrics, accident & emergency, geriatrics, etc.; death, dying and bereavement; beliefs and practices of different faiths; professional practice: ethics, pastoral boundaries, confidentiality, record keeping, clinical audit; caseload management, supervising volunteers, education and training; a large selection of prayers and readings for routine and emergency pastoral situations, anointing and laying on of hands, and much more.

Dykstra, Robert C., ed. *Images of Pastoral Care: Classic Readings*. St. Louis, MO: Chalice, 2005.
This book is an edited volume of works that have predominated over the past several decades in contemporary pastoral theology. Through the writings of nineteen leading voices in the history of pastoral care, Dykstra shows how each contributor developed a metaphor for understanding pastoral care. Such metaphors include the

solicitous shepherd, the wounded healer, the intimate stranger, the midwife, and other tangible images. Through these works, the reader gains a sense of the varied identities of pastoral care professionals, their struggles for recognition in this often controversial field, and insight into the history of the disciple.

Faber, Heije. *Pastoral Care in the Modern Hospital*. Philadelphia: Westminster, 1971.

Furniss, George M. *The Social Context of Pastoral Care: Defining the Life Situation*. Louisville, KY: Westminster John Knox, 1994.

Because their work focuses primarily on the fields of theology and psychology, pastoral caregivers have often neglected to take into account the social forces that affect both the careseeker and the caregiver. In this groundbreaking book, sociologist and chaplain George Furniss introduces them to a third discipline, sociology, to draw upon in their work. Furniss offers an introduction to sociological approaches that are particularly relevant to those in the field. Brief biographical notes about key figures in sociology and a glossary of terms are supplied to assist those who lack extensive background in sociology.

Gerkin, Charles V. *An Introduction to Pastoral Care*. Nashville: Abingdon, 1997.

"Gerkin introduces readers to the history, theory, and practice of pastoral care. This book represents the best of Protestant liberal pastoral theology and fills a long-standing gap. . . . The narrative-hermeneutical paradigm which Gerkin offers holds and works with many of the complexities of pastoral care in postmodern times."—Carrie Doehring.

Heuch, J. C. *Pastoral Care of the Sick*. Minneapolis: Augsburg, 1950.

Holst, Lawrence E., ed. *Hospital Ministry: The Role of the Chaplain Today*. New York: Crossroad, 1985.

Good content in some chapters; the first chapter being the best.

Kirkwood, Neville A. *Pastoral Care in Hospitals*. Second ed. Harrisburg, PA: Morehouse, 1998.

Bringing comfort and concern to the bedside of the sick or dying is a challenge for lay people and clergy alike. In this practical guide, the author shares his wisdom—gleaned from some twenty years of experience as a hospital chaplain—on the art of hospital visitation.

This classic handbook is now updated, with an all-new section addressing best practices for hospital chaplains, with additional sections addressed to clergy and trained lay pastoral workers, as well as ordinary lay people who simply want to visit their fellow-parishioners, which shows visitors ways to make the encounter meaningful and enriching to the patient. Kirkwood guides readers through the minefield of hospital visits—from false heartiness to too much talking—and offers a theology of visitation that can guide both professionals and laity in their ministry.

A variety of exercises and a section of prayers for specific circumstances make this a must-have resource for all who work with the sick and dying, and an excellent text for course work.

Mitchell, Kenneth R. *Hospital Chaplain*. Philadelphis: Westminister, 1972.

Paget, Naomi K. and Janet R. McCormack. *The Work of the Chaplain*. Valley Forge, PA: Judson, 2006.

The ideal starting point for all—including seminarians—who are exploring a call to minister outside the walls of the church. Unlike most other books in this field which are specific to one form of chaplaincy and are often written from an autobiographical viewpoint only, this new resource meets a critical need for an introductory and overview look at chaplaincy in general.

Patton, John. *Pastoral Care: An Essential Guide*. Nashville: Abingdon, 2005.

The essentials of pastoral care involve the pastor's distinctive task of caring for those who are estranged—the lost sheep. Taken from the biblical image of the shepherd, the pastor by virtue of his or her professional calling cultivates wise judgment in order to hear the hurting and offer guidance, reconciliation, healing, sustaining presence, and empowerment to those in need. This book will outline the quintessential elements pastors need to wisely minister in today's context by discussing four major kinds of lostness: grief, illness, abuse, and family challenges.

The purpose of the book is to fulfill the need for brief, substantive, yet highly accessible introductions to the core disciples in biblical, theological, and religious studies. Drawing on the best in current scholarship, written with the need of students foremost in mind, addressed to learners in a number of contexts, *Essential Guides* will be the first choice of those who wish to acquaint themselves or their students with the broad scope of issues, perspectives, and subject matters within biblical and religious studies.

———. *Pastoral Care in Context: An Introduction to Pastoral Care*. Philadelphia: Westminster, 2005.
An expert in the field of pastoral care, the suthor demonstrates that pastoral care is a ministry of the church. He focuses on the community of faith as an authorizer and source of care and upon the relationship between the pastor and a caring community. Patton identifies and compares three paradigms of pastoral care: the classical, the clinical pastoral, and the communal contextual. This third paradigm emphasizes the caring community and the various contexts for care rather than focusing on pastoral care as the work of the ordained pastor.

Ramsay, Nancy J., ed. *Pastoral Care and Counseling: Redefining the Paradigms*. Nashville: Abingdon, 2004.
Pastoral Care and Counseling has changed radically since the publication of the *Dictionary of Pastoral Care and Counseling*. Rapid changes have occurred in theological, social, and medical contexts broadening the understanding of care. The shift from the "living human document" to the "living human web" both enriches and challenges the study and practice of pastoral theology

Schiapani, Danile S., and Leah Dawn Bueckert, eds. *Spiritual Caregiving in the Hospital: Windows to Chaplaincy Ministry*. Kitcyhener, Ont.: Pandora, 2006.
This book acknowledges and celebrates the unique contribution of hospital chaplains, fosters understanding and support for their work, and seeks to elicit interest in their ministry of spiritual caregiving.

Schnase, Robert C. *Testing and Reclaiming Your Call to Ministry*. Nashville: Abingdon, 1991.

Stevenson-Moessner, Jeanne. *A Primer in Pastoral Care*. Minneapolis: Augsburg, 2005.
Based on her twenty years of teaching and on her own experience in pastoral care, the author has written a basic pastoral care text to assist in the emotional and spiritual preparation of pastoral caregivers. Stevenson-Moessner sees pastoral care as the interconnection and interplay of love of God, love of neighbor, and love of self. Her brief book engenders confidence and caring in the initiate, and assuages the fear and anxiety that naturally occur when one accompanies people in life-changing pain and travail. Through bibical parables—especially the Good Samaritan and the Good Shepherd—and stories from her own experience, the author imparts genuine wisdom and meaningful support to those who courageously dare to offer caregiving ministry in whatever situation or through whatever method or paradigm.

Sullivan, Winnifred Faller. *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law*. Chicago: U of Chicago, 2014.
Most people in the United States today no longer live their lives under the guidance of local institutionalized religious leadership, such as rabbis, ministers, and priests; rather, liberals and conservatives alike have taken charge of their own religious or spiritual practices. This shift, along with other social and cultural changes, has opened up a perhaps surprising space for chaplains—spiritual professionals who usually work with the endorsement of a religious community but do that work away from its immediate hierarchy, ministering in a secular institution, such as a prison, the military, or an airport, to an ever-changing group of clients of widely varying faiths and beliefs.
In *A Ministry of Presence*, Winnifred Fallers Sullivan explores how chaplaincy works in the United States—and in particular how it sits uneasily at the intersection of law and religion, spiritual care, and government regulation. Responsible for ministering to the wandering souls of the globalized economy, the chaplain works with a clientele often unmarked by a specific religious identity, and does so on behalf of a secular institution, like a hospital. Sullivan's examination of the sometimes heroic but often deeply ambiguous work yields fascinating insights into contemporary spiritual life, the politics of religious freedom, and the never-ending negotiation of religion's place in American institutional life.

Vandecreek, Larry, ed. *Contract Pastoral Care and Education: The Trend of the Future?* New York: Haworth Pastoral, 1999.
"This volume aptly illustrates individual dissatisfaction with historic limitations, efforts to be innovative, to overcome obstacles, and to build and maintain community support often in response to negative institutional policies. It is well worth reading by anyone interested in contemporary pastoral care and education in institutional settings including, in particular, health care facilities."—Stuart A. Plummer.

———, ed. *Scientific and Pastoral Perspectives on Intercessory Prayer: An Exchange Between Larry Dossey, M.D. and Health Care Chaplains*. New York: Haworth, 1998.

Written by eight chaplains, the articles in this text are in response to an essay by Larry Dossey, a nationally known physician who speaks and writes about prayer. The contributors to the book discuss his points of view on intercessory prayer, which are based on quantum physics. You will learn if this area of physics can make a difference in how you practice your faith, how you worship, and what you think about or expect from prayer.

Vandecreek, Larry, and Marjorie A. Lyon. *Ministry of Hospital Chaplains: Patient Satisfaction* (Healthcare Chaplaincy Series). New York: Haworth Pastoral, 1997.

Vandecreek, Larry, and Sue F. Dromgoole Mooney, eds. *Parish Nurses, Healthcare Chaplains, and Community Clergy: Navigating the Maze of Professional Relationships*. New York: Haworth Pastoral, 2003.

Wimberly, Edward P. *African American Pastoral Care: The Politics of Oppresion and Empowerment*. Cleveland, OH: Pilgrim, 2006.
It provides a perspective on pastoral care often absent from traditional texts.

Appendix A

Agendas and the Chaplaincy

By Gerald S. Wylie, BCC[2]

When I first started doing the work of a hospital chaplain and still had much to learn, I visited a patient on the oncology floor in the hospital where I ministered. He looked pale and obviously uncomfortable. After introducing myself, I said something like, "I came by to see if I could encourage you." He looked at me rather sternly and said, "I don't need to be encouraged. I need sleep." Fortunately I learned much from that rookie mistake. I learned never to assume that I knew what was best for a patient. To do so is to have a faulty agenda, and as you will read, that is a mistake.

The dictionary defines the word *agenda* as, "Things to be done." As it applies to the chaplaincy, it means to initiate a visit with an objective or a plan of action based on the needs or desires of the Chaplain rather than the needs or desires of the patient. It means that the Chaplain, not the patient, determines the direction the visit takes.

Our agenda could be to offer or provide some very good things. It had been my agenda to encourage the patient mentioned previously, to bring some spiritual comfort and support to a man sick from cancer. Certainly there couldn't be anything wrong with that. After all, I was motivated by a heart-felt desire to help someone in need.

Actually, there is plenty wrong with that type of approach. First, I assumed he needed or wanted my help. Then I assumed I knew what kind of help he needed without first getting to know him or even spending any time with him. I saw a sick man and jumped to conclusions. Because I entered the room with an agenda I assumed to know the needs of someone without bothering to listen and hear what the real needs were. As a result, the patient felt discounted.

There are many different agendas that can influence our ministry to patients. For the sake of clarity I will categorize these agendas under Personal Agendas and Professional Agendas. Keep in mind that the agendas I will be discussing are faulty agendas, agendas that hinder effective ministry in the hospital.

[2] Jerry Wylie has been serving with distinction as an HCMA Board Certified Chaplain since 1990 at Memorial Hospital in Belleville, IL. Used with permission.

Personal Agendas

Meeting One's Own Needs

Studies have shown that some people who enter occupations that are primarily geared toward meeting the needs of others, such as counselors and ministers, were reared in seriously dysfunctional families. They have a basic need to help others in order to gain acceptance and to feel better about themselves. Outwardly they appear very loving and self-sacrificing. In reality, they are seeking to meet their own needs. When this is the case, there is a tendency to put meeting the needs of a person before the person himself. A patient, for example, is viewed as a need to be met instead of a person who has value and is worth getting to know and understand.

This first type of personal agenda can be very harmful, especially for the Chaplain. Early burn out is a very strong possibility. And no one will understand because people will have viewed the Chaplain as being wholly characterized by love and compassion for others. This agenda may also hurt or upset the patient who is left feeling discounted and insignificant because the Chaplain never bothered to hear him and has now gone off to find a patient with more serious needs. It is also important to point out that the Holy Spirit can and does free ministers from the chains of coming from a dysfunctional family. I still maintain, however, that it is vital for ministers to administer frequent awareness checks to prevent a faulty agenda from becoming a dominating factor in ministry.

Prejudices

A second type of personal agenda describes those attitudes and actions that stem from feelings deep inside us, feelings to which we may be blind. This agenda can influence our ministry as Chaplains when we encounter people who are different from us, people of different race, sexual orientation, religion, economic or social class, age, etc. In other words, the prejudices that inflict our entire world can also show their ugly heads in the hidden agenda of Chaplains. Although outwardly we may appear to be ministering out of love, there is an inner attitude of disapproval, judging, or looking down our nose at someone.

"No, this doesn't apply to me. I don't have a problem with prejudice. I love everyone." I hope this isn't our attitude. Do you have a problem with smokers who can't quit even though they are killing themselves? I do. How about obese people or blatant sinners? Are you prejudice-free when dealing with homosexual AIDS patients? May we all seek to be open-minded about ourselves and be willing to regularly exercise the discipline of self-evaluation. If we aren't aware of our prejudices and admit to them, a hidden agenda will be at work when we visit certain types of patients. That's not good, to say the least.

Escape Difficult Situations

There is a third type of personal agenda that I call an escape agenda. It influences our ministry when we encounter a patient or situation that makes us feel very uncomfortable and uneasy. For example, I have a problem with whiners, patients who complain and cry about relatively minor problems. There is a part of my personality, a subject not related to this paper, that cannot deal with people who whine. I find myself not listening to the patient but thinking of a polite way to make my escape. There are certain situations that could cause a Chaplain to enter an escape mode, perhaps a smelly room, a jaundiced patient, or a crisis involving a small child.

It is likely that most Chaplains have a certain type of patient or situation that triggers the escape agenda. When this is the case, it is necessary to be fully aware of the source of those inner feelings and begin to work on them. Otherwise we will always become uncomfortable and uneasy and will have to leave ministry to that patient to someone else.

Professional Agendas

Concerning the role of hospital Chaplains, Lawrence Holst writes:

> "It is my contention that *all pastoral care has a basic, primary, definable, fundamental role* (italics his). By role is meant a basic task or purpose as determined by one's office, profession, or position. Role is a combination of external (imposed) and internal (self) expectations. In the case of a hospital chaplain, that role is determined by one's religious tradition, by one's context, by one's skills, and by the needs of those who receive that ministry.
>
> "I would define that basic, fundamental role of pastoral care *as the attempt to help others, through words, acts, and relationships, to experience as fully as possible the reality of God's presence and love in their lives*" (italics his).[3]

Holst goes on in his book to describe the many functions of the Chaplain, the "ways and means whereby role is implemented."[4] There are numerous factors that determine the functions that a Chaplain may emphasize in his/her ministry. Some of these are the expectations of the hospital in which a Chaplain ministers, the Chaplain's training and denomination, personal skills and personality, and the Chaplain's own faith system. So what we find is that each Chaplain ministers in a unique way. A problem arises, however, when a Chaplain emphasizes a function to such an extent that it overshadows the overall role of a Chaplain. The role must always hold sway over a function. When it doesn't, when the function is over emphasized, the Chaplain's ministry becomes pushing an agenda. I call these professional agendas and I will now consider several of these.

Prayer and Scripture Reading

Most Chaplains recognize that prayer is an important and necessary function. And many feel the same about the reading of Scripture. I know of a Chaplain, however, who believes that praying is his job and he pushes it on people who do not want it. He judges his own effectiveness by whether or not he has prayer with a patient. Knowing and understanding the patient is not his primary concern. Consequently, praying has become a professional agenda. It gets in the way of a personal, understanding, and compassionate ministry. Again, prayer and the reading of Scripture are important functions of the Chaplain, but I have listed them as the first type of professional agenda because their use can be inappropriate when they are pushed upon people.

Evangelism

Then there are the Chaplains who equate the chaplaincy with evangelism. It is their agenda to make sure a patient has accepted Christ as his personal Savior, especially if the patient is near death. A person's salvation is also a concern of mine and I have had the marvelous privilege of leading people to the Lord on their deathbed. But for some Chaplains their agenda is the salvation of lost souls. If they are asked about their ministry as Chaplains, they relate how many people they led to the Lord that year. In my opinion, and I know there are those who disagree with me, a Chaplain who has an agenda of leading people to the Lord is really an evangelist who happens to work in a hospital. He is not really doing the work of a Chaplain.

Analyzing Patients

A third type of professional agenda can be a problem especially for those Chaplains who have had CPE training. CPE training can be of great value for a Chaplain, providing skills necessary for self-examination and awareness, equipping the Chaplain to be proficient in being aware of what is going on with the patient, and giving training in asking insightful and probing questions of the patient. Problems arise, however, when

[3] Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad Publishing, 1985), 46.

[4] Ibid., 46-52.

the Chaplain begins looking at patients as psychological case studies, or even worse, subjects for a verbatim. I am afraid some Chaplains aspire to be what I call junior psychologists who get their kicks out of analyzing patients in order to discover root problems and needs. They have gotten their eyes off the role of the Chaplain and have become enamored by an inappropriate agenda.

Institutional Visits

The final professional agenda relates to the expectations placed on Chaplains by the institution in which they minister. Of course many of these expectations are necessary and should not be a problem for the Chaplain. For example, it is expected that Chaplains visit patients who are seriously ill, are scheduled for surgery, or have other special needs. These expectations are certainly acceptable. Sometimes, however, time constraints become an issue and the Chaplain finds himself trying to squeeze a number of visits into a short amount of time. The quality of the quantity of visits becomes what I call institutional visits. I face this problem when the surgery schedule arrives late to my office. There is always the temptation to conduct short, institutional visits to pre-surgery patients so that I can leave at quitting time.

Some of you may minister in hospitals that require the Pastoral Care Department to participate in one of the models of hospital quality assessment and improvement, such as the Total Quality Management model or the Continuous Quality Improvement model. This may require you to assess or chart each visit. For the most part this could be a benefit to your ministry, giving you credibility in the hospital and giving you a means to evaluate your ministry. But because of the time involvement the process could also affect the amount of time you have available to spend with patients or limit the number of visits. It that case, the agenda could be to leave enough time to do paperwork.

The Example of Christ

What does it look like to minister as a Chaplain without a personal or professional agenda? Where does one find a perfect example? There is, or course, no perfect human example, except for that example found in the ministry of the perfect minister of pastoral care: Jesus Christ. Being the divine Son of God, Jesus' ministry was always and totally characterized by the manifestation of the love and presence of God. He never operated under a faulty agenda.

We have no examples of Jesus ministering as a Chaplain in a hospital, but we do have many examples of His ministry to needy and hurting people. From the Gospel of John, I will look at Jesus' encounter with three individuals, three entirely different individuals who had a desperate need to experience personally the love and presence of God. The first is a wayward woman, the second is a blind beggar, and the third is a doubting disciple. Hopefully these illustrations will help point the way to a ministry that is free from personal and professional agendas.

The Wayward Woman

The story of the wayward woman is recorded in John 4. When I study Jesus' approach with this Samaritan woman, I am impressed with the intimacy of the encounter, with the fact that Jesus was so personal with her. He did not allow the prevailing prejudices to hinder his ministry. She was a woman and a Samaritan; Jesus was a man and a Jew. But Jesus approached her as a fellow human being who had physical needs just as she did ("Will you give me a drink?"). Jesus' encounter with this woman continued on a personal level with His penetrating statements based on a personal knowledge of her life. He knew her. This knowledge didn't cause Him to judge and condemn her. He didn't press her into repenting of her sin or to acknowledge her need of a Savior. His personal knowledge of her led Jesus to gently and compassionately seek to create in this wayward woman a desire for the gift of eternal life. Jesus communicated to this woman by establishing a personal relationship that He cared about her. She, of course, responded, and her needs were met.

Notice the three steps Jesus took in dealing with this woman. He started with her physical needs, moved on to her relational needs, and then dealt with her spiritual needs. And in the whole process He was warm and personal in relating to her. He was not a professional minister who kept His distance. He was understanding, compassionate, and interested in her as a person. That is an important key to being an effective Chaplain, showing interest in a person by listening and being attentive. Jesus, of course, has an infinite advantage over us. He knew all about the wayward woman because He is omniscient. He is God. We have to work at getting to know someone on a personal level, but it is a necessary work. In fact, I don't believe we have the right to deal with a patient on a spiritual level, especially since the patient has little control over who comes into her room, until we have demonstrated a real concern and interest in the patient based on a personal relationship. After we have gained the trust of a person, and after she feels safe in telling us that she has had five spouses and a lover, then we know enough about the person to begin to create a desire for the gift of eternal life through Jesus Christ. A personal or professional agenda will not hinder our ministry if we follow the process of establishing a personal relationship.

The Blind Beggar

In chapter 9 of the Gospel of John we read of Jesus' encounter with a blind beggar. As Jesus and His disciples were walking along the road they saw a very common sight, a blind beggar. The disciples reacted in a very common way: they were callused to the beggars needs. They were only moved to bring up a theological problem. They said to Jesus, "Rabbi, who sinned, this man or his parents, that he was born blind?" (John 9:2). Unfortunately, the disciples did not see this man's pain and sorrow. But Jesus did, and He dealt with it. Notice that Jesus did not bypass the physical needs of the man to get to the spiritual needs. He did not ignore the physical sight to get to the spiritual sight. He healed the man and sent him away. It wasn't until later, when Jesus again came upon the now seeing beggar, that Jesus dealt with the man's spiritual blindness.

Of course, Chaplains cannot heal the patients they visit in the hospital, but that doesn't mean they can ignore the physical needs just because they feel the spiritual needs are more important. I know there is little a Chaplain can do about a patient's physical needs, but neither can these needs be ignored in the attempt to get to issues the Chaplain thinks are important. May I suggest that one effective way to create in patients a desire to discuss spiritual needs is to demonstrate a sincere interest and concern for their physical needs.

The Doubting Disciple

We read of the doubting disciple in John 20. The phrase "Doubting Thomas" has become a figure of speech in our language, referring to someone who doubts but shouldn't. It is a derogatory term. We tend to judge people who are characterized by doubting. Did Jesus judge Thomas? Not in the least. When Jesus appeared to Thomas after His resurrection, and knowing of his doubts, Jesus simply said, "Put your finger here; see my hands. Reach out your hand and put it into my side. Stop doubting and believe" (John 20:29). Why didn't Jesus come down hard on Thomas's lack of faith? After all, He really blasted the Pharisees. I believe Jesus was gentle with Thomas because His tender heart sensed that the doubt of Thomas was born out of sorrow and painful questions about the reality of God's love. Jesus sensed that His formerly totally committed disciple (see John 11:16) was struggling. He wanted to believe but he couldn't. Because Jesus knew this, He was gentle, compassionate, and understanding. He didn't write Thomas off.

The key to Jesus' tenderness and understanding is that He knew the heart of Thomas; He knew Thomas personally. That's the lesson for the hospital Chaplain. Jesus ministered on a personal, intimate level and so should we, even if that means not presenting the Gospel, or not having prayer, or not trying to dig into a person's psychological baggage. Seeking to minister on the basis of a personal or professional agenda is not following the example of Jesus because it would put the needs and desires of the chaplain first.

In Summary

No doubt it is your goal to minister according to the example of Jesus. The first step toward that goal is ***awareness***. You must be aware of your deficiencies; of your tendencies to minister according to personal and professional agendas. Though sometimes painful, the discipline of self-evaluation is an absolute necessity for an effective Chaplain ministry. It is to be hoped that this paper will assist you in this process.

Prayerful dependence upon the Holy Spirit is another absolute as you seek to minister according to the example of Jesus. Can a mere human hope to copy Jesus' compassion, insight, and ability to create the desire for the gift of God's grace? No, of course not. You are not, however, a mere human Chaplain. You have the Holy Spirit, who works through you to produce a supernatural ministry. More than hard work, more than many hours at the hospital, more than much training, you must saturate your ministry with prayer.

Finally you must ***seek to be obedient to the example of ministry given by Jesus***. From Jesus' encounter with the wayward woman, the blind beggar, and the doubting disciple, the following principles can and should be applied to your ministry as a Chaplain:

1. Ministry must be based on a personal knowledge of a patient. It takes time and careful listening to understand and appreciate a patient's concerns.

2. Chaplains must not bypass issues that are of concern to the patient in order to get to spiritual issues.

3. Chaplains must seek to establish a relationship with the patient, a process which often can be accomplished in just a few minutes. This relationship is built on the Chaplain's desire to hear a person's story, to reverence that story, and to communicate an attitude of presence with the person. It is a relationship built upon the trust a person has in the chaplain when he senses that the chaplain is not carrying out a role based on a faulty agenda.

4. Chaplains should seek to create in a patient a desire for the gift of God's grace. This is best accomplished by being compassionate, sensitive, understanding, and patient. We should not try to push God's grace upon patients.

5. The ministry of a Chaplain should be one of gentleness and tenderness. The chaplaincy and aggressiveness usually do not mix.

6. The Chaplain must remember that each visit and each patient is unique. If the Chaplain functions essentially the same in each room, there is no doubt a faulty agenda is at work, adversely affecting the ministry.

I wish it were easy to minister in the hospital each and every day without being influenced by personal and professional agendas. It saddens me as I think of the times I have allowed a faulty agenda to control my visit with a patient. It saddens me even more to acknowledge that I was aware of functioning according to an agenda even as I did it. Clearly, awareness is not enough. But praise be to God that He has given me His Spirit. He continues to work in my life and ministry, impressing upon me the need of avoiding the influences of personal and professional agendas through total dependence upon the Holy Spirit. This same Spirit also continues to impress upon me the need of obedience to the example of Jesus, and He gives me the power necessary to be obedient. I cannot think of a more exciting and challenging ministry than the hospital chaplaincy. What a joy it is to know that the ministry He has given us, when carried out through the power of God, is going to be an effective ministry, in spite of our deficiencies, and that it will bring glory to the precious name of God.

Appendix B

Theological Orientation and Role Definition of Hospital Chaplains: A Survey of Hospital Chaplains' Ministry of America (HCMA) Chaplains

By Douglas M. Cecil, D.Min.[5]

Introduction

The hospital environment is rapidly changing, both technology and the way patients are treated. Treatment plans are influenced by DRGs (diagnosis related groups) and patients are confronted at the admission desk with advance directives.

Medical care and patient's self-determination have skyrocketed to the forefront of national attention with names like Cruzan and Kevorkian. National health care programs have become a political volleyball.

Into the midst of this fast changing, competitive environment enters the chaplain. What is the chaplain's role and responsibility in the midst of all of this change? Lawrence Holst well describes the tension that a chaplain faces when he speaks of a chaplain walking between two worlds, the world of "religion and medicine."

> *To move between these two worlds that are so markedly different-yet were at one time united-is to be in tension. The tension can be painful, confusing, exciting, creative. Like many tensions, it is never fully resolved and perhaps never will or should be*.[i]

The source of the tension that the chaplain faces can be readily identified. The chaplain, often being an ordained minister, often has specialized training as a pastor in the context of a local church. The pastor becomes a chaplain and is then thrust into a foreign, highly specialized field with a distinct vocabulary and unique set of problems.

> *The chaplain identifies with both worlds, yet does not feel entirely at home in either. Chaplains are an enigma to both worlds: medicine does not consider them 'medical enough' and questions their relevance; the church often does not consider them 'pastoral enough' and questions their identity. But the fact is that despite the tensions and enigmas, the hospital chaplain is very much committed to both worlds and is a vital link between them*.[ii]

The 'role' of the chaplain appears to be the issue that receives the most attention and coverage in the currently available materials. What are the role and responsibilities of the chaplain in the modern hospital?

Review of the Related Literature

Within those books and articles that deal with the hospital chaplain, and specifically the role of the hospital chaplain, several role models have been suggested. A brief survey of the suggested roles is presented here. Note that the discussion of the role of the hospital chaplain is a fairly recent topic.

[5] Dr. Cecil served as an associate professor of Pastoral Ministries at Dallas Seminary for eighteen years and was an HCMA Board Certified Chaplain for twenty-four years. He is now the Life Stage 5 Pastor at Christ Chapel Bible Church in Fort Worth, TX. Used with permission.

Gemmel views the role of the chaplain in hospital ministry as no different than the function of the minister in the parish ministry. He states that, "the chaplain is the Church's representative and servant."[iii] Gemmel goes on to state that,

> *[T]he function of the chaplain within the hospital . . . is to relate the dynamic content of the Gospel to the experiences through which men and women pass while they are hospital patients, that they may know its saving grace in the power of God's Holy Spirit*.[iv]

Heije Faber describes the role of the minister (his general term for chaplain) in the modern hospital from his perspective.[v] In order to do this, he makes the unusual comparison of a minister in the hospital to a clown in a circus. The minister, he suggests through simile, is like the clown in the circus. Faber states that, "the clown is a necessity in the circus, without whom the circus is no longer a circus but is reduced to a string of numbers."[vi] Therefore, the clown brings unity and comic relief to an otherwise tense environment.

But Faber goes on to argue that the clown offers more to the circus than mere comic relief. The clown is a reminder of human frailty and weakness. He is able to reach and entertain people because of his humanness. The people may leave the circus impressed by the feats of the performers but they also leave feeling more human because of the clown.

The clown not only performs a vital role, but also changes the climate of the circus through his presence. Similarly, the chaplain, who is comfortable with himself, is able to soften the institutional aspect of the hospital climate.[vii]

Faber explains that his purpose is not to look just at the minister's task, but to look at the minister himself.[viii] His desire to look at the minister himself stems from his conclusion that usually the minister, because of the tensions that exist in the hospital, feels inferior, ceases to be himself and fails to see himself making a contribution. In this situation, the minister loses direction and purpose. Almost in desperation he raises the question, "What is the essence of the pastoral ministry? What is irreplaceable about it? And what, in the light of this, are the possibilities open to us of realizing this essential ministry?"[ix]

Faber suggests that the essence of pastoral ministry in the hospital is to join the sufferer in his struggles. He would acknowledge that the minister is a representative of Christ, yet the definition of "a representative of Christ" is in question. To be a representative of Christ is to offer pastoral solidarity with another.

> *The pastoral ministry is therefore pastoral solidarity with the other, supporting him in the quest to become one who dares to believe in himself, because he has discovered through the minister*, experienced (emphasis his) *through him, that Christ believes in him. As a result, he begins to look for that light in hope and in turn finds himself wanting and able to be in solidarity with others.*
>
> *To represent Christ is therefore essentially a way of being (i.e. an interaction of word and deed), in the deepest sense an attitude. When we grasp this, we can see that the presence of the minister changes the 'climate' of the hospital: instead of being an institution it becomes a home. It becomes much more than a factory, a place in which 'feats' are performed. This happens in the same way in which the 'climate' of the circus changes through the presence of the clown, who by his performance puts the 'feats' of the others in perspective*.[x]

George W. Barger and his associates surveyed chaplains in Nebraska in 1984. A questionnaire was mailed to all the members of the OAICA (Omaha Area Institutional Chaplains Association) and the Nebraska State Chaplain's Association. The results of this survey showed that chaplains see themselves playing three major roles in the hospital: counselor, professional and religious functionary.

Counseling in the survey was defined as meeting the patient's needs, and being available to assist people no matter how large or small the need may be. A religious functionary was defined as one who "lifts up spiritual values within a hospital" and gives "concrete support through prayers, the Sacraments and Bible reading."[xi]

Perhaps the most interesting finding of the survey was the lack of consensus among chaplains regarding their role. As the authors remarked, "Perhaps the most important finding of this study is the low level agreement that exists among chaplains as they describe their role expectations."[xii]

Norman Dawson categorizes the chaplain's function at the hospital into four major roles.[xiii] He views himself (the chaplain) as priest, teacher, counselor and "clown." It is interesting that the image of a clown with reference to the hospital chaplain comes up a second time. In any event, Chaplain Dawson sees his initial role as being a counselor. He says that the initial aim of the chaplain "should be to discover the nature of that person's need at that moment. Having discerned that the chaplain will be in a position to decide the most appropriate role, that of priest, counsellor, teacher or clown."[xiv]

Lawrence E. Holst has tried to summarize what he has observed about the role of the chaplain. Holst observes that the impact of Clinical Pastoral Education (CPE) has forced the pastor to move past his own world and to join the sufferer in his world. He observes that,

> *. . . the C.P.E. (Clinical Pastoral Education) movement attempted to stimulate pastors to explore their own inner world in order to become more sensitive companions to other's struggles with the vital issues of life. C.P.E. boldly attempted to link the external and internal world of the learner, the cognitive with the emotive, theory with practice, theology with psychology*.[xv]

Holst goes on to suggest that,

> *The task of pastoral care is to join the sufferer, to enter the pain, to engage the absurdity, to descend into hell . . . not to minimize or to mitigate the suffering, but to help the sufferer to put the suffering in perspective*.[xvi]

Raymond G. Carey lists what he views as the roles of the hospital chaplain.[xvii] He conducted a survey among permanent staff chaplains, one-year CPE residents, and CPE students who were taking the CPE training for one unit of credit. The result of the survey found that these chaplains viewed themselves in five major roles: comforter, liturgist, witness, resource person, and counselor.

In addition to the roles that are listed above, other chaplain authors have written that the chaplain can take a role in research,[xviii] as ombudsman[xix], which handles complaints against the institution and is a patient representative, or other roles depending upon the specific setting[xx] or institution.[xxi] These role definitions are based on observation and the expertise of the particular chaplain author.

It is clear that there have been a number of roles suggested for the hospital chaplain. From the review of the literature we see the following suggestions: servant, clown, counselor, professional, religious functionary, priest, teacher, mediator, mobilizer, enabler, comforter, liturgist, witness and resource person.

The Need for the Study

Most of the data collected and reported in the related literature was from individuals of predominantly the same theological orientation, individuals sympathetic with the practice of Clinical Pastoral Education (CPE). But, what are the role and responsibilities of other hospital chaplains who are not primarily from the same theological orientation and training? Are the role and responsibilities of a chaplain from a different theological orientation and training the same? Do the religious convictions of the respondent influence the responses to the research? Would a different theological orientation alter the results?

A study was proposed that would survey the role of a hospital chaplain from a different theological orientation. The research data base was limited to Hospital Chaplains' Ministry of America (HCMA) trained chaplains. This study assumed that HCMA chaplains, having subscribed to a doctrinal statement, would reflect a different theological orientation and clinical training program.

The Descriptive Survey Method

The descriptive survey method was chosen for this study for two main reasons. First, the descriptive survey method looks at the phenomena of the moment and then describes precisely what the researcher observes. The underlying assumption of such an approach is that the given conditions that are established in the study usually follow a pattern or norm so that the results can be used to establish a course of action for the future. In this case, research of hospital chaplaincy, the question is "How do HCMA hospital chaplains currently view their role?" The descriptive survey method would answer that question.

Secondly, the descriptive survey method is appropriate in this instance because other studies in the past have employed this method. It is acknowledged and agreed upon that what one researcher found to be valid in one sample population at one particular time cannot be accepted for all time as a constant. However, the studies of the past which employed a similar method will give insight into the data that is recovered in this study. The accumulation of data over a period of time, therefore, may allow conclusions that have a firm base in fact.

The Descriptive Survey Design

The survey was designed from the review of the related literature. It explored two main questions. The first was, "What is your *purpose* as you visit in the hospital?" Or, stated another way, "What are you trying to accomplish as you visit in the hospital?" The second was, "In what *role* do you see yourself as you visit in the hospital?"

Under each of these two main questions several possible purposes and roles were listed. The response that was required of the respondent was one of degree, based on a five choice scale that was bracketed from "never" to "always." The answer scale was designed to affirm the observation that often chaplains find themselves in situations where they need to adapt their role and purpose to reflect the needs of the patient at that moment. The chaplain may enter a situation with one role in mind, yet find that he or she should change roles to help meet the need of the patient.

The scale also acknowledges the fact that chaplains find themselves in all of the roles that were listed at some time or another. Every chaplain has found himself or herself in the role of counselor, for example. Yet that may or may not be that particular chaplain's primary view of his ministry. The scale was designed to reflect the degree to which the chaplain values a particular role or purpose and how often they find themselves in that particular role.

The survey also addressed the possibility that role and purpose might often be indistinguishable from each other. Chaplains might see themselves in one role with two purposes, or just the opposite. In most cases, however, it doesn't appear that chaplains have made a distinction between role and purpose or thought through the options or possibilities. The purpose often expresses the role and the role often represents the purpose. Therefore there should be a high correlation between the purpose and the role. If the responses do not reflect a correlation between the role and the purpose, then the respondent or the instrument could be suspect.

From the review of the related literature eight main categories were identified and isolated. These categories of the way that a chaplain views his or her purpose and role, were mentioned at least twice and often times three times in the literature. In some instances the categories were identified by responses from another survey that was taken.[xxii] This literature background gives evidence that these eight categories are common roles used to identify chaplains.

Counselor

The counselor role was mentioned numerous times in relation to hospital ministry.[xxiii] It is seen by some chaplains as their primary ministry and the ministry that is used initially when approaching a patient.[xxiv] A

counselor is defined as a person who meets the patient's needs.[xxv] The chaplain's role as a counselor is to discover the nature of the patient's needs at that moment and then meet those needs, whatever those needs may be. A counselor would therefore be primarily patient directed and interested particularly in the patient's personal needs at the moment.

However, the role of the chaplain as counselor also bleeds over from counseling spiritual issues into counseling personal issues. Patients for example may need counseling on medical ethics or family problems. Hospital employees may need counseling with their personal and work related problems.

On the questionnaire this purpose is measured through the statement, "to be able to meet the patient's needs at that moment." The role is simply portrayed as "counselor."

Comforter

The role of the chaplain as a "comforter"[xxvi] is also described by some as "teacher"[xxvii] and "mediator."[xxviii] In this role, the chaplain helps the patients deal with their fears and anxieties resulting from their illness. The chaplain lends objectivity about the illness and helps the patients to put their illness into perspective and to reassemble their lives which have been upset by the onset of an illness.

The chaplain in this role also has a ministry to the patients' families at the time of serious illness or death. Such ministry is one of bringing comfort to the distressed.

The questionnaire reflects this purpose of the chaplain with the statement, "to help the patient maintain a healthy and realistic perspective and therefore be able to cope with the fears and anxieties that result from illness." The role is titled "comforter."

Professional

In this role, the chaplain is a professional in a professional environment. The chaplain has a place in the administrative hierarchy of the hospital.[xxix] But, the chaplain also is available to the physicians and nurses as a professional resource person.[xxx] Often the chaplain is seen as an expert in certain areas that overlap between the medical and spiritual worlds such as grief and crisis counseling.

The chaplain, as a part of a medical care team, is available to conduct lectures and classes in his area of expertise. The chaplain in this role is also able to communicate to patients the concern and dedication that the entire medical team has for the patient's well-being.[xxxi] The chaplain's support and experience as a professional is also welcomed on the bioethics committee, or on the oncology team.

On the questionnaire this purpose of the chaplain is measured by the statement, "to serve as a resource person and provide answers to the tough questions that are being asked." The role is simply identified as "a professional resource person."

Religious Functionary

In the role of the religious functionary, the chaplain is there to help uphold spiritual values in the hospital.[xxxii] The chaplain keeps the spiritual dimension of healing in the forefront of everyone's mind.[xxxiii] In this role the chaplain also makes spiritual resources available to the patient, often by arranging worship services or by administering the Sacraments.[xxxiv] The chaplain, as the religious functionary, provides concrete support of the patient through prayers or Bible reading.

Other terms that are used to describe this role are "priest"[xxxv] and "liturgist."[xxxvi] The primary focus of this role is on doing something rather than on being something. The chaplain in this role is primarily focused on providing expected religious services and duties rather than on being a representative of God.

The questionnaire addresses this purpose as "to provide spiritual resources through Bible reading, the Sacraments or a worship service." The role is simply portrayed as a "religious functionary."

Ambassador for Christ

As an ambassador for Christ, the chaplain is a servant, church's representative,[xxxvii] and witness.[xxxviii] The chaplain serves as a witness in times of crisis of God's love and concern. Often this role of a chaplain is accomplished by mere presence. As a representative of Jesus Christ, the chaplain is able to show compassion, mercy, care and love. In 2 Corinthians 5:20 we read that "we are ambassadors for Christ." This surely applies in the hospital as well as in other settings.

As an ambassador for Christ, the chaplain has an opportunity to share God's love and concern for the individual. This might take place through touching or listening, but it also might take place as the chaplain shares the gospel message with the patient.

Some might specifically refer to this ministry as the ministry of presence, or as the "incarnational ministry." However, the chaplain's ministry as an ambassador for Christ often goes beyond mere presence to also include the presentation of the gospel. Prayerfully leading a patient to a place where he or she expresses trust in Jesus Christ would be appropriate for the chaplain in the role of ambassador.

On the questionnaire, this role is simply reflected as "an ambassador for Christ." The purpose is stated, "to share the good news of Jesus Christ with the patient and be with them in times of crisis as a witness of God's love and concern."

A Reminder

This particular image of a clown describes a role of the chaplain in a unique fashion. The role of the chaplain is compared to the role of a clown in a circus. In the role of a clown, the chaplain brings unity and comic relief to an otherwise tense environment.[xxxix] But more importantly, the clown is one who is a reminder of our human frailty and weakness. The chaplain, in the role of a clown, is one who is able to carry and express our inadequacies.[xl] The chaplain helps the patient to feel more at home in the hospital environment and to come to grips with their humanness.

On the questionnaire, the role of the chaplain in this category is expressed simply by the statement, "A Reminder." The purpose that is expressed on the questionnaire is represented as, "to remind the patient of our human weakness and frailty so that the patient is able to feel more comfortable with his condition in the hospital environment."

Encourager

The role of the chaplain in this particular ministry is that of an encourager. The chaplain encourages the patient to marshal his or her energy and will to get better.[xli]

The chaplain helps the patients to maintain their will to live. The chaplain in this role is there to help the patients see the things that are worth living for and the consequences of giving up too soon.

On the questionnaire, the purpose is reflected by "to encourage the patient to marshal his/her energy and will to get better." The role of the chaplain is described as "an encourager."

Partner

In the role of the partner, the chaplain is to "join the sufferer, to enter the pain, to engage the absurdity, to descend into hell . . . not to minimize or to mitigate the suffering, but to help the sufferer to put the suffering in perspective."[xlii]

As is the case with all of these roles, a chaplain in general tries to assume this role to some extent, trying to be a compassionate partner with the patient and to go through the illness with them as a friend and a witness for Christ. However, as with all of these roles, the chaplain cannot fulfill all of the requirements that the role demands. The chaplain cannot *fully* enter into the sufferer's world; but the chaplain can point the sufferer to the One who is able to fully enter into his world.

This ministry of identification with the patient, of becoming a compassionate partner is described as "trying to join the sufferer and to enter into the sufferer's world." The role is simply described as "a partner."

The Procedures Used to Administer the Instrument

The instrument was administered at one session of the Hospital Chaplains' Ministry of America (HCMA) national convention in Anaheim, California on Monday afternoon, May 21, 1990. The administer was allowed five minutes to introduce and distribute the instrument to the respondents.

The participants were given until the end of the day, which was about an hour, to complete the questionnaire. After the introduction and distribution of the questionnaire, the organization's secretary conducted a short business meeting regarding the mailing policy of the organization. Most of the responses were filled out during this presentation.

Following the business meeting, the afternoon session was dismissed. The completed questionnaires were collected at the exit. A few completed questionnaires were turned in the next day.

The statistical package for the Apple Macintosh, "JMP,"[xliii] was chosen to handle the data due to its graphic capability. The age of the respondents was entered as an interval number, as were the years of hospital ministry and number of beds in the hospital.

The Results of the Data

The results summarized a profile of the respondents, and the respondents' view of role and responsibility in the hospital. There were 96 respondents to the questionnaire. The average age of the respondent was 60. The individual had been in hospital chaplaincy for 7 years and served a hospital of 250 beds.

The respondents were asked to place their theological orientation on a continuum between "liberal" and "fundamentalist". The religious convictions of the respondents were: 42% stated that they were "evangelical," 38% stated that they were "conservative" and 20% saw themselves as "fundamentalists." There were no respondents to the other two categories, "neo-evangelicals" or "liberal."

Based upon the data, the respondents primarily view their role and responsibility as being an "ambassador" for Jesus Christ. The other roles in their order of response were: "comforter," "counselor," "encourager," "partner," "professional resource person," "religious functionary" and "reminder."

From the essay section of the questionnaire, the respondents viewed their purpose and role as an "ambassador." However, the respondents viewed their role in being an accepted and needed member of the hospital staff significantly higher in the essay section than the corresponding question in the body of the questionnaire.

When the data was analyzed against the profile of the respondents, it was observed that the profile of the respondent who chose the response of "ambassador" was most likely to be the individual over the age of 60 and has been serving as a chaplain under 5 years, who possesses a doctorate and holds "fundamentalist" religious convictions. Yet the differences in the data which indicate this particular response preference were not large.

The Results Compared to the Literature

When compared to other data that has been collected from other sources, the respondent's responses to this study was close, but differed in a few significant areas. The role of the "liturgist" or "religious functionary" ranked significantly higher in Holst's study that was reflected in the literature than in the data that was collected for this study.

The models of ministry that were suggested from the literature were many. The roles suggested were: servant, clown, counselor, professional, religious functionary, priest, teacher, mediator, mobilizer, enabler, comforter, liturgist, witness and resource person. Holst, in his latest research,[xliv] listed the role of a chaplain as comforter, witness, liturgist and resource person (tie) and counselor.

Holst defines his roles as follows. The comforter helps the patient "cope with fears and anxieties resulting from illness."[xlv] The witness is one who prays with the individual and spends time with families as a testimony of God's love and concern. The liturgist administers the Sacraments and the resource person conducts lectures and classes. The counselor counsels with patients and employees on personal and work related problems.

The results of this current study bring new information to the discussion. It is granted that the categories that were used by Holst, and the categories that were used in this research project were different; however a comparison can be established. Holst's research listed the *comforter* as the respondents' number one choice, while this study listed the *ambassador* as the top choice among the respondents. The top choices from both research projects are given here in order:

Holst	**HCMA**
Comforter	Ambassador
Witness	Comforter
Liturgist and Resource	Counselor
Counselor	Encourager

One main difference between the two findings is in the placing of the liturgist and resource person. In this study, the resource person and religious functionary ranked #6 and #7 out of 8 possible choices. In Holst's findings, the liturgist and resource person ranked significantly higher. It might also be observed how "counselor" appeared in Holst's results compared to its placement in the current questionnaire.[xlvi]

The other difference that might be highlighted is that in the current questionnaire, the "ambassador" generated significant support. In Holst's findings, the mean values were highest for the comforter, while just the opposite was true for this study.

However, the possibility also exists that different theological traditions, while defining terms differently actually intend to communicate the same concept. For example, it may be that for Holst the combination of the witness and liturgist role is, in fact, the ambassador that is reflected in this study.

The question that was being considered in this analysis was, "Did religious convictions influence the responses in any way?" The answer seems to be that there was some correlation between the religious convictions and theological orientation of HCMA and the responses generated by this study. The more the respondents viewed their religious conviction as "conservative" or "fundamentalist", the higher the mean of "ambassador."

When the respondent's convictions are compared with the respondents who chose the "ambassador" as their primary purpose, the more conservative the religious orientation of the respondent the higher the response on the "ambassador" scale. When contemplating the "ambassador" role, the "fundamentalist" conviction had a 4.63 mean while the "conservative" conviction generated a 4.54 mean, and the "evangelical" had a 4.44 mean. This same pattern occurred throughout all of the roles. The respondents who viewed their religious convictions as "fundamentalist" consistently has a higher mean on all the roles than the other two categories.

The only difference was that when considering the role of "ambassador" the response mean was highest among the fundamentalist, conservative and evangelical in that order. On every other role that was considered the response mean ranking was fundamentalist, evangelical and then conservative.

In Conclusion

The results of the questionnaire might indicate that the theological orientation of the respondent influences the perception of the chaplain's role in the hospital. There appears to be a slight difference between the related literature and the way chaplains of this particular segment and theological orientation perceive their purpose and role.

While those chaplains in HCMA who consider themselves as more conservative view both their primary purpose and primary role in the hospital as being an "ambassador" for Christ, being "a significant part of the medical team" was also an extremely important role for the chaplain even though it ranked low in purpose. So while the respondents acknowledge their role as an ambassador, they also appear to embrace and desire to acknowledge their role as a health care team member.

Discussion

The theological orientation of a chaplain, or at least the theological orientation of the chaplains that are represented in this study, appears to influence the way they view their role in the hospital. Or, in other words, the religious conviction of the respondent did seem to influence the chaplains' response.

The data of this study also clearly affirms, in at least one segment of hospital chaplaincy which is defined by theological orientation, the role and the responsibility of the "ambassador." Yet all would probably acknowledge that this role is not the only responsibility that the chaplain must be prepared to perform.

The ways that a particular role is expressed in ministry can be many. There might be one role but many ways that role might be expressed. The role may remain constant, however the associated responsibilities of the chaplain could be expressed through the other terms that were used in the questionnaire such as, "to meet needs," "to encourage" or "to comfort."

Therefore, the chaplain might have the role as an "ambassador" for Jesus Christ, who, in the expression of that role, performs many functions. As an "ambassador," the chaplain may function as a "counselor" in a particular situation. The chaplain in this role is still primarily an "ambassador" who is performing the "counselor" function.

The current debate and associated literature appears to have overlooked two important components: a chaplain's theological orientation and a clear distinction between the role and responsibility of a chaplain. First, a chaplain's theological orientation is vitally important in the way that ministry will be carried out. The theological orientation of a chaplain will help define their role and purpose in the hospital.

Second, a chaplain's role is not exclusive from other responsibilities that might be performed. While a chaplain might view their role in a particular way, that role will not remain exclusive. Other responsibilities will be carried out. However, whatever that specific role happens to be in a chaplain's mind will influence their conduct. A chaplain who views their role in the hospital as a clown will conduct ministry differently than one who views their role as an ambassador.

Future training and equipping of pastors and chaplains should keep these two components in mind. A program that might try to curb an individual's theological expression might do more to hinder an individual in the ministry than help. Also, while current equipping appears to teach a variety of chaplain responsibilities, emphasis should be given to the chaplain's theological orientation which, in turn, is going to help define that chaplain's associated role.

The chaplain does appear to be between two worlds. However, the answer does not appear to impose a given set of responsibilities upon a chaplain apart from their theological orientation. Such a training strategy might do more to encourage the confusion than help to solve it.

References

[i]Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad Publishing, 1985), 12.

[ii]Ibid., 26.

[iii]Alexander Gemmell, *The Hospital Chaplain* (Edinburgh: The Saint Andrew Press, 1970), 8.

[iv]Ibid., 11.

[v]Heije Faber, Pastoral *Care in the Modern Hospital* (Philadelphia: Westminster Press, 1971)

[vi]Ibid., 81.

[vii]Ibid., 87-88.

[viii]Ibid., 88.

[ix]Ibid., 89.

[x]Ibid., 90-91.

[xi]George W. Barger and others, "The Institutional Chaplain: Constructing a Role Definition" *The Journal of Pastoral Care* 38:3 (1984): 183.

[xii]Ibid., 179.

[xiii]Norman W. Dawson, "Reflections of a Hospital Chaplain" *Modern Churchman* 27:4 (1985): 10-15.

[xiv]Ibid., 12.

[xv]Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad Publishing, 1985), 16.

[xvi]Ibid., 25.

[xvii]Raymond G. Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains" in *Hospital Ministry: The Role of the Chaplain Today,* Lawrence E. Holst, ed. (New York: Crossroad Publishing, 1985), 28-41.

[xviii]Edmond Phillips, "The Research Ministry: A New Concept for a Hospital Chaplaincy" *Journal of Religion and Health* 9:3 (1970): 218-32.

[xix]Leila M. Foster, "The Chaplain: Patient's Advocate and Institution's Ombudsman" *The Journal of Pastoral Care* 29:2 (1975): 106-10.

[xx]An example would be in ministry to families. See Maurice Graham, "The Role of the Chaplain with Religious Families Who are Resistant to Treatment" *The Journal of Pastoral Care* 40:3 (1986): 273-75.

[xxi]William R. Morrow and Thomas J. Matthews, "Role-Definitions of Mental-Hospital Chaplains" *Journal for the Scientific Study of Religion* 5:3 (1966): 421-34.

[xxii]George W. Barger and others, "The Institutional Chaplain: Constructing a Role Definition" *The Journal of Pastoral Care* 38:3 (1984): 176-186. This survey identified three roles which are articulated below.

[xxiii]This role was mentioned by George W. Barger and others, "The Institutional Chaplain: Constructing a Role Definition" *The Journal of Pastoral Care* 38:3 (1984), Norman W. Dawson, "Reflection of a Hospital Chaplain" *Modern Churchman* 27:4 (1985), and Raymond G. Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", in *Hospital Ministry: The Role of the Chaplain Today,* ed. Lawrence E. Holst (New York: Crossroad Publishing, 1985).

[xxiv]Dawson, "Reflection of a Hospital Chaplain", 12. He sees himself in this role primarily.

[xxv]George W. Barger and others, "The Institutional Chaplain: Constructing a Role Definition" *The Journal of Pastoral Care* 38:3 (1984): 182.

[xxvi]Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", 41. He uses this name in his article.

[xxvii]Dawson, "Reflection of a Hospital Chaplain", 13.

[xxviii]Gerald H. Pryor, "Hospital Chaplain Handbook: A Practical Guide" (D.Min. dissertation, Western Conservative Baptist Seminary, 1985), 5.

[xxix]Barger, "The Institutional Chaplain: Constructing a Role Definition", 183. He not only refers to this role as a professional but also defines this role primarily by the position.

[xxx]Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", 41.

[xxxi]Pryor, "Hospital Chaplain Handbook: A Practical Guide", 5. He mentions this is a task of the chaplain in this particular role.

[xxxii]Barger, "The Institutional Chaplain: Constructing a Role Definition", 183.

[xxxiii]Dawson, "Reflection of a Hospital Chaplain", 11.

[xxxiv]Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", 40. He refers to this role as a liturgist.

[xxxv]Dawson, "Reflection of a Hospital Chaplain", 11.

[xxxvi]Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", 40.

[xxxvii]Alexander Gemmell, *The Hospital Chaplain* (Edinburgh: The Saint Andrew Press, 1970) 8.

[xxxviii]Carey, "Change in Perceived Need, Value and Role of Hospital Chaplains", 41.

[xxxix]Heije Faber, *Pastoral Care in the Modern Hospital* (Philadelphia: Westminster Press, 1971), 81-83. The author goes to great length in this book to defend this image of the chaplain as a clown.

[xl]Dawson, "Reflection of a Hospital Chaplain," 14-15.

[xli]Pryor, "Hospital Chaplain Handbook: A Practical Guide", 5.

[xlii]Holst, *Hospital Ministry: The Role of the Chaplain Today,* 25.

[xliii]*JMP: Software for Statistical Visualization on the Apple Macintosh* (Cary, NC: SAS Institute, 1989)

[xliv]Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad Publishing, 1985)

[xlv]Ibid., 40

[xlvi]Ibid., 41. In Holst's findings, the mean values assigned by the chaplain response group was: the comforter (2.90), witness (2.70), liturgist and resource person (2.47) and counselor (2.14). It was also interesting to note that in Holst's findings, when the mean value was combined with the other groups of patients, nurses and physicians, the ranking changed. Comforter was listed first and had a mean value of 2.78, followed by liturgist (2.59), witness (2.50), resource person (2.28) and counselor (1.96).