PASTORAL CARE IN A CLINICAL SETTING: THE ROLE HOSPITAL CHAPLAINCY PLAYS AS PART OF A BROADER MEDICAL TEAM.

by

REV. DEVIN ATHERSTONE

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SUPERVISOR: Dr Franklin Jabini

The opinions expressed in this thesis do not necessary reflect the views of the South African Theological Seminary.

DECLARATION

I hereby acknowledge that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted to any institution for a degree.

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Rev. Devin Atherstone

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Last but by no mean least, my Saviour. You have placed me on a path that I would never have imagined walking. Your goodness and blessings have truly followed me all the days of my life. I owe everything to You!

"The hospital is a place of paradox, of contradictions and blurred realities. A place where many of our patients' fondest hopes and prayers are miraculously answered. A place where many of their deepest fears and agonies are painfully endured.

It is the place where hospital chaplains do ministry."

- Holst (2006:8)

SUMMARY

The research discusses the manner in how hospital chaplains can form part of a broader medical team, in two medical institutes in Somerset West, Western Cape. A total of 120 patient questionnaires were completed in both government and private sectors. The questions targeted all aspects of the hospital stay, emotional and spiritual facets. A medical staff questionnaire was designed to discover the mindset of the medical professional regarding the need for spiritual care in hospitals. This information laid the foundation as to the philosophy of hospitals towards chaplain ministry.

A detailed analysis of the professional chaplain was researched. This demonstrated the competency levels of qualified chaplains and the value that they offer patients and staff alike. Through recent research, evidence was presented to substantiate the need for a soul care professional as medical staff often negates (for obvious reasons) the emotional and spiritual needs of patients.

A biblical exploration was undertook, seeking to identify what pastoral care is. Biblical images and motivation for effective scriptural counsel was examined to determine guidelines and principles for hospital visitation. Further recommendation was made as to explore the crucial role that the local church plays regarding the necessity of visiting the ill.

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CHAPTER 1

Introduction

Due to the nature of this thesis, certain explanations are needed upfront as not to misinterpret key concepts and definitions. These terms will be identified and discussed in the section below.

1.1. Definitions of Terms

- Throughout the thesis the masculine pronoun will be used in a "generic and inclusive fashion" (Kollar 1997:7), unless otherwise stated.
- Unless designated, scripture quotations are from the New International Version.

Hospital Chaplain:

Unless designated, the term *chaplain* will be referred to as a *hospital chaplain*. Kirkwood (2005a:ix) suggests that chaplains are often seen as professionals that work alongside other health care professionals as "the expectation of a hospital chaplain by hospital administration is high" and generally they offer pastoral care beyond their own denomination community. McClung, Grossoehme, and Jacobson (2006:147) claim that "Chaplains are trained extensively to provide spiritual care to patients, families, and staff as they assist in meeting the organization's mission to provide patient-centered care." Chaplains are therefore seen as having more responsibility than the hospital visitor, the lay pastoral worker and the visiting clergy (Kirkwood 2005a:vii). For this thesis, the researcher refers to the hospital chaplain as a qualified professional, with the relevant theological training, ordination and further experience in clinical counselling.

Pastoral Counselling:

Collins (2007:36) characterises pastoral counselling, as a specialised training in which pastoral counsellors help people deal with problems by using a variety of healing methods in ways that are consistent with sound biblical and theological teaching. Allender (1997:40) supports Collins' definition by explaining that pastoral counselling has a narrower focus with an intense, highly focused interaction. The Clinebell Institute denotes the following;

> "An important dimension in pastoral counselling different from other approaches to counselling and psychotherapy is the conviction that mental and emotional health is best understood when spiritual, religious and psychological needs of individuals are addressed."[1]

Pastoral Care:

Brushwyler et al (1999:2) describe pastoral care as having its roots in Word and Sacrament; it does not have its origins in various scientifically grounded personality theories or schools of psychotherapeutic modalities. Its heritage is in the sacred scriptures, in prayer, in proclamation, and in care of the soul. Howard (1996:9) writes that "pastoral care is understood historically to embrace the helping acts performed by representative Christians as they facilitate the healing, sustaining, guiding, and reconciling of troubled individuals, people whose difficulties occur within the context of ultimate meanings and concerns." The task of pastoral care involves assisting people to develop, grow, and mature spiritually in spite of the difficulties of life (Peterson 1997:22), by helping them connect with God and the worshiping community. In other words Pastoral care is often seen 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" (Holst 2006:46).

Spirituality:

Spirituality can be a complex dissection of the human experience. According to Anandarajah and Hight (2001:83), spirituality can be dissected

[1] www.theclinebellinstitute.org.

into three main consortiums; *cognitive aspects (*i.e. search for meaning, purpose and truth in life and the beliefs and values by which an individual lives), *experiential aspects* (the individuals inner resources i.e. feelings of hope, love, connection, inner peace, comfort and support) and *behaviour aspects* (the way a person externally manifests individual spiritual beliefs and inner spiritual state). However, Kliewer (2004:616) states that spirituality in its broader sense is a "search for what is sacred or holy in life, coupled with a transcendent (greater than self) relationship with God or a higher power or universal energy." Maugans (1996:11) comments that spirituality is a system which focuses on those elements that impart vitality and meaning to life's events. Spirituality is seen as more personal which is often expressed through formalized religions.

Religion:

Religion is often seen as a "by-product" of spirituality, in other words, religion is a deeper connectedness to "…a community with shared beliefs and rituals" (Koenig 2004:1194). The Latin root of religious, "lig," can be translated as ligament, i.e. to "connect, tie, or bond." Puchalski, Dorff & Hendi (2004:690-691) said, "Part of what religions do is give us a picture of how we are tied to our family, our community, the larger human community, the environment, and the transcendent element in our experience (expressed in the three monotheistic religions of God)."

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO):[2]

This established United States organisation "sets standards for healthcare organizations and issues accreditation to organizations that meet those standards. JCAHO conducts periodic on-site surveys to verify that "an accredited organization substantially complies with Joint Commission standards and continuously makes efforts to improve the care and services it provides." JCAHO's mission is to continuously improve health care for the

[2] JCAHO can be accessed at www.jointcommission.org for a more detailed reading.

public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

Theological Assessment:

This is the skill of understanding and assessing a patient's story from a theological perspective. Taylor (1991:7) writes that "the task of theological assessment is to identify the beliefs that contribute to a parishioner's *(a patients)* difficulty."

1.2. The Research Problem

1.2.1. Background to the Problem

Being hospitalised can bring a person's life into perspective, especially in a time of crisis. A hospital has a unique way of bringing the drama of life and death to the forefront; at times it confronts people with the serious question about the purpose of life. Wilcock (1996:66) states that it is hard for a patient to believe in a God who cares, who is merciful and who offers security when their life situation that was once familiar and reliable is now disintegrating, where one's own territory is lost and the new environment is not home. Kirkwood (2005a:13) acknowledges this by suggesting that "a hospital ward is packed with the widest possible range of feelings and emotions." For many patients, being hospitalised is to be in a crisis. The Greek word for crisis, *krisis,* contains a two-sided character: danger (threats) and opportunity (possibilities) (Holst 2006:4). As a chaplain, the researcher has witnessed some of these emotions, some of which include

- A need for a strong sense of dependence,
- Being afraid of the outcome,
- For many people there is some sense of regression, in other words feeling and being treated like a child.
- Being hospitalised might stir up memories of what it was like to be sick as a child and whether one felt cared for or not.

- There is often questioning - Why is this happening? What happens if I am not all right?
- Families, friends, and other loved ones are often in a difficult situation as well. They may be worried, feel very helpless as a loved one suffers or struggles, and wonder what the outcome will be and if their lives will change significantly.
- Some even lose their sense of hope, in themselves and God.

With such a strong sense of emotions, what significance does spirituality play in medicine? As early as 1872, English anthropologist Francis Galton conducted a research essay on the effects of intercessory prayer on mortality among English royalty, clergy, and missionaries.[3] Since then a significant amount of research and literature has been produced by discovering the role that religion and spirituality have in the medical field.

Recent research studies conducted in the United States of America within the field of health science and spirituality have revealed two significant findings. Firstly, "research is increasingly demonstrating a relation between religion/spirituality and health and secondly, physicians should be aware of this research and understand its clinical implications" (Koenig 2004:1194). Medical research analysis conducted across hospitals in the United States reveal that as much as 96 percent of family physicians in Missouri consider spiritual well-being important to health (Ellis and Campbell 2004:1158). Anandarajah and Hight (2001:81) conducted a study and found that 94 percent of hospitalised patients believed that their spiritual health is just as important as their physical health. Kliewer (2004:617) goes on to suggested that in a public survey done in 1996 by *USA Weekend* showed that 63 percent of patients believe doctors should ask about spirituality issues, but only 10 percent have actually been asked. In another study, 77 percent of patient's surveyed said physicians

[3] www.abelard.org/galton/galton.htm

should consider patients' spiritual needs, and 37 percent wanted physicians to discuss religious beliefs with them more frequently. The writers of *Spirituality and Health: What we know, what we need to know* (George et al 2000:102) suggest that people frequently testify that their source of personal strength comes from the practice of their spiritual life, despite relative neglect by social and behavioural scientists. It has even been suggested that scientific methods are able to demonstrate a correlation between spiritual well-being and health (Ellis et al 1999:105). George et al. (2000: 110) takes this further by providing the reader with "three mechanisms by which religion affects health," namely, health behaviours (i.e. healthy lifestyle), social support (church fellowship for support), and coherence hypothesis (understanding their purpose in life). In spite of the high percentage of "current" statistical indicators regarding the patient's desire for medical staff to recognise their spiritual needs during a hospital stay, Shastri et al (2008:1) indicate that most times spiritual needs of patients are disregarded by medical professionals. Nevertheless they go on to explain that since the post cold-war era there has been greater acceptance towards the role of religion and spiritualism in mitigating diseases. However, medicine and religion have not always had the relationship as what current statistics suggests. Quoting Bruchhausen (2007:177),

> …about a century ago, preformed by enlightenment ideas on linear progress of humankind and often explicitly following Auguste Comte's cultural evolution theory of human development from magic via religion to science, many historians and sociologists dismissed any important role of religion in and for modern society. This was especially true for the view of health, illness and healing and has influenced the writing of medical history until today. Hence the period since the eighteenth century has been almost exclusively treated as an era with obvious characteristics: by that time science seemed to have excluded religion from medicine.

McCormick (2009) says that in most cultures in early historical times, the priest and the medicine man were one, until the development of scientific medicine led to a division between the professions. Bruchhausen (2007) attests to McCormick's statement; "Priests were to be trained in knowing, preventing and treating the most common disease." As modern medicine developed at a

rapid rate, a chasm developed between religion and medicine. Holst (2006:23) notes that more focus was placed on the cause of suffering than upon the sufferer. The question asked during the eighteen hundreds, was "how church and priest might assist in medicine and public health – and not so much the other way round."

Despite everything, one cannot disregard the fact that the likes of Florence Nightingale (1820 - 1910),[4] David Livingstone (1813 – 1873),[5] Andrew Davidson (1836 – 1918)[6] and John William Arthur (1881 – 1952)[7] to name just a few, have had a positive influence on history regarding the affiliation between medicine and religion. The Ebers papyrus (854a: 99, 2-5) contains a misplaced gloss which makes it clear that doctors, priests and magicians were all involved in healing (Nunn 1993:5). Kliewer (2004:617) maintains that spiritual leaders were "some of the earliest "healers." One such leader, Luke the Gentile was a physician as scripture indicates in Colossians 4:14; "Luke, the beloved physician, and Demas, greet you" (KJV). Notwithstanding the fact that one cannot ascertain too much concerning Luke's medical background, certain scripture verses indicate that his beloved friend, Paul, was in "need for frequent medical care." For instance, 2 Corinthians 12:7 speaks of Pauls "thorn in the flesh, and thus presumably needed a doctor's care from time to time.[8] 2 Corinthians 11:23–27 denotes that Paul suffered much actual physical persecution during his ministry, as pointed out by Morris (2004: a). Throughout the years many religions began embracing the need to care for the sick as a primary mission, which lead to numerous of the world's leading medical

[4] www.sociology.uoguelph.ca/fnightingale/spirituality/Health-Care-as-God's-Work.htm for further reading on the philosophy of Florence Nightingale.

[5] www.livingstoneonline.ucl.ac.uk/biog/dl/bio.html for an in depth study on the medical writing of David Livingstone.

[6] Rabetafika (1999:170) makes for easy reading on the life of Andrew Davidson.

[7] See www.mundus.ac.uk/cats/1/50.htm for further reading on the life of John William Arthur.

[8] This particular statement poses three diverse views as expressed by Shelly (1994:1602). Some suggest that the "thorn in his flesh" was referring to a spiritual problem (anxiety, sexual temptation or perhaps guilt). Others may view this statement as a physical infirmity. Yet others may reason that it referred to Paul's frequent persecutions.

institutions having religious and spiritual roots (Mueller, Plevak, & Rummans 2001:1225).

Medical scholars are recognising a connection between spirituality and health. Author and physician Larry Dossey observes that the medical field has come to a landmark transition since the early 1990s as only a handful of medical schools offered courses on the connection between spirituality and health. Now, more than sixty of a hundred and twenty five schools offer such courses (Slutz 2009:1). Woodbridge (2007:86) quotes Carl Jung when he made the following claim; “religions are systems of healing of psychic illnesses. That is why patients force the psychotherapist into the role of priest, and expect and demand of him that he shall free them from their distress.” Jung goes further in saying that, “we as therapists must occupy ourselves with problems, which, strictly speaking, belong to the theologian.”

If, as Sloan and VandeCreek (2000) point out that there is “no evidence at all that other religious activities -- such as prayer or reading the Bible -- play a role in improving health, despite their importance in people's spiritual lives,” why then is there an earnest movement to have spiritual care established as an important factor in healthcare? To answer this the researcher will elaborate on VandeCreek and Burton’s (2001:83) philosophy as to the relationship that health care and spirituality have. In their article, the authors identify five incentives. Although from a United States perspective, it is the researcher’s belief that this should be carried to manifest all healthcare services around the world. (1) The first principle is that healthcare organisations are obligated to respond to spiritual needs because patients have a right to such services. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) stipulates that, “Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values.” Although the South African Department of Health has yet to recognise the aspect of spiritual care, the main impetus behind JCAHO, flows from the belief that care of the body alone cannot be effective if the mind,

heart, and soul are ignored. (2) The second principle is that fear and loneliness experienced during serious illness generate spiritual crises that require spiritual care. As previously stated hospitals can be a scary and at times a lonely place which can isolate patients from their support communities when they need them most. (3) Thirdly, when a medical cure is not possible and patients question the meaning of life, spiritual care can play a significant role in alleviating the patient's turmoil. When human ability reaches its end, God's ability remains. Compassion and comfort become important foci of care when illness is chronic or incurable. (4) The fourth principle is the care of staff members. Working long hours under pressure, stress becomes a concern for organisations that recognise employees as their most valuable resource, thus making spiritual care vital to the institute. Research has shown that spiritual care contributes to a healthy organisational culture. (5) The final principle understands that spiritual care is important in healthcare organisations when allocation of limited resources leads to moral, ethical and spiritual concerns. Some medical decisions are unavoidable, and it is in these instances that such decisions interact with personal values and beliefs of all involved.

1.2.2. Statement of the Problem

This study will examine how two hospitals (government and private) within the Helderberg Basin recognise, value and address a patient's spirituality by understanding the role that a chaplain plays as part of a broader medical team.

Special reference will be made to the following key questions:

- What value and importance does spirituality play within the lives of hospital patients?
- How do hospitals address the patient's spiritual well-being?
- If health care professionals do not adequately address the spiritual needs of patients and their families, who does?
- What biblical principles are needed to effectively address the spiritual needs of hospital patients?

1.2.3. Delimitations of the Study

Due to the substantial number of hospitals within South Africa, travelling time, expenses, and time restraints, as well as limited literature research that is available in a South African context, the researcher will focus on two hospitals within the Helderberg Basin (Somerset West, Western Cape). The study has been limited within these boundaries in order to provide the most accurate and safest environment for physicians and patients to collaborate with the researcher.

1.2.4. Value of the Study

This study will contribute to the wider field of practical theology in the sphere of pastoral care. Through the interpretation and analysis of the collected data via means of quantitative and qualitative methods, the value and significance of a chaplain will be determined. From this study recommendations will be made to help minimize the gap that currently exists in meeting the spiritual needs of hospital patients.

These results should be of interest to hospital administrators, medical practitioners, pastoral caregivers and the broader church hereby demonstrating the benefits of a working chaplain as part of the broader medical team.

1.3. Design and Methodology

1.3.1. Research Design

The basis of the research design will be built around Cowan's (2000) LIM model. The design would look like this:

1) *Articulating concerns, identifying issues:* There seems to be a lack of approach in meeting hospitalised patients' spiritual needs. This will be explored in Chapter two.

2) *Interpreting the world as it is:* Research has revealed that many physicians say that barriers prohibit a physician in meeting the spiritual needs of patients. This will be explored in Chapter three.

3) *Interpreting the world as it should be:* Studies reveal that a person's spiritual well-being is just as important as their physical well-being. This will be explored in Chapter three.

4) *Interpreting our contemporary obligations, acting accordingly, and evaluating our action:* Investigations disclose that many patients find strength and healing from their faith. As pointed out by McCormick (2009:a), the physician practicing in the United States is not "alone in relating to the spiritual needs of the patient, but enjoys the team work of well trained hospital chaplains who are prepared to help when the needs of the patient are outside the competence of the physician." This will be explored in Chapter four.

Interviews with numerous hospitalised patients in a government and private medical institute amongst the medical and surgical wards will take place. Due to an insufficient amount of written material within a South African context, particularly for the Helderberg Basin, Chapters four, five and six will make use of a literary approach.

1.3.2. Methodology for Chapter 2: Empirical Research

This quantitative and qualitative aspect of the study will focus on obtaining information from hospitalised patients in the form of questionnaires. These questionnaires would be the most proficient way of acquiring "a broad overview of a representative sample of a large population" (Mouton 2001:152 and Flannelly, Ellison & Strock 2004:1233).

The development of the Fetzer Institute's scale (BMMRS) to "identify, develop and measure the dimensions of religion that were considered to be the

most likely to influence health" (Flannelly et al. 2004:1233) will be incorporated into the questionnaires. George, Larsons, Koeing and McCullough (2000:105-106) describe the ten domains of the BMMRS scale as follows:

1) *Religious/Spiritual Preference of Affiliation*: Membership in or affiliation with a specific religious or spiritual group.
2) *Religious/Spiritual History*: Religious upbringing, duration of participation in religious or spiritual groups, life-changing religious or spiritual experiences, and "turning points" in religious or spiritual participation or belief.
3) *Religious/Spiritual Participation*: Amount of participation in formal religious or spiritual groups or activities.
4) *Religious/Spiritual Private Practices*: Private behaviours or activities, including but not limited to prayer, meditation, reading sacred literature, and watching or listening to religious or spiritual radio or television programmes.
5) *Religious/Spiritual Support*: Tangible and intangible forms of social support offered by the members of one's religious or spiritual group.
6) *Religious/Spiritual Coping*: The extent to which and ways in which religious or spiritual practices are used to cope with stressful experiences.
7) *Religious/Spiritual Beliefs and Values*: Specific religious or spiritual beliefs and values.
8) *Religious/Spiritual Commitment*: The importance of religion/spirituality relative to other areas of life and the extent to which religious or spiritual beliefs and practices serve to affect personal values and behaviour.
9) *Religious/Spiritual Motivation for Regulating and Reconciling Relationships*: Most measures in this domain focus on forgiveness but other issues may be relevant as well (e.g., confession, atonement).
10) *Religious/Spiritual Experiences*: Personal experience with a divine or sacred as reflected in emotions and sensations.

Due to the nature and make-up of the religious diversity within South Africa, the utilisation of the BMMRS scale to identify any spiritual meaning in the lives of hospital patients, would allow the most beneficial study to take place as the scale is comprehensive and inclusive of all spiritual and or religious spheres.

It is during this stage that the caption of data will take place as well as seeking to understand and compare the data analysis to that of 'current' research data taken from the United States (Koenig 2004, Anandarajah et al. 2001, Ellis & Campbell 2004, Kliewer 2004, Larimore 2001, and Fetzer Institute 2003).

1.3.3. Methodology for Chapter 3: Addressing the Patient's Spirituality

A specific questionnaire and interview will be designed for physicians and medical staff alike. These questions will focus on the physician's and medical staff's attitude in recognising and addressing the spiritual needs of their patients and possible barriers as suggested by Ellis et al 1999, Sloan & VandeCreek 2000 and Koenig 2004 pertaining to a physician-patient relationship. This key element to the thesis will allow me to gain invaluable insight regarding the attitudes of physicians and medical staff with reference to the patient's spiritual well-being. From the revealed data, the researcher will be able to determine the level of education needed to minimise the idea that physicians and medical staff should shy away from religious or spiritual content in the doctor-patient interaction. Various spiritual measurement tools will be discussed as means of a simple and effective way the physician and medical staff can address their patient's spiritual needs without being unethical.

The broadest possible sample area will be created by attempting to access both private and governmental medical physicians working in the various medical, surgical and casualty wards. The sampling group will be inclusive to all religious beliefs within South Africa.

1.3.4. Methodology for Chapter 4: The Hospital Chaplain as a Pastoral Caregiver

Through a detailed literary methodology, the function, task, and criteria of how a chaplain could become part of the medical team will be discussed. Several concerns have been raised by scholars regarding the chaplain forming part of the broader medical team. These arguments will be discussed in this chapter. Through research, a strategy system would be identified as to an effective way of ascertaining the need of the chaplain's assistance.

1.3.5. Methodology for Chapter 5: Biblical Principles and Characteristics For Pastoral Care

A literary process will be the focus point for this chapter. This chapter will consist of three sub-headings.

5.1. *The Church and Hospital Care:* The role that the church has played throughout the ages with regard to hospital care shall be addressed.

5.2. *Scriptural Reference:* With the use of an assortment of scholarly commentaries and articles, an assortment of scripture references will be examined that demonstrate the importance of pastoral care to the sick through the biblical image of shepherding.

5.3. *Characteristics of Biblical Counselling:* An assortment of articles and literature will be examined to define the parameters of pastoral care that takes a look at how Christianity has associated itself to psychology. Reference to the way in which scripture is used as a resource will be discussed.

1.3.6. Methodology for Chapter 6: Recommendations

This chapter will examine how chaplains in South Africa could move forward despite the lack of assistance by the government. Certain challenges would need to overcome if chaplains are to move into a profession that is recognised by the medical society.

1.3.7. Methodology for Chapter 7: Conclusion

This chapter will provide the concluding remarks as to the thesis by summarising the previous chapter themes.

CHAPTER 2

The Patient's Spirituality in Healthcare

2.1. Research Methodology

Chapter two is dedicated to the empirical research of hospitalised patients through the use of a detailed questionnaire. Focusing questions akin to the BMMRS scale such as, does the patient have any spiritual needs whilst been hospitalised? What exactly is the role of the patient's spirituality while in hospital? And should the hospital look at facilitating the patient in alleviating any spiritual stress or crisis? These are just some of the questions that will be answered in the following chapter.

An overview of the composition and history of each hospital will be addressed in order to gain an understanding of the locale of the captured data. A dissection of each question and answer given by the patients will be analysed through a detailed questionnaire. The patients that participated in the study either completed the questionnaire on their own, or due to limitations as result of their illness, dictated their answers to me.

Due to the sensitivity and confidentiality of patient's rights, official names of the hospitals will be omitted and replaced with a unique code.

2.2. The Demographic Profile of the Helderberg Basin, Somerset West

The Helderberg Basin finds herself surrounded by the Hottentots Holland mountain range and the Helderberg Mountain. Comprising of seven towns, Somerset West being the largest, surrounding towns encompass mostly Coloured and African residences of Macassar, Strand, Gordon's Bay, Sir Lowry's Pass Village, Lwandle and Nomzamo (see figure 1).

According to the City of Cape Town Council website,[9] the socio-economic profile of the Helderberg is wide ranging, with beautiful, affluent areas on the one hand and poor, informal areas on the other. It can be estimated that 193 000 people live in the area. Of these, 77 percent live in formal housing, and 23 percent in informal housing. Currently there are only two fully functioning 24hour hospitals within the Helderberg Basin. It is within these contrasting borders of Somerset West that the government (D.E) and private hospital (P.L) find themselves, noticeably within a 5km radius from each other. Therefore it's reliable to say that the community will be hospitalised at either the D.E or P.L Hospital. The remaining areas that make up the Helderberg Basin are; the Strand, Macassar, Gordon's Bay, Sir Lowry's Pass, Lwandle and Nomzamo. Government Day Clinics can be found in Macassar, Sir Lowry's Pass, Strand, Somerset West and Lwandle.

Many social issues face the resident of the Helderberg Basin. Drug and alcohol abuse, violence, rape and crime are just many of the daily struggles that residents face. It has been estimated that the number of liquor outlets in the Basin, totalling 487, is almost double to that of places of worship. Shebeens, being one of the "headaches" of the police are located almost entirely in the areas of Lwandle, Broadlands, Nomzamo, Macassar and Sir Lowry's Pass (Helderberg Basin Transformation Research Project).

Drugs and drug-related crimes have been on the increase since 2005. According to Helderberg Crime Watch statistics,[10] drug-related crimes have increased by 51 percent over the last four years in the Somerset West area. Strand has seen a 15 percent increase, while Gordon's Bay has seen a 7 percent decrease.

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[9] http://www.capetown.gov.za/en/subcouncils/Subcouncil08/Pages/Aboutsubcouncil8.aspx

[10] http://www.hcw.org.za/saps_crimestats.html

Figure 1: Helderberg Basin Area

The majority of South African people could testify to the stark difference between the governmental and private health sectors. For the last year or two, government officials have been drafting potential plans and policies to minimise the ever growing gap between the public and private health sector. In a news article, Peters (2010:4) outlines the chief differences between state and private health institutions.

- Government hospitals provide medical care to 85 percent of South Africa's population, while only 15 percent is covered by private hospitals.
- Employment of medical doctors account for 10 653 in the state sector and 24 034 in the private sector.
- There are 178 404 nurses of which 104 571 work in the public sector.[11] It is estimated that up to 70 000 would retire in the next few years.
- Medical specialists account for only 25 percent of the state hospitals employment.
- A total of 35 percent of government medical posts are vacant.
- Public hospitals have undergone massive financial cutbacks, compared to an ever growing private sector.

2.3. History and Composition of the D.E Government Hospital in Somerset West, Western Cape, South Africa

2.3.1. Brief History of the D.E Hospital

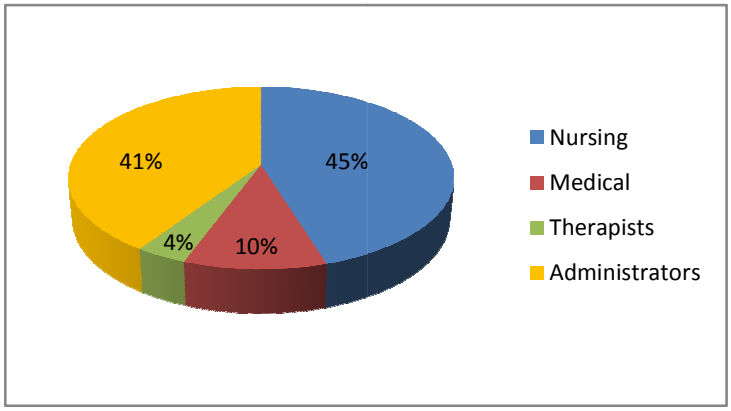
The D.E Hospital, built in 1939 was an undertaking of the local community as it was feared that the Cape Explosive Works factory (later AECI) may yield many injuries within the Helderberg Basin. During the year of 2006/2007, the process to change the name of D.E Hospital was initiated after a round of community Imbizo's. During this a number of objections about the name of the hospital were raised by local communities. After consultation with numerous members, the Western Cape Minister of Health, Pierre Uys, decided

[11] This statistic can be challenged as according to the South African Nursing Counsel, there are over 22100 qualified nurses (2009).

to rename the hospital to the region/town in which it functioned, thus becoming the D.E Hospital.[12] Since then D.E has become a 162 bed district hospital consisting of: ten wards, a three-bed High Care Unit and three theaters, each rendering comprehensive acute hospital services to a population of 530 000 people in the region. It has estimated that approximately 76 percent of treated patients are under the age of 40 years and 10 percent under the age of 5years.

2.3.2. D.E Hospital Composition

Figure 2: Hospital Personal Classification



This chart indicates that 59 percent of hospital employees are patient caregivers within their field of expertise. This is relevant as one of the important responsibilities of a chaplain is to nurture staff needs. Chapter four will give attention to this matter in broader detail.

Figure 3: Hospital Ward and Bed Classification

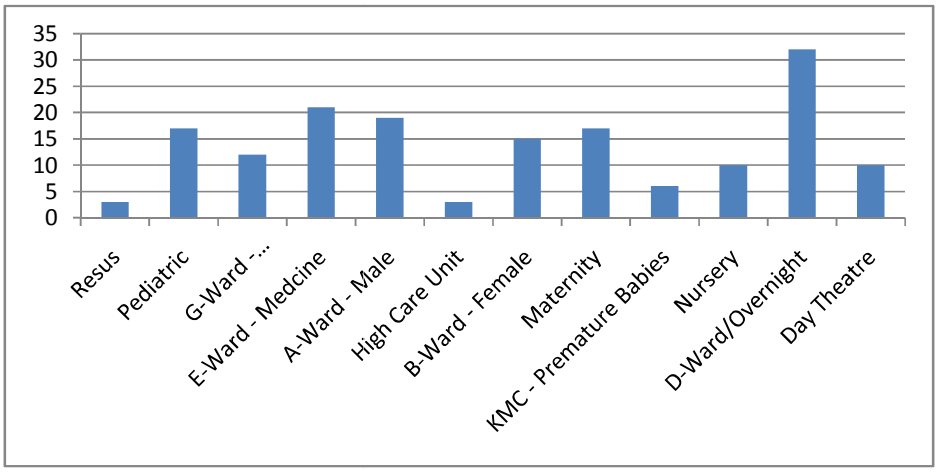
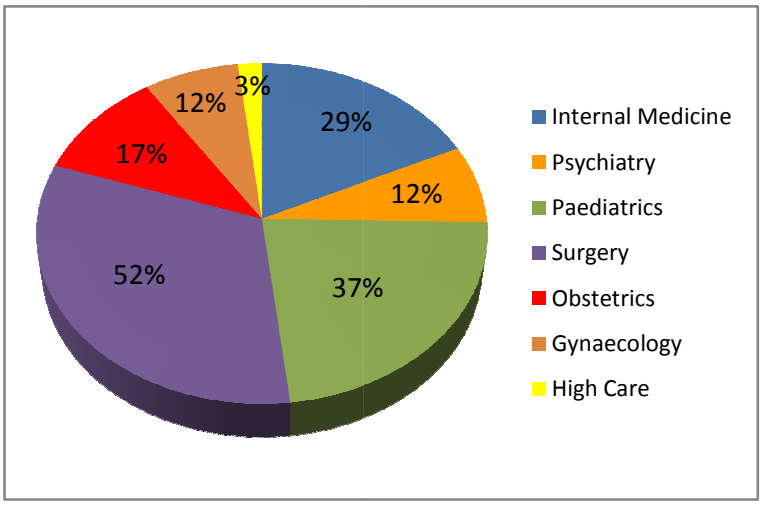


Figure 3 designates the ward categorization and bed allocation within the D.E Hospital. Each ward focuses on a particular illness or specialized care. This is of significance as the chaplain's approach and methodology will be dependent on the patient's illness and circumstances.

Figure 4: Discipline



The above chart gives indication as to the percentage breakdown of the seven disciplines within the D.E Hospital. The two largest, paediatrics (23 percent) and surgery (32 percent) constitute half of the hospitals discipline.

Table 1: Range of Services Provided

Inpatient services	**Outpatient services**
General surgery	General surgery (Day patients)
Orthopaedic surgery	Orthopaedic surgery
Paediatrics including Neonatology	Paediatrics
High risk Obstetrics	High Risk Obstetrics - Basic Ante Natal Care
Gynaecology	Gynaecology
Internal Medicine	Internal Medicine
Anti Retroviral Therapy	Anti Retroviral Therapy
Psychology	Psychology
Anaesthesiology	Anaesthesiology
High Care Unit	High Care Unit
Ophthalmology including lens implants	Ophthalmology
Basic Ear Nose and Throat Surgery	Urology

Urology	Stoma therapy
Emergency Unit – Medical, Surgical , Paediatric and Trauma	Physiotherapy
Physiotherapy	Occupational Therapy
Occupational Therapy	Social work
Social worker	Psychiatry
Psychiatry	Rape Crisis Unit

The above table specifies the 18 inpatient and outpatient services of the D.E Hospital.

2.4. History and Composition of the P.L Private Hospital in Somerset West, Western Cape, South Africa

2.4.1. Brief History of the P.L Private Hospital Composition

P.L Private Hospital offers local, national and international patients a broad spectrum of professional medical services that continues to strive on its well-established reputation for affordable, specialised, and professional health care. Unfortunately, I was unable to obtain a great deal of information as to the history of P.L Private Hospital. From various websites I was able to obtain the following concerning the history of the P.L Group:

In 1983, the then Rembrandt group commissioned Dr E. Hertzog to undertake an achievability study on private hospitals. It was then that P.L Group was founded. Operating on three platforms: P.L Southern Africa, which comprises around 13,000 employees, 7,000 beds and over 50 multi-disciplinary hospitals in South Africa and Namibia; P.L Switzerland, where "*X"*, the largest private hospital group in Switzerland owns 13 hospitals; and P.L Middle-East, with a controlling share in "*X"* Management Services, which operates the largest private healthcare group in the UAE. Further expansion has been tabled for the next two years.

2.4.2. P.L Private Hospital Composition

As within the government hospital, the P.L. private hospital medical staff consists of more than 61 percent of the hospital employment.

Figure 5: Hospital Personal Classification

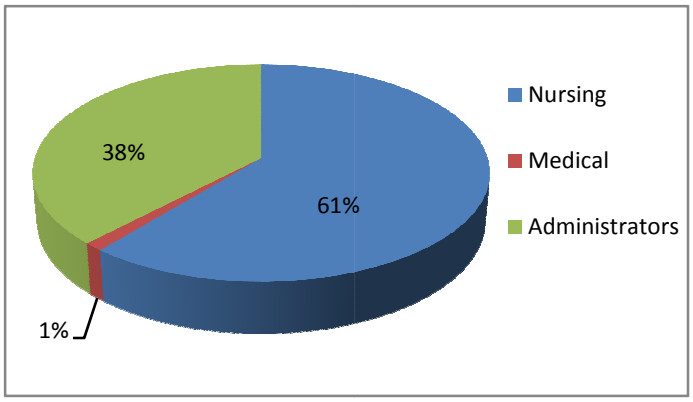
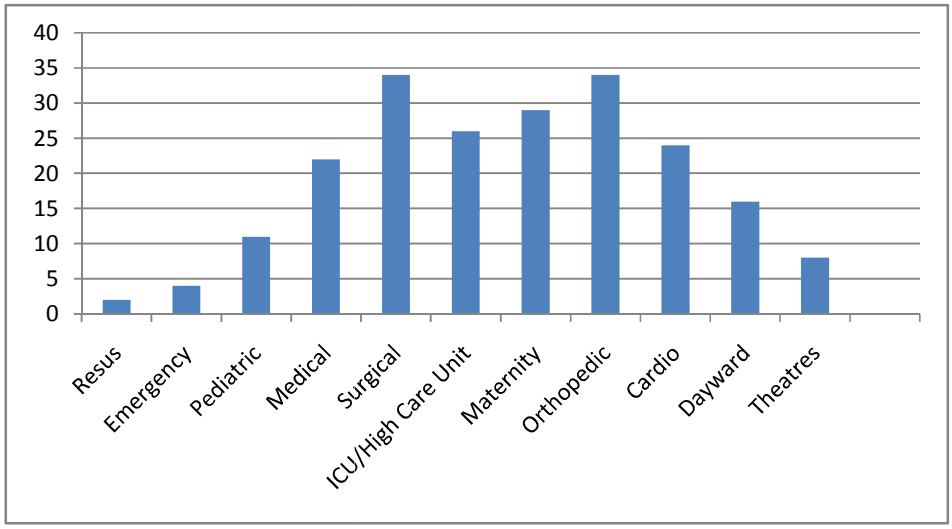


Figure 6: Hospital Ward and Bed Classification



The above figure shows the ward allocation within the private hospital.

Table 2: Range of Services Provided

Inpatient services	Outpatient services
Cardiac unit	Diabetes support group
Emergency centre	The Compassionate Friends

Neonatal intensive care unit	Heart rehabilitation support group
Antenatal clinic	Helderberg health support group
Baby massage clinic	Nutrition support group
Baby Wellness clinic	Reach for Recovery (breast CA support)
24Hr stroke treatment clinic	Rheumatology support group
Pain management clinic	
Pre-admission centre	
Sleep clinic	
Woundcare clinic	
Cathlab	
CT Scan	
MRI	
Pathology	
Radiology	
Renal dialysis	

2.5. The Patient Questionnaire and Results

The patient questionnaire is a key element to the research. From answers given, I was able to construe two facets of the questionnaire. Namely, what prominence do the patients' place on their spiritual or religious beliefs while they are hospitalised and secondly, how do these answers compare to research carried out in the United States. By using the first component of Cowan's (2000) LIM model, *articulating concerns, identifying issues*, I was capable of ascertaining the attitude the hospital has towards their approach in meeting the spiritual needs of their patients.

A chief questionnaire was designed for the use of carrying out the research. The standard questionnaire includes 38 questions in 4 separate segments namely; General, Hospitalisation, Religious/Spiritual, and Visitation. It is of importance to note that questions fourteen, twenty, twenty-two and thirty-

six of the original numbering sequence has potential for more than one answer. Notification will be denoted for easy appraisal of the questionnaire summary.

The heart of the questionnaire has been designed to focus on the tripartite of man i.e. body, soul and spirit.[13] As understood by many Christian scholars, the body, soul and spirit, although three separate entities, cannot be separated from each other, even if D'Souza (2007:57) claims that "Western medicine, unlike traditional Eastern systems, has dichotomised the body/mind and soul/spirit." Puchalski et al (2004:694) provides the reader with evidence that followers of both the Jewish and Muslim faith believe that "humans are integrated wholes, that body, mind, emotions, and will are all connected and that these faculties all affect one another." Two scripture verses seem to emphasis the tripartite thought. 1 Thessalonians 5:23, *"Now may the God of peace himself sanctify you completely, and may your whole spirit and soul and body be kept blameless at the coming of our Lord Jesus Christ"* and Hebrews 4:12, *"For the word of God is living and active, sharper than any two-edged sword, piercing to the division of soul and of spirit, of joints and of marrow, and discerning the thoughts and intentions of the heart"* (ESV). It is for this reason that one can deduce that the trichotomy of man is so deeply entwined into each other that all of the three characteristics that man has, have an effect on each other. This is of paramount when a chaplain ministers to a patient as he cannot disregard the overlap of the trichotomy, as displayed in figure 7.

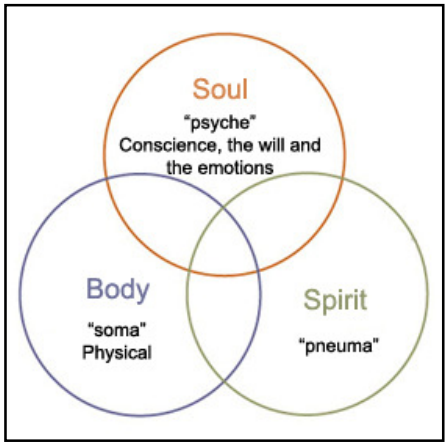
A simple illustration will elucidate how the trichotomy could work. A chaplain visits with a patient, Mrs. Smith, who has undergone surgery. Consider the efficiency of the chaplain in the following situation. Mrs. Smith *body* is experiencing physically pain and perhaps weakness from the surgical procedure. Does not the state of her body affect her *soul* (being unable to concentrate on what the chaplain is saying due to being physically sore) which

[13] The opposing view to the trichotomy of man is the dichotomous theory. This teaches that man is twofold having a physical and spiritual dimension, or body and soul. Many theologians argue that there is no differentiation between the "Soul" and "Spirit" and that they are often used interchangeably in scripture e.g. (John 12:27 and John 13:21).

could in turn affect her *spirit* (the effective understanding the gospel message of comfort, hope, and strength etc.)? As straightforward as the above example is therein lies an important truth. Whether one holds to the trichotomy or dichotomy school-of-thought, the reality is that the physical facets of a person can have an effect on their emotional and spiritual disposition.

Due to the confidential nature of this research, every patient that partook in the questionnaire was guaranteed complete anonymity and confidentiality and at no time will any private information be available to the public. A distinctive code was formulated so that the researcher is able to distinguish between the government and private hospital patient and to which ward the patient belonged. No further correspondence was necessary unless the patient indicated. Owing to the cultural diversities in South Africa, each questionnaire was translated into Afrikaans and Xhosa. With the help of two trained Xhosa speaking pastors, Xhosa patients were identified to be included into the study.

Figure 7: Trichotomy of Man



2.6. Patient Criterion

It was of importance that patient selection was done on a random base as not to disregard any ethnic, religious or gender group. The only criterion for patient selection was based on the patient's corpus mentis condition. All government wards were targeted namely: Medical, Surgical, Maternity, Over

Night and High Care. Only the Medical and Surgical wards were covered in the private hospital as permission was not granted to conduct the questionnaire in the Intensive Care Unit due to confidentiality. For a thorough study, both government and private Emergency Units were disregarded as the study was concentrated to admission patients only. The hospitals ethical committee granted permission to conduct the patient survey.

A verbal explanation was given to every patient explaining the purpose and confidentiality clause for the study. Respondents had the choice not to participate in the study at any given time**,** and had the option of completing the questionnaire themselves or having it read to them**,** to facilitate inclusion of physically disabled persons and those with low literacy skills.

2.7. The Questionnaire Results

The following section deals with the complete research summary of the questionnaire. The individual hospital summaries can be seen in Appendix 1 and Appendix 2. The final summary of the questionnaires will be displayed in block cells, whilst when relevant data is assessed; a tabulated chart will be used for easy evaluation purposes.

A total of 120 patients were surveyed, 60 patients from each hospital centre, whilst 10 patients declined partaking in the study.

2.7.1. General Questions

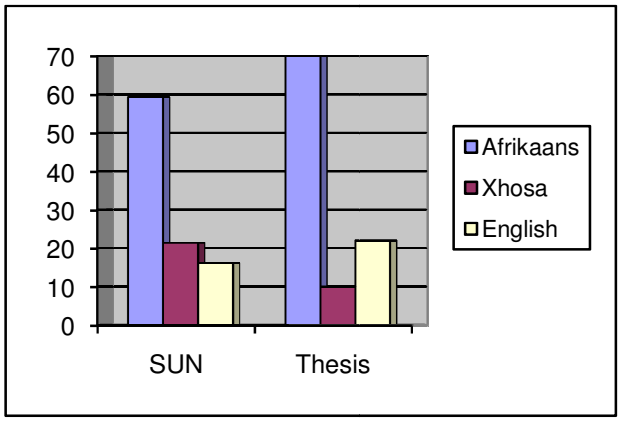
This section of the questionnaire, consisting of five questions was designed to acquire background information of the hospitalised patient or family member of the patient. These questions target the areas of gender, age, population group and residential area. I felt that is was important to begin the questionnaire with general questions as to make the patient relaxed and comfortable in answering the survey.

Sample Description: N=120

English **26**	Afrikaans **84**	Xhosa **10**

Afrikaans speaking patients constituted 70 percent of the 120 patients that were surveyed, while English patients consisted of only 22 percent and Xhosa speaking patients make up just 10 percent. These results reflect similar findings to that of the research carried out by the Theological Faculty of the University of Stellenbosch.[14]

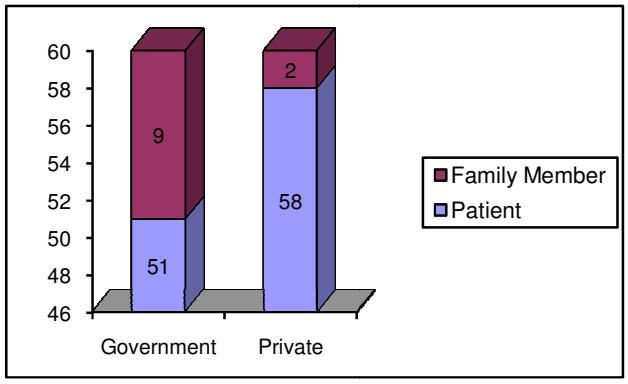
Figure 8: Languages



2.7.1.1. Are you the Patient or Family Member?

Patient **109**	Family **11**

Figure 9: Ratio: Patient and Family



McClung et al (2006:150) emphasises that "family members are vulnerable to spiritual distress from a patient's illness, and may need the

[14] Helderberg Basin Transformation Research Project (HBTRP)

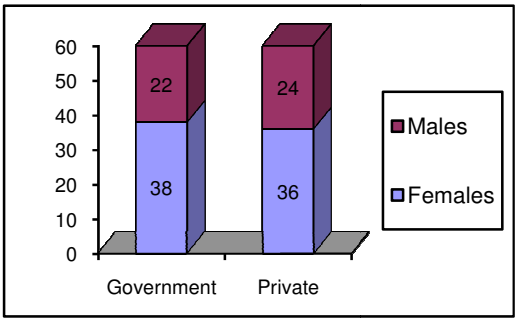
chaplain's services as much as the patient." This is relevant as a family member may actually become the "patient." For instance, the hospitalised patient may have already come to terms with his hospitalisation, whereas, one of his family members may have anxiety, concerns or questions surrounding their loved one and therefore may still be seeking peace. The focus then is shifted towards that family member and not so much with the actual patient at this time. The Family Systems Theory centres on obtaining homeostasis, morphostasis and morphogenesis over a period of time. Moslener (1999:442) asserts that all members of a family are interrelated in such a way that a change in one person affects change in others. This in turn will affect the entire family system. Individuals need to be understood within their family system. Why is this person feeling the way he is? Is there something deeper going on here? McClung goes on to say that a study that was conducted on 156 cancer patients**,** and their families revealed that the patients' caregivers expressed as much desire for spiritual care as the patients.

The nine family members that completed the questionnaire in the government hospital were that of toddlers under the age of five years. The two family members from the private hospital where of adult age.

2.7.1.2. Male or Female?

Male **46**	Female **74**

Figure 10: Population: Male and Female



2.7.1.3. What age group do you belong in?

0-12	**0**	31-40	**11**
13-19	**7**	41-50	**18**
20-30	**19**	51-60	**15**
		60+	**45**

No Answer **5**

It is with interest to note that over 36 percent of the patient's surveyed are over the age of 60 years. Out of the 120 patients, only 5 provided no answer.

Figure 11 provides an age analysis breakdown between the government and private sector. One can see that there is more than a 50 percentage difference between the two medical sectors in the 40+ age groups. Is this just a coincidence or is there more to this statistic? Figure 12 possibly gives us an indication as to why there is such a difference between these age group sectors. The answer could lie in the fact that the P.L private hospital finds itself in a neighbourhood of residents of predominantly 46 years and upwards. While the D.E government hospital is in the 40-45 year old zone, it must be noted that the areas of Nomzano and Lwandle are dominated by the younger generation (20-29 years) which is the main feed to the government hospital.

Figure 11: Age Group

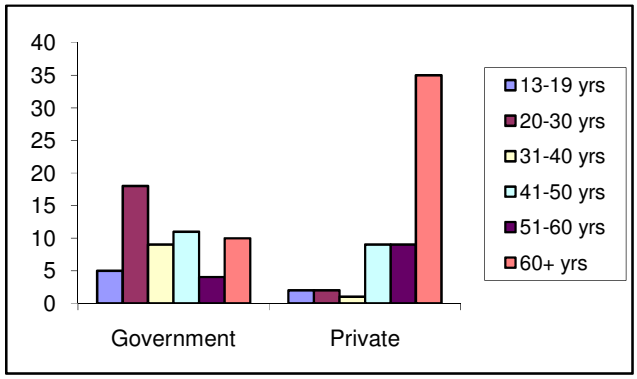
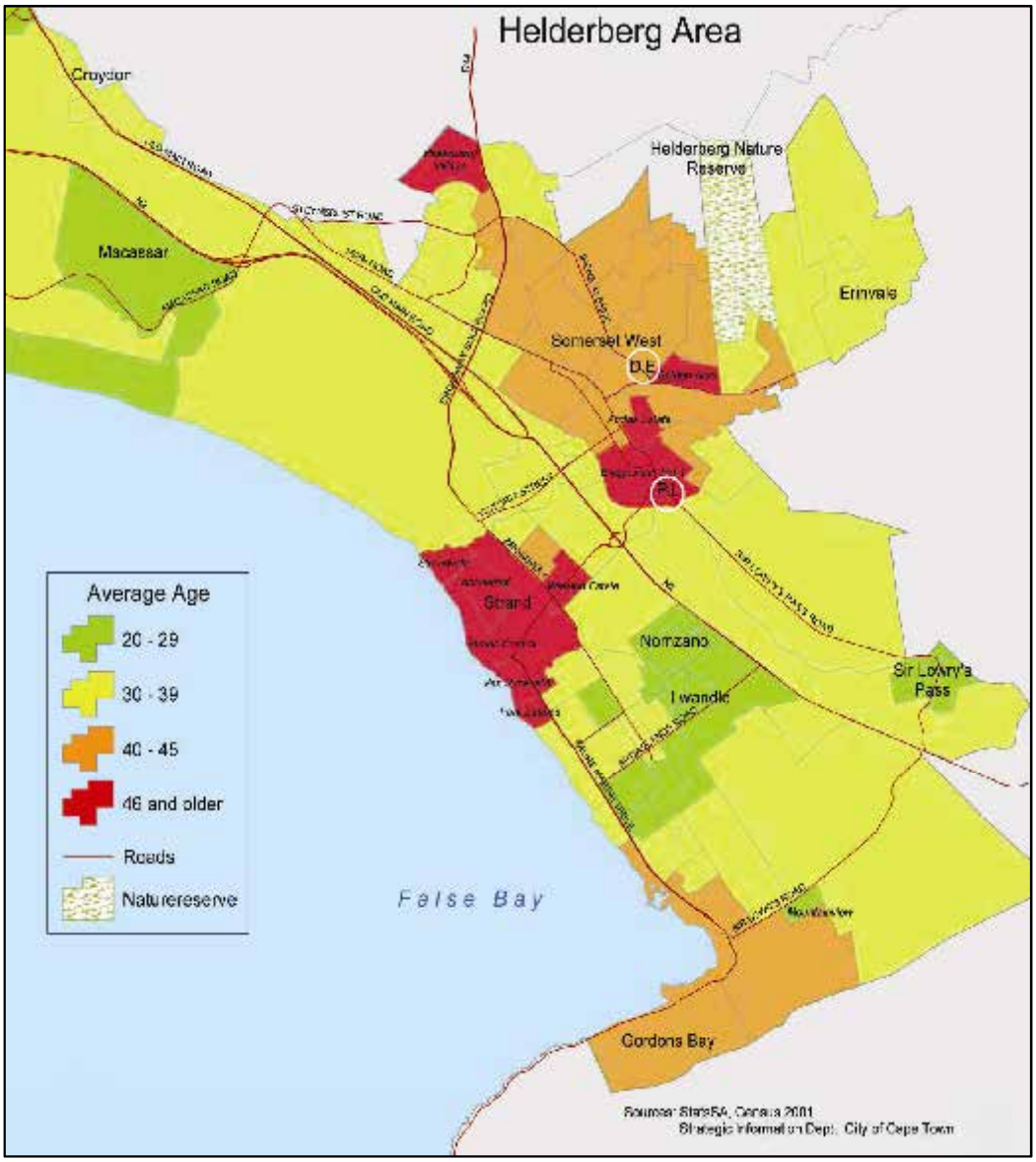


Figure 12: Helderberg Basin Area: Average Age of Residents



2.7.1.4. To which population do you belong?

Coloured	**49**	African	**19**
Asian	**0**	Indian	**0**
Caucasian	**51**		

No Answer **1**

According to the HBTRP, the African populace of the Helderberg Basin

accounted for 24.8 percent, the Coloured populace 42.6 percent and the White populace 32.2 percent. Once more these statistics are similar to that of the above results.

2.7.1.5. Which area do you reside in?

S/West	**21**	Macassar	**14**
Strand	**38**	Grabouw	**18**
G/Bay	**10**	Other	**19**

2.7.2. Hospitalisation Questions

The following nine questions are aimed at the actual hospitalisation of the patient. The attitude of the physician and nursing staff towards the patient are reflected in these questions. In addition the apparent emotional well-being of the patient is observable in this section. Due to the belief that a person is a trichotomous being and that all aspects of a person are interlinked, one needs to conclude that the emotional aspects of the person could evidently affect their spiritual needs.

2.7.2.1. Is your hospitalisation pre-arranged or emergency?

Pre-arranged	**52**	Emergency	**66**

No Answer **2**

2.7.2.2. Is this your first hospitalisation in this hospital?

Yes	**38**	No	**82**

2.7.2.3. Reason for your hospitalisation and illness type?

Medical	**53**	Trauma	**14**
Surgical	**44**	Follow Up	**7**

No Answer **2**

Illness type?

Alcohol problem.	Heart attack.	Diabetic.
Ectopic pregnancy.	Cellulites of the leg.	Home accident.
Heart issues.	Overdose.	Cancer.
Asthma.	Stroke.	Infection.
Measles.	Amputation.	T.B.
Stroke.	Remove gall bladder.	Biopsy.
Flu.	Burns.	Broken foot.
Back.	Appendix.	Kidney stone.
Pneumonia.	Knee replacement.	Hip replacement.
Kidney problems.	Gastro.	Intestine operation.
Heart stint.	Burns.	Obstructive bladder.
Work accident.	MS.	Urology operation.
Motor vehicle accident.	Post brain operation.	Screw in spine.
Lung infection.	Chronic sinusitis.	

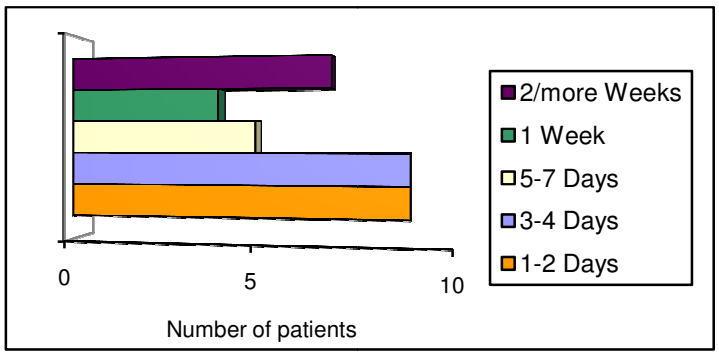
2.7.2.4. Current duration of stay in hospital?

1-2 days	**37**	1 week	**18**
3-4 days	**33**	2 week/more	**12**
5-7 days	**16**		

No Answer **4**

Some patients revealed that the need to address any religious or spiritual concerns by the chaplain would depend on their duration of stay in hospital. Perhaps the need of a chaplain visit would increase the longer their hospital stay? To authenticate if this view is true, the above question was combined with question 2.7.3.4 in a bar graph, as shown below (figure 13). It was with surprise to discover that patients who were hospitalised between one and four days had between 6 to 15 percent a greater need for their spiritual needs to be addressed than those patients who stayed in hospital for longer than five days. Contrary to what some patients indicated that the longer they were hospitalised for, the greater the need may be to have their spiritual needs addressed. Perhaps it should be an indication that no matter how long a patient is hospitalised for, there will always be those that need to be comforted.

Figure 13: Length of Hospitalisation vs. Spiritual Needs



2.7.2.5. In which manner do you feel the doctor relates to you as a patient?

Poorly	**1**	Good	**38**
Satisfactory	**5**	Excellent	**72**

No Answer **4**

Why?

Treated me as a patient and not a bed number.
Good diagnosis.
Provided good care.
All of my questions were answered.
Good manners and easy to talk to.
Doctor speaks Xhosa.
Friendly
Poor communication in the ward - ICU good.
Doctors are helpful and active.
On the ball.
Caring.
Doctor very knowledgeable.
A people's doctor.
Good listener.
Doctors attentive to my needs.
Care was less than expected.
Does what they say.
Doctor too busy to burden them.
They respect me.
He cares about my baby.
Doctor reacted quickly.
Has sympathy.
Sympathetic.
Only wants the best for me.
Professional.
Good diagnosis.
Explained procedure clearly.
Good communicator.
Good bedside manners.
No often around.

2.7.2.6. In which manner do you feel the hospital staff relates to you as a patient?

Poorly	**2**	Good	**45**
Satisfactory	**9**	Excellent	**63**

No Answer **1**

Why?

Provided good care.	Staff helpful.
Friendly.	Professional.
Treat me with dignity and respect.	Can sometimes forget things as they are busy.
Make me comfortable.	Great care.
Smiling faces.	They attend to my needs.
Not very friendly.	Caring staff.
	Efficient.

2.7.2.7. How are your physical needs being met in the hospital?

Poorly	**6**	Good	**60**
Satisfactory	**11**	Excellent	**41**

No Answer **2**

2.7.2.8. How are your emotional needs being met in the hospital?

Poorly	**4**	Good	**57**
Satisfactory	**19**	Excellent	**24**

No Answer **16**

2.7.2.9. What would you say are your greatest needs/concerns in hospital?

Material	**22**	Emotional	**23**
Spiritual	**17**	Other	**21**

No Answer **46**

More than one answer could be stipulated.

This question was originally not in the questionnaire. However**,** after presenting the questionnaire for feedback purposes to a Christian medical physician, it was suggested that placing a question that not only focuses on 'what spiritual needs a patient may have', but also 'what their greatest point-of-need may be' would be beneficial. With just over 50 percent (Census 2001) of people being either unemployed or not economically active in the Helderberg Basin, by focusing only on the spiritual needs, proper homage would not be paid to Jesus' words in Matthew 25:37-40,

"Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?' "The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.

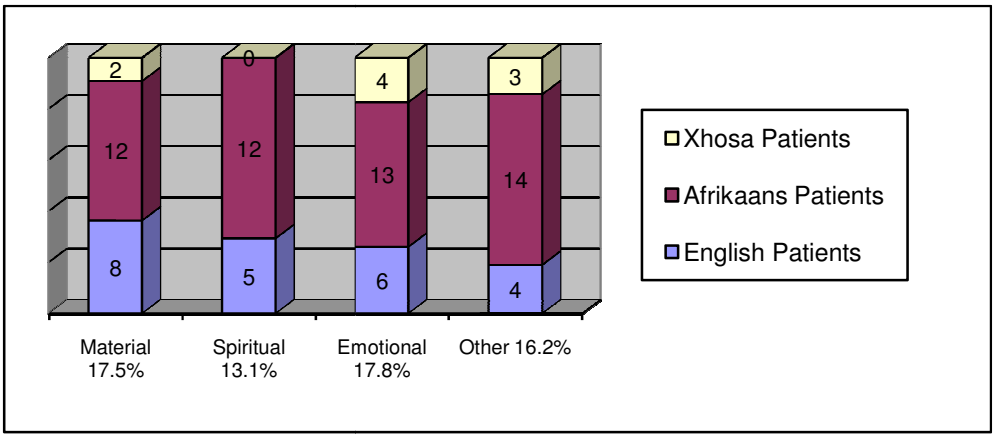
and Isaiah's words in chapter 58:6-11 (The Message)

"This is the kind of fast day I'm after: to break the chains of injustice, get rid of exploitation in the workplace, free the oppressed, cancel debts. What I'm interested in seeing you do is: sharing your food with the hungry, inviting the homeless poor into your homes, putting clothes on the shivering ill-clad, being available to your own families. Do this and the lights will turn on, and your lives will turn around at once. Your righteousness will pave your way. The God of glory will secure your passage. Then when you pray, God will answer. You'll call out for help and I'll say, 'Here I am.' "If you get rid of unfair practices, quit blaming victims, quit gossiping about other people's sins, If you are generous with the hungry and start giving yourselves to the down-and-out, Your lives will begin to glow in the darkness, your shadowed lives will be bathed in sunlight. I will always show you where to go. I'll give you a full life in the emptiest of places firm muscles, strong bones. You'll be like a well-watered garden, a gurgling spring that never runs dry. You'll use the old rubble of past lives to build anew, rebuild the foundations from out of your past. You'll be known as those who can fix anything, restore old ruins, rebuild and renovate, make the community livable again.

One cannot assume that the only needs for a hospitalised patient would be emotional, physical or spiritual. One can decipher from the above summary table that 'material' and 'other' needs where just as concerning for patients as that of 'spiritual' needs. The diagram below (figure 14) is an indication of the

value of: Material needs (finance, food, housing, and etc.), Emotional needs (relationships, abuse, and etc.), Spiritual needs and Other needs between 10 Xhosa, 84 Afrikaans and 26 English patients that were surveyed. Between the four needs categories, spiritual needs were 4 percent lower than the rest. Perhaps this is a good indication that the chaplain needs to broaden his field of nurture by taking into account that many patients have various concerns other than just in the field of spirituality. This links in with the trichotomy premise that all spheres of a person are interlinked and that "feeding" a patient physically needs to take place before "feeding" the patient spiritually. The chaplain's role as a pastoral caregiver will be examined further in Chapter four.

Figure 14: Needs and Concerns



2.7.3. Spiritual and Religious Questions

These fifteen questions examine the patients' spiritual and religious needs while in hospital. The questions range from church membership to the doctor praying with the patient. These set of questions laid the foundation as to the patient's view of their spiritual life.

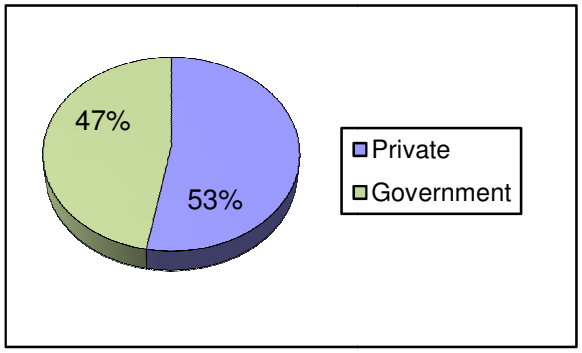
2.7.3.1. What faith group do you belong to?

Christian	**104**	Non-believer	**4**
Muslim	**5**	Eastern	**0**
Traditional African	**2**	Other	**2**

No Answer **3**

The pie-chart below (figure 15) is an indication to the Christian faith group breakdown ratio between the two medical institutions.

Figure 15: Christian Faith



To gain further appreciation of the spiritual background of the patient, one should link this question with questions 2.6.3.2 and 2.6.3.3 (*"What denomination do you belong to?"* and *"Are you an active church member?"*). By grouping the three questions together, one finds some interesting results.

It is commonly known that the majority of persons would say that they belong to a "Christian faith group" in spite of not a) practising Christian principles and b) being active members of their religious institution. Of the 120 patients surveyed, 104 denoted "Christian" as their faith group. Of the 104 patients only 70 percent indicated that they are active in their church. This implies that 30 percent are non-active Christians, yet express some religious upbringing. According to Statistics South Africa 2001, Christians make up 85 percent of total population in the Helderberg Basin, while Islam 5 percent and Non religion just 10 percent. I can merely conclude that being "Christian" does not always mean that a person is a committed and involved Christian.

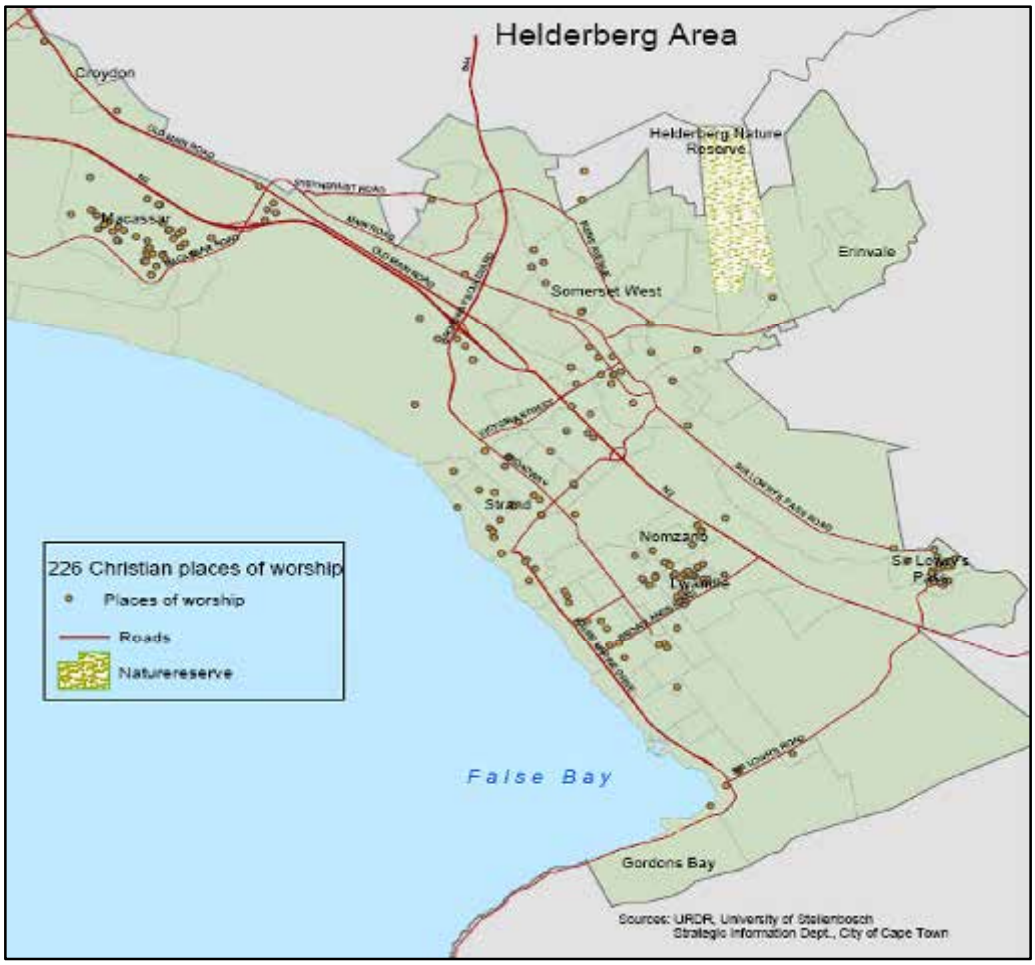
It has been estimated that there is around 244 places of worship in the Helderberg Basin. Many different venues and structures are used for worship purposes, e.g. houses, formal buildings, schools or other places. The HBTRP concluded that there is one Christian church for every 660 people in the

Helderberg Basin. For a more detailed analysis of "places of worship" within the Helderberg Basin, see figure 16.[15]

Table 3: Place of Worship: Helderberg Basin

	House	Religious Building	School Building	Other
Christian	**39**	**99**	**34**	**54**
Muslim	**0**	**3**	**0**	**2**
Hindu	**0**	**0**	**0**	**0**
Jewish	**0**	**1**	**0**	**0**
Traditional African	**7**	**0**	**0**	**7**
Other	**0**	**1**	**0**	**0**

Figure 16: Christian Places of Worship: Helderberg Basin



[15] Above figures obtained on the following site: stbweb02.stb.sun.ac.za/urdr/downloads/Helderberg.pdf. P.19

2.7.3.2. What denomination do you belong to?

Spiritualist	**2**	Zion	**2**
Pinkster	**4**	Methodist	**8**
AGS	**4**	7th Day	**1**
NGK	**34**	Independent	**16**
Apostolic	**4**	Anglican	**12**
Presbyterian	**1**	Baptist	**1**
Moravian	**3**	Church of England	**1**
Muslim	**2**	Jehovah Witness	**1**
Catholic	**2**		

No Answer **22**

According to the research carried out by the Stellenbosch University Theological Department (HBTRP:46), the top four religious groups were the Dutch Reformed Church (NGK) accounting for over 17 percent, The Anglican Church 7 percent, Methodist 9 percent, while all Independent churches accounted for 21 percent. As one can interpret from the above table, the NGK, Methodist Church, Independent churches and the Anglican Church all were in the top four by a considerable margin. 41 percent of patients, who specified a 'No Answer,' indicated that they belong to a Christian faith group.

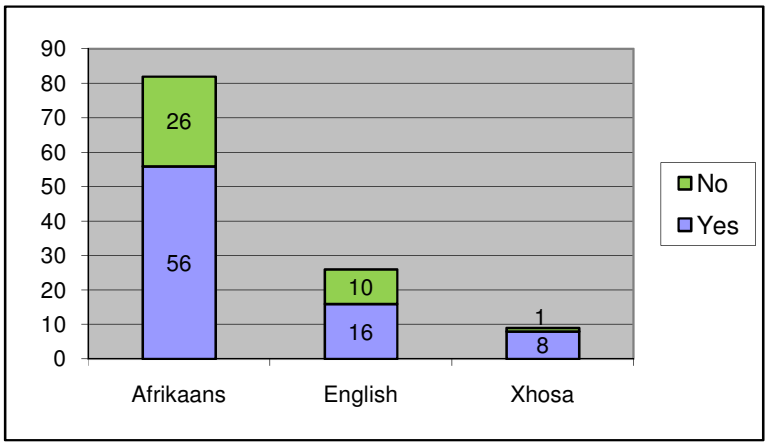
2.7.3.3. Are you an active member of your religious church / mosque / institution?

Yes **81**	No **34**

No Answer **5**

I felt that this was an important question as it would provide an indication as to the level of involvement of the patient within their faith group. I was surprised to see that around 30 percent of the 'Christian' patients are inactive religious members. The bar graph displayed below (figure 17) presents a breakdown of active church members within their language culture group.

Figure 17: Active Church Members



2.7.3.4. Do you as a patient have any religious or spiritual needs during your hospital stay?

Yes **36**	No **59**	Unsure **18**

No Answer **7**

Although 47 percent of the patients specified that they did not have a spiritual need while been hospitalised, 69 percent of the 59 patients, expressed that *"if a hospital chaplain was made available to meet their religious or spiritual needs, they would request a visit"* (See question 2.6.4.5). Some patients indicated that the probability of having a spiritual need would increase, the longer their hospitalisation was. Although the patient may not have a pending spiritual need, indication is that the presence of a chaplain would still be beneficial to the patient.

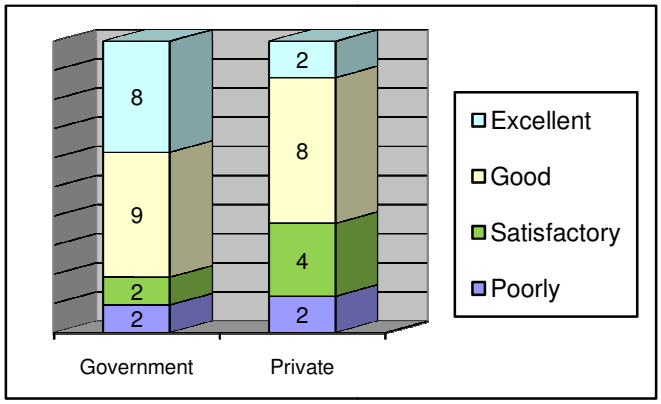
2.7.3.5. If yes, how are those needs met in hospital?

Poorly **4**	Good **17**
Satisfactory **6**	Excellent **10**

No Answer **83**

Figure 18 provides an analysis of the value between the government and private medical institute with regards to spiritual satisfaction.

Figure 18: Spiritual Satisfaction



2.7.3.6. If yes, who is meeting your religious/spiritual needs while in hospital?

Nurse **5**	Friends **4**	Other **6**
Doctor **4**	Religious Member **19**	Family **13**

No Answer **81**

More than one answer could be stipulated.

Although a visit by one of their religious members counted for 37 percent of all visits, numerous reasons could denote why this percentage is so low, from poor communication between the patient and their religious faith group to the 'lack of interest' by the medical staff to enquire about the need to contact the patient's pastor. In spite of this, the role of the local Christian church is essential when it comes to ministering to their members in times of illness. Further discussion will occur in Chapter five concerning the church's role for a hospitalised patient.

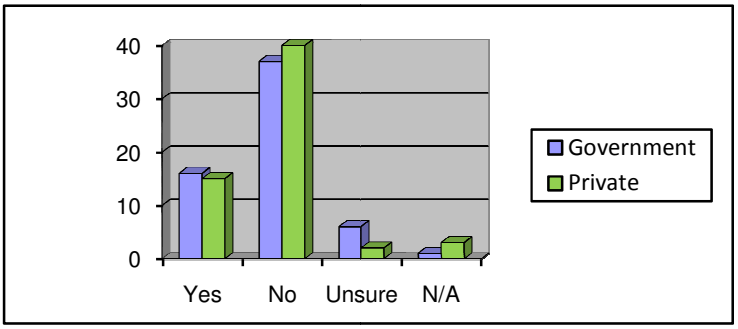
2.7.3.7. Did any staff member enquire about your religious/spiritual needs?

Yes **31**	No **77**	Unsure **8**

No Answer **4**

Every patient upon admission to either the D.E government or the private P.L institute should have been asked about their religious affiliation as stipulated on the patient folder. In a random selection of patient files, little as 2 percent of patients were asked this question by staff of the D.E hospital. Once more, one can specify reasons as to this, yet the fact remains that a great deal of patient support could effectively take place if more emphasis was shown to the patients' spiritual history. Figure 19 indicates that 64 percent of admitted patients were not asked by staff members about any religious or spiritual needs.

Figure 19: Religious Enquiry



A simple 'spiritual assessment' technique carried out upon admission could help eliminate the high percentage of patients that are not asked about their religious or spiritual needs. Chapter three will explore this further.

2.7.3.8. Where do you find your sources of hope (excluding God) in stressful situations?

This question was specifically intended to "exclude God" as a source of hope, for the very reason as not to have patients indicating, a) the obvious source of hope for Christians, b) to avoid the typical "Sunday-School" answer and c) for provision of diversity of answers.

Self **38**	Religious Community **29**	Other **8**
People **53**	Tangible Objects **3**	

No Answer **11**

More than one answer could be stipulated.

In a study of 337 patients who were consecutively admitted to the general medicine, cardiology, and neurology services of the Duke University Medical Center in North Carolina, nearly 90 percent reported using religion to some degree to cope, and more than 40 percent indicated that it was the most important factor that kept them going (Koenig 2004:1194).

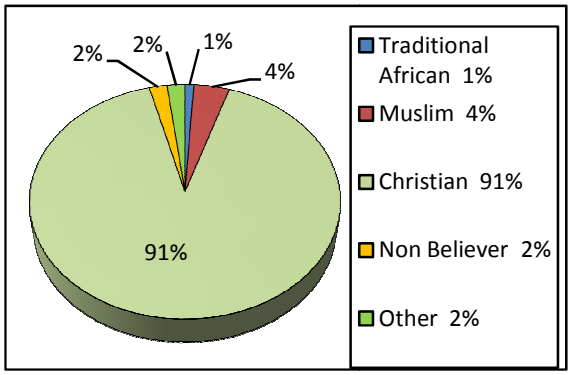
2.7.3.9. What importance does your religion/spirituality have to other areas of life (e.g. personal values and behaviour)?

Irrelevant	**4**	Important	**88**
Some what	**11**	Uncertain	**12**

No Answer **5**

Of the 88 patients who responded that their spirituality is important in other areas of their life, 91 percent were Christians. In a comparison, a Gallup survey conducted in 1990 showed that 75 percent of Americans said that their religion is central to their lives (Puchalski et al 2004:692). The pie-chart below (figure 20) provides a percentage analysis of the 88 respondent's faith group.

Figure 20: Faith Category



Through this question I was able to deduce the level of importance of the patient's faith in his entire life. Yawar (2001:529) describes the wide variety of ways in which people seek to fulfil the purpose of their lives, by relating examples of people living in the United Kingdom. For many British people there is a dichotomy between "an inner realm, in which faith may or may not be an important influence, and an outer realm which has been heavily secularized,

with utilitarianism a major influence." Yawar goes further by stating that this is not true for everyone. "For some British Christians, spirituality, and therefore faith, must fully embrace the outer realm if it is to have integrity." This idea can play out within the hospital wards as different faith groups require distinctive religious requirements in dealing with illness or death.

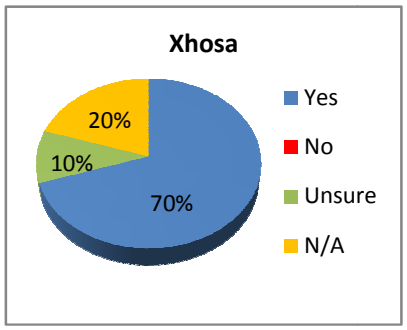
2.7.3.10. Do you believe that your faith can aid in your emotional and physical healing?

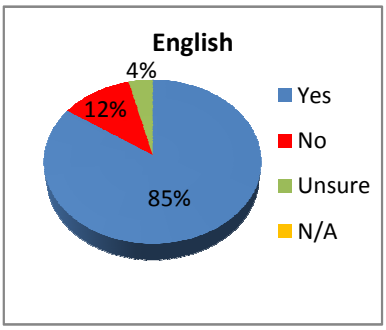
Yes **105**	No **4**	Unsure **7**

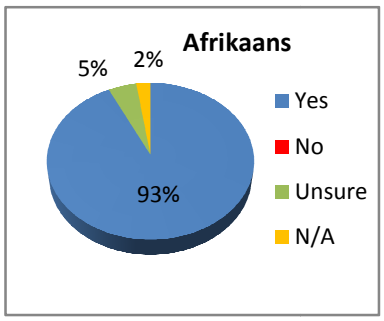
No Answer **4**

Studies by Ehrlich (2009), Curlin et al (2007), Piderman et al (2008), Levin (1994), Comstock & Partridge (1972), Anandarajah et al (2001) and Thoresen (1999) have revealed how the influence of one's spirituality could have an effect in the healing process of a patient. Even though most of these studies have been conducted within the borders of the United States, the current study reveals that over 85 percent of patients believe that their faith can aid in their emotional and physical healing. With such a high percentage rate, accompanied by the doctor's beliefs with regards to the above question, there can be of little doubt that a more dedicated emphasis should be placed on the patients spiritual needs. Kliewer (2004:616) states that a healthy spirituality can aid in prevention, improve outcomes, and facilitate coping, and should be supported and encouraged. While a negative spirituality can hinder the process of healing and therefore should be addressed.

Figures 21: Faith and Healing







The above graphs (figures 21) is an indication as to the belief that faith plays an aid in the healing process. In a separate study of 135 relatives and close friends of loved ones who had died, Shastri et al (2008) concluded that "those having strong faith in religion and spiritual beliefs were found to come out of their grief and become resolute than those not professing religious beliefs." Mueller et al (2001:1225) says that throughout history, religion, spirituality, and the practice of medicine have been intertwined.

2.7.3.11. As a hospital patient, do you feel that it is important for the hospital to meet your religious/spiritual needs?

Yes **80**	No **18**	Unsure **16**

No Answer **6**

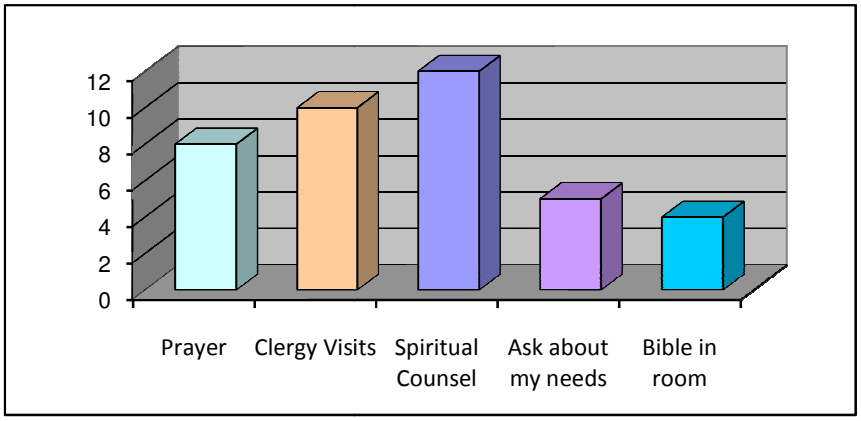
Although not all would agree with this idea, only 15 percent indicated that the hospital should focus solely on the physical ailments and leave the spiritual needs to the patient's religious group or the individual.

If yes, in what way(s) could the hospital meet them?

Informal conversations.
Visitations from churches.
Hospital to focus only on physical needs.
Encourage me as a patient.
If I need a pastor, the staff must get me one.
They should ask about my religious needs.
Someone to pray with the patients.
Prayer time.
Pastoral visits.
Chaplain visits.
Bible in the room.
Provide spiritual support.
Talking to the patients.
To provide a church service.

Figure 22 illustrates the patient's individual recommendations for the hospital to meet their spiritual needs.

Figure 22: Top Five Spiritual Recommendations



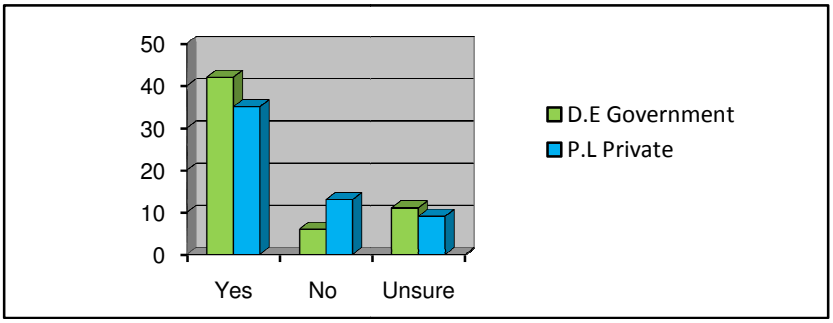
2.7.3.12. As a hospital patient, do you feel that you can openly talk about your religious/spiritual needs to staff members?

Yes **77**	No **18**	Unsure **21**

No Answer **4**

This question is an indication as to the freedom that the patient has in conversing about their spiritual or religious needs with the nursing staff. In most medical facilities, the nursing staff would be the eyes and ears for the doctor, relaying information to the doctor that could be of relevance. Perhaps the boundaries that exist between nurse-patient are similar to that of the doctor-patient relationship. The bar chart below (figure 23) is in indication as to patient responses to the above question.

Figure 23: Openness to Spiritual Conversation with Staff



2.7.3.13. Would you appreciate being able to talk to the doctor about your religious/spiritual needs?

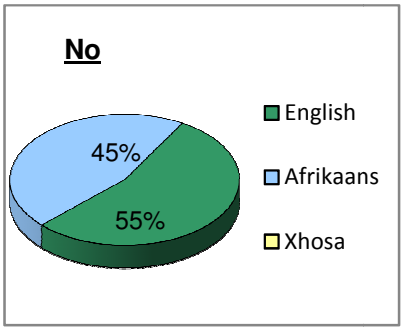
Yes **67**	No **22**	Unsure **27**

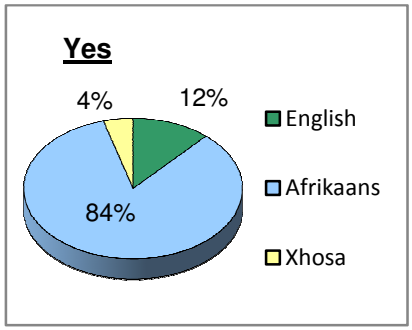
No Answer **4**

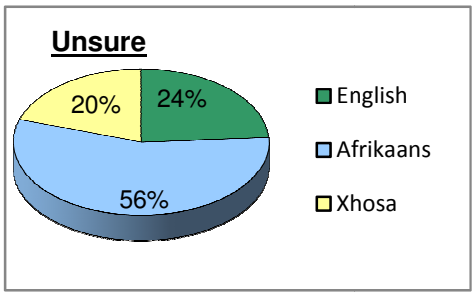
Spiritual inquiry in health care is controversial "as it oversteps the boundaries of medicine and diminishes the power of religion" (Sloan et al 2000). Some scholars agree that certain barriers would be breached if the patient entered into a spiritual conversation with his doctor (Ellis & Campbell 2004, Kliewer 2004, and Shastri et al 2008). This will be discussed later in Chapter three. Yet it seems that most physicians affirm the importance of spiritual health, but are divided about their role in the spiritual assessment of a patient. McCord et al (2004) supports the idea that patients have a desire to discuss spiritual needs with their physicians, but report that this rarely takes place. In a study of 231 Missouri family physicians, 96 percent considered spiritual well-being important to health. However, they reported infrequent discussions of spiritual issues with patients (Ellis & Campbell 2004:1158). In a separate survey one participant stated, (Ellis, Campbell, Detwiler-Breidenbach & Hubbard 2002: 251).

> *"Every physician ought to be dealing with [patients'] spiritual issues. [For example,] how can you justify not talking about spirituality to a patient with depression when you can prove scientifically that strengthening faith commitment helps them? It really comes down to a quality of care issue."*

Figures 24: Total Responses: Openness to Spiritual Conversation with Physicians



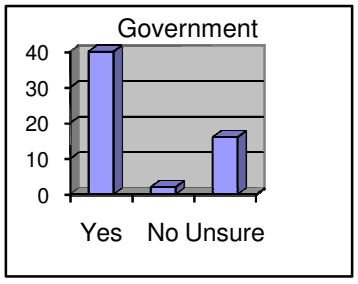


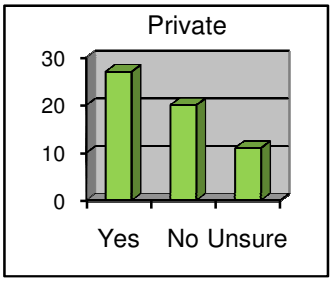


The pie charts above (figures 24) indicate the 'yes,' 'no' and 'unsure' responses from patients surveyed. Experience has shown that cultural groups differ in their candidness and expression regarding their faith. Of the 7 Government English patients, 71 percent specified they 'would appreciate being able to talk to the doctor about their religious or spiritual needs.' Of the 10 Government Xhosa speaking patients less than 35 percent 'would appreciate being able to talk to the doctor about their religious or spiritual needs' and only 25 percent of the 43 Afrikaans speaking patients disagreed or were unsure of speaking to the doctor about their religious or spiritual needs. Of the 60 Private hospital patients, 3 English speaking patients out of 19 'would appreciate being able to talk to the doctor about their religious or spiritual needs,' that is less than 15 percent. Conversely, 56 percent of Afrikaans speaking patients, out of a total of 41, 'would appreciate being able to talk to the doctor about their religious or spiritual needs.'

The following two bar graphs that appear below (figures 25) reveal the patients' response from both hospitals regarding the above question. From the research that was analysed, results showed that government patients had a 30 percent stronger inclination to want to discuss their spiritual needs with the physician then private patients.

Figures 25: Individual Hospital Responses





2.7.3.14. Would you ever want the doctor to pray with you?

Yes **77**	No **20**	Unsure **19**

No Answer **4**

Surprisingly 64 percent of the 120 patients surveyed revealed that they would feel comfortable if the doctor prayed with them. This question was also asked of physicians, their results will be scrutinised and compared with the patient's response in Chapter three.

2.7.3.15. Do you think that it's appropriate or inappropriate to discuss your religious/spiritual matters with the doctor? Why?

Appropriate **82**	Inappropriate **30**

No Answer **8**

Many positive responses were given by patients from both medical institutions. Below are the positive and negative responses.

Why? – Positive

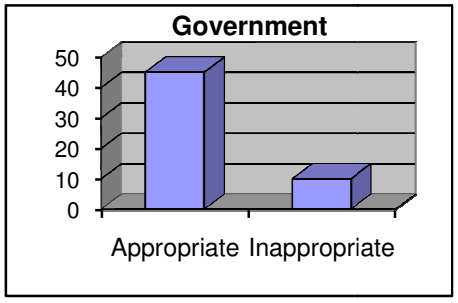
Knows how to care for you.
Helps my own spirit.
To have peace of mind.
I would not initiate conversation.
If I had a concerning need.
Holistic medicine in practice.
If the doctors initiates conversation.
Emotional, physical & spiritual all part of man.
As long as the doctor is not offended.
Nothing wrong with talking to doctor.
If the conversation led to that.
They must know how you feel.
Will speak to him if I get bad news.
Makes me feel good.
God works through the doctors hands to bring healing.

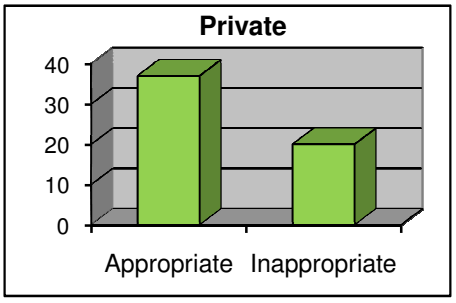
Why? - Negative

Personal matter.
Doctor is too busy.
Not all believe the same.
Would rather speak to my pastor.
It would devalue their profession.
Would rather talk with someone else.
No need to as my daughter's religious.
Doctor's job to make me physically well.
Doctor must concentrate on my illness.

The appropriateness of discussing religious or spiritual matters with the doctor is shown below in figures 26. A very similar response was given between both medical institutions with a slight difference of less than 10 percent.

Figures 26: Discussing Spiritual Needs





2.7.4. Visitation Questions

The subsequent nine questions center on the patients knowledge, function and visitation by the chaplain. This section is valuable as it offers me insight into the validity of the chaplain working within the hospital.

2.7.4.1. Do you know what a chaplain is?

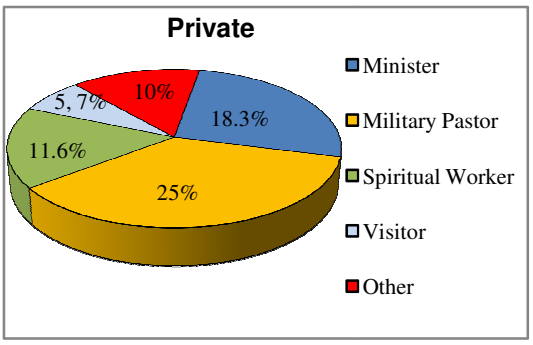
Yes **69**	No **50**

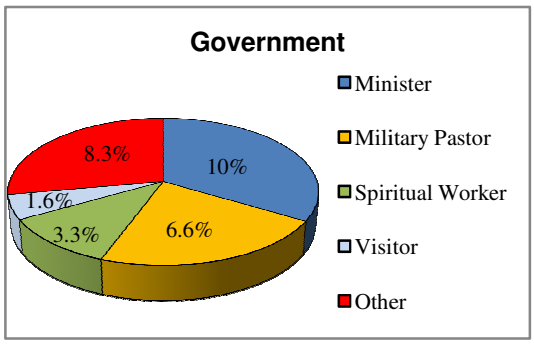
No Answer **1**

If yes, how would you define a hospital chaplain?

Experience has shown that many people are not familiar on how to describe a chaplain. Research has revealed that 42.5 percent of all patients confirmed the notion that they are unsure as how to explain what a chaplain is. The pie charts below (figures 27) assign the various ideas of how patients describe what a hospital chaplain is. Of the 69 'Yes' answers, 9 patients responded with 'Yes' but never defined what a hospital chaplain is and only 2 patients more-or-less knew that a hospital chaplain is described as "an employed hospital worker that visits with patients."

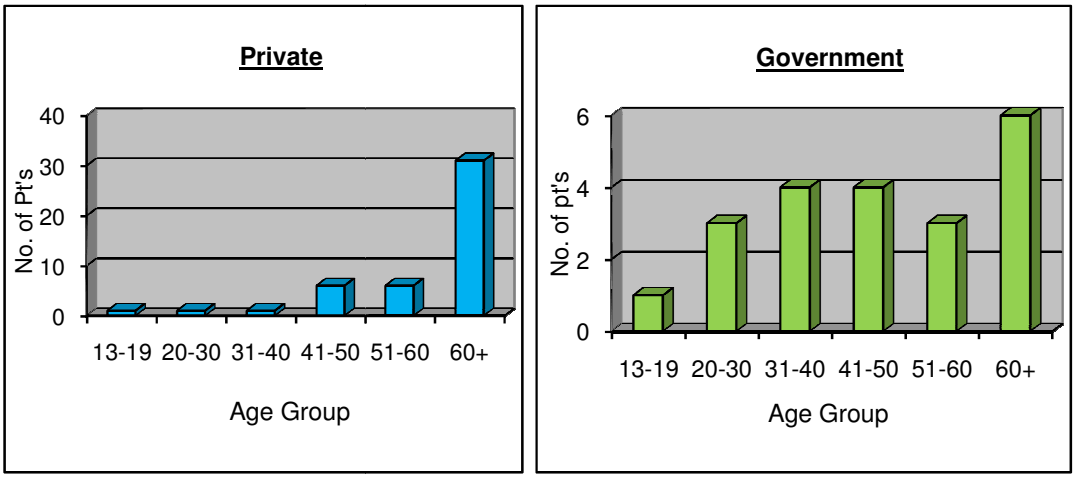
Figures 27: Definition of Chaplain





The other fascinating statistic is the age group dissection weighed against the knowledge of what a chaplain is (figures 28). Experience has shown that the older population will ascribe the idea that a chaplain is someone who works in the military or air force. This idea pays homage to the Hollywood thought of how they portray chaplains in movies. Often the chaplain would arrive at a house to inform the newly widowed woman that her husband has been killed on the battlefront. From the research, it would seem that the majority of patients who indicated that they knew what a hospital chaplain is are over the age of 60 years. They count for 53 percent of 'Yes' answers. 2 patients responded 'Yes' but did not indicate their age.

Figure 28: Age Group Dissection



2.7.4.2. If no, were you aware that a hospital chaplain can be defined as a 'professional religious worker'?

Yes **66**	No **48**

No Answer **6**

Thompson (2005:72) writes, "In my clinical practice days, hospital chaplains were often retired ministers with no special additional credentials. Not anymore." Due to the suspected high number of patients not knowing what a chaplain is, this question would allow patients to acquire some idea as to a laymen's definition when describing what a chaplain is by using the words,

'professional religious worker.' There can be no question that today's chaplains are qualified, ordained ministers with special skills that work within hospitals, the military, emergency services and educational institutions (Kirkwood 2005a, Thompson 2005, LaRocca-Pitts 2004, Piderman et al (2008), Press Ganey). Further exploration of the credentials and skills of the chaplain will be discussed in Chapter four.

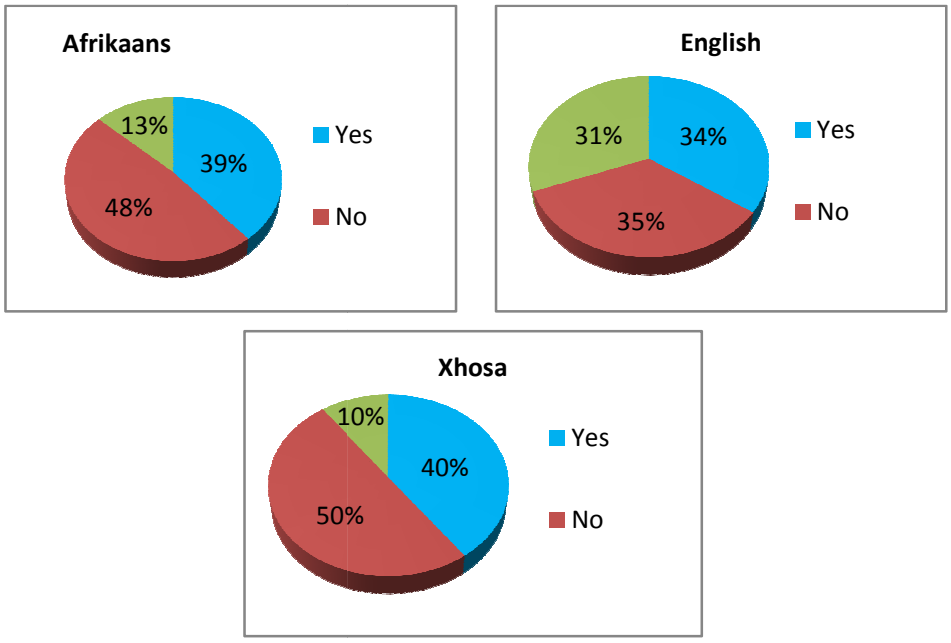
2.7.4.3. Are you aware of the functions of a hospital chaplain?

Yes **46**	No **44**	Some What **19**

No Answer **1**

As one can deduce from the pie-charts below (figures 29), Afrikaans and Xhosa patients had similar response percentages while English speaking patients were equally balanced between the three responses.

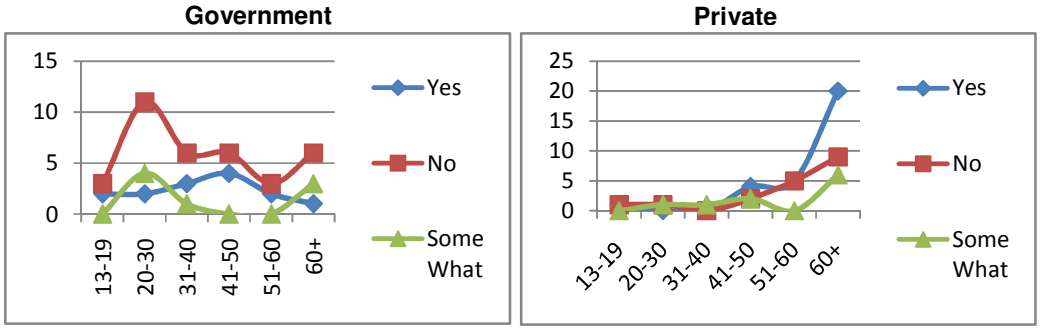
Figures 29: Chaplain Functions

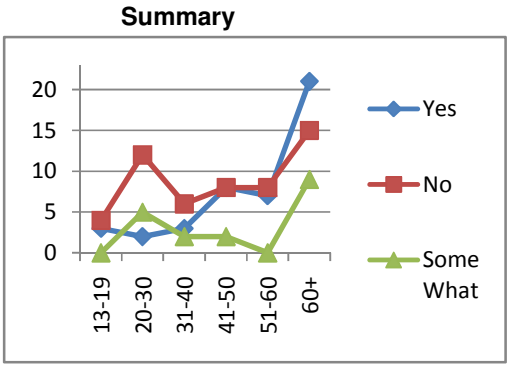


Similar to question 2.7.4.1, the fascinating result lies within the patient's age group. As originally thought, the older the patient, the more informed they may be of the function of a chaplain. However, in the three line graphs shown

below (figures 30), the idea that the older the patient is, the more aware they may be of the chaplains function, may not be entirely true.

Figure 30: Age Group Dissection





2.7.4.4. Do you know how to request a hospital chaplain visit?

Yes **41**	No **75**

No Answer **4**

Although only the D.E government hospital is serviced by a chaplain, particular information from the P.L private hospital could be beneficial for future ministry. The above statistic shows that there still remain a high percentage of patients who do not know how to request a chaplain visit, in spite of a full-time chaplain working in the government hospital. What is more surprising is that there are more private patients (<8 percent) who know how to request a chaplain visit without there being a full-time chaplain. Although a higher percentage, these results fair reasonably well against a survey conducted by Piderman et al (2008:60) in Rochester, Minnesota. (United States), where 45.3

percent of 535 patients were unsure of how to contact a chaplain, 36 percent expected that a chaplain would visit them without having to request a visit, and 33 percent expected follow-up visits. Recommendations will be made in Chapter four on how to effectively utilize the services of a chaplain in order for patients to be aware that a chaplain can be made available to meet their needs. In addition, this illustrates the important role that the medical staff plays in exposing the patients to the chaplain.

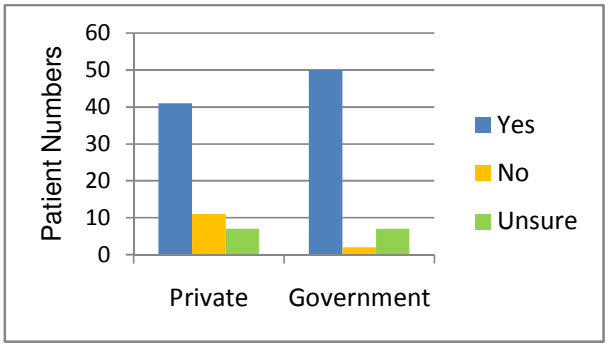
2.7.4.5. If a hospital chaplain was made available to meet your religious /spiritual needs, would you request a visit?

Yes **91**	No **13**	Unsure **14**

No Answer **2**

76 percent of the patients affirmed that they would be partial to a chaplain visit during their hospital stay. Across the board only 11 percent of hospital patients declined to be visited by a chaplain, as shown in figure 31.

Figure 31: Requesting a Chaplain Visit



2.7.4.6. How often would you like to be visited by a hospital chaplain?

Daily **17**	Every Few Days **59**	Weekly **28**

No Answer **16**

This question ties in closely with question 2.7.2.4 (*Duration of hospitalisation*). As expected, several patients iterated that the longer they are hospitalised, the greater the need may arise to visit with a chaplain. Due to the

research not been carried out within the ICU where patients generally stay longer then ward patients, the majority of patients (72 percent) stayed less than one week. In addition the suspected percentage of the 'daily visits' by the chaplain would increase the more intense and traumatic the patient's diagnosis.

2.7.4.7. What need(s) would you have wanted to be addressed by the hospital chaplain?

Prayer **73**	General Counsel **37**	Religious Rites **10**	Comfort **16**
Talk **34**	Ethical Counsel **3**	Calm my anxiety **9**	Other **6**

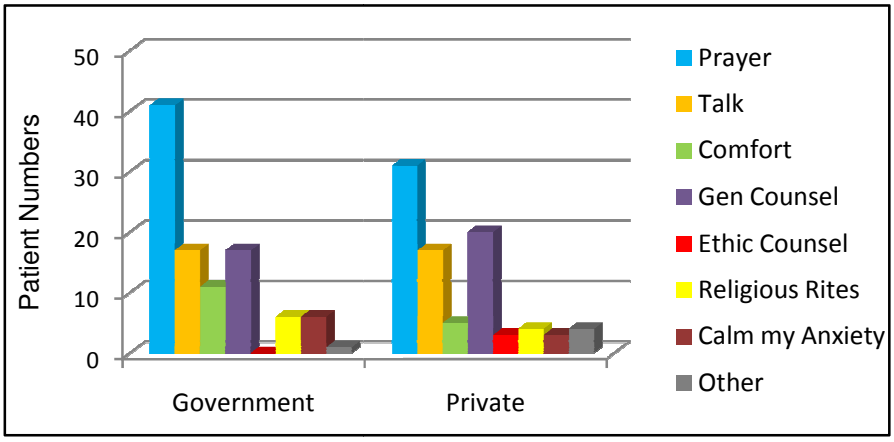
No Answer **14**

More than one answer could be stipulated.

Figure 32 provides the reader with the individual analysis for each hospital where the research was conducted. In the Press Ganey (2010:6) survey the following needs and resources were among the most requested by patients:

- Personal or unique faith
- Prayer
- Scripture reading
- Prayer or dialog with fellow church members
- Counselling from chaplain or leader of faith
- Attending a religious service
- Daily spiritual experience
- Meditation
- Spending time at a location of spiritual energy (e.g. church, specific geographic location, or nature settings), and
- Help or counselling from ancestors.

Figure 32: Chaplain Visits



2.7.4.8. Do you feel that it would be of value if the hospital had a counselling / prayer room for patients and family use?

Yes **108**	No **6**

No Answer **6**

The challenge that remains a part of many hospitals in the Helderberg Basin is the lack of an inter-faith chapels (or prayer rooms). An overwhelming majority of the patients requested that a counselling or prayer room would be most beneficial in meeting their spiritual needs. Privacy in the wards is an intricate necessity in counselling a patient or family member. Many of the government hospital wards have up to 6 beds and only a small handful of private rooms. Within the private sector, private rooms are more accessible.

The use of an inter-faith chapel could be most beneficial for patients to feel comfortable in using it as a place of prayer, reflection, or simply somewhere to be quiet. With South Africa being a multi-religious country freedom of religion and religion tolerance, a neutral chapel would likely be the acceptable proposal. Ultimately the chapel should be a place of prayer for people of all faiths and of no faith. It would be intriguing to see how a multi-faith chapel would be used by patients of diverse faith groups.

2.7.4.9. Would you object to a general introductory hospital chaplain visit?

Yes **7**	No **110**	Unsure **1**

No Answer **2**

Ending the survey with this question allows me to have a firsthand impression of how patients feel if the chaplain was to come and introduce his services to the patient. This would give exposure to the patient and make the patient aware that the chaplain is available if the patient felt the need to speak with him. As from the results, there is an overwhelming assurance that patients would not object to the chaplain visiting with the patient.

2.8. Chapter Summary

Results seem to indicate that the patient's spiritual life is important to them. By centring only on the physical elements of the patient, some significant reservations could occur. Preliminary observations indicate that patients would like the physicians and medical staff to address their spiritual or religious needs as this is as important to them as their physical and emotional needs. Most patients denoted that they can openly speak to the physician and medical staff concerning their spiritual needs.

Majority of the patients indicated that their faith can play an important role in their physical and emotional healing and felt that the hospital should have a supplementary role in meeting these spiritual needs. Simple indications seem to be involvement by local churches or faith groups, bibles in the wards and a chapel or prayer room for patient, family and staff use.

Although not all the patients could not accurately define what a chaplain is or describe their functions, it was found that a visit by the chaplain would bring comfort to the patient.

In Chapter three key answers from the patient questionnaire will be analysed against the physician's and medical staff's response to the same questions. The role that each physician and staff member play in meeting the patients spiritual needs will also be considered.

CHAPTER 3

Addressing the Patient's Spirituality

To give justice to addressing spiritual needs in patients, an analysis of both physician and nurse is important.[16] Chapter three seeks to deal with this by identifying the stance of both physician and nurse.

Sections 3 and 4 focus on the physician questionnaire. This will determine the mindset of the physician regarding spirituality and medicine in patient care. In sections 5 and 6, the nurse's questionnaire deals with similar questions to that of the physician survey. Comparison of the two questionnaires will be accomplished seeking to understand the attitude and approach of the medical staff towards any spiritual matters of the patient. It is important to note that the majority of the government medical staff is familiar with the function and workings of the chaplain due to the current relationship that they have with the researcher. However as Fitchett et al (2009:1808) maintains, "Little is (still) known about physicians' experience with and impressions of chaplains." I trust that this will be minimised after the study.

Two forms of measuring tools will be used to attain the medical staffs' attitude in recognising and addressing the spiritual needs of patients. First, a short 25 point questionnaire will be carried out with the doctor and staff nurses. Secondly, when possible a brief interview will be conducted so that I will be able to interact with the doctor to help understand possible barriers that could be relevant to a physician-patient relationship with reference to the patient's spiritual well-being. This section deals with the second and third principle of Cowan's (2000) LIM model; *interpreting the world as it is,* as currently barriers prohibit a physician-patient spiritual dialogue and *interpreting the world as it should be,* as a patient's spiritual well-being is just as important as their physical well-being.

[16] No distinction is made between "nurse" and ward "Sister."

3.1. The South African Doctor

Who is the average South African doctor? What training do they have to endure and for how long? So much has been written with reference to South African doctors leaving our shores to seek work where the "grass is greener" and not having to tolerate poor working conditions.

Training to become a doctor in South Africa can take between five to six years to obtain their undergraduate degree. Thereafter an internship to a period of 24 months takes place. In order to fully register with the HPCSA (Health Professional Counsel of South Africa) as an independent practitioner and work in South Africa as a doctor, a compulsory community service year needs to be concluded. Upon completion and full registration as an independent practitioner a South African doctor is free to work in the private sector, or continue in the government sector in order to specialise.

The experience that medical doctors will endure differs quite substantially between the government and private sector. Thom (2000) maintains that in the "teaching hospitals, first year medical officers were given very little opportunity for independent decision-making. In isolated rural hospitals community service doctors were often the only full-time medical staff."

Yet despite the 'negative' stigma surrounding the working affairs of South African doctors, Malan (2009) is insistent that with the high standard of work ethic, South African doctors have a good work reputation worldwide and are often sort after in countries such as Britain, United States, Canada and Australia.

3.2. Physician and Staff Criterion

There was no official criterion to the selection of physicians and nurses to participate in the study. Doctors and nurses were randomly selected to participate with a verbal explanation given, explaining the purpose and

confidentiality clause for the study. Respondents had the choice not to participate in the study at any time.

3.3. The Questionnaire Results

The doctor's questionnaire is very much comparable to the patient questionnaire. This was arranged with the purpose of being able to evaluate responses between patient and physician. The questionnaire consists of three sections: general questions, patients need questions and hospital chaplain questions. This chapter will deal with the complete summary of the questionnaire. As with the patient questionnaire, the final analysis will be displayed in block cells, whilst relevant data will be tabulated in charts for easy comparison purposes.

3.3.1. General Questions

Seven questions designed to acquire background information and religious beliefs of the physician compose this section of the questionnaire.

Sample Description: N=14[17]

3.3.1.1. Male or Female?

Male **9**	Female **5**

3.3.1.2. What age group do you belong in?

20-25 **0**	36-40 **4**
26-30 **8**	40+ **0**
31-35 **2**	

3.3.1.3. What medical area are you practicing in?

Medical **4**	Trauma **2**	Other **3**
Surgical **4**	Paediatrics **0**	All **1**

[17] An estimate of 42 physicians is employed at both medical centres.

3.3.1.4. What faith group do you belong to?

Christian **14**	Traditional **0**	Eastern **0**	Other **0**
Muslim **0**	African **0**	Non-believer **0**	

The above question makes for interesting interpretation when one compares it with question 3.3.1.6. All 14 physicians stated that they belong to a Christian faith, yet 2 stated that they are not active members in their faith group. As with the patient questionnaire, having being raised in a Christian environment does not necessarily imply that one is a (active) Christian. Harrison (1960:114) expresses that the term 'Christian' is often used laxly to people who make a facade of being believers in Christ in a religious sense but who admire and try to copy some features of his character (yet never follow his teachings).

3.3.1.5. What denomination do you belong to?

NGK **5**	Apostolic **1**	Anglican	**1**	IFCC[18]	**2**
Baptist **3**	Methodist **1**	7th Day	**1**		

3.3.1.6. Are you an active member of your religious church / mosque / institution?

Yes **12**	No **2**

3.3.1.7. What importance does your religion or spirituality have to other areas of life (e.g. personal values and behaviour)?

Irrelevant **0**	Important **14**
Some what **0**	Uncertain **0**

[18] International Federation of Christian Churches: Shofar Christian Church.

3.3.2. Patient Needs Questions

This section encloses eight questions that seek to understand the stance that the physician has on the subject of meeting the patient's spiritual or religious needs. Comparison will be represented against answers given by the patients to determine any similarities or chasms that may exist.

3.3.2.1. Do you as a medical doctor enquire about your patients religious or spiritual needs?

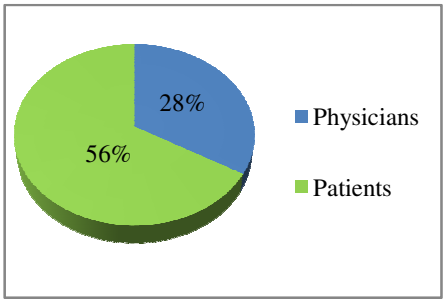
Yes	**4**	No	**7**	Sometimes	**3**

Why:

Not significant unless patient insists on sharing.
Often too busy and do not think about it.
Too shy.
Holistic approach.
I respect their relevant faith.
Except if it affects management.
Seldom but only if patients has some belief.
The time spent with patients is inadequate.
Spiritual motivation can help deal with the patient's illness.
No Time to enquire.

Statistically there is a 28 percent difference as to the patient's desire for the doctor to enquire about their spiritual needs, versus the physicians approach. In other words for every 5 patients, 2.79 patients desire that the doctor ask about their spiritual needs *(P=0.558)*, yet 1 in every 2 doctors don't make an effort to enquire. This statistic is very much in line with other data results showing that only up to 10 percent of patients are asked by their doctors about their spiritual needs (Kliewer 2004 and Larimore 2001). Yet research constantly demonstrates an immense amount of patients are yearning for their physicians to engage them in spiritual conversation. Figure 33 below displays the percentage difference.

Figure 33: Percentage Difference: Enquiring about patients spiritual needs



3.3.2.2. Do you believe that the patient's faith can aid in their emotional and physical healing?

Yes **14**	No **0**	Unsure **0**

With full support to the statement "a patient's faith can aid in their emotional and physical healing," why then are physicians so hesitant to converse with the patient regarding their spiritual disquiets? Perhaps Larimore (2001:36) answers this best when he articulates that academicians suggest that "it is a general mandate of modern developed societies to keep professional roles separate… [as] distinct spheres of activity… [to] ensure competence and boundaries."

3.3.2.3. Do you think that it's appropriate or inappropriate for the patient to discuss their religious or spiritual needs with you?

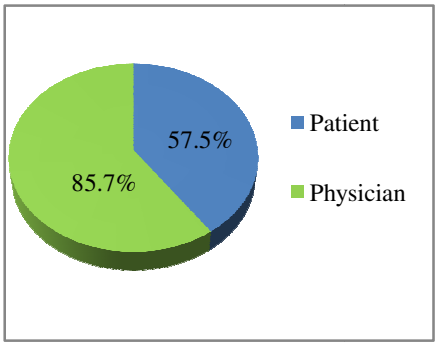
Appropriate **12**	Inappropriate **2**

Why?

Helps with healing.
Patient should feel free to discuss anything with us.
Everybody has a God-shaped hole.
I focus on the physical complaint only.
Proper management.
It's often more important to a patient than their physical needs.
To understand where they are coming from and their belief structure.
In acute care situation one is not always in contact with the patient long enough.
Due to time constraints it is better to sort out the medical needs.

Apart from two physicians, there is an overwhelming positive response by physicians to discuss the patient's spiritual need. Conceivably the doctor may not approach the subject unless the patient has made reference to a spiritual 'doorway' and thus initiates the conversation. Figure 34 exhibits the percentage breakdown between patient and physician.

Figure 34: Appropriateness for Spiritual Discussion

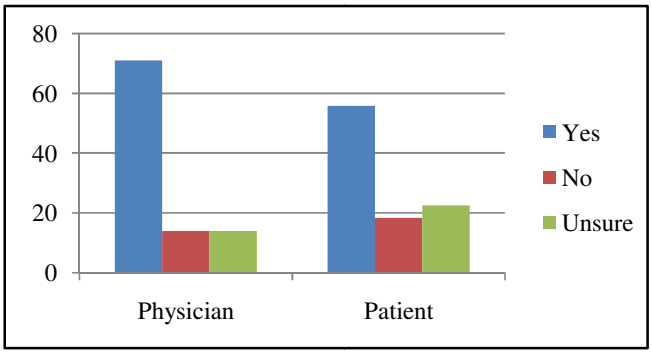


3.3.2.4. Would you appreciate it if the patient talked to you as their medical doctor about their religious or spiritual needs?

Yes **10**	No **2**	Unsure **2**

It would seem that from the revealed data both patient and physician would welcome and value a dialogue concerning the patients spiritual needs *(P=1.42).* If this seems to be the case, the physician is possibly waiting for the patient to open the "spiritual" conversation. In figure 35, the comparison percentage of physician-patient is shown.

Figure 35: Physician-Patient Comparison Percentage



3.3.2.5. Do you feel as a medical doctor there is any value in speaking with patients about their spiritual state?

Yes **12**	No **0**	Unsure **2**

The response to this question is rather indifferent as 12 physicians *(P=1.71)* indicated that there is value in speaking to their patients about their spiritual state, however, in the previous question only 10 physicians *(P=1.42)* indicated that they would actually speak to their patients about spiritual needs. Most physicians stated that the benefit of being familiar with the patient's religious stand-point would help allow the physician to provide a holistic care approach to treatment. Individual physician response is indicated below.

Why:
So can provide different level of support.
Helpful for the patient, but also encourages me.
People are scared, vulnerable, need assurance and need hope.
Spiritual issues can be emotionally taxing and remove my focus from the problem at hand.
Asses their support system.
Helps to understand the patient's world view.
Comfort for patients.
It would help them deal with their illness.
Part of whole patient approach.

3.3.2.6. Do you think patients would want you as a medical doctor to know about their religious or spiritual state?

Yes **6**	No **1**	Unsure **7**

The respondents were very much split down the line, which is surprising as question 3.3.2.4 showed a 71 percent in favour of knowing the spiritual view-point of the patient through conversation.

3.3.2.7. Would you ever pray with your patient?

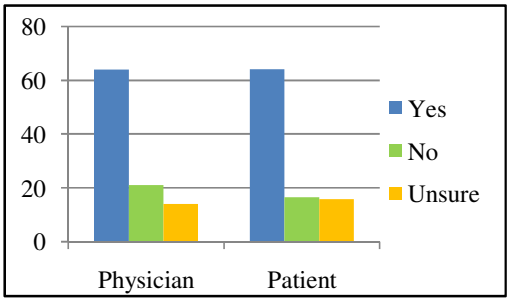
Yes **9**	No **3**	Unsure **2**

Is this percentage just a matter of religious doctors vs. non-religious doctors or is there more to this than what meets the eye? Psychologist Richard

P. Sloan[19], director of the behavioural medicine programme at Columbia-Presbyterian Medical Center in New York has strong sentiments concerning physicians praying for the patient. Sloan argues that patients could want all sorts of things that are not necessarily in their best interests, and so just because a patient wants something doesn't mean a physician has to offer it if there is no good base of evidence that it is effective. Hence, a prayer request by a patient should be politely and respectfully referred to their pastor, priest, or rabbi.

In retrospect to Sloan's argument a ratio of 1.28 for every 2 patients would want to receive prayer by their attending physician. This ratio is exactly the same for the physician to oblige to the request of prayer (figure 36). From this evidence, does it mean that physicians are praying with their patients? No. Why? Most physicians stated that they would only pray with a patient "if they requested it first". This is not unfamiliar territory. In a Time/CNN poll it was found that "64 percent of patients thought that physicians should join their patients in prayer, but 92 percent said they never had a physician make that offer" (Larimore 2001:37).

Figure 36: Physician-Patient Prayer Comparison Percentage



3.3.2.8. Do you think that it's appropriate or inappropriate for a medical doctor to pray with a patient?

Appropriate **10**	Inappropriate **2**	Unsure **1**

No Answer: **1**

[19] For an interesting debate between psychologist Sloan and psychiatrist Koenig refer to www.medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=124094.

Controversy surrounds this matter. In a Daily Mail news article[20] NHS doctors are calling on the British Medical Association (BMA) for the legal right to be allowed to pray alongside their patients without the threat of disciplinary action after a patient complained when a registered nurse prayed for her and was suspended for her actions.

Selected patients on an on-line blog[21] have shown that it could undermine the physician's skill if he was to pray with his patient. Others wondered if the prognosis for repair and recovery was far worse than presented for the informed patient consent. Nevertheless, 71 percent of surveyed physicians find no fault in praying with a patient.

Some of the physician's responses that were surveyed are:

So can provide different level of support.
Part of holistic care.
Depends on the circumstances.
If the patient requests it, but I would prefer the chaplain doing it.
It greys the professional relationship.
I am first a Christian before a doctor.
To show support to the patients.
This would uplift the patient's spirit and emotions.
Work load is too heavy. There are better trained individuals to assist in the patients spiritual needs.

3.3.3. Hospital Chaplain Questions

In the following section, containing ten questions, the notion of the hospital chaplain's relationship with the physician will be analysed and discussed.

3.3.3.1 Before practicing at your current hospital, have you ever worked with a hospital chaplain?

Yes **4**	No **10**

[20] www.dailymail.co.uk/health/article-1196049/Doctors-want-right-pray-patients-fear-reprisal.html
[21] www.bioethicsdiscussion.blogspot.com/2005/07/should-physicians-pray-with-their.

No surprising results were revealed with this question as I suspected that the majority of the physicians would not have worked with a chaplain prior to their current employment. Very few South African hospitals recognise hospital chaplaincy as a profession therefore they do not have the services of a chaplain. Many hospitals work on an on-call list of local religious ministers that volunteer their time. When needed, they would be called out. In a selected study carried out by Fitchett et al (2009:1808), he found that 89 percent from a total of 1144 physicians have had experience with chaplains. It is with little doubt that the United States are the front runners in hospital chaplaincy.

3.3.3.2. How would you define a hospital chaplain?

Some of the physician's responses that were surveyed are:

Offer spiritual support.
Similar to social worker that focuses on spiritual aspects.
As a helping hand.
Heals emotional scars that medication cannot fix.
Somebody with a solid foundation.
A person who is willing to talk to people about their spirituality to bring comfort.
Spiritual guidance and support for patients experiencing physical disease.
A Christian representative that supports patients mentally and spiritually.
Someone with pastoral experience who is trained to consult with patients about themselves, their spiritual state and who has more time to spend with the patient than a doctor.
Pastor.
A person in the hospital trained to counsel patients about their acute situation as well as giving a religious slant.
Someone that listens to patients to provide comfort and share the gospel.
A Priest that uplifts the emotions and spiritual side of patients.
The "go-to-guy" to add the spiritual component to the multi disciplinary patient centred approach.

3.3.3.3. Are you aware of the functions of a hospital chaplain?

Yes **5**	No **1**	Some What **8**

Current statistics have shown that some work can still be done to outline better parameters as to the function of the chaplain. The above question could

tie in with question 3.3.3.5 below as some of the functions of the chaplain would be revealed when the doctor refers a patient.

3.3.3.4. Have you ever as a medical doctor referred to a hospital chaplain?

Yes **13**	No **1**

In general it seems that physicians have little training to guide referrals to chaplains. Some evidence suggests that in the absence of adequate training, the physicians' referral patterns are most likely shaped by their own religious or spiritual values and experiences. Fitchett et al. (2009:1808) goes on to say that the physicians' referrals may also be shaped by their understanding, or misunderstanding, of chaplains.

3.3.3.5. When do you think it's appropriate to refer to a hospital chaplain?

Additional examination will take place in the next chapter as to the referral protocols of the chaplain.

Some of the physician's responses that were surveyed are:

In acute situations.
Terminal patients.
For psychological and emotional needs.
Patients that express spiritual needs intervention.
When a patient is in need of emotional or spiritual help.
Suicide, death and any persons struggling with a life decision or anyone who requests a chaplain.
When I perceive patients have a spiritual need.
As often as patients would accept it and find it appropriate.
Counselling bad news.
Whenever one feels that a patient needs counselling.
Patients with bad prognosis or for moral support.
To uplift the emotions of a patient and for support.
Whenever the patient requires it.

3.3.3.6. Do you feel it is the doctor's responsibility to refer to a hospital chaplain?

Yes **11**	No **1**	Unsure **1**

Yes & No: **1**

Some physicians indicated that the responsibility of referring to a chaplain does not solely lie with the physician's discretion. They believed that the patient has a right to also request a chaplain visit or that medical staff in addition to physicians can request the chaplain to visit with the patient.

3.3.3.7. If a hospital chaplain was made available to meet your patient's religious or spiritual needs, would you request the services of the hospital chaplain?

Yes **14**	No **0**	Unsure **0**

This question shows the value in endorsing a chaplain to work within medical institutions as all physicians specified that the services of a chaplain would be beneficial to their primary care. Five of the fourteen physicians who practice in the private hospital, denoted that they would refer to a chaplain if chaplaincy services were available to them as an allied medical service.

3.3.3.8. Do you feel that it would be of value if the hospital had a counselling or prayer room (inter-faith) for patients and family use?

Yes **14**	No **0**

With full support by physicians and a 90 percent desire from patients, there is little doubt that the hospital would benefit from having a chapel. As previously discussed, the sensitive nature of having diverse religious ethnicity in South Africa, the use of encompassing a hospital chapel would need to first be addressed by hospital management and ethics committee alike. In an on-line article, *Transforming Hospital Chapel into Welcoming Space* (2010), chaplain Chuck Ceronsky says that many hospitals in the United States are

creating a “new spiritual space that's as evocative as possible, spiritually, for everybody and isn't religiously specific… This allows the chapel to be more welcoming to people of all faiths.” This would be an interesting debate to examine the different opinions from various religious groups with regards to establishing an inter-faith chapel or prayer room that is non-offensive to all religious and spiritual belief groups.

3.3.3.9. As a medical doctor, do you feel that it is important for the hospital to meet the patient’s religious or spiritual needs?

Yes **12**	No **1**	Unsure **1**

With extensive agreement of support from physicians that the patient’s faith can aid in their emotional and physical healing, it is understandable that 12 out of 14 doctors would agree that the hospital has an important role in meeting not only the physical aspects of the patient but also their spiritual needs.

The physician’s responses regarding ways in which the hospital can help meet spiritual needs of the patients are:

Provide the necessary support.
Prayer room very beneficial.
Dying people who need bereavement.
Emotional distress.
Allowing church members of the patient to visit and pray.
Prayer room and chaplaincy services.
Prayer facilities and sermons.
Medical schools should incorporate pastoral care into their programmes, not so doctors can practice it but so it becomes an integrated part of the health care system.
Have a prayer room.
Prayer room.
Hospital chaplain
Making patients aware of the services of the chaplain.
Moral support and to preach the gospel.
It is the patient’s religious affiliation that is responsible for this, not the hospital.

3.3.3.10. Would you appreciate it if some training / educational programme was established, for you to gain better insight into addressing the patients spiritual needs without being unethical?

Yes **9**	No **1**	Unsure **2**

No Answer: **2**

I've already done a course.
This should be a standard part of medical school.
It's never unethical.

More than half of the physicians indicated that they would be interested in having a workshop to assist them in addressing spiritual needs of patients. One physician said that the skills of addressing a patient's spiritual need should be a standard feature of medical school. Authors such as Larimore (2001), Kliewer (2004), Slutz (2009) and Shastri (2008) found that a trivial amount of training is accounted for in the field of spirituality and health that a medical student would encounter. They did however maintain that there is a steady increase of academic literature being written with reference to spirituality and health. Their findings are as follows;

> *"Only 5 percent of physicians report that religious and spiritual issues were addressed in their training. Nearly one half (60 of 126) of America's allopathic medical schools now provide training in addressing faith and spiritual issues with patients" (Larimore 2001:37-40).*
>
> *"In the early 1990s, only of a handful of medical schools offered courses on the connection between spirituality and health. Now, more than 60 of 125 schools offer such courses" (Slutz 2009:1).*
>
> *"A review of 2348 studies published in four major psychiatry journals between 1978-1982 revealed that only 59 articles (2.5%) accounted for spiritual variables" (Shastri 2008:1).*
> *"A search by Oregon Health and Science University faculty in 1999 of a large public library database of popular magazines using the key words "spirituality and health" revealed only 25 articles from 1990 to 1994, but over 100 articles from 1995 to 1999. A similar movement can be seen in the medical literature. A search of MedLine using the keyword "spirituality" produced 52 articles from 1960 to 1990, 90*

from 1991 to 1995, and almost 200 from 1996 to 1999. A more recent search produced 554 citations from January 2000 to April 2003" (Kliewer 2004:617).

3.4. The Interview Questions

When possible a brief interview took place between physician and me. It was felt that interviews, over questionnaires, allow for healthier rapport between the two parties so that finer information could be accumulated by me. Not all answers are noted in verbatim form. Where necessary, words were altered or added, but at no time did this detract from the original message of the physician. A total of five questions were asked.

3.4.1. How would you define "quality of care"?

Phy1: The same care that your mother would want to receive. To provide all levels of care – physical, emotional and spiritual.

Phy2: Holistic approach to health care – medical, social and physical needs and been able to provide the best medical care possible.

Phy3: The best I can give. Holistic in nature with an individualised and appropriate care to each patient.

Phy4: Body, soul and spiritual care.

Phy5: Proper diagnosis, treatment and medication. The availability for every patient to have a hospital bed. All basic human rights needs.

Phy6: Holistic and effective management of patients

Phy7: How satisfied patients are with their care and where this meets good evidence based scientific medical practice.

Phy8: Care in line with international standard of practice.

Phy9: Quality care involves different aspects depends on the situation. Generally though, it involves providing the patient with the correct treatment to a proven standard with a holistic approach.

Phy10: The level of care of patient on a physical, emotional and spiritual level.

Phy11: Having a multi-disciplined approach to health care. Having all disciplines involved in the patients care.

Phy12: All patients to receive appropriated medical care and patient satisfaction.

Phy13: Care that takes care of medical, social, mental and spiritual aspects of the patient's life.

Phy14: Care tailored to fit the needs and preferences of the patient taking into consideration the nature of the illness, the appropriate treatment in a timely manner in a fair non-discriminatory way.

3.4.2. Do you feel that it is important for a medical physician to receive some training with regards to taking a "spiritual history" of a patient? Why?

Phy1: Yes: Especially in more serious situations. I normally listen to what the patient and family talk about in order to gain insight into their spiritual life for example, sometimes families talk about a "higher hand involved." The time factor may be an issue.

Phy2: No: Not enough time in the ER ward. Not practical as patients would tell me if it was important to them.

Phy3: Yes: It could provide more insight for me as a doctor, which could change my treatment plan.

Phy4: Yes: It forms people's worldview.

Phy5: Yes: It can aid in making a better diagnosis.

Phy6: Unsure: May be irrelevant.

Phy7: Yes: Holistic care is impossible without this. We should have a bio-psycho-social-spiritual model. Training is needed because we are useless at it.

Phy8: Yes: I believe that physical symptoms can be rooted in a "spiritual pathology."

Phy9: Yes: It would make it easier to bring up the subject of religion.

Phy10: Yes: A careful approach in dealing with their answers is needed.

Phy11: Yes: It's helps to understand the patient's background and provides insight into their care.

Phy12: Yes: Religion has an impact on patient's perception on their illness. At times I would need consent on some treatment.

Phy13: Yes: To avoid conflict of interest when tacking a patient's spiritual history.

Phy14: No: Medicine is complicated and vast enough. When there is an emotional problem a psychologist sorts it out, social problems a social worker. People can and are trained to address spiritual problems.

3.4.3. What are some of the barriers in discussing spiritual issues with your patients?

Phy1: Time. Sensitivity. No privacy in the ER ward.

Phy2: No real relevance and more interested in the medical side.

Phy3: Time.

Phy4: Coming from a different religious background.

Phy5: Time. Lack of a private room. Myself, as I'm too shy and lack of confidence. Would be easier if I had some sort of guideline.

Phy6: Language and interdenominational issues.

Phy7: Political correctness.

Phy8: Political correctness and freedom of religion.

Phy9: No time to build a relationship with the patient before discussing the subject.

Phy10: Cultural and trust issues. Different religious backgrounds.

Phy11: Language. Not knowing about the different religious groups.

Phy12: Time and religious training. There is no ethical dilemma in discussing spiritual issues with patient.

Phy13: Time and different religious and spiritual backgrounds.

Phy14: Time. Workload. Acuity of the disease.

3.4.4. What are the functions of a hospital chaplain?

Phy1: After hour calls. Provide support to families. I always ask families permission. I have never had a family or patient say “no.”

Phy2: Similar to social worker but with more of a religious slant. Grief and death counselling.

Phy3: Supports patient from a spiritual point of view.

Phy4: Spiritual and emotional support.

Phy5: Counsel patients in time of spiritual or emotional needs. All things that medicine doesn’t help with. Debriefing staff.

Phy6: Counsel and support.

Phy7: Meet patient’s pastoral needs. Help advise doctors on how to approach patient’s spiritual side.

Phy8: Spiritual support and guidance. Physicians don’t always have enough emotional empathy and energy and time to offer this type of support.

Phy9: Provide counselling and spiritual support for patients and families within the hospital environment.

Phy10: To give support on a spiritual level to patient and family member.

Phy11: Spiritual guidance. Help with bereavement. Help give bad news to patients and family.

Phy12: Religious counselling. Help to break bad news to patients and to provide moral support to patients and staff.

Phy13: Help patients deal with bad news by motivating them spiritually and giving them hope with stories that happened in the past.

Phy14: Part of quality of care. Trained to take a spiritual history and help with spiritual needs of patients.

3.4.5. Do you have any further suggestions as to the medical-chaplain working relationship?

Phy1: I would like to see that all the trauma staff is debriefed every 6 months. To become involved in the ICU wards.

Phy2: Never worked with a chaplain before, but does add to the level of care. Perhaps clear guidelines can be drawn up so that we know exactly what type of patients to send.

Phy3: No Answer

Phy4: Regular feedback to ensure quality of care.

Phy5: Perhaps better awareness of the chaplain for new doctors. Introduce what the chaplain does with every new doctor that starts at the beginning of the year.

Phy6: Openness

Phy7: Hospitals to have a chapel for patients and families.

Phy8: Work with a physician that understands and supports spiritual issues. Regular communication between physician and chaplain that would compliment treatment plans. Build a solid and trusting relationship between physician and chaplain.

Phy9: No answer.

Phy10: No answer.

Phy11: Have a chapel.

Phy12: Regular communication with the doctor.

Phy13: Make their functions known to the staff so that staff could access his services more efficiently.

Phy14: Should have a referral form with feedback components.

3.5. The South African Nurse

The typical health care nurse would study for a period of four years at either a university or specialised college. During their studies, they are required to complete a one year community service. After completion the student will receive either a diploma or degree in basic nursing. The student could continue

for an extra year at university or college level where they would gain further specialised training in a particular area. Nurses can then register their profession with the South African Nursing Counsel.

Thembi Mngomezulu, deputy director of the Democratic Nursing Organisation of South Africa (Denosa), the largest nursing union in the country, agrees that South African nurses, much like the doctors are generally frustrated with their pay, conditions of work and treatment (Nadioo 2000) and often seek employment outside of South African boarders. Table 4 exhibits the number of nurses that have redeployed oversees in 2009. South Africa over the past year or two has seen intense strikes by nursing personal over wage issues and other related matters. As previously revealed, nursing staff account for nearly half of the working staff for both Government (45 percent) and Private (61 percent) medical sectors.

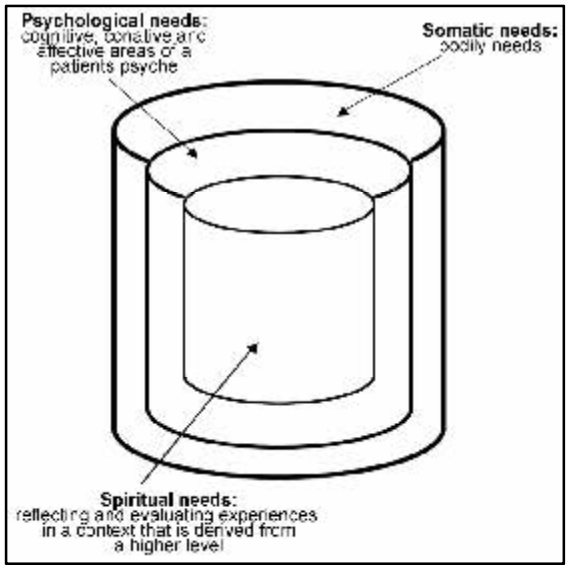
Nursing staff are on the frontline of health care. Out of all healthcare professionals, nurses spend majority of the time with their patients. Figure 37 displays the three dimensions that a nurse would deal with when providing care to a patient.

Table 4: Verification and Transcript Statistics – 2009 (SANC)[22]

Country	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**TOTAL**
Australia	71	-	-	-	-	-	-	-	-	-	-	-	**71**
Canada	12	-	-	-	-	-	-	-	-	-	-	-	**12**
Ireland	2	-	-	-	-	-	-	-	-	-	-	-	**2**
New Zealand	8	-	-	-	-	-	-	-	-	-	-	-	**8**
UK	10	-	-	-	-	-	-	-	-	-	-	-	**10**
U.S.A	3	-	-	-	-	-	-	-	-	-	-	-	**3**
Other	4	-	-	-	-	-	-	-	-	-	-	-	**4**
MONTH TOTALS	**110**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**110**

[22]The above figures indicate the number of persons who have requested that verifications of qualifications and / or transcripts of training be sent to the countries indicated only and NOTHING ELSE. It is specifically stated that nurses are not required to notify the Council if they do leave the country. The fact that a nurse has requested a verification be sent does not necessarily mean that she / he has taken up the offer of a position in another country.

Figure 37: Different dimension of patients needs.[23]



3.6 The Questionnaire Results

The questionnaire format follows suit with the previous questionnaires, through three sections: general questions, patients need questions and hospital chaplain questions. Vance (2001) states that the spiritual needs of patients in the United States are becoming a desirable goal for nursing care. However, she does suggest that little is still known regarding how nurses' own beliefs and experiences affect spiritual care giving. The objective is to understand how nursing staff consider the patient's spiritual needs.

Similar to the doctor and patient questionnaire, the nursing survey is comparable to each other, however for easy comparison purposes, a tabulated graph will be illustrated at the end of this section, displaying the patients, physicians and nurses' response to certain questions that are common on all three questionnaires.

[23] Juta's Manual of Nursing (2007:107).

3.6.1. General Questions

Seven broad questions define this section of the questionnaire.

Sample Description: N=18[24]

3.6.1.1. Male or Female?

Male **0**	Female **18**

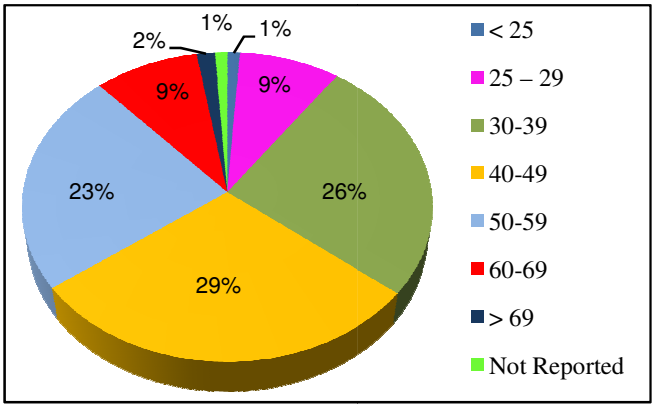
According to latest nursing statistics (SANC), there are presently 26,259 female nurses and 1,432 male nurses working in the Western Cape region. Currently the population for the Western Cape stands at 5,35,6900. This would mean a ratio of around 193 people to 1 nursing staff in the Western Cape. The current Western Cape gender balance is 18:1.

3.6.1.2. What age group do you belong in?

20-25 **1**	26-30 **2**	36-40 **3**
31-35 **2**	40+ **10**	

This study has revealed that 55.5 percent of nursing staff are over the age of 40 years. This seems to be on par with the current age distribution demographics of SANC (see figure 38) as 63 percent of nursing staff in South Africa are over the age of 40.

Figure 38: Age Distribution: All Nurses in South Africa (2009)[25]



[24] An estimate of 456 nursing staff is employed at both medical centres. An exact number could not be obtained when the study took place as the surveys were conducted over a period of months.

[25] www.sanc.co.za

3.6.1.3. What medical area are you practicing in?

Medical	**3**	Trauma	**4**	Other	**4**
Surgical	**4**	Paediatrics	**3**		

3.6.1.4. What faith group do you belong to?

Christian	**17**	Traditional	**0**	Eastern	**0**	Other	**0**
Muslim	**1**	African	**0**	Non-believer	**0**		

As with the physician's questionnaire, majority of the nursing staff are of a Christian faith background.

3.6.1.5. What denomination do you belong to?

NGK	**5**	Latter Rain	**1**	AGS	**1**	Independent	**3**
Methodist	**1**	Apostolic	**1**	Muslim	**1**	Anglican	**1**

No Answer **4**

3.6.1.6. Are you an active member of your religious church / mosque / institution?

Yes	**16**	No	**2**

3.6.1.7. What importance does your religion or spirituality have to other areas of life (e.g. personal values and behaviour)?

Irrelevant	**1**	Important	**15**
Some what	**0**	Uncertain	**0**

No Answer **2**

3.6.2. Patient Needs Questions

This section incorporates eight questions that seek to understand the nurse's view on meeting the patient's spiritual needs.

3.6.2.1. Do you as a nurse enquire about your patients religious or spiritual needs?

Yes **13**	No **3**

No Answer **2**

Why:

Need to know what religion the patient is in order to respect his/her view.
I believe that both physical and spiritual healing go together.
People recover quicker if they have made peace.
Unless the patient expresses the need to talk about it.
Sometimes.
To avoid confrontation.
To Muslim patients - so that their religious needs are met.
Out of respect for the patient.
Only on admission.
To find out what type of support is needed.
All needs of the patient need to be treated.

In the same study carried out by Vance (2001), she found that a number of reasons were offered to explain why nurses may omit identifying and addressing the patient's spiritual needs. Some of these are: (a) the belief that a patient's spirituality is private to the individual and is outside of the nursing role; (b) anxiety over distinguishing between the delivery of spiritual care and proselytising; (c) lack of education and training in meeting the patient's spiritual needs, especially if the nurse's spiritual beliefs and practices are different from those of the patient; (d) lack of time; (e) fear that problems will surface that the patient or nurse may not be able to cope with or confront; and (f) the nurse's lack of attention to her own spiritual self. It is of interest to note that this list is very comparable to that of the physicians (see chart 36).

3.6.2.2. Do you believe that the patient's faith can aid in their emotional and physical healing?

Yes **17**	No **0**	Unsure **0**

No Answer **1**

3.6.2.3. Do you think that it's appropriate or inappropriate for the patient to discuss their religious or spiritual needs with you?

Appropriate **14**	Inappropriate **2**

No Answer **2**

Why?

To answer questions they may have.
Sometimes they need to be uplifted and their faith is what keeps them going.
For treatment purposes.
It is part of total care.
Because if their needs aren't met it causes stress, which can be negative to their health.
It's the patient's choice.
Different beliefs can be conflicting.
Good for healing.
Their spirituality is just as important as their physical being.
Only if the patient wants to.
It depends on the patient.
For effective treatment, I need to know what religion they are.

3.6.2.4. Would you appreciate it if the patient talked to you as their nurse about their religious or spiritual needs?

Yes **16**	No **0**	Unsure **1**

No Answer **1**

3.6.2.5. Do you feel as a nurse there is any value in speaking with patients about their spiritual state?

Yes **16**	No **0**	Unsure **1**

No Answer **1**

Why:

They need to know the truth and know where they are going to.
There may be unresolved spiritual issues which can hamper recovery.
Especially with terminally ill patients.
Their spiritual life is just as important as their emotional and physical being.
It might make them feel better.
To uplift the patient.
Sometimes patient's need more then medicine.

3.6.2.6. Do you think patients would want you as a nurse to know about their religious or spiritual state?

Yes **6**	No **0**	Unsure **11**

No Answer **1**

3.6.2.7. Would you ever pray with your patient?

Yes **16**	No **1**	Unsure **1**

3.6.2.8. Do you think that it's appropriate or inappropriate for a nurse to pray with a patient?

Appropriate **16**	Inappropriate **0**

No Answer **2**

Why:

Patients sometimes ask you to pray with them, it also gives them a sense of comfort.
If our religions are the same.
It is up to the patient and sister but I would think if the patient wishes you to pray with them it can only reassure them if you do.
Depending on the patients need for prayer.
To uplift the patient.
We are Christians.
Unsure.
Power of prayer is unbelievable.
If the patient asks.
If the patient feels comfortable with it.
If the patient wanted me too.
Patient's are people like us and sometimes they need prayer.

3.6.3. Hospital Chaplain Questions

This section contains ten questions relating to the chaplain-nurse relationship.

3.6.3.1 Before practicing at your current hospital, have you ever worked with a hospital chaplain?

Yes **4**	No **14**

3.6.3.2. How would you define a hospital chaplain?

To help patients through difficult times.
Gives spiritual guidance.
Being there for the patients in a religious way.
Take care of patients spiritual needs.
He must be capable and spiritually equipped in helping patients and staff with problems.
A person you can talk to too express your feelings and get comfort.
A pastor.
Friendly, strong.
Help patients with their problems.
To provide spiritual and emotional support to the patient and staff.
Sometimes we are too busy to call the chaplain, so he makes ward rounds.
Someone who talks and prayers with patients.
He is employed to assist the spiritual needs of patient's, families and staff.

3.6.3.3. Are you aware of the functions of a hospital chaplain?

Yes **10**	No **2**	Some What **6**

3.6.3.4. Have you ever as a nurse referred to a hospital chaplain?

Yes **10**	No **6**

No Answer: **2**

3.6.3.5. When do you think it's appropriate to refer to a hospital chaplain?

Some of the nursing staff responses were:

When a patient needs spiritual guidance or counselling.
For Overdose patients.
Emotional patients or family.
When a patient is dealing with trauma, possible death and any emotional and spiritual needs.
Terminally ill patients.
Family support.
Deaths.
Stress.
As needed by the patient.
Nearing death.
Loneliness.

In a situation that you feel uncomfortable in (death).
If a patient has a problem.
For prayer.
Dying and sick patients.
Anytime.
When patients are depressed or when they need help with any emotional problem or when they need God.

3.6.3.6. Do you feel it is the doctor's responsibility to refer to a hospital chaplain?

Yes **3**	No **9**	Unsure **3**	Yes & No **2**

No Answer: **1**

3.6.3.7. If a hospital chaplain was made available to meet your patient's religious or spiritual needs, would you requests the services of the hospital chaplain?

Yes **17**	No **0**	Unsure **1**

3.6.3.8. Do you feel that it would be of value if the hospital had a counselling or prayer room (inter-faith) for patients and family use?

Yes **18**	No **0**

3.6.3.9. As a nurse, do you feel that it is important for the hospital to meet the patient's religious or spiritual needs?

Yes **16**	No **1**	Unsure **0**

No Answer: **1**

Some of the ways that the hospital could meet these needs are:

Give them an opportunity to speak to someone about their spiritual needs.
Making a prayer room available.
Allow church visitors and chaplains.
Provide a counselling room.
Prayer room.
Availability of bibles and religious books.

Through a chaplain as nurses don't have time to talk to patients.
Too prayer for patients and staff.
Having a chapel or prayer room. Having a chaplain on duty 24/7.

3.6.3.10. Would you appreciate it if some training / educational programme was established, for you to gain better insight into addressing the patients spiritual needs without being unethical?

Yes **14**	No **2**	Unsure **2**

Table 5 provides an easy layout description of respondents to central questions.

Table 5: Description of Respondents: Patients, Physicians & Nursing Staff

Descriptor	**Patients**		**Physicians**		**Nurses**	
Sample Size	*NO.*	*%*	*NO.*	*%*	*NO.*	*%*
Number of questionnaires distributed	130	--	15	--	20	--
Completed questionnaires	120	92.3	14	93.3	18	90
Gender						
Male	46	38.3%	9	64.2%	0	0%
Female	74	61.6	5	35.73	18	100
Age						
> 20	7	5.8%	0	0%	0	0%
20-30	19	15.8	8	57.1	3	16.6
31-40	11	9.1	6	42.8	5	27.7
41-50	18	15	0	0	10	55.5
51-60	15	12.5	0	0	0	0
60+	45	37.5	0	0	0	0
No Answer	5	4.1	0	0	0	0
What faith group do you belong to						
Christian	104	86.6%	14	100%	17	94.4%
Muslim	5	4.1	0	0	1	5.5
African Traditional	2	1.6	0	0	0	0
Non-believer	4	3.3	0	0	0	0
Other	2	1.6	0	0	0	0
No Answer	3	2.5	0	0	0	0

Religious Preference						
Dutch Reformed Church (NGK)	34	28.3%	5	35.7%	5	27.7%
Other Protestant	10	8.3	4	28.5	1	5.5
Anglican	12	10	1	7.1	1	5.5
Apostolic	4	3.3	1	7.1	1	5.5
Independent	16	13.3	2	14.2	3	16.6
7th Day Adventist	1	0.8	1	7.1	0	0
Muslim	2	1.6	0	0	1	5.5
AGS	4	3.3	0	0	1	5.5
Catholic	2	1.6	0	0	0	0
Spiritualist	2	1.6	0	0	0	0
Pinkster	4	3.3	0	0	0	0
Moravian	3	2.5	0	0	0	0
Church of England	1	0.8	0	0	0	0
Jehovah Witness	1	0.8	0	0	0	0
Zion	2	1.6	0	0	0	0
Other	0	0	0	0	1	5.5
No Answer	22	18.3	0	0	3	16.6
Active Religious Member						
Yes	80	66.6%	12	85.7%	16	88.8%
No	34	28.3	2	14.2	2	11.1
No Answer	6	5	0	0	0	0
Importance of spirituality to areas of life						
Important	87	72.5%	14	100%	15	83.3%
Some what	11	9.1	0	0	0	0
Irrelevant	4	3.3	0	0	1	5.5
Uncertain	13	10.8	0	0	0	0
No Answer	5	4.1	0	0	2	11.1
Faith can aid in emotional & physical healing						
Yes	105	87.5%	14	100%	17	94.4%
No	4	3.3	0	0	0	0
Uncertain	7	5.8	0	0	0	0
No Answer	4	3.3	0	0	1	5.5
Prayer with the patient						
Yes	77	64.1%	9	64.2%	16	88.8%
No	20	16.6	3	21.4	1	5.5
Uncertain	19	15.8	2	14.2	1	5.5

No Answer	4	3.3	0	0	0	0
Aware of the functions of a chaplain						
Yes	46	38.3%	5	35.7%	10	55.5%
No	44	36.6	1	7.1	2	11.1
Somewhat	19	15.8	8	57.1	6	33.3
No Answer	1	0.8	0	0	0	0
Is it important for the hospital to meet patients religious needs						
Yes	80	66.6%	12	85.7%	16	88.8%
No	18	15	1	7.1	1	5.5
Uncertain	16	13.3	1	7.1	0	0
No Answer	6	5	0	0	1	5.5
Value for hospital to have a chapel						
Yes	108	90%	14	100%	18	100%
No	6	5	0	0	0	0
No Answer	6	5	0	0	0	0
Make use of a chaplain to meet the needs of a patient						
Yes	91	75.8%	14	100%	17	94.4%
No	13	10.8	0	0	0	0
Uncertain	14	11.6	0	0	1	5.5
No Answer	2	1.6	0	0	0	0
How would you define a hospital chaplain (Main categories)						
Like a pastor that works in a church	8	6.6%	2	14.2%	1	5.5%
Works in the military / Navy / Police	16	13.3	0	0	0	0
Spiritual Counsellor	8	6.6	4	28.5	7	38.8
A visitor to patients	3	2.5	0	0	1	5.5
Pastor of the hospital	5	4.1	1	7.1	0	0

As revealed through the questionnaires, the majority of physicians and nursing staff agree that a patient's spiritual or religious belief is an important aspect to healthcare. Most agree that a patient's spiritual life is an important feature to the healing process and that through the services of a hospital chaplain the pressures and time constraints of medical staff could be alleviated. Furthermore they felt that the hospital has a vital role in meeting the spiritual

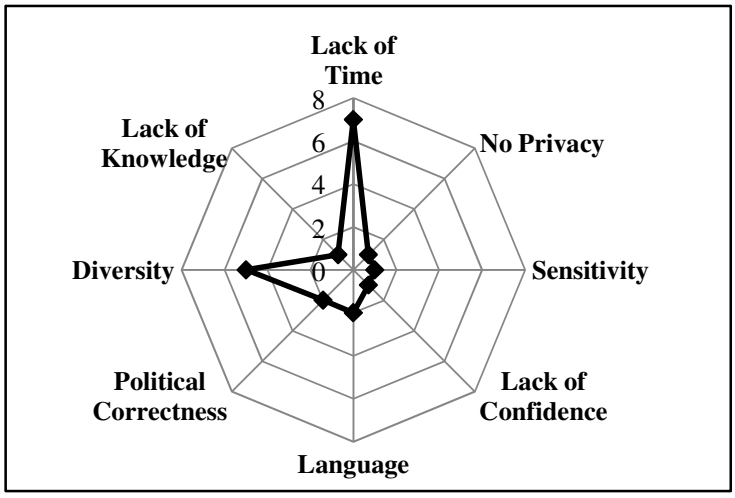
and religious needs of patients.

3.7. Barriers and Issues

Barriers are described as “something that stops people entering a place or making progress” (Waite & Hawker 2009:70). The latter part of the definition, “making progress” can be true to the physician-patient relationship if barriers exist. Although majority of the physicians and nursing staff agree that conferring with a patient about their religious needs is important, many have yet to engage the patient regarding this matter. With nearly every study being conducted in the field of healthcare and religion, the author will at some stage convey certain barriers that medical staff comes up against in conversing with a patient. So the question arises as to why physicians are so reluctant to enter into this sphere. Through a consortium of authors and the medical staff questionnaire, I will attempt to expose, clarify and analyse some of these barriers that the medical staff may face.

Figure 39 displays eight major barriers that were revealed by the questionnaire. It was noted that “lack of time” and “diversity” (culture and faith) accounted for more than 50 percent of all barriers mentioned.

Figure 39: Barriers to Addressing Spiritual Issues



Other studies have revealed similar barriers to the above chart. Authors Ellis et al (2004:1161) expounds that a physicians background could have an effect on whether the patient feels comfortable in raising any religious or spiritual concerns. With a strictly "medical approach" the patient will feel less likely to discuss any religious matters, however, if the patient feels that the physician has similar "life priorities" facilitation on spiritual discussions could occur. In addition, the physician's bedside manners and attitude have an impact on patient-physician spiritual discussions. It was found that the friendlier the physician is the greater chance that the patient would raise spiritual concerns.

Most scholars will be in agreement with what Daaleman (2004:370) writes that although religion and spirituality have become more visible within health care, there are still considerable ethical issues raised when physicians incorporate these (spiritual) dimensions into their care. Shastri (2008) affirms that in times gone by a patient's personal affair, such as religious belief, sexuality, and social affairs were not discussed with the physician. This is all in the past as now days on every admission the physician or nurse will obtain a brief patient history as this could impact the medical care being given to the patient. Shastri goes further to say that "not enquiring about such issues like religious beliefs may constitute a part of negligence on behalf of the clinicians" as he has to derive their clinical importance to the medical matter at hand.

So why should medical staff deal with religion when taking care of patients? In describing Foster, Lioy (2009) says that there are four reasons why physicians should heed to the religious needs of patients. Firstly, the medical team should not discount or disregard any religious views held by patients as this could be disastrous for the patient and the hospital. Secondly, patients often consign the physician as a role of a secular priest for the reason that patients and their loved ones desire the medical team do more than just technically sophisticated treatment. Third, illness can often prompt people to ask serious religious questions. This is important as some people believe that

physical, emotional and spiritual aspects of a person are interconnected, therefore healing in the emotional and spiritual realm are just as important. Lastly, a physician's own belief system can impinge on and influence the way he cares for a patient. Regardless of the differences, the foremost goal for the medical team is to "help the patient, not to win arguments." Koenig (2004:1197) deliberates the fact that the negative impact that religious struggles can have on health outcomes, treatment compliance and the effects of religious belief on medical decisions, give plenty reasons why doctors should know about their patients' religion and its effect on their medical care.

Like Ellis, Koenig (2004:1197) elucidates his ideas as to why physicians do not embrace spiritual discussions with their patients. He says that many physicians are unaware of the research being conducted regarding the role of spirituality in patient care. A second contributing factor is the lack of training and knowledge in taking a "spiritual history" of a patient. Very few medical schools train their doctors in taking a "spiritual history." The confidence factor can be overcome with adequate training and experience. Concerning time, there will always be pressure on the physician. It seems that many medical institutions have the mindset of "time is money," in other words, more patients in less time.

3.7.1. Overcoming Barriers

Not all scholars agree that spiritual beliefs of a patient are important in health care. In an article, *'Religion and Medicine: Why faith should not be mixed with science,'* author Sloan and VandeCreek (2000) outline rationale that challenge the pro-spiritual healthcare relationship. They say that there is not sufficient scientific data that discloses a link between religious activities and a healthier lifestyle. Furthermore they say that "if there are benefits, there may be an enormous difference between attending church on your own and attending because a physician recommends that you do so." As we generally accept our physicians' professional authority and expertise spiritual bullying could occur if

physicians start inquiring about the spiritual needs of patients. What are patients supposed to think if the doctor advises them to pray more or start attending church? Additionally many physicians have no expertise in spiritual matters and when physicians cross over to the realm of clerics; this abuses the physician's authority. They close by saying that this is "not what medicine is about. Nor is it what religion is about."

So how do we overcome these barriers? Most scholars agree that education is the key to unlocking this debate. By learning a simple spiritual measurement tool, medical staff can broach ethical ways in speaking to patients about their beliefs and chaplains will be capable of summarising the patient's spiritual belief system.

3.8. Spiritual Measurement Tools

Koenig (2004:1199) strongly argues that the primary role of the physician is to ask the questions, become aware of the issues that might affect medical care, and mobilise the resources necessary to address them. If spiritual issues are present, then trained experts (i.e. chaplains) need to be brought in, just as a neurologist would be consulted for neurological problems. Using a brief spiritual measurement tool does not have to be complicated. Much like other medical evaluation forms out there, a spiritual measurement tool is a simple way of underlining any possible spiritual or religious concerns that may impinge on patient care. The initiative behind assessment tools is to provide a method of identifying spiritual resources that can be used in patient treatment. LaRocca-Pitts (2004) feels that all patients should be spiritually screened in order to determine if a spiritual intervention is needed.

Before one can clarify what spiritual measurement tools are, clear definitions need to be established between spiritual screening, spiritual history and spiritual assessment. LaRocca-Pitts (2009:8) donates the following definitions:

- *A spiritual screen* is the shortest and generally uses one or two static questions aimed at determining the patient's faith affiliation and whether the patient has special religious and/or cultural needs. A spiritual screen obtains information that rarely changes in the course of a patient's admission. Generally, a clerk during registration performs the spiritual screen.
- *A spiritual history* is more involved than a screen. Its questions engage the dynamics of the patient's faith or spiritual experience identifying specific ways in which a patient's religious or spiritual life, both past and present, impact the patient's medical care. A spiritual history may need to be performed more than once during a single hospitalisation and periodically during the progression of a disease. A physician, nurse, social worker or chaplain can take a spiritual history.
- *A spiritual assessment* is an in-depth look at the patient's spiritual makeup with the goal of identifying potential areas of spiritual concern and determining an appropriate treatment plan. This assessment is normally carried out by the chaplain.

For any spiritual measurement tool to be effective, clear components are to be displayed, such as establishment of a safe environment, clear information, and the simpler the tool the 'better' the tool. Academics concur that spiritual screening should at least include the patient's faith tradition (if any), whether the patient has a support system to help address his spiritual needs, and whether the patient's faith tradition or spiritual pursuits dictate special requirements such as diet, prohibited medical treatments, or other cultural considerations.

In the next few sections the researcher explains three spiritual history screening tools, two spiritual assessment models and a model that the researcher has developed as a hospital chaplain working in the Helderberg Basin. Each model will be demonstrated with a real incident

case study that the researcher has experienced. All names have been changed in order to provide full confidentiality.

3.8.1. History Screening Models

History screening models, which are generally conducted by medical staff, is a sufficient way to carry out spiritual reviews in patients. Screening models are simple, convenient and easy to use therefore very little training is required. Each of the HOPE, FICA, and FACT *spiritual history screening* make use of an acronym.

3.8.1.1. The HOPE Model

Case Study 1: Jane

> Jane, a 43-year old homeless woman was admitted into hospital after collapsing on the street. Medical history revealed that Jane is a frequent sufferer of fits, yet the patient cannot recall ever having a fit. When asked how she feels about being hospitalised, Jane became quiet. The nursing staff informed me that Jane was somewhat reluctant to be discharged into the care of her extended family. Upon further searching, Jane informed me that she finds her strength and comfort in her faith and often prays when times get hard. No direct reason was obtained as to the reason Jane felt uncomfortable to be cared for by her extended family.

Originated by Anandarajah & Hight, (2001), this easy model is widely recognized and used by many medical personal.

H: Sources of **h**ope, meaning, comfort, strength, peace, love and connection.
O: **O**rganized religion.
P: **P**ersonal spirituality and practices.
E: **E**ffects on medical care and end-of-life issues.

McCormick (2009) suggests that the HOPE questions is a nonthreatening model as it begins with open ended questions related to one's support systems without immediately focusing on the word "spirituality" or "religion.

With each letter, the caregiver can originate any question relating to the letters meaning. For example: **H** - "What do you hold on to during difficult times?" "What sustains you and keeps you going during this difficult time?" **O** – "Do you belong to any particular religious community?" "How important is that for you?" **P** – "What aspects of your spiritual practices do you find most helpful to you?" **E** – "Has being sick affected your ability to do the things that usually help you spiritually?"

Jane seems reluctant to discuss reasons why she does not want to be in the care of her extended family. During difficult times, she holds onto her faith through prayer **(H)**. Jane gave no indication that she belonged to any religious group **(O)**. Prayer was mentioned as a personal spiritual practice **(P)**. Jane says that she continues to pray despite her circumstances **(E)**.

3.8.1.2. The FICA Model

Case Study 2: Thandi

17-year old Thandi admitted to hospital after ingesting an unknown amount of tablets. In discussion with her, Thandi revealed that the tablets belonged to her mother. Thandi revealed that she was not doing well at school and got into an argument with her mother. Thandi is repeating grade 10. When asked how things are at home, she quietly responds fine. Thandi lives with her mother and 2 older brothers. She says that she doesn't know the reason as to why she is doing badly in her schoolwork. When asked what gives her meaning in life, she says that her future studies as a designer keeps her motivated. After further exploration Thandi admits to belonging to a Methodist church group. When asked if she felt letdown by God, she replies yes. She later confesses that she doesn't really go to church anymore because she feels far away from God and that she doesn't understand why God doesn't help her. Thandi informed me that she has a few close friends, but is now worried as she thinks the kids at school will tease her for drinking the tablets. After discussing therapeutic matters and ways in which we can assist her, prayer was provided to Thandi.

Designed by Puchalski and Romer (2000), this four letter acronym is used in the following manner:

F: **F**aith, Belief, Meaning.
I: **I**mportance or **I**nfluence of religious and spiritual beliefs and practices
C: **C**ommunity connections.
A: **A**ddress/**A**ction in the context of medical care.

F - "What do you believe in that gives meaning to your life?" **I** - "Do you consider yourself to be a religious or spiritual person?" **C** - "How important is your faith (or religion or spirituality) to you?" **A** - "How can we assist you in your spiritual care?"

Thandi is suffering emotionally and spiritually. According to Thandi she finds meaning in her life by looking at her future plans as a designer **(F)**. However Thandi has poor insight into dealing with her school problems. Thandi admits to belonging to a spiritual church **(C)** but seldom attends **(I)**. A Xhosa pastor will connect with Thandi upon discharge for follow up **(A)**.

Although this model was designed for medical staff to complete within a few minutes, it allows the staff to come away with a rich deposit of information that is non-confrontational.

3.8.1.3. The FACT Model

Case Study 3: John

> John is an unmarried 47 year old Caucasian male that was hospitalised for a few weeks following an accident at home which left him with suspected parlays in his legs while cutting parts of a tree that had blown over. After being in the ICU for a few days, John was transferred to a general ward. I had known about John, yet was never able to connect with him while in the ICU. While John was physically “improving” (some sensation had returned to his legs), he often stated that the doctors were optimistic that within 6 months to 1 year he would be able to walk again.
> John is a carpenter by trade who has his own business and apprehensive to return to work. John made mention of his only older brother as family member. Throughout the conversation he said that his brother would be the one that wouldn’t be able to handle the situation if the accident happened to him. John gave no indication as to outside help when he is discharged, as he often repeated that doctors were optimistic that he would be able to walk

again, so he would be okay. No mention of any spiritual support group or extended family.

LaRocca-Pitts (2008) designed this simple method to screen a patient's spiritual history story.

F – **F**aith (or Beliefs).
A – **A**ctive (or **A**vailable, **A**ccessible, **A**pplicable.
C – **C**oping (or **C**omfort); **C**onflicts (or **C**oncerns).
T – **T**reatment plan

F - Do you consider yourself a person of faith or a spiritual person? **A** - Are you currently Active in your faith community? **C** - How are you coping with your medical situation? **T** – Evaluate patient's coping skills.

John often mentioned his carpentry skills were very important to him. As an unmarried man with no children, fulfilment was found in his work **(F)**. There was no mention of any faith or spiritual belonging **(A)**. John's coping mechanisms seem to stem from the positive regard that doctors have over his ability to walk again in a year's time **(C)**. This could be a way John disguises his true feelings of being 'paralysed.' With regards to a treatment plan, further discussion with John needs to take place to explore his feelings if he were not able to walk again, how would he cope? **(T)**.

LaRocca-Pitts (2009:13) insist that FACT is not solely a typical spiritual history model obtaining only information, rather "FACT asks the clinician to make an assessment upon which the clinician provides an intervention."

The next two models are more complex which are by and large completed by a chaplain or pastoral caregiver.

3.8.2. Spiritual Assessment Models

Due to the complexity of assessment models, completion is usually

carried out by professional pastoral caregivers.[26] Two complex *spiritual assessment* models, the 7 x 7 and The Conversational Assessment tool will be discussed.

3.8.2.1. The Conversational Assessment Model

Case Study 4:

> Mary is anxious about surgery on Wednesday and requested a chaplain visit. 40-year old Mary sustained injuries of 2nd degree burns over 65% of her upper torso and facial area. Her injuries were caused after her garment caught alight while cooking. Discomfort, some anxiety and loneliness were present. She lives with her boyfriend, as currently Mary is in divorce procedures. Her immediate family live outside of town. When asked about her support systems, Mary said that she finds peace through prayer and attending church. Mary expressed that she believes God has a purpose in all that has happened. Mary has on occasions experienced God's provision first handedly. Mary often finds her calling in helping others. Apart from prayer, Mary likes to escape by reading.

Lewis' (2002) Conversational Assessment model has its influence by Pruyser's (1976) Spiritual Care Gates. In *The Minister as Diagnostician*, clinical psychologist Pruyser (1976), with an interest in pastoral psychology, describes his experience with pastoral caregivers,

> "These pastors all too often used our physiological language, and frequently the worst selection from it - stultified words such as *depression, paranoid, hysterical*. When used to conceptualise their observations in their own language, using their own theological concepts and symbols, and to conduct the interviews in full awareness of the pastoral office and church setting, they fell greatly at sea…. when clients clearly sought pastoral answers to questions of conscience or correct belief, the pastors tended either to ignore these questions or to translate them quickly into physiological or social - interactional subtleties."

[26] It is of the researcher's opinion that chaplains should be qualified pastoral caregivers with relevant hospital experience. Further exploration on the education of hospital chaplains will take place in chapter four.

The Conversational Assessment model tries to alleviate Pruyser's ideology of theological assessments. This model has four levels which the chaplain-patient conversation will enter into. The first level is the actual establishment of report and dialogue between chaplain and patient. As chaplains sometimes enter into the patient's world uninvited, their function is to facilitate rather than disrupt the interpersonal process of pastoral care.

During conversation, the chaplain assesses three things: the immediate crisis, the patient's connection to a spiritual resource and theological care gates. The patient's immediate crisis can be seen in five distinct categories: *Disruption* (disruptive patterns to normal life), *Discomfort* (physical pain), *Disfigurement* (the loss, or anticipated loss, of body image through scarring, burns, chemotherapy etc.), *Disability* (serious change in lifestyle through loss, or anticipated loss), and *Death Concerns* (anticipation of imminent death).

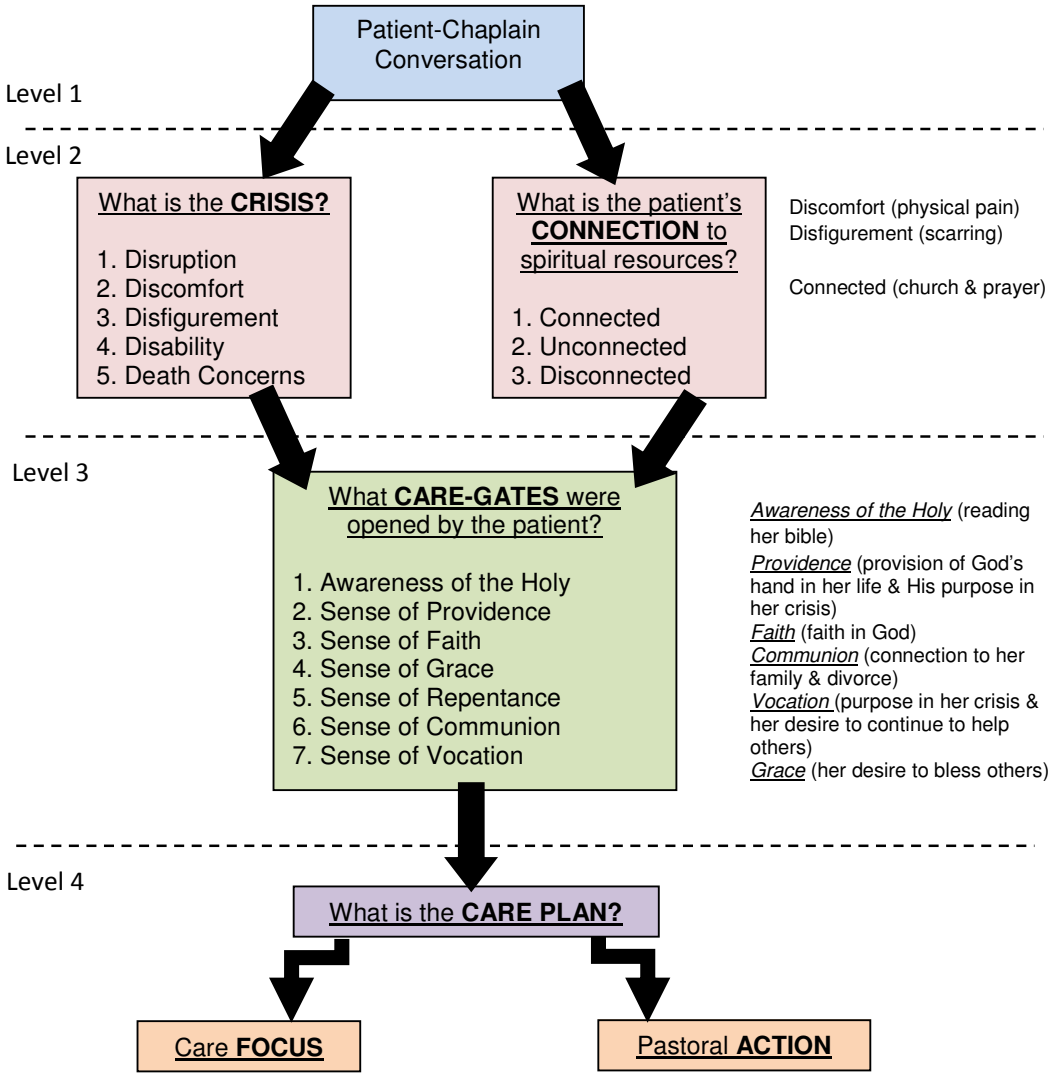
Three categories define the connection to a spiritual resource: Connected, Unconnected and Disconnected. *Connected* patients are obtaining some source of spiritual support, either through relationships, belief systems or religious communities. Pastoral care may still be required even though a patient is connected spiritually as patients may still struggle with changes in their beliefs or relationships while trying to maintain a connectedness. *Unconnected* patients have never associated with any religious community or live by any belief system. In *disconnected* patients there has been some spiritual support system in the past but for reasons this system has broken down or never internalised (Lewis 2002:7-11).

Pruyser (1976:60-77) offers a series of pastoral diagnostic elements that can help caregivers listen for theological themes. These seven theological diagnostic categories or care gates provide an intentional framework for understanding the patient's theological experience. The following descriptions underline these seven themes:

1. *Awareness of the Holy* ~ Does the patient disclose an experience of awe, bliss, or reverential fear in relation to God or any object he or she invests with ultimate concern.
2. *Sense of Providence* ~ Does the patient express an awareness of God's immanent involvement and benevolent activity in the world and in individual lives?
3. *Sense of Faith* ~ Does the patient disclose a sense of trust and openness toward God and others?
4. *Sense of Grace* ~ Does the patient express a sense of gratefulness, an awareness of having been blessed, or a desire to bless others?
5. *Sense of Repentance* ~ Does the patient indicate an experience of change or recognize a need for change in attitude, behaviour, and relationships?
6. *Sense of Communion* ~ Does the patient indicate a vital interpersonal relationship with God and with others – positive or negative?
7. *Sense of Vocation* ~ Does the patient disclose a sense of being called, a purpose in life, or a desire to contribute towards something beyond self?

The important element in any assessment is active listening. Very few times will a patient openly state a spiritual theme or struggle. It is the skill of the chaplain to identify the theological theme behind the story that the patient is telling. Once the care gate has been identified, the chaplain must determine the care plan. In the care plan, two elements are decided, the care focus and the pastoral action. Here the chaplain will choose to *focus* on either a spiritual strength or a spiritual struggle in the patient's life. After this the chaplain will settle on a *pastoral plan* or task to help aid the patient's spiritual dilemma. The entire process will look similar to figure 40.

Figure 40: Conversational Assessment Flow



Generally, spiritual assessments are more time consuming and complex than spiritual history or screening tools. For the Conversational Assessment model, it would be recommended that some training be required to eliminate any theological misconception due to the use of the theological jargon in the care gates. Nevertheless it must be noted that this model does not attempt to measure or quantify spirituality, religiosity, or spiritual injury, but rather offer a natural flow of dialogue when appropriately used.

3.8.2.2. The 7 x 7 Assessment Model

Case Study 5: Jane

> Jane's husband, Paul was to undergo surgery that morning. During preoperative procedures, complications occurred. Medical staff informed the family in the waiting room of the incident. The family being worried asked for chaplain support. Upon arrival to the waiting room, Paul's only child, Sue, her husband and family friends had already gathered. Jane informs the chaplain of the incident and why Paul originally came to hospital (dentistry surgery). Hospital staff were informed that Sue was close to nine months pregnant for safety reasons. Jane expressed that they have been married close to 35 years. Her concern was that he would not be able to see his granddaughter. Jane narrated how the two of them met at the age of 16. When asked how they are feeling, Jane tearfully said that she regrets so much. Upon further deliberation, she says that neither her nor Paul graduated college, due to financial and social reasons and now it feels that Sue is living the life that she wanted. During the conversation Jane often commented that their apprehension grew as time marched on. She asked the chaplain to pray with them and said that their pastor's wife will be arriving shortly for on-going support.

The 7 x 7 assessment model, established in the mid-eighties is well known amongst pastoral caregivers. I believe that the 7 x 7 model is one of the most thorough but complex models out there. Originated by George Fitchett (2002:40) he describes the process of this model based on six aspects:

1. Functionality: Focuses more on how a person makes meaning in his life rather than on what that meaning is.
2. Whole person assessment: Influences of culture, family, personality and health.
3. Religious multidimensional approach: Identifying practices, beliefs, experiences and change.
4. Method of gathering information: It allows for a natural flow of patient-caregiver conversation, whereby information can be formalised afterwards.
5. Framework: Creates a framework where information can be organised rather than recreating a new spiritual assessment tool.

6. Conceptually sound: To develop a sound model that in comprehensive, applicable and conceptual.

The entire model is divided up into two dimensions; Holistic and Spiritual, each consisting of seven subdivisions, hence the name 7 x 7. Table 6 defines each dimension.

Table 6: 7 x 7 Assessment model

Holistic Assessment	
Dimension	*Description*
Medical Dimension	What treatment is the patient receiving?
Psychological Dimension	Psychological history, personality traits, general approach to life.
Family Systems Dimension	Immediate and extended family relationships.
Psycho-Social Dimension	History of the patient's past and present life.
Ethnic and Cultural Dimension	What cultural influences are there?
Social Issues Dimension	Is the crisis compounding by larger social problems?
Spiritual Dimension	

Spiritual Assessment	
Dimension	*Description*
Beliefs and Meaning	Meaning and purpose in life.
Vocation and Obligations	The patient's calling in life and current problems viewed as sacrifices to the patient's sense of calling.
Experience and Emotions	Any encounters with the Divine or demonic?
Courage and Growth	Engaging possible new beliefs and ideas.
Rituals and Practice	What spiritual rituals or practices are associated with the patient's belief and meaning in life?
Community	The patient part of a larger community system?
Authority and Guidance	What authority does the patient give to the caregiver, himself and any another source?

By employing the 7 x 7 model in case study 5, the spiritual assessment of Jane could be described as:

> Jane was identified as the "patient." She is rightly concerned about her husband's condition. They were married as young sweethearts,

over 35 years ago. They only have one child who is eight months pregnant. Jane is struggling with her calling and vocation in life as she seems to identify her life through her daughter. Social issues have prevented Jane and Paul to live a "full life." Although Paul's illness may be short-lived, Jane expresses concern that Paul would not be alive to see his granddaughter (no future story). Jane's strength is clearly displayed through prayer. Authority was given to the chaplain as he led them in prayer. The family's pastor's wife will continue to provide spiritual care.

The strengths of the 7 x 7 model are in the diversity and flexibility of the assessment and its inclusiveness of all faith groups. This model can be used to summarise the patient's story into a single spiritual assessment, whether for an individual patient or in a group setting. The chief drawback to employing this model is the time-factor. A full assessment may take more time than a chaplain has in an acute setting, however the flexibility of the model allows the chaplain to use only key dimensions when necessary (Fitchett 2002:102).

The idea of spiritual assessments should not hamper the chaplain-patient conversation. It is not about visiting the patient with a clipboard armed with questions. Rather as Fitchett (2009:2) describes that spiritual assessments are not there to alter our use of open-ended pastoral conversations in which we respond sensitively and empathically to the needs and feelings of the person. Change has come about after the visit has happened. The 7 x 7 categories guide the chaplain into reflecting upon the patient conversation thereby charting a short spiritual summary.

3.9. A Chaplain Assessment Model

Identification to a spiritual assessment model is important to any pastoral caregiver as not all models will be relevant to the work environment. Therefore the model has to work within the environment that the caregiver finds himself. The researcher has found that the benefit of adapting various spiritual measurement models to suit the environment and criterion of patients is vital. A sample of this form can be observed in Appendix 3.

The assessment form is a combination of Charles Kollars (1997) Solution-Focused Pastoral Counselling approach, Pruyser's (1976) Conversational Assessment model and various psycho-social questionnaires. The model has been organised into six main categories namely; patient information, referral details, problem description, patient's strength and weaknesses, comments and pastoral plan. For *patient information* an attached patient sticker is required. The sticker will have their full name, birth date, address, contact number, and hospital reference number. In the *referral details,* a note of who referred the patient, date and time the patient was visited and which admissions ward the patient is in. Under *problem description* the reason for the patients' admission is charted, a brief medical description that is obtained from either staff or the patient's medical file and any other important information that will add to the care plan. *Strengths and weaknesses* have eight sub-categories: relationships (A), extended family (B), immediate family (C), emotional support (D), spiritual support (E), employment (F), emotional coping (G) and daily tasks (H). Each of these categories has an option to appraise the patient's level of commitment in order to determine if it is a strength or weakness. Additional comments are noted in the space provided. In relationships, the connection to either a partner or parent and whether that relationship is stable is noted. The current support that the patient receives from their family is noted in the extended and immediate family section. For emotional support the level of care that the patient is currently or will receive upon discharge is identified. Do they belong to a community group, medical support group etc? Spiritual support is recognising whether the patient belongs to a spiritual community and the level of involvement. The next category inquires about the patient's current employment or schooling. Under emotional coping, the patient's emotional response to the current situation is noted. How well are they coping with their illness or situation? This is important as it determines the emotional stability of the patient both in hospital and upon discharge. The last thing that we would want is to send the patient back into a situation that is damaging to their being. Daily tasks looks at the patient's functionality upon discharge. Will he be able to continue functioning in an

optimistic manner? Supplementary *comments*, observations and summary notes are completed under this section. If the patient would benefit from a follow up visit or if further evaluation from another professional is recommended, this will be noted of that as part of the *pastoral plan*.

So how does one go about developing a usable assessment model if current models are not suitable for their work environment? Fitchett (2002:99) directs our attention to five matters that one should take into account when choosing a particular model. The first aspect is the models *setting* in which it was designed for (church, hospital, palliative care institutions etc.). Is the model explicitly Christian? And can it only be used with individuals? The second matter is *form*. In which context is the model designed for – is it purely a pastoral conversation approach, a structured interview approach, a questionnaire and who needs to complete the assessment? Third is the clinical ministry *process*. This is the manner in which all patient information is gathered, interpreted by the caregiver, charted in the file, developing goals and care plan and then communicating all this to the relevant parties. The fourth element concerns how much theological or psychological *training* the caregiver would need to be efficient in? How technical is the model? The final aspect in choosing a model to your assessment needs is *time*. How much time does it take to complete the entire spiritual assessment, including the assessment summary?

The chaplain's approach to the pastoral plan for the patient is important. Kollar (1997) has been one of the main motivators in the pastoral care field that focuses on counselee's solutions rather than on their problems. He helps the patient visualise their situation without the problem and asks "how are you going to achieve this?" Kollar (1997:40) suggests that "the search for the root cause (to a patient's problem) often intensifies and maintains the problem." To a large degree I would support Kollar in his theory of solution-focused counselling. Focusing on the problem is a great way to gain information of the situation; however there can be a danger if the counselling process remains

there. There is nothing more deflating then for the patient to succumb to his "helpless" situation. Conversely there is nothing more heartening then for the patient to realise he holds the key to empowerment. By focussing on the patients strengths and abilities, allows the patient to reach a competency level of functioning. By directing the patient to aspects that are currently present in their life can help empower the patient to overcome his problem. Kollar believes that the greatest assumption to solution-focused counselling is that God has given each patient the ability to create solutions.

3.10. The Importance of Spiritual Assessments

In South Africa there are no regulations that implicitly state that chaplains, physicians or nursing staff have to obtain a spiritual assessment from patients. If that was the case, what would the benefits be to spiritual assessments or would this just create further paperwork for staff? Hodge (2005:1) elaborates that

> "assessments help to provide effective, culturally sensitive services while concurrently providing a forum to explore spiritual strengths that might be used to ameliorate problems or cope with difficulties."

Fitchett (2002:20) addresses this in his writings by outlining several advantages.

1. It provides a foundation for Action: Assessments help set and clarify goals for caregiver and patient.
2. It provides a foundation for Communication: It brings the caregiver and patient to the clearest possible description of the situation at hand.
3. It provides a foundation for Contracting: It allows the caregiver to seek further support from other hospital departments.
4. It provides a foundation for Evaluation: It provides the basis for knowing if the treatment plan has been successful or unsuccessful.
5. It provides a foundation for Accountability. It allows for personal accountability between caregiver and patient for treatment being given.

6. It provides a foundation for Quality: This permits quality assurance and accountability in the work carried out by the caregiver.
7. It provides a foundation for Research: This will allow pastoral caregivers to evaluate its fundamental theories and practices and not just rely on global tradition.
8. It provides a foundation for Identity: This tool is not just another measurement act, but rather the major tool used in our profession.

All things considered, spiritual assessments should not "impose a view, let alone a definition, of spirituality, but should seek to elicit the thoughts, memories and experiences that give coherence to a person's life" (Rumbold 2007:61).

3.11. Chapter Summary

Little doubt remains that physicians and nursing staff perceive the spiritual and religious needs of patients as an important facet to healthcare. Majority of medical staff agree that the hospital as an institution can play an important role in helping to alleviate spiritual distress in patients. By merely placing bibles next to each bed, inviting neighbouring church groups to visit with patients and having a chapel on the premises are all simple ways of sustaining the patient's spiritual life while in hospital.

Perhaps the debate is not so much whether physicians agree that spirituality plays a role in their patient's hospitalisation but rather as Curlin and Hall (2005:370) insinuate, the deliberation lies in the manner in which medical staff address any religious concerns. Through the use of a simple spiritual history screening tool, medical staff are able to ethically assess the patient's spiritual life and determine the importance of that aspect in their medical care.

By addressing the spiritual and religious dimensions in patient care, clinicians can be truly holistic and bring patients' wellbeing to the forefront.

Spiritual and or religious care that is ethical and sensitive is an invaluable part of total patient care (D'Souza 2007:58). If little doubt remains regarding the importance of the patient's spiritual wellbeing when hospitalised and the realisation that medical staff have insufficient time to address these needs, Chapter four will explore a possible solution to address this issue through the use of a hospital chaplain.

CHAPTER 4

The Hospital Chaplain as a Pastoral Caregiver

Chapter four focuses on the chaplain as a pastoral figure to the hospital. In this chapter the brief historical beginnings of chaplaincy ministry will be explored by taking a glimpse from a United Kingdom and United States perspective. The functions that the chaplain typically carries out by seeking to identify the role that the chaplain plays to patients and medical staff will be observed. The academia of the professional chaplain, his duties and challenges that surrounds the chaplain will be dealt with.

4.1. Brief History of Chaplaincy

There seems to be a definable lack of information about the history of chaplains in South Africa. Research reveals that the core emphasis of chaplaincy appears to stem from the United States and the United Kingdom, particularly amongst the Military faction. Despite the difficulty of historical information, most scholars agree that the word chaplain itself appears to be of Western European origin. The legend as most understand it is that of St. Martin of Tours. Upon seeing a beggar out in the cold, St Martin tore his military cape in half to share it with the man. The Catholic Encyclopedia denotes the following to St. Martin's capella;

> This was a short cloak preserved as a relic by the Kings of France. They carried it with them when they went to war and on the field enshrined it under a tent. This tent gradually received the name capella, and the custodians of the relic were thence called capellani.

Swift (2009:9) says that perhaps the absent writings on the history of chaplaincy may be a contributing factor in the crisis of contemporary chaplaincy, emphasizing the lack of a clear sense of identity and forward momentum. Due to the lack of South African chaplain history, I will highlight

some of the early developments of chaplaincy in the United Kingdom and United States.

Swift suggests that for a thousand years chaplains have been ministering in British hospitals (2009:9). It has been said that "the main purpose of hospital care was not to save lives but to allow the pious to exercise Christian charity through healing."[27] It seems form early historical accounts that the main impetus of hospitals were for the sick to have an opportunity to confess their sins before death. Bird writing in 'Medicine for Body and Soul,' provides us with a similar account that relates to soul treatment in early century hospitals as the first line of treatment for bodily illness was reconciliation with God, and spiritual healing and preparation for death by confession and enjoined penance preceded bed-rest and medical treatment (2001:109).

The early beginnings of hospital chaplaincy work in the United States can mainly be credited to the likes of Rev. Anton T. Boisen, Dr. Flanders Dunbar, Dr. William A. Bryan, and Dr. Richard C. Cabot. These professionals were instrumental in establishing the training programme called Clinical Pastoral Education (C.P.E). C.P.E will be further explored later in the chapter. In the United States, The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)[28] first addressed religion in hospitals in 1969. As this initiative grew, it was only in the Nineties that JCAHO reframed in their guidelines that it was the patient's right to be treated in having their spiritual and religious needs met. Over the years the Joint Commission revisited the way in which it stipulates that hospitals meet the spiritual needs of patients. Smaller institutions could make use of a 'clergy list' of volunteer ministers to visit with patients. Larger institutes could employ qualified chaplains who have graduated from an accredited Master of Divinity degree programme (Clarke and Clarke 2009:841-843).

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[27] Faye Getz as quoted in Swift (2003:9).

[28] This committee ensures the provision of safe quality care at healthcare organisations across the United States.

No matter what the historical beginnings were, Swift remarks that in the Canons of Lateran Council IV the task of medical doctors was 'to warn and persuade' the sick to see a priest before medical treatment begins, as sickness may sometimes be the result of sin, and if the priest can remove the 'cause' then the person will respond better to the bodily treatment. These instructions of the Council sit under the central truth of the times that 'the soul' is more precious than the body (2009:10). This statement bears truth to the connection of chaplaincy with the medical world.

4.2. The Nature and Role of the Hospital Chaplain

Foremost the clarification of a chaplain needs to be established. As noted in Chapter one, a hospital chaplain was seen originally as a priest or minister who had charge of a chapel. Today chaplains should rather be seen as a professional that works alongside other health care professionals. Emphasis cannot be made clearer that a hospital chaplain is not a medical professional, psychiatrist, psychologist, or social worker. He is a clergy person who has received extensive and intensive clinical pastoral training and has met certain competency standards in order to be certified as a professional hospital chaplain (Mack 2003:xi). The difference between chaplains and other clinicians is that chaplains are specialists in spiritual care; it is what they do, rather than part of what they do (Mohrmann 2008:4).

The fundamental task that the chaplain carries out is what Holst (2006:46) describes as:

> The attempt to help others, through words, acts, relationships, to experience as fully as possible the reality of God's presence and love in their lives" i.e. providing pastoral care.

Handzo (1996:45) reminds us that regardless of the patient's ethnic, religious, or cultural background, the chaplain can address these issues, both in terms of the common human experience and with an informed perspective on and reverence for the specifics of the patient's background.

Over the years, chaplaincy has been revolutionised from its original connotation as “a priest or minister who had charge of a chapel.” In today’s terminology a chaplain is “an ordained member of the clergy who is assigned to a special ministry.” Loewy and Loewy (2007:53) reasons that this role is not confined to any particular church or denomination, and that clergy may be appointed to serve in a variety of institutions and corporate bodies, such as prisons, hospitals, schools, and universities.

Perhaps the best scriptural depiction of the role that the chaplain plays in patient-care can be seen in 1 Corinthians 9:19-23;

> *“Even though I am free of the demands and expectations of everyone, I have voluntarily become a servant to any and all in order to reach a wide range of people: religious, nonreligious, meticulous moralists, loose-living immoralists, the defeated, the demoralized—whoever. I didn't take on their way of life. I kept my bearings in Christ—but I entered their world and tried to experience things from their point of view. I've become just about every sort of servant there is in my attempts to lead those I meet into a God-saved life. I did all this because of the Message. I didn't just want to talk about it; I wanted to be in on it” (The Message).*

The above scripture passage portrays an underlying truth to the chaplain’s role. While the main imputes for the chaplain is providing spiritual care, the manner varies in how this task is carried out. The phrase *“I have become all things to all men”* shows the need for the chaplain to have a flexible approach to patient-care and that one should not place the chaplain’s role as pastoral caregiver solely in a box. There will be many times when the chaplain has to extend the normal realm of pastoral care to minister to a patient or family member. As previously mentioned the chaplain’s mission has traditionally been to provide care to patients, their families and staff by focusing on the spiritual and emotional aspects of the patient, yet due to the expansion of the chaplain’s role in hospitals, this has led to their job description becoming blurred. These days, as Seelye (2009, chap. 8) conveys, “they help the doctors and nurses see issues that we may not have been aware of, or minimized, or turned a blind eye to, or just been too rushed to hear,” thereby forming a critical part of the

team. Chaplains if utilised correctly, can be more than just 'an ear for the lonely.'

From the patient questionnaire, the researcher encapsulated definite roles of a chaplain by examining the needs that the patients would want the chaplain to address (see question 2.7.4.7 in Chapter two). The researcher will outline some of the imagery and functions that identify a chaplain.

4.3. Common Imagery and Functions used to Identify Chaplains.

1) *Counsellor.* Psalm 73:24: "You guide me with your counsel, and afterward you will take me into glory." 33.3 percent of the surveyed patients requested the counsel of the chaplain. The Oxford Dictionary (Waite & Hawker 2009:203) defines a counsellor as "a person trained to give advice on personal or psychological problems." For that reason the chaplain's role as counsellor is to discover the nature of the patient's needs at that moment and then meet those needs, whatever those needs may be. Typically there are three types of counsel common among hospitalised patients. The first is spiritual counsel. Pruyser's spiritual care-gates outline seven categories that hospital patients may face. Others may need to be simply reminded of God's comfort through sacred scripture. Personal issues form the second type of counsel that may be required by the chaplain. Family dynamics have a major influence on the patient's well-being and hospitalisation. Family systems theory is an advantageous skill for the chaplain to acquire. Staff support is a vital aspect of the chaplain's responsibility. Staff work long hours and are constantly under pressure to perform. Sometimes they need someone unrelated to the situation who can listen without judgment. Lastly, ethical counselling may come to the forefront of the chaplain's visit as end-of-life issues are always present in a hospital environment. Normally the terms NFAM or NFAR[29] are used when in South African hospitals when discussing death and dying patients. This form of medical care (or the lack thereof) can be very disturbing for both patient and

[29] Not For Active Management and Not For Active Resus.

their family. Helping families come to terms with the fact that there is nothing further that medical intervention can do, is often a question of ethics and religious rights. The chaplain can play a counselling role by exploring the family's thoughts and reasons to their belief in addition to playing the middleman between family and physician. In the end it's the chaplain's prerogative to integrate the patient's body, mind, and spirit in the face of their illnesses, traumas, losses, and life transitions. The counsellor role is reflected by "general and ethical counselling" on the patient questionnaire.

2) *Religious Functionary.* 1 John 3:18: "Dear children, let us not love with words or tongue but with actions and in truth." In this role the chaplain makes spiritual resources available to the patient. Of the 120 patients, 69.1 percent asked for prayer or Religious Rites. It is this function that the chaplain in his role primarily focuses on providing expected religious services rather than on being a representative of God. Scripture reading, prayers, the Sacraments or memorial services are all ways of portraying the religious functionary role. Perhaps the chaplain's influence on patient-care should be seen as an opportunity to help, to love, and to serve those in need (Vanzant 2009:174). The religious functionary role is reflected by "prayer and religious rites" on the patient questionnaire.

3) *Comforter.* 2 Corinthians 1:3-4: "He comes alongside us when we go through hard times, and before you know it, he brings us alongside someone else who is going through hard times so that we can be there for that person just as God was there for us" (The Message). 13.3 percent of patients observed the chaplain as a source of comfort. In this role, the Chaplain helps the patients deal with their fears and anxieties resulting from their hospitalisation. Comforting a patient can take on many different forms from holding an elderly patient's hand, to reading the patient's favourite scriptural text. All forms of comfort are depicted by the situation the chaplain finds himself. Comfort can often extend to the patient's family. As with Case study 5, Jane although being the wife of the patient, was recognised as the "real patient" seeking comfort.

Such ministry is one of bringing comfort to the distressed by all means possible. It is therefore crucial that the chaplain understands and acknowledges the different theological beliefs of patients. Some see God as Divine Healer that removes all illnesses. Others see their illness as a curse for their unforgiven sin. While some may feel the blessing of illness as depicted by Paul through scripture. Yet others may view God as Comforter rather than focusing on a God that just provides through their hospitalisation. Whatever the beliefs, the chaplain is there to help provide comfort to the hospitalised patient. The comforter role is reflected by “comfort” on the patient questionnaire.

4) *Encourager.* Hebrews 3:13: “You must encourage one another each day. And you must keep on while there is still a time that can be called today” (Contemporary English Version). The role of the Chaplain in this particular ministry is that of an encourager. This role is often portrayed in the lives of overdose and suicidal patients. The role here is to help patients maintain their will to live by evaluating and encouraging effective coping mechanisms with and through support systems. This role provides the chaplain with an opportunity to share in the patients self-worth through Christ’s love, desire and plan for their lives by assisting patients to understand the things that are worth living for and the consequences of giving up too soon. Other patients experience the receiving of unpleasant news. A newly diagnosed illness. A life threatening illness. Another surgical procedure. All incidents that shake a patient’s previously safe world. Through these experiences the chaplain plays the encourager by offering words of support, a listening ear, or by providing a safe environment for the patient to share their anxieties without passing judgment. This purpose is reflected by “calm my anxiety” on the questionnaire, which accounted for 7.5 percent of patients.

5) *Ambassador.* The idea of the chaplain being an ambassador stems from 2 Corinthians 5:20, “We are therefore Christ's ambassadors, as though God were making his appeal through us.” As an ambassador for Christ, the Chaplain is a servant of God’s representation to the medical world. Often

through mere presence, the chaplain serves as a witness in times of crisis of God's love, concern and hope. Vanzant (2009:30) terms this as the ministry of presence where he elicits that one can do a world of good without saying a word. Trained chaplains are to be a witness and a presence and to let patients feel that they are not alone in their suffering. The chaplain may be the only represented Christ that the patient will encounter and they have the choice to either be a worthy ambassador or a poor ambassador.

6) *Professional.* Colossians 3:23: "Whatever you do, work at it with all your heart, as working for the Lord, not for men…" Most individuals still consider a chaplain to be a retired minister or someone who visits patients in their free time. Studies have shown that this cannot be further from the truth, yet this is what most of the Helderberg patients (and dare I say South Africa) express. It is the yearning of the researcher that a chaplain is seen as a professional in a professional environment. Thompson (2005:72) accredits this thought as hospital chaplains were often retired ministers with no special additional credentials. This has changed remarkably over the years. Expanded dialogue regarding the training and credentials of hospital chaplains will be discussed as a separate heading later in the chapter. Often the chaplain can be seen as an expert in certain areas that overlap between the medical and spiritual worlds such as grief and crisis counselling. Mandziuk (1994:376) maintains that chaplains can function as a business partner to physicians when making difficult (ethical) decisions. Discussion of the particular duties of the chaplain will take place at a later stage in this chapter.

7) *Partner.* Isaiah 41:10: "So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand." In the role of the partner, Veterans Affairs (1997:2) describe the chaplain as 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".

The underlying foundation of the chaplain's role is to be a compassionate partner to the patient and walk with them the road of their illness as a witness for Christ. 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 duties of the chaplain differ slightly to that of the functions. Duties can be seen as the manner in which the functions are carried out on a day-to-day basis. The following section will deal with the duties that the chaplain performs.

4.4. Duties of the Chaplain

In describing the *'Role of the Chaplain Today,'* Holst (2006:8-11) tells his readers that hospital chaplains experience two vastly different worlds - a medical world and a religious world. Throughout this research I have attempted to minimise the chasm that currently exists between the medical and religious world by identifying relevant data and historical facts that once revealed a close existing relationship. Nonetheless, Holst insinuates that the medical and religious world each have their own domain and demands, its assumptions and mission. Often these worlds complement each other, other times they are in conflict. Mohrmann (2008:5) offers the same idea as Holst, by asserting the fact that hospital chaplains are members of two professions. Firstly, chaplains are ordained as trained leaders by their own faith tradition and so are accountable to those faith group principles. Secondly, chaplains are also members of their professional registered body. Mohrmann continues "Hospital chaplains then have differing, and potentially conflicting, moral obligations entailed by their adherence to two relatively distinct professions." The question remains, how does the chaplain function within these two worlds? This can be answered by looking at certain duties that the chaplain fulfils.

How does one describe duty? Duty can be defined as "a task required as part of their work" (Waite & Hawker 2009:288). Many tasks or duties are

performed by the chaplain on a daily basis. It is worth noting that certain features will influence not only the duty but also the level of care that the hospital chaplain executes, namely the religious training and background that the chaplain received, the hospital context in which the chaplain ministers in and lastly the crisis situation that the chaplain is called upon. In spite of these variations, there will always be common responsibilities among hospital chaplains.

Four broad duties commonly exist as a chaplain.

1) *Confidant:* Being a confidant allows the patient to convey what it is like for them to be in hospital without any judgment (hopefully) being passed by the chaplain. This is what I call the 'middleman' ministry. The chaplain's presence is not as a medical staff member or a representative of the patient's family, but rather as a neutral person in the hospitalisation process. It is the chaplain's duty to create an environment that is emotionally and physically safe in which the patient can converse. This is an important duty for the minimisation of the patient being labelled by medical staff 'just as a diagnosis or bed number.' With time constraints being a barrier for medical personal, this task provides the patient with an opportunity to speak with the chaplain, so as to help eliminate loneliness and concerns. Loneliness is a massive factor for the patients of the Helderberg Basin. I find that the source of this stems from two reasons; financial constraints and the lack of transport and reliability of public transport.

2) *Educator:* Chaplain's from time to time play an educational role. Many times the patient and family do not always understand the medical implications that have been discussed by the doctor. Upon visiting with patients, the chaplain could ask them to reveal what they understand about the illness. This allows the chaplain to gain insight into their understanding of what is going on. It could be that when the patient or family repeat what the doctor has informed them, time and again they give an inaccurate account; this can be as a result of shock, educational levels, language barriers, or simply denial. All of these

elements can prevent the patient from understanding their prognosis which in turn can cause further emotional and spiritual distress. As an educator, chaplains should make sure that the patient has a level of understanding about their illness before being discharged or before the family returns home for the day. I believe there is power in information for when a patient understands their illness and prognosis, there becomes less anger or mistrust towards the hospital.

3) *Translator:* It may be that the chaplain help translate the signs and symptoms of imminent death for families sitting by the bedside. Again, the fact that time is an issue for doctors, allows chaplain's the opportunity to minister at the bedside of a dying patient. The hospital is not only a world of uncertainties but also a world that is vastly unfamiliar for many people. Numerous equipment. Different sounds and smells. Staff members coming in and out of the room. Tubes and cords being placed on a loved one. Bottles of fluid hanging above the bed all add to the emotional chaos of families. The chaplain as a translator will explain what is happening in the moment. What those machines do and how to read them. Why their loved one is breathing the way he is. Jacobs (2008:1) describes this process in a similar manner by suggesting that nurses and physicians know these things without having to think about them; the chaplain is often the one who observes what the family does not know, and who offers comfort by explaining what can be explained.

4) *Advocate of Diversity:* As advocate chaplains are there to meet the requests of all religious groups and not just what society terms as 'Christian.' With the diversity of religious groups in South Africa and the stance that government has of the 'right to religious freedom,' it is the responsibility of the chaplain to be self-informed of the various religious faiths. Chaplain's need to provide efficient spiritual care that does not intimidate or offend an individual. There will be times that as a Christian chaplain we are not be able or allowed to bestow spiritual care to patients of certain beliefs. It is then our role to be of resource to that patient or family by helping them in any other way (i.e. calling

upon religious leader from their own faith). Additionally, chaplains could be an advocate for a patient whose faith interferes with any medical procedure, such as Jehovah's Witness declining blood products or the religious practice of faith groups after a death has occurred. When this occurs, chaplains help the physician "understand" why the patient refuses medical intervention and ensure that the patient realises the decision that he is taking. If chaplains are able to assist in an advocate role, there will undoubtedly be a greater appreciation towards the staff as seen by the patient and his family.

4.4.1. Additional Functions

On a daily basis the following functions will be performed by a healthcare chaplain.

1. To assist families and staff when a patient dies.
2. To respond to CPR situations in support of family members that are present and to assist staff.
3. To identify Not For Active Management (NFAM) or Not For Active Resus (NFAR) situations in support family members and to assist staff.
4. To respond promptly to every request for a chaplain's visit,
5. To facilitate and coordinate the visits from clergy of faith traditions not represented by the hospital when requested.
6. To provide for sacramental ministries when requested or appropriate.
7. To provide for worship opportunities for patients, families and staff.
8. Critical Incident Stress Debriefing to staff.
9. Bioethics-End of Life Decisions.
10. To be a conduit for communication for the patient and family as to further information and
11. Educational functions due to multi-faith groups for the purpose of worship practises.

4.5. Chaplaincy Skills

In a classical sense the pastoral visitor's toolbox would contain many of the "traditional spiritual care tools" like prayer, scripture reading, religious rituals, presence, active listening, sustaining, and comforting. Yet when a visit takes place within a hospital, the traditional care tools in its own entity may not always be sufficient. Hospital visits add a certain dynamic to the chaplain's visit that may be outside of the traditional skills. La-Rocca-Pitts (2004:3) suggest that a chaplain would require some less traditional tools. Some of which are listed as follows:

- Knowledge of how illnesses could affect the emotional, social, psychological, and spiritual wholeness of the person.
- The ability to work on an interdisciplinary team with other healthcare professionals and the capability to communicate one's interventions effectively to this team, either through verbal or charting means.
- Familiarity with and sensitivity to the diversity of religious faiths and how each tradition responds differently to health issues, illness, and death (see table 7).
- Training in current bioethical issues and the skill to apply that training in a variety of patient-care situations.
- Awareness of and an ability to use psychosocial and behavioural models as they relate to illness responses and
- Comfort with one's self and an ability to move through one's own anxieties, preferences, and biases in order to meet patients where they are and journey with them toward their own understandings of wholeness and healing.

Taylor (1991:4) distinguishes that a skilled visitor *(or chaplain)* is adept in using the helping skills, theological assessment, and religious resources to communicate the gospel message in an ethical and non-threatening means. In other words, chaplains take the traditional pastoral skill to the next level.

However the chaplain must constantly be careful not to overstep the boundary from acting as pastoral caregiver to physician.

4.6. Challenges for Healthcare Chaplains

In spite of the illustrious progression of professional chaplains, many challenges lie await for the twenty-century hospital chaplain. Holst (2006:viii) suggests that

> "When the modern hospital was put together, and as denominational impetus gave way to governmental, purely profit-making, or pluralist community motivations, the chaplain was rarely programmed in… The hospital professionals generated their own practices and ideology and these worked to exclude the religious professional."

From Holst's point-of-view it would seem that the chaplain's role has become somewhat of a parenthesis ministry practice. Is this due to the lack of understanding the chaplain's role? Are chaplains a financial burden to the hospital administration? Are chaplains under qualified to offer their services? Or is it that spirituality and medicine should not overlap? These questions pose a vigorous debate from a pro and anti-chaplain perspective. This section will deal with these questions for it is the thesis objective to eradicate any negative conception of the chaplain's role in healthcare.

The researcher considers the challenges that chaplain's face to be defined into two groups. These two groups I call; self-challenges and outer-challenges. In self-challenges these are challenges that the chaplain faces internally. In other words challenges around his own identity as a pastoral caregiver, his background influence, his educational schooling etc. Outer-challenges are those surrounding challenges that the chaplain has little or no control over. Financial constraints, governmental policies, accreditation body and other healthcare disputes.

Holst (2006:13-26) advocates that four tensions exist for the chaplain when ministering in the two worlds of medicine and religion.[30] Building upon his unique impressions, I have divided his four tensions into my own two categories; self and outer challenges.

4.6.1. Self-Challenges

4.6.1.1. The Formal Training Challenge

The formal training that a chaplain receives can bring tension to a chaplain. The Clinical Pastoral Education movement in the early nineteen hundreds led to a dramatic shaping of pastoral care training. The inspiration behind the establishment of C.P.E was to effectively train pastors in caring for the ill by getting them out of the theological classrooms and into the hospital wards. With the influence of the psychology movement, C.P.E borrowed many of the psychology ideas and incorporated them into their practice and training.
Chaplains are products of recognised faith tradition: they graduate from seminaries, they become ordained, and they are required to document their relationship to a recognised faith tradition as one of the requirements for chaplaincy certification. However, as De Vries, Berlinger and Cadge (2008:12) indicate that once certification has taken place, many chaplains are called on to be "multi-faith" in their approach to pastoral care. With the government's policy of "freedom of religion," chaplains need to be available to patients who reply "none," "other" or who have a different religious stance to their own. By deploying chaplains outside of the religious traditions in which they were trained further confuses their professional identity.

4.6.1.2. Pastoral Identity Challenge

With the illustrious advancement of spiritual care in medicine, the identity of the chaplain has subsequently changed. Russell (1997:1) maintains that a

[30] Training, influence of psychology, the hospital context and the relationship between medicine and religion act as Holst's four tensions.

retired minister or one with extra time who is willing or likes to visit with patients is not chaplaincy ministry. Today many hospital personnel still think that chaplaincy ministry is simply just visiting with patients. This is far from the mark. Professional chaplaincy is far more complex than 'just visiting the ill.' The chaplain is a health care professional that tends to the spiritual needs of all the patients; while the clergyperson is a religious leader who tends to the religious needs of his or her congregants.

Understanding the chaplain role that one fulfils as a pastoral caregiver will go a long way to forming a healthy identity. The hospital chaplain should not confuse his role as a spiritual caregiver to anything else. Loewy et al (2007, chaps 2-4) in a condemning article argues that healthcare needs to revisit the terms "chaplaincy," "healthcare professional," and "member of the healthcare team." Loewy's further suggests that United States chaplains are increasingly claiming that their profession should be seen as part of the medical healthcare team. His first argument against this notion is that chaplains are not and should not fall into the same category as other medical personal. Simply stated, chaplains are not physicians, social workers, physiotherapists, dieticians, nurses, occupational therapists, psychologists or psychiatrists. I subsequently agree with Loewy's statement in that chaplains are spiritual caregivers. The *Encyclopaedia Britannica* (2009) dates the concept of chaplaincy to the early centuries of the Christian church, and describes a chaplain as "originally a priest or minister who had charge of a chapel, now an ordained member of the clergy who is assigned to a special ministry."[31] The key terms being "clergy" and "ministry." Clergy is generally understood to mean "a body of ordained ministers," while Ministry is generally understood to mean "the office held by persons who are set apart by ecclesiastical authority to be ministers in the church or whose call to special vocational service in a church is afforded some measure of general recognition." Thus, no matter what additional specialised training chaplains receive, they need to remain members who are in good

[31] www.britannica.com/chaplain.

standing of a religious clergy, dedicated to a ministry that remains, in its essence, faith-based.

4.6.1.3. Age and Age Appropriateness Challenge

Although not be relevant to all, this challenge could surface for younger aged chaplains. “You’re too young to be a chaplain.” “I would never have guessed that you are a chaplain. How old are you?” could be just some of the comments youthful chaplains face. The study found that many people’s expectations of a chaplain were that of a retired minister that wore a religious collar. This is a challenge that has to be dealt with internally. In 1 Timothy 4 verse 12, author Paul writes about Timothy,

> *“Don't let anyone make fun of you, just because you are young. Set an example for other followers by what you say and do, as well as by your love, faith, and purity”* (Contemporary English Version).

Finding different techniques and approaches to accommodate the age factor are simple ways to eradicate this challenge.

4.6.1.4. The Self-Evangelist Challenge

This challenge, or as Kirkwood (2005a:89) calls, a temptation, happens when the caregiver becomes an evangelist at every bedside visit. The idea is to be assured that the patient is right with the Lord. Kirkwood suggests that this mentality has some theological and ethical blemishes for the reason that one is limiting the work of the Holy Spirit in the patient’s life. Without the Spirits working, all the talk in the world will not bring enlightenment unto the patient. Some patients are just not ready for the harvest at that particular time. One has to allow the prompting of the Spirit to guide the conversation. It has been shown that ‘bible-bashing’ can drive a wedge between the person and the church.

Ethically, the patient’s permission should be given to approach this subject. Many unconcealed factors may be in play regarding the patient’s illness and cognitive state of mind. The chaplain should earn the right to raise

spiritual matters, for uninvited spiritual delving is breaching privacy. Allow the work of the Spirit to open spiritual doors and don't place limitations on God to conform to our ideas.

4.6.2. Outer-Challenges

4.6.2.1. The Hospital Context Challenge

The hospital context that the chaplain works in bestows tension upon the ministry of the chaplain. Most chaplains have had some parish experience. Within the parish walls, ministry is relatively safe. One knows their congregation, the worship services are familiar, the same theology exists and the functions as pastor are clear. However all that was once familiar becomes foreign to a chaplain. Instead of congregational members, one is at bedsides ministering to patients that have different beliefs. Instead of sacred Scriptures, the chaplain familiarises himself with medical charts. And the close knit support from the loving parish members are replaced with busy medical personnel. The chaplain has no unilateral access to the patient. Physicians, nurses, physiotherapists, social workers, dieticians all have access to the same patient. As Holst describes; "the hospital chaplain is nobody's pastor and everybody's pastor" (2006:14) that is not of the hospital but considerably in the hospital.

4.6.2.2. The Influence of Psychology Challenge

Holst (2006:18) describes the influence of psychology as creating pressure upon the chaplain. Many scholars have felt that psychology has become the chaplain's theology. The discipline of psychology has been in the clinical world for many years, while theology has only been around for a brief period, thus pastors have sort help from the clinical world in order to 'fit in,' sometimes at the cost of the traditional pastoral role. Nevertheless the positive sway of psychology has allowed the chaplain to find common ground with other medical personnel with regards to a universal language. Given that medical staff don't necessarily identify with the theological language used by chaplains,

psychological language has provided a vocabulary that could be readily shared between the two. The idea is that chaplains seek to merge theological understanding with 'sociological and psychological' principles. This challenge will be discussed further in Chapter five.

4.6.2.3. The Medical and Religious Relationship Challenge

Holst (2006:22) describes the conflict that medicine and religion have on each other by contrasting biblical illustrations with today's medical outlook. While the Bible illustrates numerous scriptural passages concerning suffering, the main impetus of the Gospel is helping the sufferers to emotionally engage and transcend their suffering. Jesus did spend time healing the sick, although it must be said that His main emphasis was not on healing the suffering, but rather on sin itself. On a personal level, Jesus endured, submitted and transcended suffering. Holst notes that the early medical institutes "offered more spiritual comfort than they did physical relief" (2006:23). Once the establishment of multi-billion Rand medical institutes took effect, the goal posts of medical care were radically shifted. Illness had to be seen as more than just a spiritual reflection. Suffering was an enemy to be conquered, not endured. A bout of medical technology and arsenal exploded. Medicine began an aggressive attack upon illness – and ultimately "won". Many of the illnesses had been eliminated or prevented. Yet as with every decision made, there are always consequences. Holst tells that with the medical expansion, a wedge was veritably driven between religion and medicine - there was more focus on the causes of suffering than upon the sufferer. In the early nineteen hundreds chaplains battled to find their place in the medical field due to the advancement of medical cures. However, overtime old illnesses were replaced by new illnesses that became more and more difficult to treat, thus causing the medical field to rethink more holistically, thereby re-creating the chaplain role.

4.6.2.4. The Financial Challenge

The question of financial support for spiritual caregivers is a hotly debated topic. Many people have argued that the stipend of chaplains should be contributed by their parish and not the tax payer. For many hospital administrators their argument is that state and government should never provide financial support to anything representing religion - the separation of religion and state should be absolute. Through the conducted research it appears that those who are in support of this view have not yet acknowledged and understood the benefits that a chaplain brings to the medical institute.

The lingering dilemma could be seen as two-fold. Firstly, in a private sector, chaplaincy services would cost the medical institute financially. Hospital administrators argue that patients are not paying for spiritual care, so how can the hospital reclaim that cost given that chaplaincy is offered as a 'free service' to patients? The second quandary, related to the government sector, would cost the tax payer to fund the stipends of chaplains. In a paper presented to the National Health Services (NHS) of the United Kingdom, the National Secular Society (NSS), which is a rallying point for opposition to the religious resurgence in the United Kingdom, stipulated that chaplains cost the U.K tax payer £40million annually.[32] Their underlying message is simple; "a secular state should guarantee freedom of conscience, but eliminate religious privilege." Keith Porteous Wood, Executive Director of the NSS believes that churches and religious organisations should fund their own presence in hospitals. Their argument was substantiated that the amount paid out to chaplains would pay for around another 1,300 nurses or over 2,500 cleaning staff. Their belief is that if people were given the choice they would choose to have extra nurses or cleaners because frontline services are under pressure. It goes without saying that those who are pro-NHS payment are mainly chaplains. The Reverend Chris Swift, a former president of the College of Health Care Chaplains, said:

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[32] This article was sourced at www.secularism.org.uk/who-should-pay-for-hospital-chap.html.

> "The NSS report is based on erroneous and simplistic assumptions that do not delve into the real work that chaplains from all faiths carry out in the NHS on daily basis in often emotionally fraught situations."

Perhaps the complexity of the matter lies in the lack of measurement. De Vries et al (2008:12) state that unlike medical work where interventions can be tested, chaplaincy work is difficult to measure. Is quantity more important that quality? The idea that chaplains need to visit with a certain number of patients a day can be justified, however, how does one put a value to that care being provided? Can the care be effectively measured and if so would this provide an antidote to the financial debate? Conversely, I believe that the medical institute should contribute financially to the services of the chaplain; after all, the chaplain is providing a service, albeit a 'free service.' The weigh up lies in the outlook of significance – is finances more important than patient satisfaction?

Latest financial indicators suggest that the private medical institutes in South Africa have acquired a net profit of over 4 Billion Rand for the year 2009-2010. The Rev. George F. Handzo, vice president at the HealthCare Chaplaincy, a New York City organization that trains and places many chaplains articulates that chaplaincy is a non-revenue-producing service, and in the economics of modern health care, that's not a good place to be. Handzo adds that there is a lot of indirect contribution to the mission of a hospital, as well as to its margin: customer satisfaction, customer retention and goodwill in the community. He ends by saying that from a revenue standpoint, that's crucial.[33] Given these two arguments perhaps there is room for a balanced approach to ending this debate whereby church and state contribute to the services of chaplain care or as McClung et al (2006:149) suggests that some professional chaplains today are employed by organisations which provide clinically trained, board certified chaplains to a multitude of different institutions through contractual agreements.

[33] Hoffman J 2007. In The Trenches - The Hospital Chaplain; Offering Comfort to the Sick and Blessings to Their Healers. Online article.
www.query.nytimes.com/gst/fullpage.html?res=9F04EEDB1331F934A25754C0A9619C8B63.

4.6.2.5. The Cultural Challenge

Juta's Manual of Nursing (Young et al 2007:130) in South Africa defines this challenge of culture as "a shared set of norms, values, perceptions and social conventions that give cohesion to a group, race or community, enabling them to live together and function effectively and harmoniously." The difficult task that awaits the South African chaplain is the multi-cultural experience. This cultural challenge extends further than just religious beliefs. Language barriers and cross-cultural interaction are all part of the challenge, with the primary objective of not offending the patient or family member. Christian psychologist, Collins (2007:108) illustrates the cultural challenge as an iceberg (figure 41). Many of the cultural challenges lie beneath the surface. Collins suggests that "if we look only at the visible and ignore the invisible, there could be disastrous consequences…" Turner (2001:592), a Biomedical Ethicist, addresses the question of medical ethics in a multi-cultural society this way:

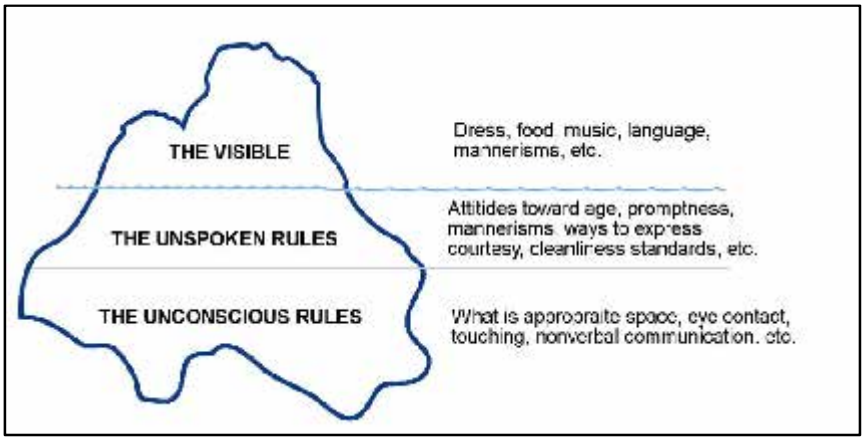
> Let us consider the position of a physician or nurse in London, New York, Sydney or Toronto, *(and South Africa)*[34], where patients come from diverse cultural and religious backgrounds. Some patients wish to receive detailed information about their diagnosis, prognosis, and treatment options. Other patients follow a different cultural script, expecting family members to make important health-related decisions and shield them from 'bad news'. Some patients, fearful that they will become captive to sophisticated medical technologies, prepare advance directives refusing various possible medical interventions. Others, perhaps because of deep religious belief, want 'everything done', and insist on cardiopulmonary resuscitation even in circumstances deemed medically futile by healthcare providers. Some families seek to practice their religious traditions by asking physicians to circumcise their male children - an act that other groups see as child abuse and a violation of human rights. Members of some right-to-die organizations insist that compassionate healthcare providers and legislators would permit physician-assisted suicide, whereas members of many Jewish, Muslim and Christian religious communities declare that legalization of physician-assisted suicide would seriously devalue human life. To contribute usefully to contemporary debates, ethicists need to better address the multiethnic, multi-faith character of contemporary social settings.

[34] Parenthesis mine.

They need to recognize the existence of a plurality of 'communities of interpretation' and 'local moral worlds'.

As noted in Turner's explanation, the South African chaplain, let alone healthcare worker, cannot escape the reality of embracing the cultural climate. Language can pose a challenge to the solely English speaking chaplain. As the study statistics have revealed the majority of the patients are Afrikaans speaking. Having a basic understanding of the Afrikaans language would go a long way to overcoming this challenge.

Figure 41: Cultural Iceberg



Appendix 4 has a transitory look at the more popular religious groups in South Africa, showing how their beliefs can have an effect on their medical care. It may seem that the different religious practices contain common elements, the details which define the religious practice, will certainly differ from one religion to another. Kirkwood (2005b:5) denotes that even within the same religious grouping, cultures may still differ. An English Christian, for instance, will have customs and beliefs that will differ from those of a Xhosa Christian. So, how do chaplains care for believers from other faith systems and also remain ethical to those they serve as well as to themselves? Zucker, Bradley and Taylor (2007:16-17) say that there are basically two types of professionally trained chaplains: monofaith and multifaith. Monofaith chaplains serve a shared immediate religious connection, religious language, broadly common religious

beliefs and a relatively shared denominational understanding of Divinity. Whilst the multifaith chaplain, cares for individuals who profess religions other than theirs and thus are expected to respect religious boundaries that are not their own. The crux of the matter lies in the fact that just because chaplains could do something, it does not mean that they should do it (2007:20). If chaplains are not "prepared" to minister to a patient of different beliefs, the principle of referral to another professional should take central stage.

4.6.2.6. The Negative Religious Affect Challenge

Flannelly et al (2004), Koenig (2004), Mueller et al (2001), Pargament (2001), Sloan et al (2000), and others have called attention to the negative ways that religion can affect mental and physical health. Although the overwhelming majority of conducted research has illuminated the positive influence that religion has on health, possible "flaws" could exist. Sloan et al (2000) advocates that there is little evidence that greater participation in religious activities would produce healthier individuals. Continuing, Sloan suggests that "On the whole, it is weak, with significant methodologic flaws, conflicting findings, and a lack of clarity and specificity" (2000, chap. 5).

The following imperfections exist. The first problem lies in passive coping styles, in which patients deny biomedical treatment for a higher power. Certain religious beliefs will denounce the use of medical care and products. For instance, the Jehovah's Witness belief not to accept blood products, the belief by adult Christian Scientists or members of the Orthodox Reformed church against taking antibiotics or receiving immunizations. A second problem is seen as feelings of abandonment. The patient may feel that God has abandoned them in their suffering despite His promises of never leaving or forsaking us. Abandonment by one's own faith community has also led to a negative effect on health. Thirdly, some patients may feel that God caused their suffering and so their belief is that personal problems reflect divine judgment or punishment. This often leads to feelings of anger and resentment towards God. Flannelly et

al (2004, chaps 11-12) continues by stating that these negative religious coping practices have left patients with depression, anxiety, poor rates of recovery and increased risk of death. Perhaps the systematic issue at hand is chronic religious doubting. Research has revealed two reasons why this may cause health problems. The first is that chronic doubters may lack an important source of existential certainty and clarity, which may increase vulnerability to stressful conditions and secondly they may feel guilt or embarrassment and consequently refrain from sharing their concerns with others. All of which could result in psychological distress and decline in physical health. Nevertheless, despite their opinions, most academics would agree that there is yet "no direct relation between religious involvement and psychopathology" (Mueller 2001:1230).

4.7. Day in the Life of a Chaplain

Many people have asked what a typical day is in the life of a chaplain. A Chaplain's day is never the same as the other. Described below is a typical day in the life of a chaplain:

08h30-10h30: PAMS[35] ward rounds take place on Monday mornings. All patients are accessed from an allied medical point-of-view.

10h30-13h00: Attend to the referrals that were picked up by the ward round. Notification of a Dead On Arrival of a 4 month old baby boy. Upon the chaplain's arrival to the casualty department, the patient's parents were present. Grief stricken, they relayed the incident to the chaplain. Through active listening, pastoral support, encouragement and prayer with scripture reading were provided to the family. Shortly thereafter the report was completed by the South African Police Services, the family leaves.

Three Overdose patients were referred by the physician. Arrangement by hospital management has approved that before patient discharge, the patient's

[35] Profession Allied Medical Services (includes social worker, chaplain, dietician, and physiotherapist).

risk factor and support systems are assessed. In Overdose cases, the Risk Assessment Form (Appendix 5) is used.

13h00-13h30: Lunch time.

13h30-14h00: Ward rounds at the second hospital, picking up any patient referrals.

14h00-14h45: Notified of a Not For Active Management (NFAM) case of a 1 month old baby boy. The staff requires the chaplain to provide support to the mother. The Physicians have informed the patient's mother of the diagnosis and current medical plan.

14h45-15h45: Attend to administrative issues. Return all emails and begin charting the day's work.

15h45-16h00: Follow up visit with the NFAM patient. There is no change in the situation.

16h00: End of the day.

4.8. Associations, Training and Certification

One objective for this thesis is to assert the idea that chaplains are not 'regular pastors' that 'just visit the sick.' Research has shown that chaplains are trained professionals within their specialised field, in this case, hospitals. Scholars, such as, Fitchett (2002), Holst (2006), Jacobs (2008), Kirkwood (2005), Lioy (2009), McClung et al (2006), Piderman et al (2008), Thompson (2005), VandeCreek et al (2001) and many others emphasise that chaplains are highly trained individuals. In the early centuries, parish ministers were very often the "jack-of-all-trades." Preaching, teaching, evangelising, visiting the sick were all part of the pastors duty. Nowadays, many pastors specialise in a particular field; senior pastors, youth pastors, worship pastors, family pastors, children's pastors etc. And now too, to have hospital chaplains. Jacobs (2008:2) notes strongly that there was a time when chaplains got their jobs by default because they could not lead a congregation. He continues by saying that this may reveal something about how religious denominations used to view the care of the sick: as a fall-back option, rather than as a vocation in its own

right. With well-established organizations and associations, professionally trained chaplains—like physicians, nurses, mental health professionals, and social workers—are called to care for the sick: this is there vocation.

Does this mean that the local pastor is not welcomed to walk the hallways of the sick? Not the least bit. Chaplains do not (should not) replace the local pastor. The pastor has a responsibility to care of his flock, including hospital visitations. The chaplain is there to fulfil a special requirement in a medical environment that cares and supports all members of society, religion and race.

4.9. Associational Bodies

With the steady influx of spiritual emphasis in healthcare, a need arose to collaborate, control and monitor this "new movement." This lead to the establishment of two distinguished United States organisations; the ACPE and APC. There seems to be a definable lack of associational bodies in South Africa that accredit and oversee chaplains. This section will deal with the history and influence that these two associations have had on chaplaincy ministry.

4.9.1. Association of Clinical Pastoral Education[36]

The Association of Clinical Pastoral Education or ACPE is the controlling body of the C.P.E (Clinical Pastoral Education) programme. With a rich history, dating back to the early-mid nineteen hundreds, four influential associations joined forces to establish the ACPE in 1967.

The history of ACPE started in the 1920s. Up until this time hospitals usually invited retired clergy to provide chaplaincy services. It was only in the mid 1920s, under the leadership of Rev. Anton Boisen, at Worcester State

[36] For constraint reasons only an overview of ACPE's history is talked about. A more detailed history can be sought at www.acpe.edu/cpehistory.htm.

Hospital in Massachusetts, a new form of theological education known as Clinical Pastoral Education (C.P.E) developed. As a former mental patient, Anton Boisen invited four students, to spend the summer of 1925 with him at the hospital as he felt a calling to "break down the dividing wall between religion and medicine." Boisen designed a programme where his four students served as ward attendants during the day, attended staff meetings, and in evening participated in seminars with Chaplain Boisen and various members of the professional staff. Wanting to nudge theological students out of their classrooms and into the hallways, Dr. Richard C. Cabot (1925), father of medical social work, called for an internship for 'theologicals' similar to those in medical school for "A Clinical Year for Theological Students." Holst (2006:16) describes the C.P.E movement this way, "in part, it grew out of dissatisfaction with traditional theological education of the day, considered by many to be too abstract, too removed from life, too divorced from the practical tasks of ministry." This lead to an increasing number of theological students wanting to enrol in his programme.

It was in 1930 that Dr. Richard Cabot, Henry Hobson, Samuel Eliot, William Healy, and Ashley Leavitt met to draft a constitution and bylaws. Out of this meeting the Council for Clinical Training of Theological Students was formed, lasting until 1967. In 1932 a split in the Council developed eventually leading to a major break in 1935. Leading the one side, Cabot and Guiles formed the Institute for Pastoral Care in 1944. This Institute gained rapid popularity with training centres establishing across the Boston and Chicago area.

A third group that emerged in the 1940s was the Lutherans. Awakened to the fact that their hospital chaplaincy was in jeopardy, Dr. Louis Sick, the President of Concordia Seminary, sent Rev. Ed Mahnke off to get clinical training. Only in 1949, after various meetings with several major Lutheran bodies, did the Lutheran Advisory Council on Pastoral Care emerge. The purpose of this Council was to promote clinical training as part of theological

education, help seminaries to develop training centres, and establish standards for clinical training programmes. The Lutheran Advisory Council with its established Standards formed a large part of the current Standards for ACPE.

The final association, the Southern Baptist Association of Clinical Pastoral Education was formed in 1957 under the auspicious of Dr. Oates. This association providing primarily Southern Baptist chaplains with certification.

In October of 1967, after several years of joint discussions and planning, the four groups merged into the Association for Clinical Pastoral Education, Inc (ACPE). The organisation, consisting of three commissions: Standards, Accreditation of Centres and Certification supervisors has been on the Federal Government's Department of Education's Commissioner's list of nationally recognised accrediting agencies/associations in the field of clinical pastoral education (C.P.E) since 1969. The ACPE is a multicultural, multi-faith organisation devoted to providing education and improving the quality of ministry and pastoral care offered by spiritual caregivers of all faiths through the clinical educational methods of Clinical Pastoral Education. C.P.E is internationally recognised amongst today's clergy and graduate students in theology. Over the last 80 years, C.P.E includes over 3,300 members that make up the Association for Clinical Pastoral Education, with some 350 ACPE Accredited C.P.E Centres, and approximately 600 ACPE certified faculty members (called C.P.E Supervisors). There are to date 118 Theological Schools as members, and 21 Faith Groups and Agencies who are partners with ACPE.

4.9.2. Association Professional Chaplains[37]

The APC is one of the most recognised associations in the United States that governs the level of care being provided by professional chaplains. APC is a national, multi-faith, not-for-profit organisation that advocates for

[37]A more detailed history of APC can be viewed at www.professionalchaplains.org.

quality chaplaincy care of all persons in health care facilities, correctional institutions, long term care units, rehabilitation centres, palliative care, and the military and other specialised settings.

The Association of Professional Chaplains mission is to certify and serve its membership and to promote professional chaplaincy. Through their vision, APC seek to

> "strengthen the professional competency of chaplains, so that chaplains will demonstrate quality outcomes to those they serve. Demonstrate the distinctive value of professional chaplaincy, which can be communicated to external stakeholders and result in the promotion of professional chaplaincy and social justice."

Appendix 6 details the chronological history of A.P.C.

4.9.3. Association of Christian Counselling of South Africa[38]

The Association of Christian Counsellors in South Africa (ACC) was formed in 1993. Strong associations exist with the American Association of Christian Counsellors. The ACC comprises of professional, pastoral and lay counsellors throughout South Africa. All counsellors, representing diversity in practice and training, share a commitment to Biblical truth and psychological excellence.

The ACC exists to promote excellence in Christian counselling in South Africa by these guiding principles that contribute to the professional development of its members:

- disseminating information, educational resources and counselling aids.
- encouraging and facilitating international contact and interaction with other Christian counsellors.
- stimulating interaction and mutual encouragement among counsellors.
- encouraging the integration of counselling principles with Biblical theology.

[38]An overview of ACC is talked about. A more detailed history can be sought at www.accinsa.co.za.

- inspiring the highest levels of counsellor training.
- contributing to the strengthening of families.
- endeavouring to bring honour to Jesus Christ.

4.10. Training and Certification

4.10.1. The United States

McClung et al (2006:149) states that since 2000, JCAHO (The Joint Commission on the Accreditation of Healthcare Organizations) has required hospitals to have a qualified chaplain defined as a person who is board-certified by one of four cognate groups in the United States and Canada, or who is eligible for certification (JCAHO, 2005). Since JCAHO's acknowledgment of a patient's "fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values," attending to the patient's spiritual needs is no longer an option for health care organisations. With this recognition that health care organisations; acknowledge a patient's rights to spiritual care and provide for these needs through pastoral care, a standard level of pastoral care needed to be established.

For certification, the professional chaplain will undergo a laborious amount of specialised training. The primary requirement for any chaplain is a theological degree from an accredited institution. The next step is the Clinical Pastoral Education process which is well established to equip future chaplains. Under the asepsis of Association of Clinical Pastoral Education, accredited C.P.E centres have been established all throughout the United States, representing 22 different medical settings. Typically a student can participate in either the part-time C.P.E programme (10 or 11 week ministry and training experience), or the Extended Community C.P.E programme (one or more units of training on a part-time basis), or the C.P.E Residency programme (four units with a stipend and employee benefits). Majority of chaplains that end up

receiving accreditation have completed the Residency programme. The C.P.E Residency programme will provide the student with;

- A developmental perspective of human growth and personality.
- Various literature and perspectives on theology and behavioural sciences in pastoral care.
- The rationale and procedures for referral.
- Theories and models of pastoral care and counselling.

Certain skills will be developed and attained as a C.P.E resident. Some of these skills are:

- Develop your own personality and spiritual path.
- Learn how your thoughts, attitudes, beliefs and behaviours affect the way you do ministry.
- Explore the relationship between your beliefs and behaviours.
- Identify your weaknesses and strengths as person and pastor.
- Learn to articulate and modify your goals for personal and professional development.
- Fine-tune your skills and knowledge through assessment and supervision.
- Cultivate effective pastoral relationships with the health care team through your emerging understanding of self.
- Articulate a theological perspective congruent with your understanding of people.
- Make pastoral assessments using psychological, social and faith perspectives.
- Develop a pastoral plan in ministry.
- Lead worship using your pastoral identity and the needs of patients and hospital staff.

Owing to C.P.E being primarily an outcome based programme, the training chaplain will need to meet certain outcomes during the year. Supervision, verbatim and didactics all form part of this process with mid-term and final evaluations being submitted to your supervisor and presented to your

peer group showing that you have addressed the outcomes and objectives of C.P.E. There are two levels of outcomes. Both of the levels address the fundamentals of pastoral formation, pastoral competence and pastoral reflection with level 2 requiring a level of competence that permits for certification. Outcomes of level 1 and 2 can be viewed in Appendix 7.

On successful completion of C.P.E, those wishing to be certified seek approval and endorsement from their religious organisations and participate in a rigorous certification process that includes at least 1,600 hours of supervised clinical pastoral education demonstrating standardised competencies, presenting work samples, and meeting with a committee of credentialed peers (Piderman et al. 2008:58). Once the chaplain has been approved for eligibility, the certification process begins which can easily take up to two years.

4.10.2. South Africa[39]

The University of Stellenbosch, in partnership with the Military Academy in Saldanha has introduced an MPhil in Chaplaincy Studies degree. Students holding a four-year degree in Theology or any other appropriate four-year qualification may qualify for the MPhil.

The curriculum seems to be less personified than C.P.E in that it aims to equip spiritual leaders in preventive care, crisis preparedness and life skills development through the understanding of chaplaincy in a military, correctional or police context with an outlook to pastoral services and assistance.

The curriculum content includes the workings of a military chaplain, general management, spirituality within pastoral assistance in the HIV pandemic, pastoral care and counselling, theology, organisational development, ethics, to name a few. Some clinical work will be performed under supervision in the hospital context.

[39] For further information visit www.sun.ac.za/university/jaarboek/2011/Teologie2011Eng.pdf.

4.11. Summary

Is certification a necessity for chaplaincy ministry? The idea behind such rigorous training, is best articulated by Jacobs (2008:2) as he iterates that, chaplains must have a working knowledge of the psychology and sociology of religion and be attentive to the diversity of culture, gender, sexual orientation, and spiritual and religious practice among patients and families. Chaplains are also trained to assess patients' spiritual and religious resources and needs and to work with them on the specific issues and concerns that arise when a person is hospitalised. Thompson (2005:72) answers the question about the purpose of chaplains receiving certification by identifying this process to that of physician's credentials. The idea behind certification is

> "To protect people from a dangerous (marginally competent or impaired) practitioner. Our mind set should be that, at least in the case of some people, a marginally competent or impaired chaplain can be just as dangerous."

For the goal of the chaplains specialised, hospital based training is to prepare chaplains to work in intense medical environments.

4.12. Chapter Summary

There can be little doubt that today's hospital chaplain has undergone a major transformation process. Research has shown that the chaplains are more than 'just the pastor that holds a patients hand.' Nowadays, chaplains are trained professionals that have undergone numerous hours of specialised training and supervision.

Through well established associations, the professional chaplain is endorsed and protected by accrediting bodies through the enforcing of ethical codes. While a lack of accredited associations in South Africa, the United States, Canada and the United Kingdom are rich in reputable professional organisations.

Although defining the chaplain's role to a sole task is impractical, the main impulse is that of a pastoral caregiver, through which carrying out this task is done in numerous ways. The resulting obstacle can be that the chaplain faces many social and personal challenges in trying to be the "jack-of-all-trades."

CHAPTER 5

Biblical Principles and Characteristics for Pastoral Care

Chapter five will focus on principles and characteristics of pastoral care and the relationship that it has had with secular counselling. Given that this thesis focuses on the hospital chaplain, it is the belief that the principles and characteristics of pastoral care and chaplaincy overlap. Before any pastoral care features are discussed, the relationship between church and hospital care will be considered.

5.1. The Church and Hospital Care

5.1.1. A Historical Relationship[40]

As previously stated in Chapter one the relationship between church and medicine has long been established. Care for the sick in the Christian church is regarded as a prime duty amongst the faithful. It has been found that during the Middle Ages a close relationship existed between 'hospitals' and the Church. Establishment of lazar houses for the segregation and succouring of lepers, to monastic infirmary where sick and elderly brethren were looked after, were considered important places for the spiritual welfare of the patient. Inevitably many of those in charge of medieval hospitals were priests and there can have been little or no distinction between 'medical' and spiritual care.[41] Moll (2009) argues that when an epidemic struck in the ancient world, pagan city officials offered gifts to the gods but nothing for their suffering citizens. Christians found this insufferable, and they set about taking care of these people and others

[40] For a more detailed reading see "The Influence of Christianity on Graeco-Roman Medicine up to the Renaissance" by Retief (2005).

[41] Information Sheet History of Hospital Chaplaincy. Visit www.nhs-chaplaincy-spiritualcare.org.uk/infohistoryhcc.htm.

similarly afflicted. This draws upon the theological concept of the *imago Dei*, that humans were created in the image of God.

The Christian church was the main caregiver for people in the early years. Following on the principle, *"Love your neighbour as yourself,"* the Christian church set up what has been termed "a miniature welfare state in an empire which for the most part lacked social services" (Ferngren 2009:138). Especially during the plague struck generations, the church was often the only institution that took care of the ill. Yet the Christian church was not without her opposition, for as the church continued to expand in the early centuries, fiercer persecution by the Roman Empire was deployed upon her. Nevertheless this did not halt the church's mission of taking care of the ill. A better organisational structure was needed for this vocation of taking care of the ill. The church therefore called upon the hands of the presbyters (priests) and deacons. Their objective was to visit the ill and take care of the needy through collection of alms. According to Ferngren, due to the motivation of the ecclesia, hard working volunteers and strong leadership, the local congregation created in the first two centuries of its existence an organisation, unique in the classical world, that effectively and systematically cared for its sick (2009:114). As Retief (2005:266) suggests when citing Ferngren and Amundsen, "neither the pagan temples nor the mystery religions created a caring community like that of early Christianity."

As the Roman Empire began to adopt Christianity as the state religion, the expansion of the provision of care intensified. It was the First Council of Nicaeain in 325 A.D. that urged the Church to provide for the poor, sick, widows, and strangers. It was said that the Council further ordered the construction of a hospital in every cathedral town (Price 2007:6). Among the earliest were those built by the physician Saint Sampson in Constantinople and by Basil, bishop of Caesarea. It was this century that saw the rapid growth of the church, especially in larger Roman cities. Ultimately this culminated in a spherical effect – the larger the church, the greater need for benevolent care,

which led to the greater requirement of church staff which led to the increased size of the church and so on. And so as the ministry of caring for the sick increased, so did the number of ill people who were supported. Ferngren continues by advocating that the clerical orders, who were men chosen for their spiritual qualities, were the main caregivers to the sick. If they possessed any medical qualifications it would merely have been incidental (2009:115). Ferngren deduces by saying that the church established a role, previously unknown in the ancient world, of charitable concern for the sick, which ultimately led to the creation of both *diakoniai* and the earliest hospitals (2009:138). Retief (2005:275) supports this view saying that "Christianity's greatest contribution to medicine lay in the early establishment of caring communities, which brought personalised medical care to the sick, irrespective of nationality, social status, age or disease."

History has proved beyond doubt that the church has played a vital and central role in caring for the ill. It has only been in the twentieth century that the state began replacing the church with the responsibility of caring for the sick. Whether through clergy, passionate adherents, or chaplains, hospital ministry is essential to the gospel message of "loving your neighbour" (Mark 12:31). Nevertheless the gap between church and hospital has widened over the years. With the advancements in health ministry, chaplains have sought to minimise this growing chasm by taking the role of pastoral carer into the hospitals. Conceivably this may be due to the pastorate having little time on his hands to spend in the hospitals, for the demand of congregational ministry has lead him to be the "jack-of-all-trades." Interestingly though, Jacobs (2008:2) declares that there was a time when chaplains got their jobs by default because they could not lead a congregation. Because of the strenuous demand of ministry the churches view of caring for the sick could be seen as a fall-back option, rather than as a vocation in its own right. Yet today, professional chaplains—like physicians, nurses, mental health professionals, and social workers—are called to care for the sick and the suffering: this is their vocation.

5.2. Scriptural Reference to Pastoral Care Images

5.2.1. What is Pastoral Care?

Before any pastoral care images are discussed, the question of "What is pastoral care" needs to be answered. Christianity, states Evans (2000:66), is not only a belief system but a way of life whose parameters were set out in the teachings of Jesus; and that had pastoral aspects. Simply stated, pastoral care is seen as the art of "the care of souls" (Collins 2007:36), through the overall ministries of healing, sustaining, guiding, and reconciling people to God and to one another. Looking deeper, Hiltner (1958:15) indicates that the theology of pastoral care is a formal study of Christian shepherding. Evans (2000:1) says that the basis of pastoral theology lies with the words of Jesus*, "'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'; and, 'Love your neighbour as yourself"* (Matthew 5:43, Mark 12:31 and Luke 10:27).

Christian counselling and soul care is a broad and ancient part of Christianity that predates the contemporary mental health professions (Hathaway 2009:1). Johnson (2010:10) says that psychology is agreed amongst scholars to have only found its roots in the mid-to-late-1800s. However with advancements in therapeutic methods, Howard (1996:8) has observed how pastoral care has lost its heritage over the years for two simple reasons; people have begun identifying pastoral care with pastoral counselling and thus the true meaning of care in its historical sense is lost and secondly, pastoral care has begun to accept certain implied values and concepts of humanity in secular mental health practice, thus losing its ties to Christian theology.

So what encapsulates the ministry of pastoral care? Using the fundamentals of care and counselling, certain tasks are carried out by the pastoral caregiver. Clebsch and Jaekle (1967) have alliterated that pastoral care comprises of four essential functions that have spanned many centuries; (1) Healing – helping the person move beyond their impairment by restoring

wholeness to body and mind. (2) Guiding – assisting the person in choices if viewed as affecting the present and future state of their soul. (3) Sustaining – encouraging the person to endure and rise above situations in which restoration to their previous condition is unlikely. (4) Reconciling – helps the person re-establish broken relationships between people and between God. Clineball (1984:42) adds an extra function to Clebsch and Jaekle's list; (5) nurturing – develop and maintain their God-given potentials. With these five functions at work, pastoral care has come a long way.

Traditionally pastoral care has functioned primarily on the basis of scriptural readings and pastoral authority – telling people on the basis of scripture what to do, with little prominence on actually listening to the patient. With the inspiration of American psychologist Carl Rogers influence on the humanistic approach to psychology, pastoral care began changing its approach in the mid 1940s to a more nondirective formal touch. Listening, insight and human behaviour all become an integral part of pastoral care with the focus on establishing rapport with the client. In the late sixties, a new development under the influence of pastoral psychologist Howard Clinebell grew. His approach brought back the historical elements of pastoral care through counselling by centering around the "six dimensions of wholeness" - mind, body, intimate relationships, relationship with nature, institutional-societal liberation, and a relationship with God. Howard's hypothesis on the "wholeness of persons" is based firmly on the belief that "growth toward greater wholeness in any dimension stimulates and supports growth in the other dimensions" (1984:31). Thus the pastoral care aim is to bring balance in all six aspects of wholeness.

5.2.2. The Shepherd Image

Many images of pastoral care exist amongst scholars. Dykstra's, *Images of Pastoral Care* (2005), details many of the current pastoral images described by well-known theological authors. For a full list of these images review

Appendix 8. The researcher advocates that the most accepted and agreed upon pastoral image, is that of shepherding.

From the many descriptions laid out by scholars, the most profound is that of Mitchell (1999:832) where he describes pastoral care as having its roots firmly established in the metaphor of the Greek word, ποιμήν *(poimen)*, meaning "shepherd" and the verb ποιμαινω *(poimaino)* meaning "to shepherd". However it is interesting to note that English translations of the Bible translate *poimen* as "pastor" only once in the entire New Testament in Ephesians 4:11*: "So Christ himself gave the apostles, the prophets, the evangelists, the pastors and teachers…"* (Bluemel 2010). In the New Testament *poimen* is translated as "shepherd" 18 times in the books of Matthew, Mark, Luke, John, Ephesians, Hebrews and 1 Peter with the various uses as being; literal shepherds caring for literal sheep (4 times), to Jesus as the Great Shepherd of the church (9 times), to leadership of true believers (4 times) and an office in the church (1 time).[42] Rodgers (2010:13) maintains that for a sound biblical foundation for pastoral care, we need not look further than Jesus. Quoting Rodgers, "If we do not find a theology of pastoral care in the person and work of Christ, then we do not find a truly pastoral or Christian care." Perhaps this is why Psalm 23, is called the "hospital Psalm" as it paints a picture of Jesus carrying his lamb through dark times.

The pastoral image of shepherding (Ezekiel 34) is not solely associated to the biblical world, so wrote Cachia (1997:22). He maintains that the biblical authors adopted this image from "their neighbours in the near east", and applied the image to God as being the Good Shepherd and to the community leaders of the day. Shepherding was often seen as a lowly position amongst the Israelite people and it wasn't until Jesus' use of the image in John 10:11-14 and John 21:16-17 that elevated the shepherd position.

[42] Visit www.net.bible.org/strong.php?id=4166 for further information.

It was only later that the Christian community took up this image and began associating it with the pastors of the church. In doing so it offered "the modern pastor a classic tradition by which his ministry may be enriched" (Mitchell 1999:832). Hiltner (1958:17) writes that the image of shepherd has a special place in Christianity as it is the only religion that sees shepherding as a focal and central point. This makes shepherding distinctive to our Christian religion, whereas other high religions have teachers, guiders, or spiritual directors. Does this mean that pastoral care in essence, is shepherding? Hiltner suggests that depending on what approach one has of pastoral care, the answer can be yes or no. "No" being that pastoral care is viewed as just one of the pastoral "offices" (example: evangelism, teaching, administration, outreach etc.) or "yes" if pastoral care is viewed to be in every facet of the minister and church (1958:19). Although predominately carried out by ordained clergy, pastoral care may also be carried out by "representatives of the religious community who are authorised and trained to offer care that reflects that shared values and commitments of the group."

5.2.3. The Good Samaritan Parable

A well-known story in scripture is that of the parable that Jesus tells in Luke 10 – the parable of the Good Samaritan. This story tells of how a man on his way to Jericho was attacked and left for dead. Three men crossed his path with only one stopping to help. The parable was told in response to a question of "what must I do to inherit eternal life?" Scott (1991:190) divides the parable into two chief sections;

	Part 1	Part 2
Lawyer's question.	Inherit eternal life.	Who is my neighbour?
Jesus' counter question.	What is written in the Law?	Who proved to be a neighbour?
Lawyer's response.	Deut. 6:4 / Lev. 19:18	The one who showed mercy.
Jesus' command	Do this and you shall live.	Go and do likewise.

Hiltner (cited in Dykstra 2005:48) understands that the uniqueness of the shepherd image is found in the parable of the Good Samaritan (Luke 10:25-37). For Hiltner, presenting the gospel to reach a particular need, displays the metaphor of Christian shepherding (2005:47). The simple idea of the story is that one needs to love their neighbour as themselves, or as some might say, "caring about others" (this is the chaplain's core belief). By looking deeper, the story implies that a transgression against God is committed when the act of shepherding is ignored; in the parable's instance, the act of healing was called upon (2005:48). The idea of the Good Samaritan as a shepherd lies with the fact that the wounded man needed nothing more than bandages and an inn - verbal testimony to faith was not needed at this time. A Christian shepherd would always have a shepherding outlook, looking for any particular need whenever it may emerge as his dominated viewpoint (2005:47). Much of chaplaincy ministry is in line with Hiltner's statement. Hospitalised patients may also be emotionally or spiritually vulnerable. As a Christian shepherd, the chaplain would seek out these needs and address them to his ability. The manner in which the Samaritan assisted the wounded man was not only verbally. He did not say, "Hang on I'll call someone to help." Nor did he say, "Peace, may the Lord be with you" and leave. The Samaritan helped the man physically - dressing his wounds, putting him on his donkey, taking him to the inn, and paying his bill. In 1 John 3:18, John states that one needs to love "*in deed and in truth"* and not (only) with words. Many times the chaplain's task would be to assist the patient practically (help making telephone calls, providing a glass of water to drink to help calm nerves, supplying a bible to read, sitting in silence etc.). Steere (1997:76) says that the shepherd image provides the reader with a powerful metaphor of "spiritual presence in a caring process sustaining our lives." So how does the parable of the Good Samaritan translate into hospital pastoral care?

5.2.3.1 Who Is My Neighbour?

To answer that question, one needs to understand the neighbour. The crux of the parable seems to stem from the question asked by the lawyer in

verse 29; *"who is my neighbour?"* The manner in which Jesus defines "neighbour" was not answered in a direct way but rather through the parable making it clear that our neighbour is whoever has a need, it doesn't matter who they are or where they come from. Buckingham (1991:107) remarks that Jesus pointed out that to have eternal life you need to love God and love your neighbour and that you cannot love God without loving your neighbour. This question of "who is your neighbour," can be appreciated in the Samaritan's attitude, which was addressed by Jesus to the lawyer, to which his reply was *"The one who had mercy on him"* (verse 37). Wilson (2011) provides us with the mercy concept as *eleos* (ἔλεος) *"*the emotion roused by contact with an affliction which comes undeservedly on someone else." This word is based on the Hebrew concept of *hesed*, faithfulness between individuals that results in human kindness, mercy, and pity. Mercy is a character trait that chaplains require. Jesus commands his disciples very specifically in Luke 6:36: *"Be merciful, just as your Father is merciful"* and in Micah 6:8: *"But he's already made it plain how to live, what to do, what God is looking for in men and women. It's quite simple: Do what is fair and just to your neighbor, be compassionate and loyal in your love..."* (The Message). The Samaritans merciful attitude is reflective of Proverbs 25:21, Matthew 5:7, Matthew 18:33, Luke 6:27-31, and 1 Peter 3:8-9,

Both the Levite and Priest had "reasonable" excuses not to help the wounded man. Both parties held important duties in the temple and ceremonial cleanliness was of utmost importance. The priest was to offer sacrifices, prayers, incense etc, while the Levites assisted the priests in their services inside and outside the temple (Barnes 1962:213). Both knew that the law clearly states that anyone who touched a dead man would be unclean (Numbers 19:11 and Leviticus 21:11) thus preventing them from serving God in the temple. So why take the chance and help the wounded man? Yet it was the lowly Samaritan that came to the aid of the wounded man. Collins (2003) makes the distinction of "Who is my neighbour?" by turning the question around to "Are we neighbourly?" and do we "go and do likewise?" More specifically

Collins continues, “in light of this parable, he who needs our aid, no matter who he is, is our neighbor.”

5.2.3.2 Why Love Your Neighbour?

After identifying who our neighbour is; why is it important to love your neighbour and how does one love their neighbour? Keddie (1994:81) asserts that the essence of compassion is to drive out all selfish considerations and the Samaritan resolved to help the wounded man as best he could. The focus was on the wounded man, not on his surroundings. Chaplaincy too focuses on the patient and not on the patient’s environment, race, background, or religious culture. One cannot overlook the serious claims that Jesus and his followers laid down regarding loving others as ourselves with Proverbs 14:21, Romans 13:9-10, Galatians 6:10, 1 John 4:20, and Galatians 5:14 providing insight into these claims.

Furthermore one of the most repeated commands (eight times) in the Bible is that of loving your neighbour (Leviticus 19:18, Matthew 19:16-22, Matthew 22:34-40, Mark 12:28-34, Luke 10:25-37, Romans 13:8-10, Galatians 5:13-14, James 2:8). In addition the idea of being a loving neighbour is a theme that Jesus carried with him in many of his teachings; found in Matthew 5:43-44, Matthew 7:12, Matthew 22:36-40, Matthew 25:35-37, and John 13:34-35.

Love is a tangible action which leads to a practical manifesto for Christian life (Keddie 1994:81-82). Chaplain ministry is about taking time to simply care for another. This “simple act” can make all the difference in the world to restore someone who is in despair and isolated. Daily Exegesis (2009) states that “…ministry is an act of healing and restoring right relatedness - we all can act through mercy to restore our neighbor after a wound.”

5.2.3.3 What Was Needed?

As mentioned, the fact that the wounded man needed his wounds to be attended above anything else, lends the reader to ask, is healing part of

shepherding? As indicated by Hiltner (2005:50), all shepherding moves to seek healing. Since much has been authored about healing in the Christian faith, it is not the researcher's objective to examine this in its entirety, however there is some degree of shepherding that lies in healing. Generally speaking, individuals often associate healing to the physical realm. Although many of Jesus' miracles were associated to physical healing,[43] not all healing should be seen as physical. Sustaining an individual through difficult times to bring restoration to their soul, in spite physical restitution, is healing. Accounting for this thought, Hiltner (2005:51) suggests that due to the medical marvels

> "we tend to misunderstand the simple but profound conception of healing that is found in the New Testament. The New Testament intuitions are of a different order from that of differential diagnosis and treatment. We must separate them from such comparisons just as we do in connection with the physical worldview of people living at that period."[44]

True healing will embrace the trichotomy of man. A terminal stricken cancer patient seeking inner peace is an example of such healing. When we initiate such belief, "shepherding and healing are of a piece" (Hiltner 2005:53).

5.2.3.4 Summary

From a simplistic outlook, the parable points to the fact that one needs to take care of your neighbour just as the Samaritan portrayed. This is the underlying work of chaplaincy ministry; showing empathy to the hurt and lonely, no matter their culture, background or spiritual state. Steere (1997:83) argues that when we care for someone we are not converting them or getting them into

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[43] John 4:46-54 (Healing of the royal official's son), Matthew 8:14-15 (Healing of Simon Peter's mother-in-law), Luke 4:40 (Healing the sick during the evening), Matthew 8:1-3 (Healing a leper), Luke 7:1-10 (Healing a centurion's servant), Mark 2:1-12 (Healing a paralyzed man), Mark 3:1-6 (Healing a withered hand), Luke 7:11-17 (Raising a widow's son), Matthew 9:20-22 (Healing a woman with internal bleeding), Mark 5:22-24 (Raising Jairus' daughter), Matthew 9:27-31 (Healing two blind men), Matthew 9:32-33 (Healing a mute man possessed by a demon), John 5:1-17 (Healing a man who was crippled for 38 years), Mark 6:53-56 (Healing of many in Gennesaret), Mark 7:31-37 (Healing a deaf man with a speech impediment), Mark 8:22-26 (Healing a blind man in Bethsaida), John 9:1-41 (Healing a man born blind), Luke 11:14 (Healing a blind and mute man who was possessed by a demon), Luke 13:10-13 (Healing a woman with an 18 year infirmity), Luke 14:1-6 (Healing a man with dropsy), Luke 17:11-19 (Healing 10 men suffering from leprosy), John 11:1-44 (Bringing Lazarus back to life), Luke 18:35-43 (Healing Bartimaeus of blindness), Luke 22:45-54 (Restoring a severed ear).

[44] For further insight into Hiltner's explanation of New Testament intuitions, see (Dkystra 2005:51-53).

church, rather we extend the same "genuine acceptance, accurate empathy, and unconditional positive regard characteristic of the client-centered therapist." Testimony to one's faith does not have a single approach to that means, rather as Hiltner (2005:49) atones "testimony to Christian faith is always a compound of the eternal gospel and specific need." Chaplaincy has that same approach – there is no one way to support a patient in need. The vehicle to testimony varies pending the situation. Hiltner (2005:49) argues strongly that the shepherding act of the Samaritan was not "ancillary to something else" that required justification from another. Furthermore, Hiltner suggests that this act is uniquely Christian – "the effort to shepherd and heal, when needed, regarded as itself the one indispensable way of communicating the gospel on those occasions."[45]

With chaplaincy ministry not always having the same support as other ministries within the church (or outlook within hospitals), the attitude portrayed by the priest and Levite could be similar of how many people see chaplaincy ministry; "I don't want to get involved" or "I don't have the time" or "there is no real need for such a work" and therefore turn a "blind-eye" to this important work. Jesus' final words in the parable *"Go and do likewise"* (verse 37b), commands us to do as the Samaritan did by showing mercy to our fellow man who was in need – through the attempt "to help others experience the reality of God's presence and love in their lives" (Holst 2006:46, defining the role of pastoral care).

5.3. Characteristics of Biblical Counselling

In this section, a look at a balanced pastoral-health care model will be presented. Albeit different influences have infiltrated the biblical counselling field, an analysis of how Christian principles and psychology work together to form various models of teaching will be sought.

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[45] Other religions recommend good works arising out of faith.

5.3.1. A Pastoral-Health Care Model

Most of the dialogue thus far has been around pastoral care that seems to fit into a more structured setting, such as a congregation. One may ask if there is any distinction between pastoral care in a congregational setting to that of pastoral care in a medical setting. Redefining the current pastoral care definition as suggested by Collins (2007:36), pastoral-health care will reflect the ministry of enabling

> "Individuals and groups in a health care setting to respond to spiritual and emotional need, and to the experiences of life and death, illness and injury in the context of a faith or belief system" (Woodward 2010).

There can be little doubt that certain influences have infiltrated the art of pastoral care. Figure 42 provides a diagram of the core sciences that have influenced pastoral care over the years. Criticism has been voiced by some pastoral counsellors (for instance Adams, Hunt, Woodbridge, Hardy) over the influence of these sciences. Woodbridge (2007) demonstrates this in his article; *"Psychotherapy: Science or Religion?"* He tells us that the ministry for curing the soul has slowly been replaced by a ministry of curing the mind, called psychotherapy (2007:83). Furthermore, Bobgan & Bobgan (1987:27) writes that as soon as religious problems were medicalised, people moved from church to couch, seeking medical personnel rather than pastors. Creating a balance between the sciences and theology is perhaps the best alternate. The idea that people can be emotionally and spiritually healed of their problems outside of Christ is somewhat flawed. Without Christ's intervention, we will continue to flounder away with little results. Mitchell (1999:833) mandates pastoral carers not to lose sight of its theological and classical moorings.

Figure 42: Pastoral Care: Influences

So what does pastoral care comprise of? The researcher deems that there are common components in both *congregational* pastoral care and pastoral-*health* care. Figures 43 and 44 below indicate some of the essential components in both pastoral care models. The term "model" is used not in the literal sense as a step-by-step procedure, but rather as a system of constituents that are important in providing pastoral care. *Individual / patient focus* provides pastoral care to an individual. Looking broader is the care to the *congregation / family members* of the patient. *Staff focus* is the colleagues that the pastor (*or chaplain*) works with, while *community focuses* on the wider kinship of the church (*or hospital*) and *self-focus* is looking after oneself as a care provider.

Figure 43: Congregational Pastoral Care Model

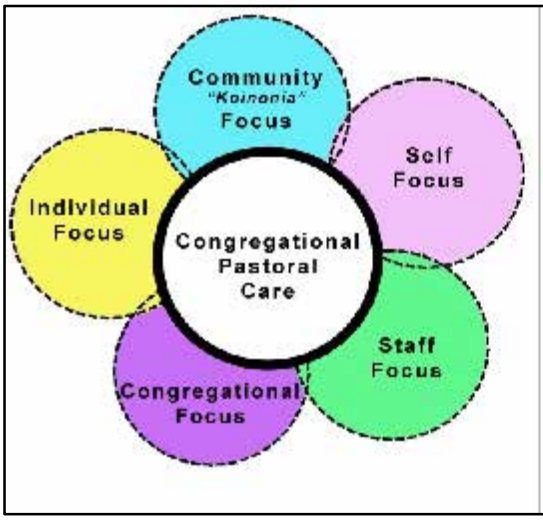
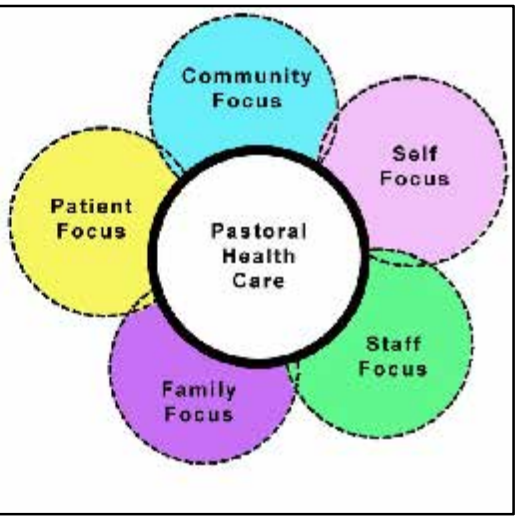


Figure 44: Pastoral Health Care Model



Keeping these influences in mind, how does a Christian counsellor or chaplain develop a model that does not convict him of any scriptural wrongdoing?

5.3.2. A Strained Christian-Psychology Relationship

Today one of the most heated debates in Christian counselling is the relationship it has with secular psychology. Observe Johnson and Jones (2000:12) comment as to the controversy between church and psychology;

> "Over the past century a complex and rich body of knowledge and practice has arisen that attempts to understand and treat human personality and behavior in ways which are usually disconnected from Christian perspectives..."

The expressed concern by scholars is not for the entire field of psychology, but the manner in which psychology influences those areas that deal with the nature of man. Well known author McDowell and Hostetler (1996:6) explain that two reactions occur regarding this debate. The first stance is those that believe "Jesus is the answer to everything." While others believe that "people need to get in touch with their past and everything will turn out fine." The Bobgan's (1987:14-15) suggest that four myths regarding psychology have ingrained the Church. (1) For both Christians and non-Christians alike psychotherapy is a means of understanding and helping humanity. (2) The best kind of counselling utilises both psychology *and* the Bible. (3) People who are experiencing mental-emotional behavioural problems are mentally ill. Ministers, unless they are trained in psychoanalysis and psychotherapy, are then supposedly unqualified to help people who are suffering from serious problems of living. (4) Psychotherapy has a high record of success. The assumption is that because psychotherapists are trained in counselling, they are better able to serve the needs of Christians who need help with problems of living.

The question to be answered then is this: Can a healthy Christian–psychology relationship exist without causing conflict? According to Potter (2007:109) this is achievable as both schools have the same end-goal; "personhood wholeness." The procedure of answering the question lies with

the “theory of Integration,” the best known process amongst scholars of combining theology with psychology. It is suggested by Carter and Narramore (1979:22) that the existing conflict between the two professions is

> “Either the *facts* of Scripture and the *theories* of psychology, the *facts* of psychology and our (mis) interpretation of Scripture, or between the *theories* of psychology and our misinterpretation of Scripture.”

Attempts have been made by psychologists to relate psychology to religion. Carter (2007:213) explains that there are four secular models; Psychology *Against* Religion, Psychology *Of* Religion, Psychology *Parallels* Religion and Psychology *Integrates* Religion that clarifies how psychologists have attempted to relate these two professional fields together. Appendix 9 provides the reader with a detailed analysis of these four models.

From the sacred-side, the views expressed in Johnson et al (2000) book, *“Psychology and Christianity: Four Views,”* seem to be the most shared notion by scholars. Since this thesis does not allow me to fully expand upon each theory, a simplistic summarised view-point will be addressed.

The first view, *“The Levels-of-Explanation,”* Myers (2000: chapter 2) gives lend to this theory that “psychology and theology are parallel disciplines that engage in different levels of explanations and thus are not truly integratable fields,” (Serowa 2009) and so psychology and religion should be kept distinct from each other. Stamps (2011) observes that;

> “Sometimes psychology will confirm aspects of Christian faith (e.g. psychological science that supports family values). Other times psychological science might cause Christians to question accepted theological perspectives and scriptural interpretations.”

The process of this model is to relate psychological and religious descriptions of human nature in order to map human nature from two directions, asking how well psychological and biblical understanding correlate (Myers 2000:60).

The second view, *"Integration,"* is the view proscribed by Collins (2000: chapter 3). According to the Integration model, this will help us understand both fields and ultimately to engage in the Christian Psychology. Watered down, the Integration motto is, "All truth is God's truth." It seems that this approach uses both bible and social science in counselling;

> "The bible gives us all we need to know about God, human depravity, salvation, amazing grace and many other issues that psychologist never touch or try to comprehend. —The Bible does not tell us about issues such as biological basis for depression, the effect of accurate empathy, the lifelong devastation of emotional or physical abuse, the means by which people learn the development stages of infancy, the fine points if conflict resolution —Psychology focuses on issues like this" (Collins 2000:110).

It would appear that this group actually puts the Bible truths at the same level as empirical evidence. Therefore, Christian psychologists and counsellors should seek to integrate psychological findings with their more fundamental Christian faith (Stamps 2011). Although difficult to define in a simplistic manner, the best conclusion would be that of Roberts critique (Johnson et al 2000:138);

> "Integration is a process by which elements of psychologies and a Christian system of thought and practice are adapted to one another to form a somewhat new system of Christian thought and practice; the resulting system can also be called and integration."

"Christian psychology", being the third view described by Roberts (2000: chapter 4) advocates building a Christian psychology by utilising the teaching of Scripture and the rich Christian tradition that serves as a commentary on it. For that reason this view offers prominence on Historical, Biblical, and Theological sources of information rather than on the psychological information. The primary aim of Christian psychology, according to Roberts (2000:155), is to make "available the distinctive psychology of the Christian tradition to the intellect and practice of person in our time." Author of "My Perspective" (n.d.:9) suggests that the task of Christian psychology is not to integrate Christianity and psychology into one system, but rather to preserve the Christian thought in such a way that Christian psychology would be recognisable by contemporary sciences as psychology. Because the bible is the authoritative source of

Christian ideas, much of the foundational work in Christian psychology will therefore "be the careful reading of Scripture by people who know what psychology in the twentieth century was and can therefore sniff out the Biblical psychology" (Roberts 2000:159).

The fourth view supported by Powlison (2000: chapter 6), is "*Biblical counseling"*. This view argues that we should not seek to integrate and is solely based on scripture. Serowa (2009) observes that the field of psychology and psychotherapy have nothing to contribute to the understanding of sinful conditions other than perhaps a more detailed description or symptom identification. Hall and Coe (2010:61) observe that the basis of Biblical counselling is two-fold; the Bible is the primary or sole datum to understand the human condition and that salvation and the work of the Spirit are of primary importance in understanding human growth. Counsellors using this approach strive for a theocentric approach to soul care that sees sin as our worst problem and Christ's work as the cure for the sin-sick soul.

Crabb Jr., in his book *Effective Biblical Counseling* (1977:31-56), has dedicated an entire chapter on the relationship between Christianity and psychology as he insists that "psychology does offer real help to the Christian endeavoring to understand and solve personal problems" (1977:37).[46] In summary he suggests four learned positions for an "acceptable relationship between secular psychology and biblical truth." The first position is called *Separate But Equal*. In this belief, counsellors insist the scripture was not meant to serve as a medical textbook or a guide to professional health treatment. They believe that "scripture has no more relevance to emotional problems than it has to pneumonia" and therefore fails to recognise the relevance of scripture to psychological problems. The second position is called *Tossed Salad*. It is in this model that counsellors "combine the insights and

[46] Johnson et al (2000:40) indicates that Crabb eventually moved away from the integration approach found in his earlier work to embrace more fully the themes of a Christian theology of sanctification in his writings.

resources of scripture with the wisdom of psychology." The dilemma with this approach is that careful screening of secular concepts needs to be done before applying them as "psychology grows out of a set of presuppositions which are violently antagonistic to scripture…" Crabb's third position, *Nothing Buttery* is the approach in which counsellors reject psychology altogether. The difficulty with this is that it reduces counselling to a simplistic model of identifying sin and commanding change. Counselling is more than just listening for and detecting sin. *Spoiling The Egyptians* is the fourth position that Crabb suggests. He maintains that a number of positions found in secular theories centre around a principle of human behaviour taught in scripture.[47] This approach reflects the idea that not all psychology concepts contradict scripture and therefore advocates that this approach is most effective as he takes only the best biblically sound ideas from psychology.

In all the theories, there seems to lie positive and negative elements to the approaches. It is of the researchers opinion that the finest conclusion that draws this debate to an "end," comes from Bobgan et al (1987:267-270), through the illustration of "the true vine" in John 15. The authors believe that the psychological ways of the world need to be removed from the church if it is to operate as the body of Christ, just as Christ removes those braches that bear no fruit. For the church will gradually become as secular as the world if she does not seek God as its source but relies on the philosophical and psychological ideas and techniques of men.

For pastoral care to find a new-level of self identity that will take it into the future, Clinebell (1984:17) suggests that the field of care needs to broaden its roots, methodology, and discover its unique contribution within this field. Even though pastoral counselling has received some criticism from psychologists regarding its role and counsel, Clinebell (1984:46) emphatically states that lonely, crisis-induced, dysfunctional and broken people still seek the services of pastoral guidance.

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[47] See Crabb (1977:52-55) for a more detailed analysis of this thought.

5.3.3. Biblical Values

McDowell et al (1996:5) says that since the Fifties an assertive effort by well known Christian counsellors "to better understand human emotions and relationships in the light of biblical analysis and solutions" has taken place. These efforts have been based on biblical principles and teachings according to God's infallible Word. The following principles serve as a guideline (McDowell et al 1996:7);

- God's is love and truth. (John 4:16, 14:6) His love motivates Him to reveal the truth to us.
- Though not all problems are spiritual, they are interrelated with a person's spiritual beliefs and spiritual state.
- A crucial factor in achieving healing and wholeness is a personal relationship with Christ for wholeness cannot be achieved apart from Jesus Christ.
- Healthy relationships are the linchpins of mental, emotional and spiritual health.
- Healing of the mind, emotion, and spirit is possible. God who restored an entire nation that had been conquered and broken can also restore to emotional wholeness.
- The goal of biblical counselling is not happiness but Christlikeness.
- Healing and wholeness will not come without sound biblical teaching and obedience to the Word and will of God.

5.3.4. Pastoral Care Resources

Regardless of what approach the pastoral carer carries, certain religious resources are at his disposal when visiting patients. To this day there remains a predominately positive regard for the use of religious resources in pastoral care, with the sacred Scriptures been the forerunner. Although not all would agree. Babler, Penley & Bizell (2007:14) advocate that many institutionalised pastoral counsellors have strayed from the use of scripture so much so that

they reject the truth of scripture in favour of personal experience. Many well known psychologists, the likes of Richard C Cabot (1868-1939), Anton Boisen (1876-1965), Carl Rogers (1902-1987), Seward Hiltner (1909-1983) and Wayne E Oates (1917-1999) that have had significant theological training, have questioned the use of scripture as a counselling tool (Babler et al 2007:18-37). Most of these theories are based on "self above God, experience above scripture." The consensus to the scripture-counselling split lies with the influence that the field of psychology has had on the church and the loss of scripture as authoritative - 2 Timothy 3:16-17; *"All scripture is given by inspiration of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness: That the man of God may be perfect, thoroughly furnished unto all good works"* (KJV).

For those who support the use of scripture in the counselling process, confirm this in the texts of Hebrews 4:12, *"For the word of God is alive and active"* and Isaiah 55:11 *"My word that goes out from my mouth: It will not return to me empty, but will accomplish what I desire and achieve the purpose for which I sent it."* The Bible can be a wonderful tool if utilised correctly. Yet there is always a danger in misusing scripture. Oswald Chambers (1937) (cited in Monroe (2010:6) says;

> "Now there is a wrong use of God's word and a right one. The wrong use is this sort of thing—someone comes to you, and you cast about in your mind what sort of man he is, then hurl a text at him like a projectile, either in prayer or in talking as you deal with him. That is a use of the word of God that kills your own soul and the souls of the people you deal with. The Spirit of God is not in that. Jesus said, "the words I speak unto you, they are spirit, and they are life."

Monroe labels this as "Bible bullets" and questions why counsellors 'bible bash' their clients. Two results occur when "Bible bullets" are in play; a breakdown of counsellor-counselee relationship and the hardening of the counselee's heart towards God (Monroe 2010:6-7).

The question then, is how can a counsellor effectively use spiritual resources without causing a breakdown in the counsellor-counselee

relationship?[48] Monroe's (2010:10) belief is that scriptures exist primarily to connect us to God and therefore should be used in the counselling process. Clinebell (1984:122) and Monroe (2010:10-15) identify general guidelines for effectively using spiritual resources.[49] (1) Understand and know the patients background through assessment. This will help eliminate alienation between the two parties. (2) Ask permission to use religious resources. This shows respect for the person's beliefs and views. (3) Provide an opportunity for the patient to respond to the resource once being used. This allows for open discussion and reflection. (4) Use the resource so that it does not take away responsibility for the patient actions. (5) Make use of the patient's feelings in the religious resources. This shows the patient that God accepts our human feelings. (6) Don't feel that one has to always use religious resources. God is present in all relationships and not only when religious words are spoken. (7) Invite the patient or their family to pray. (8) Use religious resources more frequently in crisis, bereavement and supportive counselling, than in therapy sessions. (9) Competency. The counsellor needs to be confident and be competent to use religious resources. This is the hallmark of every therapeutic code of ethics. (10) Avoid biases. Understand your biases and their impact on the patient. (11) Be familiar with the resources been used. This limits relying on personal experience and passing fads when using the text. (12) Understand your goal for the use of resources. Why should you read this specific text? How will it help? (13) Understand the context of the text. Does the message of the scriptures meet the patient where he's at?

With the help of these guidelines, the counsellor (*or chaplain*) will be able to use religious resources as a means of providing comfort and guidance to the patient. However it is important to note that these are just guidelines and nothing more. Oswald Chambers (cited in Monroe 2010:10) says that

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[48] Most of the time religious resources will be used more abundantly in a formal counseling setting then in general pastoral care.

[49] Clinebell offers nine guidelines and Monroe ten. Some guidelines are mentioned by both parties. Only guidelines that are appropriate for pastoral care in a chaplain setting will be noted.

> "We cannot, deal with the human soul and the ailments and difficulties of the human soul according to any one principle whatever. As soon as we get wedded to a shortcut in dealing with souls, God leaves us alone."

5.4. Chapter Summary

History has shown that in the past a deep-seated association between church and medicine co-existed. However with the rapid progression of the medical profession, the church was forced onto the sidelines, resulting in the decline of "fulltime" hospital pastoral care. At present, professional hospital chaplains have sought to narrow the gap between church and state by providing pastoral care on a permanent basis.

Jesus' words in John 10 and John 21, laid the foundation of the image of shepherding, which later was adopted as the focal point of Christian pastoral care. Through this image, many religious resources became available for the chaplain's disposal in providing care to the sick. If used accurately, Scripture becomes a significant tool for any pastoral visitor. Lioy (2009) supports the view that "scripture affirms the unity of body and mind in the overall health of an individual."

The field of pastoral care has seen many challenges over the years, particularly with the advancements of the mental health professions. Certain positions have illustrated the relationship between secular psychology and biblical truth.

Many similarities co-exist between formal pastoral care and hospital pastoral care. The local pastor and church member, with adequate training and guidance in hospital ministry, will be able to provide an important role in visitations.

CHAPTER 6

Recommendations

What possibilities lie for the South African hospital chaplain? To date it seems that the South African Police Services and The South African Defence Force employ the services of a chaplain,[50] yet the South African Health Department has failed to do so. Perhaps this is a study in itself? Until there is change in how the government sees hospital chaplains, the follow recommendations for providing pastoral care in a medical setting are alluded to.

6.1. A Working Relationship

The strategic and fundamental element of the chaplains "success" is that of an ongoing working relationship with all staff members of the medical institution. Where little is known about the chaplain (particularly in South African hospitals), the medical staff needs education and exposure to the functioning of the chaplain and this can only come about through a working relationship. The difficulty with this is that physicians work their community service year in government hospitals, and then often move on; creating a situation whereby the chaplain needs to establish new relationships each year. Therefore an asserted amount of time should be spent communicating with nursing staff, as they are frequently the eyes and ears for the physician and who generally have a lengthier employment contract.

Part of this relationship is keeping the functions of the chaplain at the forefront of the staff's mind. One of the key areas that can be improved is the ministry to the dying. Oden (cited in Lioy 2009) noted that the chaplain is often called to the bedside of a patient at the last moment. Portraying this as a grave sign, the patient becomes distressed. It is suggested that the earlier the

[50] The researcher has from time to time seen advertised posts in National newspapers.

chaplain is brought into the healing team, the better, so that body and soul can be treated together.

6.2. Educational Opportunities

One way to address the educational needs of staff members regarding the ministry of the chaplain is through workshops, seminars or talks. D'Souza (2007:58) suggests that "Doctors, psychiatrists and mental health clinicians should be required to learn about the ways in which religion and culture can influence a patient's needs." This research revealed that 64.2 percent of physicians and 77.7 percent of nursing staff would appreciate educational training to gain better insight into addressing the patient's spiritual needs. Most of the physicians indicated that a working knowledge of spiritual assessments would be beneficial to their practice. Many physicians indicated that learning to deal with the spiritual aspects of medical care is not part of medical school. Not surprisingly, this study has revealed that patients want and expect medical staff to deal with their spiritual needs as part of the provided care.

The second educational opportunity could lie with Seminary training. Through the researcher's experience, education on hospital visitation is very limited as a Seminary "subject." Anyone studying to graduate as a pastor will at some time or the other face the task of having to visit someone from their congregation in hospital. Providing some form of education regarding hospital ministry would be invaluable.

6.3. From Volunteer to Profession

As previously discussed in Chapter four, certain challenges await the chaplain in the workplace. Yet the greatest challenge still remains - plotting out their territory in the world of work. De Vries et al (2008:10-12) address this

challenge as chaplains try translate the tangible benefits they provide to patients, families, and staff into terms hospital administrators can understand.[51] For this to take place certain challenges need to be overcome in order to describe, to themselves and to others, what constitutes "quality" in their area of patient care.

1) *No clear jurisdiction.* Just as pastors were seen as the "jack-of-all-trades," so too has the role of the chaplain been identified. The authors call it "a vacuum identity" as the work of chaplains is often seen as filling the many vacuums that arise among the jobs of other professions in medical settings, rather than offering a well-defined service. In order to secure a place as a profession, chaplains must have a clear boundary around its work for it is difficult to stake a jurisdictional claim with an ambiguous definition of one's jurisdiction.

2) *Disagreement within the occupational group.* Several questions are still asked about the profession and definition of chaplains. Varying degrees of disagreement exist - from training qualifications to standards of practice to boundaries and duties; these are issues that threaten the chaplain's move towards professional status if few are in consensus.

3) *Self-defining.* The title "chaplain" is often misused amongst clergy and volunteer personal that make hospital visits. Just because clergy have the same degree, doesn't mean that they are qualified chaplains. As defined throughout the thesis, a chaplain is a professional that has received specific and extensive training in this area. The reality of misusing the "chaplain badge," makes it difficult for other professional groups, and the public, to see chaplaincy as a distinct health care profession. Clearer definitions need to be set defining what professional chaplains do, what volunteers do, and what clergy do with respect to chaplaincy. Furthermore one should determine which of these activities are health care services and which are religious services.

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[51] Only applicable challenges that have not yet been discussed will be addressed. Challenge seven is unrelated to De Vries et al.

4) *Challenging others' 'turf'.* Chaplains are in affect encroaching on the medical world. At times the duty of chaplain and social worker are very similar (for example, assessing the patient's home situation). Some may not see this as a threat, nevertheless, some medical social workers and clergy, who provide an important work amongst their congregations, will not look kindly on those who threaten their livelihood. Part of the "turf war" is what De Vries et al (2008:11) calls *"dirty work."* The ministry that chaplains offer could be seen as "dirty work" by the physicians, as the work they provide is described as distractions from the "real" work of medicine and not as prestigious.

5) *Quality Improvement.* Chaplains, as part of the health care field, are being asked to join the quality improvement movement of other medical professions. The difficulty with this is the manner in which one measures chaplaincy work. With quantity and quality being the norms in the health care field, should chaplains be expectant to make the "daily quota," rather than focus on the quality of their visits? Chaplaincy groups even disagree as to understand the term "best practices." Until these discrepancies are rectified, professional status will be hard to come by.

6) *Practice license*. Ordained chaplains are already members of a professional religious category, however, even with all the credentials that a professional chaplain receives (see Chapter four), those certifications are not equivalent to a state practice license that other health care providers receive. A state recognised practice license is the one feature that separates the professional from those not properly certified.

7) *Unfamiliar practice.* One of the foremost differences that the researcher has found, comparing chaplaincy with the United States, is how many patients are unfamiliar with the services of a chaplain. South Africa does not have the "chaplain culture" within her bones. Since patients are not aware of this ministry, few then seek the services of the chaplain. Engagement with the patient comes from the request of physician or nurse. Owing to this

approach conversation with the patient is not as unguarded as what it would be if the patient requested to speak with a chaplain.

The conquering of these challenges, to move from "volunteer" to recognised professional, is an intricate process. De Vries et al (2008:13) summarises this by saying that

> "Chaplains and their organizations should think about how to translate the meaning and value of their work into terms that hospital administrators and others in decision-making positions can understand."

Those wanting to enter into the field of professional medical chaplains, have the colossal task of demonstrating to hospital administrators that the work offered by chaplains, although not income inducing, is a complimentary health service that focuses on the patient's overall morale.

6.4. Recommendations for the Local Church

Due to the lack of insight by governmental health officials to incorporate chaplains within hospitals, the local church has the opportunity to rise up and fill this absent gap.

6.4.1. Standing in the GAP

Although recognition to hospital chaplaincy is not given by government and hospital administrators, this shouldn't entail the end of full-time chaplains. In Matthew 9:37, Jesus tells his disciples that "*The harvest is plentiful but the workers are few.*" This paints a similar picture of hospital ministry. An important work yet often negated or lost amongst other ministries of the church. For in the end the Lord is looking *"for someone among them who would build up the wall and stand before me in the gap on behalf of the land…."* (Ezekiel 22:30). Church volunteers (with proper training) could be the people that the Lord is looking for to "*stand in the gap*" for the sick.

Wouldn't it be great if churches were in a position to supply their local hospital with a qualified chaplain? The reality is that most churches are not financially stable to do this; however, adopting a hospital by providing lay ministry would always be beneficial.

If individuals consider entering into this amazing field of ministry, Woodward (2010:1-2), describes three important factors that should be considered.[52] The first is the supporting church. The difficulty that lies ahead for any person wanting to embark in chaplaincy ministry in South Africa is that of church support. Woodward observes that the church has lost "the vision of non-stipendiary ministry." He continues, "This loss of vision has disabled the churches in empowering their structures and members to accept and engage its shared calling as a priestly body." It must be noted that many churches are not in a position to provide a stipend for a full-time chaplain. Perhaps the way forward is to orchestrate a Non-profit Organisation (NPO) that accrues funds outside of the local church.

The second aspect for consideration is the security of chaplaincy. As discussed in the previous section, the chaplain's service is difficult to measure. The bottom line for hospital administrators is the way which hospitals think about the process of delivering health care and does a chaplain fit into this sphere? More and more we hear of society closing its doors on anything religious – separation of church and state. What the future holds of this ministry, time will tell. But as long as there is a need, the harvest is ripe for picking.

The third facet is the way in which government and hospitals understand chaplains. Although various chaplain models have been discussed, the reality of the matter is the way in which the government chooses to promote the changing patterns of health care over the next decade. Is health care becoming purely scientific or will there still be elements of humanism?

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[52] Although written for a United Kingdom perspective, the researcher has modified Woodward's statements to apply in a South African context.

These factors influence not only the future of chaplaincy, but also the progression into the Twenty first Century. With all emphasis being placed on the legalities of a professional chaplain, does it mean that there is no opportunity for the church visitor to visit patients? Defiantly not. Chaplains are not in a position to replace any person wanting to visit with a patient of their own denomination. The church visitor has every right to call upon a church member. In saying that, the church visitor would benefit from training and guidance in visiting with hospital patients.

6.4.2. Visitation Guidelines and Pitfalls

Visiting someone in hospital can be an emotional experience for the visitor. The encounter often heightens one's senses – the smell of medicines, the sight of doctors walking around, the idea of not wanting to touch anything for fear of contamination, or the sounds from various machines; all add to this 'fearsome' experience. Everything about a hospital is foreign where the unexpected can happen. Hospitalisation has a way of 'bringing the child out of a patient'. Patients are told when to eat. Wards have "lights out" time. Patients may need assistance to go to the bathroom. Sometimes patients may require the use of nappies and patients cannot just roam around. In other words, hospitals cause some patients to regress to a child-like state. Hughes (2009:7) suggests that it makes a huge difference when you go out of your way to give the patient some of what has been lost back – by simply being courteous. There is a belief that there is nothing more "comforting" for a patient, than to receive a visit from a loved one or pastoral caregiver. Pastors and church members will never escape from making a hospital visit so their presence is of utmost important. For a detailed list of these guidelines refer to Appendix 10.

Even keeping instep with these guidelines, there are danger signs that hospital visitors need to be aware as certain temptations may sneak into a visit. Kirkwood (2005a:74) explicates nineteen temptations that should be avoided

when seeking opportunities to visit hospitals.[53] Refer to Appendix 11 for a list of Kirkwoods adapted pitfalls. Although avoidable, he assures that there will be times when we succumb to them. Given that hospital ministry is demanding, tricky and sometimes awkward; the most trained professional will yield to some of these temptations. The fact of the matter is, ministry equals people, and when people are involved, emotions are involved, and when emotions are involved, sensitivity becomes the nature of the game. Therefore relying on the Holy Spirit to guide His work, through us, will help reduce the rate and regularity of falling into these temptations.

6.5. Recommendations for the Government and Training Institutions

The question of why the government does not recognise the need for hospital chaplains still remains unanswered in spite of active South African police and military chaplains. This could lend its self to an individual study. If South Africa is striving to become a more established "Third World" country that rates its self against the United States and other European countries, spiritual care in healthcare is lacking. Studies continue to showcase the tremendous effect that spiritual care has on patients. Creating workshops at hospitals that address ethical spiritual assessments could provide exposure to the need of chaplaincy work.

Religious training institutions could perhaps offer qualifications for chaplain ministry and further exposure to hospital pastoral care modules can be incorporated into their curriculum of studies. Equipping future pastors to basic hospital ministry skills, will help narrow this gap. This research has revealed that medical personal have in no way been exposed during their training to the relationship that medicine and spiritually have and the manner in which they can assist in creating opportunities for spiritual assessments. This could possibly lead to South African medical schools including spiritual teachings in their curriculum.

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[53] "Length of visit" has been omitted, due to the discussion in 5.6.1.

These recommendations are based on simple business principles of marketing - the more exposed the concept of chaplaincy is, the better the understanding will be as to the role that a chaplain can fulfil in the medical field.

6.6. Recommendations for Further Research

A great deal of study can still be conducted in hospital pastoral care. One such research is the role of faith in Intensive Care Units. This research paper was conducted outside of trauma or life threatening situations and therefore it is the researcher's opinion that deeper spiritual matters arise in death situations. Within this study lie many theological premises: the role of divine healing, the role of future stories, the supporting church for hurting individuals, the role of miracles and do medical miracles still exist? It would be profitable to seek such a study determining the manner in which hospitals support such families.

A South African study of the relationship between living a healthy religious lifestyle verses their illness can be conducted. This research will look at the role religion plays as a mechanism by which religion affects health. According to George et al (2000:110) this is the most addressed issue amongst social and behavioural professionals.

6.7. Chapter Summary

Regardless of all the challenges and difficulties that the modern chaplain faces, many opportunities exist for him. Initiating a N.P.O or N.G.O, is just one way of overcoming the financial debacle. By building and working on relationships with hospital staff, allow for educational opportunities to inform staff of the duties of the chaplain, hereby helping to minimise the "turf war."

De Vries et al (2008:10-12) described certain challenges that chaplains need to bear in mind when trying to move from lay chaplains to full-time chaplains. Until professional chaplains become a recognised profession, are

church volunteers going to “stand in the gap” and fill this void that is so needed?

In summary, I believe that hospital administrators don’t quite understand the role and benefit that chaplains offer to their medical institute. Much work still awaits South African churches to help eliminate this by providing and supporting qualified chaplains for their local hospitals.

CHAPTER 7

Conclusion

7.1. Research Review

The underlying objective of the thesis was to inspire anyone who does not see the value of the hospital chaplain by demonstrating their value in being part of the broader medical team. Throughout the thesis, the implication has been to show the reader the value of allowing patients to connect with their spiritual life in times of illness, through difficult decisions or even in lonely times. By providing the patient with this opportunity, the chaplain is the ideal professional to be the comforter.

7.2. Methodology of the Study

The LIM model of practical theology provided the ideal framework for the thesis. A questionnaire for patients was designed providing vital information regarding the necessity for a chaplain and how their spiritual life is demonstrated through their illness. A separate questionnaire for staff was created that presented information as to their belief of spirituality in healthcare and how they sought to attend to these spiritual needs.

Through articles and scripture the "*Interpretation of the world* (hospital) *as it should be"* (Cowen 2000) was explored. The conducted research revealed that the hospital has not created an ethos for the services of a chaplain. The chaplain was identified as a type of pastoral caregiver that uses unique tools, allowing patients the opportunity to explore their spirituality.

7.3. Conclusions of the Research

It became evident throughout the research that the hospital chaplain can play a crucial role in a patient's hospitalisation, by curtailing the spiritual and

emotional pain experienced. VandeCreek and Burton (2001:3) summarise the magnitude of the role hospital chaplaincy plays as part of a broader medical team in the lives of hospital patients by saying;

> "Institutions that ignore the spiritual dimension in their mission statement or daily provision of care increase their risk of becoming only biological garages where dysfunctional human parts are repaired or replaced. Such prisons of technical mercy obscure the integrity and scope of persons."

Although much can still be done by the governmental and private medical institutes in terms of meeting the spiritual and emotional needs of patients, the sending church could be the institute to *"stand in the gap"* until such advances are made.

7.3.1. The Patient's Spiritual Life

It came as little surprise that a patient's spiritual life is important to them while hospitalised. Albeit individuals go to hospital to get physically well, this is the primary motive, much can still be done to help alleviate any spiritual or emotional distress that a patient may experience. Such services can be through the ministry of chaplains, establishing a hospital "chapel" were patients, family, or staff can escape to seek peaceful tranquillity. Through discussions with patients via the questionnaire, I came to realise the lack of knowledge by patients in defining what a chaplain is. Much still needs to be done to create an ethos where chaplains are not only seen as a financial liability to the hospital administrators but as an asset to the medical field for the holistic care that they offer.

7.3.2. Addressing Spirituality in Healthcare

Although many medical staff is not acquainted in obtaining a spiritual history as indicated in Chapter three, the patient expressed that little was done to obtain their spiritual details upon admission. Much of the research been conducted revealed that positive health and life changes of a patient are the

result of a healthy spiritual life. Lubbe (2010:90) promotes the reasons why patient's still resort to religion as coping mechanisms to help contribute to a positive attitude and a sense of determination in medical rehabilitation.

Through dialogue with the physicians, it became apparent that many barriers exist, preventing physicians from spending time with the patient. However if a continual relationship existed between physician and chaplain, where the physician understood the chaplain's role, the spiritual and emotional needs of the patient could be better addressed.

7.3.3. The Hospital Chaplain as Pastoral Caregiver

As indicated in Chapter four, I came to the realisation that all throughout history, there lay a close tie between church and healthcare. Only since the rapid advancements of the medical world, has the church failed to keep in stride. Particularly in South Africa, there is no chaplain culture to speak of. Opportunities are available, outside of South Africa to persons wanting to become professional chaplains. The work of C.P.E has been evident over many years.

With the rich culture of imagery, many metaphors describe the functions of chaplains, although the most commonly used analogy is that of shepherding as portrayed in Ezekiel 34. With Scripture being the most powerful asset at the chaplain's disposal, there still lies a danger in providing "Sunday School" answers to the intricate questions raised by patients. With effective training, local clergy and hospital visitors play an important role in bridging the gap between church and state.

7.4. Final Conclusion

The fact that patients see the importance of a healthy spiritual lifestyle and that medical personal lack the training and insight into addressing spiritual needs of a patient was not surprising. The researcher is convinced that once

government and hospital administrators are exposed to the workings of hospital chaplaincy, the holistic care to patients would increase substantially.

An article by Feldstein (2001:1291-1292) provides an insightful closer to this thesis. Being a physician, Feldstein undertook the care of an 86 year old woman who suffers from brain cancer. Dr Feldstein was to review the current scan and make recommendations as to further medical care. Upon discovering that the cancer had spread, the following conversation took place:

> I pulled up a stool next to the gurney and sat down. 'Mrs. Martinez, the CT scan is abnormal.' I said. 'It shows that the cancer has spread to the brain.' Mrs. Martinez looked down. Her face became pale and stricken. I was keenly aware that this was not the kind of test result one simply tells a patient and walks out. Gently, and after a long pause, I asked, 'What is your reaction?' 'This is a death sentence,' she said, looking away." What could the doctor do? He noticed a crucifix around the patient's neck. He asked if she would like to pray. "Yes, I would." So, the doctor of the body knew that right then what she needed more than anyone was a doctor of the soul.

Who better then to address the issues of the soul, than a hospital chaplain that works alongside medical personal.

WORKS CITED

Allender D 1997. The special gift of a Christian counsellor (part 2). *Carer and Counsellor* 7(4):40.

Anandarajah G and Hight E 2001. Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment. *American Family Physician.* 63(1):81-88.

Babler J, Penley D & Bizell M 2007. *Counseling by the Book*. Florida, United States: Xulon Press. Electronic edition: Google Books, www.books.google.co.za.

Barnes A 1962. *Barnes' Notes on the New Testament*. Michigan, United States: Kregel Publications. Electronic edition: Google Books, www.books.google.co.za.

Barton BD, Beers RA, Galvin JC, Neff L, Taylor LC and Veerman DR 1988. *Life Application Bible.* Wheaton, Illinois: Tyndale House.

Bird J 2001. Medicine for Body and Soul. In Biller and others (eds), *Religion and Medicine in the Middle Ages.* Suffolk, United Kingdom: York Medieval Press. Electronic edition: Google Books, www.books.google.co.za.

Bluemel C [2010] What is the Biblical Role of a Pastor in the Church? Online article. Accessed from www.bibleanswerstand.org/pastors. 2010-11-22.

Blumhofer C 2007. Effective Hospital Visits. Online article. Accessed from www.christianitytoday.com/le/2007/fall/20.69. 2010-11-16.

Bobgan M and Bobgan D 1987. *Psychoheresy: The Psychological Seduction of Christianity*. Santa Barbara, United States: Eastgate Publishers.

Bruchhausen W 2007. Health Care between Medicine and Religion: The Case of Catholic Western Germany around 1800. *Hygiea Internationalis* 6(2):177–194.

Brushwyler LR, Fancher SC, Geoly JC, Matthews JR and Stone MR 1999. Pastoral Care vs. Professional Counseling: Discerning the Differences. Online article. Accessed from www.midwestministry.org, 2009-08-14.

Buckingham J 1991. *Parables: Poking Holes in Religious Balloons.* Florida, United States: Creation House.

Cachia N 1997. The Image of the Good Shepherd as a Source for the Spirituality of the Ministerial Priesthood. Volume 4 of Tesi gregoriana: Serie spiritualità. Rome, Italy: Editrice Pontificia Università Gregoriana. Electronic edition: Google Books, www.books.google.co.za.

Carter JD 2007. Sacred and Secular Models of Psychology and Religion. In Stevenson DH, Eck BE & Hill PC (eds), *Psychology and Christianity Integration: Seminal Works that Shaped the Movement*, 211-219. Illinois, United States: CAPS.

Carter JD and Narramore B 1979. *The Integration of Psychology and Theology: An Introduction.* Michigan, United States: Zondervan. Electronic edition: Google Books, www.books.google.co.za.

Chaplain. [2009]. In Encyclopaedia Britannica. Encyclopaedia Britannica Online: www.britannica.com/EBchecked/topic/106107/chaplain, 2009-07-08.

_____ [2010]. Catholic Encyclopedia. Online: www.newadvent.org, 2010-09-10.

_____ [2010]. Classic Encyclopedia. Online: www.1911encyclopedia.org, 2010-09-10.

Clarke P and Clarke PB (eds) 2009. *The Oxford Handbook of the Sociology of Religion*. Oxford, United Kingdom: Oxford University Press. Electronic edition: Google Books, www.books.google.co.za.

Clebsch WA and Jaekle CR 1967. Pastoral Care in Historical Perspective. New York, United States: Harper.

Clinebell H 1984. *Basic Types of Pastoral care & Counseling* (rev. ed.). Nashville, United States: Abingdon Press.

Collins GR 2007. *Christian Counselling* (3rd ed.). New York, United States: Thomas Nelson Publishers.

Collins GR 2000. An Integration View. In Johnson EL and Jones SL (eds), *Psychology and Christianity: Four Views*, 102-129. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Collins MG 2003. Parable of the Good Samaritan. *Forerunner* 12(6). Online article. Accessed from http://www.cgg.org/index.cfm/fuseaction/Library.sr/CT/BS/k/823/The-Parable-of-Good-Samaritan.htm. 2011-11-2.

Cowan MA. 2000. Introduction to Practical Theology. Institute for Ministry, Loyola University. Located at www.loyno.edu/~mcowan/PracticalTheology.html, Accessed 2009-07-20.

Crabb LJ Jr.1977. Effective Biblical Counseling. Michigan, United States: Zondervan.

Curlin FA and Hall DE 2005. Strangers or Friends? A Proposal for a New Spirituality-in-Medicine Ethic. *JGIM* April; 20(4): 370–374.

Daaleman TP 2004. Religion, Spirituality, and Medicine. *Journal of the American Board of Family Medicine* 17(5): 370-376.

Daily Exegesis 2009. The Good Samaritan. May 29. Online article. Accessed from www.dailyexegesis.blogspot.com/2009/05/good-samaritan.html. 2011-11-2.

De Vries R, Berlinger N and Cadge W 2008. Lost in Translation: The Chaplain's Role in Health Care. *Hastings Center Report.* 38(6):9-13.

D'Souza R 2007. The importance of spirituality in medicine and its application to clinical practice. *The Medical Journal of Australia* 186 (10):57-59.

Dykstra RC 2005. *Images of Pastoral Care: Classical Readings*. Atlanta, United States: Chalice Press. Electronic edition: Google Books, www.books.google.co.za.

Ehrlich SD 2009. Spirituality. *University of Maryland Medical Center*. Online article. Accessed from www.umm.edu/altmed/articles/spirituality-000360. 2011-01-11.

Ellis MR and Campbell JD 2004. Patients' Views about Discussing Spiritual Issues with Primary Care Physicians. *Southern Medical Journal* 97(12):1158-1164.

Ellis MR, Campbell JD, Detwiler-Breidenbach A, and Hubbard DK 2002. What do family physicians think about spirituality in clinical practice? *Journal of Family Practice*. 51(3):249-54.

Ellis MR, Vinson DC, and Ewigman B 1999. Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices. *Journal of Family Practice* 48, 105-109.

Evans GR (ed) 2000. *A History of Pastoral Care*. New York, United States: Continuum International Publishing. Electronic edition: Google Books, www.books.google.co.za.

Curlin FA, Sellergren SA, Lantos JD, and Chi MH 2007. Physicians' Observations and Interpretations of the Influence of Religion and Spirituality on Health. *Arch Intern Med*. 167, April 9: 649-654.

Feldstein BD 2001. Toward Meaning. *JAMA* 286(11): 1291-1292.

Ferngren G 2009. Medicine and Health Care in Early Christianity. Balyimore, Unites States: Johns Hopkins University Press. Electronic edition: Google Books, www.books.google.co.za.

Fetzer Institute, National Institute on Aging Working Group. Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research: A Report of the Fetzer Institute, National Institute on Aging Working Group. 2003. Accessed from www.fetzer.org/Resources/resources_multidimens.htm, 2010-07-10.

Fitchett G 2002. *Assessing Spiritual Needs: A Guide for Caregivers* (2nd rev.ed.). Ohio, United States: Renewal Press.

Fitchett G, Rasinski K, Cadge W, and Curlin FA 2009. Physicians' Experience and Satisfaction with Chaplains: A National Survey. *Arch Intern Med* 169(19):1808-1810.

Flannelly KJ, Ellison CG and Strock AL 2004. Methodologic Issues in Research on Religion and Health. *Southern Medical Journal* 97(12):1231-1241.

George LK, Larsons BD, Koeing HG & McCullough ME 2000. Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology* 19(1):102-116.

Hall TW and Coe J 2010. Ways of Seeing Christianity and Psychology. In Hall TW and Coe J, *Psychology in the Spirit: Contours of Transformational Psychology*, 57-74. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Handzo G 1996. Chaplaincy: A Continuum of Caring. *ONCOLOGY* 10(9):45-47.

Harrison EF 1960. *Baker's Dictionary of Theology.* Michigan, United States: Baker Book House.

Hathaway WL 2009. Clinical Use of Explicit Religious Approaches: Christian Role Integration Issues. *Journal of Psychology and Christianity.* July, 1-11.

Hiltner S 1958. *Preface to Pastoral Theology*. Nashville, United States: Abingdon Press. Electronic edition: Google Books, www.books.google.co.za.

Hiltner S 2005. The Solicitous Shepherd. In Dykstra RC 2005. *Images of Pastoral Care: Classical Readings*, 47-53. Atlanta, United States: Chalice Press. Electronic edition: Google Books, www.books.google.co.za.

Hodge DR 2005. Developing a Spiritual Assessment Toolbox: A Discussion of the Strengths and Limitations of Five Different Assessment Methods. *Health and Social Work.* November 1 2005.

Holst LE (ed.) 2006. *Hospital Ministry: The Role of the Chaplain Today* (2nd rev.ed.). Oregon, United States: Wipf & Stock.

Howard WS 1996. *Theological Context for Pastoral Caregiving: Word in Deed.* New York, USA: Haworth Pastoral Press. Electronic edition: Google Books, www.books.google.co.za.

Hughes J 2009. Making Hospital Visits. Online article. Accessed from www.difficultseasons.com/wp-content/uploads/2009/02/making-hospital-visits-1.pdf, 2010-11-25.

Jacobs MR 2008. What Are We Doing Here? Chaplains in Contemporary Health Care. *Hastings Center Report.* 38(6):1-4.

Johnson EL (ed.) 2010. *Psychology & Christianity: Five Views (2nd ed.).* Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Johnson and Jones (eds) 2000. *Psychology and Christianity: Four Views*. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Keddie, GJ 1994. *He Spoke in Parables*. Durham, United Kingdom: Evangelical Press.

Kirkwood NA 2005a. *Pastoral Care in Hospitals* (2nd ed.). New York, United States: Morehouse.

_____ 2005b. *A Hospital Handbook on Multiculturalism and Religion.* New York, United States: Morehouse.

Kliewer S 2004. Allowing Spirituality into the Healing Process. *Journal of Family Practice.* 53(8):616-624.

Koenig HG 2004. Religion, Spirituality, and Medicine: Research findings and implications for clinical practice. *Southern Medical Journal* 97(12):1194-1200.

Kollar CA 1997. *Solution-Focused Pastoral Counseling: An effective short-term approach for getting people back on track.* Michigan, United States: Zondervan.

LaRocca-Pitts MA 2004. Walking the Wards as a Spiritual Specialist. Online article. Accessed from www.hds.harvard.edu/news/bulletin/PDFs/DivBull2004summer.pdf, 2010-02-11.

_____ 2009. In FACT, chaplains have a spiritual assessment tool. *Australian Journal of Pastoral Care and Health* 3(2):8-15.

Larimore WL 2001. Providing Basic Spiritual Care for Patients: Should it be the exclusive domain of pastoral professionals? *American Family Physician*. 63(1): 36-41.

Levin JS 1994. Religion and Health: Is there an association, is it valid, and is it causal? *Social Science and Medicine* 29:69-78.

Lewis JM 2002. Pastoral Assessment in Hospital Ministry: A Conversational Approach. *Chaplaincy Today* 18(2):5-13.

Lioy D [2009]. Spiritual Care in a Medical Setting: Do We Really Need It? *Global Journal of Classical Theology* 3(2). Accessed from www.phc.edu/gj_lioyv3n2.php, 2009-10-14.

Loewy RS and Loewy EH 2007. Healthcare and the Hospital Chaplain. *Medscape General Medicine* 9(1):53. Accessed from www.ncbi.nlm.nih.gov/pmc/articles/PMC1924976/. 2010-11-2.

Lubbe G [2010]. Simply Ask: A Guide to Religious Sensitivity For Healthcare Professionals. Online article. Accessed from www.desmondtutudiversitytrust.org.za/simplyask.pdf, 2010-11-02.

Mack R 2003. *The Basics of Hospital Chaplaincy*. Florida, United States: Xulon Press. Electronic edition: Google Books, www.books.google.co.za.

Malan E 2009. South African Doctors. *Magazine International.* Online article. Accessed from www.sapromo.com/sa/wellbeing/medical/south-african-doctors, 2010-09-01.

Mandziuk PA 1994. The Doctor-Chaplain Relationship. *Western Journal of medicine* 160(4):376-377. Accessed from www.ncbi.nlm.nih.gov/pmc/articles/PMC1022440/?tool=pubmed. 2010-12-9.

Maugans TA 1996. The Spiritual History. *Archives of Family Medicine* 5:11-16.

McClung E, Grossoehme DH and Jacobson AF 2006. Collaborating with Chaplains to Meet Spiritual Needs. *Medsurg Nursing* 15(3):147-156.

McCord G, Gilchrist VJ, Grossman SD, King BD, McCormick KF, Oprandi AM, Schrop SL, Selius BA, Smucker WD, Weldy DL, Amorn M, Carter MA, Deak AJ, Hefzy H, and Srivastava M 2004. Discussing Spirituality With Patients: A Rational and Ethical Approach. *Annals of Family Medicine* 2(4). Online article. Accessed from www.medscape.com/viewarticle/487746, 2010-08-18.

McCormick TR [2009]. Spirituality and Medicine. Online article. Accessed from www.depts.washington.edu/bioethx/topics/spirit.html#ques2, 2009-07-14.

McDowell J and Hostetler B 1996. *Counseling Youth: A comprehensive guide for equipping youth workers, pastors, teachers and parents*. Dallas, United States: Word Publishing.

Myers DG 2000. A-Levels-Of-Explanation View. In Johnson EL and Jones SL (eds), *Psychology and Christianity: Four Views*, 54-83. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Milton MA 2010. "So What are You Doing Here? The Role of the Minister of the Gospel in Hospital Visitation, Online article. Accessed from www.mikemilton.org, 2010-10-10.

Mitchell BN 1999. Pastoral Care. In DG Benner et al (eds), *Baker Encyclopedia of Psychology and Counseling* (2nd ed.), 832-833. Michigan, United States: Baker Books.

Mohrmann ME 2008. Ethical Grounding for a Profession of Hospital Chaplaincy. *Hastings Center Report* 38(6):4-9.

Moll R 2009. The Health Care Debate, Early Church Style. Online article. Accessed from www.christianitytoday.com, 2010-8-23.

Monroe PG [2010]. Using The Scriptures In Counseling. Online article. Accessed from www.wisecounsel.files.wordpress.com/2006/12/the-uses-of-scripture-in-counseling-2.pdf, 2011-01-05.

Morris HM 2004. Doctor Luke. Online article. Accessed from www.icr.org/article/doctor-luke, 2009-07-09.

Moslener RW 1999. Family Syatems Theory. In DG Benner et al (eds), *Baker Encyclopedia of Psychology and Counseling* (2nd ed.), 442-444. Michigan, United States: Baker Books.

Mouton J 2001. *How to Succeed in Your Master's & Doctoral Studies.* Pretoria, South Africa: Van Schaik Publishers.

My Perspective on Integration of Theology and Psychology n.d. Online article. Accessed from www.btz.lt/English/Giedrius/works/Integration_Paper.pdf. 2011-01-20.

Mueller PS, Plevak DJ & Rummans TA 2001. Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice. *Mayo Clin Proc*. 76:1225-1235.

Nunn JF 1993. The doctor in Ancient Egypt. *Liverpool Medical History Society* 5-14. Accessed from www.lmi.org.uk/Data/10/Docs/07/07Nunn.pdf, 2010-5-19.

Pargament K 2001. Religion May Have Negative Effects On Patients. Online article. Accessed from www.cbc.ca/health/story/2001/08/13/health_god010813. 2010-11-03.

Peters M 2010 (1 August). Huge Shake-up Required for New SA Health System. Cape Town, South Africa. *Sunday Argus*, 4.

Peterson EH 1997. The business of making saints: An interview with Eugene H. Peterson. *Leadership.* 28(2):22.

Piderman KM, Marek DV, Jenkins SM, Johnson ME, Buryska JF, and Mueller PS 2008. Patients' Expectations of Hospital Chaplains. *Mayo Clin Proc.* 83(1):58-65.

Potter JV 2007. *Soul Care and Psychospiritual Counseling: An Introduction to Pastoral Care* (5th ed.). California, United States: AFS Publishing. Electronic edition: Google Books, www.books.google.co.za.

Press Ganey Knowledge Summary: Patient Satisfaction with Emotional and Spiritual Care [2010]. Online article. Accessed from www.pressganey.com, 2010-02-12.

Pruyser PW 1976. *The Minister as Diagnostician: personal problems in pastoral perspective.* Philadelphia, United States: Westminster Press.

Puchalski CM, Dorff E, and Hendi Y 2004. Spirituality, religion, and healing in palliative care. *Clinics in Geriatric Medicine Journal* 20:689-714.

Puchalski CM, and Romer AL 2000. Taking a Spiritual History Allows Clinicians to Understand Patients More Fully. *Journal of Palliative Medicine* 3(1):129-137.

Rabetafika YR 1999. Davidson, Andrew. In Anderson GH (ed.), *Biographical Dictionary of Christian Missions*, 170. New York, United States: Macmillan Reference.

Retief FP 2005. The Influence of Christianity on Graeco-Roman Medicine up to the Renaissance. *Acta Theologica.* Supplementum 7:259-277.

Roberts RC 2000. A Christian Psychology View. In Johnson EL and Jones SL (eds), *Psychology and Christianity: Four Views*, 148-177. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Rodgers B 2010. A Christological Reading of the Shepherd Motif for Pastoral Theology with Special Reference to Ezekiel 34. *The American Journal of Biblical Theology* 11(24):1-18.

Rosdahl CB and Kowalski MT (eds) (9th ed.) 2008. *Textbook of Basic Nursing*. Philadelphia, United States: Lippincott Williams & Wilkins. Electronic edition: Google Books, www.books.google.co.za.

Rumbold BD 2007. A review of spiritual assessment in health care practice. *The Medical Journal of Australia* 186(10):60-62.

Russell EV 1997. The role of the chaplain: this spiritual counselor may have more to offer than you realize - chaplains in long-term care facilities. Nursing Homes. September 1997. Online article. Accessed from www.findarticles.com/p/articles/mi_m3830/is_n8_v46/ai_19927944/?tag=content;col1, 2010-5-19.

Scott BB 1991. *Hear then the Parable: A Commentary on the Parables of Jesus.* Minneapolis, United States: Fortress Press. Electronic edition: Google Books, www.books.google.co.za.

Seelye KQ 2009. Zen and the Art of Hospital Care. Online article. Accessed from www.prescriptions.blogs.nytimes.com/2009/12/12/zen-and-the-art-of-hospital-care, 2010-02-23.

Serowa 2009. The Four Christian Views on Integration of Psychology and Theology. *Relijournal.* 5 November 2009. www.relijournal.com/christianity/the-four-christian-views-on-integration-of-psychology-and-theology/. 2011-01-20.

Shastri KV, Pande VV, Tekade AR and Gadekar AS 2008. Religious Involvement, Spirituality and Medicine: Subject Review and Implications for Clinical Practice. *Pharmaceutical Reviews* 6(1). Accessed from www.pharmainfo.net/reviews/religious-involvement-spirituality-and-medicine-subject-review-and-implications-clinical-pra, 2009-05-26.

Shelly M 1994. *The Quest Study Bible*. Michigan, United States: Zondervan.

Sloan RP and VandeCreek L 2000. Religion and Medicine: Why Faith Should Not Be Mixed With Science. Online article. Accessed from www.medscape.com, 2009-05-26

Slutz T [2009]. Congregations, spirituality, and health. Online article. Accessed from www.polis.iupui.edu/RUC/Newsletters/Responsive/vol2no5.htm, 2009-05-25

Stamps L 2011. Psychology and Christianity. Online article. Accessed from www.tgcreviews.com/reviews/psychology-christianity. 2011-01-22.

Steere DA 1997. *Spiritual Presence in Psychotherapy: A guide for caregivers*. Pennsylvania, United States: Brunner/Mazel INC. Electronic edition: Google Books, www.books.google.co.za.

Swift C 2009. *Hospital Chaplaincy in the Twenty-first Century: The Crisis of Spiritual Care on the NHS.* Surrey, United Kingdom: Ashgate Publishing. Electronic edition: Google Books, www.books.google.co.za.

Taylor CW 1991. *The Skilled Pastor: counseling as the practice of theology.* Minneapolis, United States: Fortress Press.

Thom A 2000 Community service doctors make a difference. Online article. Accessed from www.health-e.org.za/news/article.php?uid=20000203, 2010-09-02.

Thompson RE 2005. Hospital Chaplains: What, Who, and Why*? Physician Executive.* March-April 2009.

Thoresen CE 1999. Spirituality and Health: Is There a Relationship? *Journal of Health Psychology*. 4(3): 291-300. Online article. Accessed from http://www.uiowa.edu/~hlthpsy/article.htm.

Transforming Hospital Chapel into Welcoming Space. 2010. Online article. Accessed from www.wcco.com/health/hospital.chapel.meditation.2.1509329, 2010-11-10.

Turner L 2001. Medical ethics in a multi cultural society. *Journal of the Royal Society of Medicine.* 94(11):592-594.

University of Stellenbosch Unit for Religion and Development Research, 2004. Helderberg Basin Transformation Research Project. Online article. Accessed from www.sun.ac.za/theology/urdr, 2010-08-13.

Vance DL 2001. Nurses' Attitudes Towards Spirituality and Patient Care. *MedSurg Nursing: The Journal of Adult Health*. October 2001.

VandeCreek L and Burton L 2001. Professional Chaplaincy: It's role and importance in healthcare. Online article. Accessed from www.healthcarechaplaincy.org/publications/publications/white_paper_05.22.01/pdf/White_Paper_05.22.01, 2009-05-29.

Vanzant S 2009. *The Significance of One: How to make your life better*. Pennsylvania, United States: Destiny Image.

Veterans Affairs: Health Care Chaplaincy 1997. Online article. Accessed from www.ncmaf.org/policies/ECVAC/ECVAChealthcare.pdf. 2011-01-20.

Waite M and Hawker S (eds) 2009. *Oxford Dictionary & Thesaurus.* Oxford, Great Britain: Oxford University Press.

Wilcock P 1996. *Spiritual Care of Dying and Bereaved People.* London, Great Britain: SPCK.

Wilson RF [2011]. The Parable of the Good Samaritan (Luke 10:25-37). Online article. Accessed from www.jesuswalk.com/lessons/10_25-37.htm.

Woodbridge NB 2007. Psychotherapy: Science or Religion? Some Implications for Today's Church. *Conspectus* 4:83-95.

Woodward J [2010]. Health Care Chaplaincy: A Reflection on Models. Online article. Accessed from www.rps.gn.apc.org/jww/pdf/Articlepercent2023percent20Healthpercent20Carepercent20Chaplaincy.pdf, 2010-06-05.

Yawar A 2001. Spirituality in medicine: what is to be done? *Journal of the Royal Society of Medicine* 94(10):529-533.

Young A, van Niekerk CF and Mogotlane S (eds) 2007. Juta's Manual of Nursing. Landsdowne. South Africa: Juta & Co.

Zucker DJ, Bradley TP and Taylor BE 2007. The Chaplain as an Authentic and an Ethical Presence. *Chaplaincy Today* 23(2)15-24.

WORKS CONSULTED

Adams, JE. *Competent to Counsel*. New Jersey, United States: Presbyterian and Reformed Publishing.

Allan A 2001. *The Law for Psychotherapists and Counsellors.* Somerset West, South Africa: Inter-Ed Publishers.

Beck JR 2001. Psychology and Christianity: Four views. *The Denver Journal* 4. Online article. Accessed from www.denverseminary.edu/article/psychology-and-christianity-four-views. 2011-01-20.

Berlinger N 2008. The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility. *Hastings Center Report* 38(6):16-19.

Bornman PC, Krige JEJ, Terblanche J, Rode H and de Villiers JC 1996. Surgery in South Africa. *Archives of Surgery*. 131:6-12.

Cadge W & Ecklund EH 2009. Prayers in the Clinic: How Pediatric Physicians Respond. *Southern Medical Association* 102(12):1218-1221.

Cadge W, Freese J and Christakis NA 2008. The Provision of Hospital Chaplaincy in the United States: A National Overview. *Southern Medical Association* 101(6):626-630.

Cecil DM [2009]. Theological Orientation & Role Definition of Hospital Chaplains: A Survey of Healthcare Chaplains Ministry Association Chaplains. Online article. Accessed from www.hcmachaplains.org/commentary9.html, 2009-10-20.

Clark PA, Drain M and Malone MP 2003. Addressing Patients' Emotional and Spiritual Needs. *Joint Commission Journal on Quality and Safety* December (29)12:659-670.

Comstock, G.W, & Partridge, K.B. (1972). Church Attendance and Health. *Journal of Chronic Diseases*, 25, 665-672.

Diamond SA 2008 (24 December). The Psychology of Spirituality. *Psychology Today*. Electronic edition: Psychology Today www.psychologytoday.com.

Fath G 1993. Pastoral Counseling in a Hospital Setting. In RJ Wicks, RD Parsons & D Capps, *Clinical Handbook of Pastoral Care,* 349-376. New Jersey, United States: Paulist Press. Electronic edition: Google Books, www.books.google.co.za.

Fitchett G [2010]. Wondering if it's time to give up: A case example of the 7 x7 model for spiritual assessment. Online article. Accessed from www.rushu.rush.edu/servlet/satellite, 2010-09-25

Friedman EH 1985. *Generation to Generation: Family Process in Church and Synagogue.* New York, United States: Guilford Press.

Garrison AW 2005. Religion, Health, and Questions of Meaning. *MedGenMed.* 7(3):73.

Guidelines for the Pastoral Care of the Sick and Frail. 2001. Online article. Accessed from www.rok.catholic.net.au/Policies/Guidelines%20for%20Pastoral%20Care%20of%20Sick%20and%20Frail.pdf, 2010-11-15.

Handzo GO, Smith WJ, Twiname J, Twiname C, & Weiss WM 1999. The HealthCare Chaplaincy, Inc., New York, NY. *Journal of Healthcare Chaplaincy.* 9(1-2), 29-42.

Hardy RM [2009]. The Place and Importance of Pastoral Care. Online article. Accessed from www.ecounseling.com/articles/475, 2009-05-29.

Henry M 1960. *Matthew Henry's Commentary: One the Whole Bible in One Volume*. Michigan, United States: Zondervan.

Hodge DR 2001. Spiritual Assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Health and Social Work* 46(3):203-213.

Howe LT 1981 (November 11). Where Are We Going in Pastoral Care? *Christian Century*, 1160-1163.

Jonsen AR, Siegler M and Winslade WJ 2002. *Clinical Ethics* (5th ed.). New York, United States: McGraw-Hill.

King DE, Crisp J 2007. Case Discussion: Do Not Neglect the Spiritual History. *Southern Medical Journal* 100(4):426.

La Pierre LL 2003. JCAHO Safeguards Spiritual Care. *Holistic Nursing Practice* 17(4):219.

Lester AD 1995. *Hope in Pastoral Care and Counselling.* Louisville, United States: Westminster John Knox Press.

Murray K [2010]. Having the Ears to Hear: The Role of Diagnosis in Pastoral Care. Online article. Accessed from www.revisionsplus.com/Having_the_Ears_to_Hear.doc, 2010-09-22.

Nichols MP 1995. *The Lost Art of Listening.* New York, United States: The Guilford Press.

Naidoo N 2000. South Africa is losing hundreds of nurses each year. Online article. Accessed from www.queensu.ca/samp/sampresources/migrationdocuments/commentaries/2000/nurses.htm, 2010-09-02.

Powlison D 2000. A Biblical Counseling View. In Johnson EL and Jones SL (eds), *Psychology and Christianity: Four Views*, 196-225. Illinois, United States: InterVarsity Press. Electronic edition: Google Books, www.books.google.co.za.

Price C 2007. Hospitals: A Historic Perspective. *Clearly Caring* 27(5) September / October: 6-7.

Richardson PT 1996. *Four Spiritualities: a psychology of contemporary spiritual choice.* California, United States: Davies-Black Publishing.

Roach D 2004. Biblical View of Counseling Examined in Theological Journal. *Southern Baptist Journal of Theology* February 26. Online article. Accessed from www.baptistpress.org/printerfriendly.asp?ID=17734. 2011-01-22.

Siau S 2007. Psychology and Christianity: Four Views. Online article. Accessed from www.markedpages.com/2007/08/. 2011-01-20.

Smith ML 2008. Chaplaincy and Clinical Ethics: A Common Set of Questions. *Hastings Center Report* 38(6):14-15.

Stone HW 1996. *Theological Context for Pastoral Care: Word in Deed.* New York, United States: Haworth Press. Electronic edition: Google Books, www.books.google.co.za.

Thomas RM 1998. Spirituality and Medicine. Online article. Accessed from www.depts.washington.edu/bioethx/topics/spirit.html#ques2, 2009-05-21.

Vandecreek L [2010]. Physicians Providing Spiritual Care. Online article. Accessed from www.parkridgecenter.org/Page465.html, 2010-11-10.

Wade R 1999. Not a Threat: The Contributions of Christianity to Western Society. Online article. Accessed from www.leaderu.com/orgs/probe/docs/threat.html. 2010-09-10.

Warnock A 2004. Biblical counselling: What is counselling? Online article. Accessed from www.adrianwarnock.com/2004/08/biblical-counselling-1-what-is-counselling. 2010-11-11.

Winfrey D 2007 (January). Biblical therapy: Southern Baptists reject "pastoral counseling." Online article. Accessed from www.findarticles.com/p/articles/mi_m1058/is_2_124/ai_n27129602/?tag=content;col1, 2009-06-12.

Appendix 1: Comparison Questionnaire: Government and Private

Descriptor	Government		Private	
Sample Size:	**NO.**	**%**	**NO.**	**%**
Number of questionnaires distributed	67		63	
Completed questionnaires	60	89.5%	60	95.2%
Language:				
English	7	11.6%	19	31.6%
Afrikaans	43	71.6	41	68.3
Xhosa	10	16.6	0	0
Client:				
Patient	51	85%	58	96.6%
Family	9	15	2	3.33
Gender:				
Male	22	36.6%	24	40%
Female	38	63.3	36	60
Age Group:				
0-12	0	0%	0	0%
13-19	5	8.3	2	3.3
20-30	18	30	2	3.3
31-40	9	15	1	1.6
41-50	11	18.3	9	15
51-60	4	6.6	9	15
60+	10	16.6	35	58.3
No Answer	0	0	2	3.3
To which population do you belong?				
Coloured	37	61.6%	12	20%
Asian	0	0	0	0
Caucasian	5	8.3	46	76.6
African	17	28.3	2	3.3
Indian	0	0	0	0
Which area do you reside in?				
Somerset West	5	8.3%	16	26.6%
Strand	18	30	20	33.3
Gordons Bay	4	6.6	6	10
Macassar	14	23.3	0	0
Grabouw	14	23.3	4	6.6

Other	5	8.3	14	23.3
Is your hospitalisation:				
pre-arranged	24	40%	28	46.6%
Emergency	34	56.6	32	53.3
No Answer	2	3.3	0	0
Is this your first hospitalisation in this hospital?				
Yes	26	43.3%	12	20%
No	34	56.6	48	80
Reason for your hospitalisation?				
Medical	28	46.6%	25	41.6%
Surgical	18	30	26	43.3
Trauma	7	11.6	7	11.6
Follow Up	5	8.3	2	3.3
No Answer	2	3.3	0	0
Current duration of stay in hospital?				
1-2 days	17	28.3%	20	33.3%
3-4 days	15	25	18	30
5-7 days	12	20	4	6.6
1 week	8	13.3	10	16.6
2 week/more	6	10	6	10
No Answer	2	3.3	2	3.3
In which manner do you feel the doctor relates to you as a patient?				
Poorly	1	1.6%	0	0%
Satisfactory	3	5	2	3.3
Good	19	31.6	18	30
Excellent	34	56.6	39	65
No Answer	3	5	1	1.6
In which manner do you feel the hospital staff relate to you as a patient?				
Poorly	2	3.3%	0	0%
Satisfactory	6	10	3	5
Good	25	41.6	20	33.3
Excellent	27	45	36	60
No Answer	0	0	1	1.6
How are your physical needs being met in the hospital?				

Poorly	3	5%	3	5%
Satisfactory	8	13.3	3	5
Good	31	51.6	29	48.3
Excellent	17	28.3	24	40
No Answer	1	1.6	1	1.6
How are your emotional needs being met in the hospital?				
Poorly	3	5%	1	1.6%
Satisfactory	15	25	5	8.3
Good	28	46.6	28	46.6
Excellent	10	16.6	14	23.3
No Answer	4	6.6	12	20
What would you say are your greatest needs/concerns in hospital?				
Material	14	23.3%	9	15%
Spiritual	11	18.3	6	10
Emotional	14	23.3	9	15
Other	12	20	9	15
No Answer	14	23.3	31	51.6
What faith group do you belong to?				
Christian	49	81.6%	55	91.6%
Muslim	3	5	2	3.3
Traditional African	2	3.3	0	0
Non-believer	3	5	1	1.6
Eastern	0	0	0	0
Other	1	1.6	1	1.6
No Answer	2	3.3	1	1.6
What denomination do you belong to?				
Spiritualist	1	1.6%	1	1.6%
Pinkster	3	5	1	1.6
AGS	2	3.3	3	5
NGK	5	5	29	48.3
Apostolic	2	3.3	2	3.3
Jehovah Witness	1	1.6	0	0
Moravian	2	3.3	1	1.6
Zion	2	3.3	0	0
Methodist	4	6.6	4	6.6
7th Day	1	1.6	0	0
Inter-denominational Churches	12	20	4	6.6
Anglican	6	10	6	10

Baptist	1	1.6	0	0
Church of England	0	0	1	1.6
Muslim	3	5	2	3.3
Presbyterian	0	0	1	1.6
Catholic	0	0	2	3.3
No Answer	15	25	3	5
Are you an active member of your religious church/mosque/institution?				
Yes	39	65%	41	68.3%
No	17	28.3	18	30
No Answer	4	6.6	1	1.6
Do you as a patient have any religious/spiritual needs during your hospital stay?				
Yes	19	31.6%	17	28.3%
No	25	41.6	34	56.6
Uncertain	12	20	6	10
No Answer	4	6.6	3	5
If yes (#18), how are those needs met in hospital?				
Poorly	2	3.3%	2	3.3%
Satisfactory	2	3.3	4	6.6
Good	9	15	8	13.3
Excellent	8	13.3	2	3.3
No Answer	39	65	44	73.3
If yes (#19), who is meeting your religious/spiritual needs while in hospital?				
Nurse	4	6.6%	1	1.6%
Doctor	3	5	1	1.6
Family	5	8.3	8	13.3
Friends	2	3.3	2	3.3
Religious Member	10	16.6	8	13.3
Other	4	6.6	2	3.3
No Answer	38	63.3	43	71.6
Did any staff member enquire about your religious/spiritual needs?				
Yes	16	26.6%	15	25%
No	37	61.6	40	66.6
Unsure	6	10	2	3.3
No Answer	1	1.6	3	5

Where do you find your sources of hope (excluding God) in stressful situations?				
Self	23	38.3%	15	25%
People	24	40	30	50
Tangible Objects	1	1.6	4	6.6
Religious Community	14	23.3	15	25
Other	4	6.6	2	3.3
No Answer	3	5	8	13.3
What importance does your religion/spirituality have to other areas of life?				
Irrelevant	2	3.3%	2	3.3%
Some what	5	8.3	6	10
Important	43	71.6	46	76.6
Uncertain	8	13.3	3	5
No Answer	2	3.3	3	5
Do you believe that your faith can aid in your emotional and physical healing?				
Yes	51	85%	55	91.6%
No	1	1.6	3	5
Unsure	5	8.3	1	1.6
No Answer	3	5	1	1.6
As a hospital patient, do you feel that it is important for the hospital to meet your religious/spiritual needs?				
Yes	39	65%	39	65%
No	10	16.6	9	15
Unsure	8	13.3	10	16.6
No Answer	3	5	2	3.3
As a hospital patient, do you feel that you can openly talk about your religious/spiritual needs to staff members.				
Yes	42	70%	35	58.3%
No	6	10	13	21.6
Unsure	11	18.3	9	15
No Answer	1	1.6	3	5
Would you appreciate being able to talk to the doctor about your religious/spiritual needs?				
Yes	40	66.6%	27	45%
No	2	3.3	20	33.3
Unsure	16	26.6	11	18.3
No Answer	2	3.3	2	3.3

Would you ever want the doctor to pray with you?				
Yes	46	76.6%	31	51.6%
No	6	10	14	23.3
Unsure	7	11.6	13	21.6
No Answer	1	1.6	2	3.3
Do you think that it's…….to discuss your religious/spiritual matters with the doctor?				
appropriate	45	75%	37	61.6%
inappropriate	10	16.6	20	33.3
No Answer	5	8.3	3	5
Do you know what a chaplain is?				
Yes	22	36.6%	47	78.3%
No	37	61.6	13	21.6
No Answer	1	1.6	0	0
If no (#28), were you aware that a hospital chaplain can be defined as a 'professional religious worker'?				
Yes	24	40%	42	70%
No	33	55	15	25
No Answer	3	5	3	5
Are you aware of the functions of a hospital chaplain?				
Yes	15	25%	31	51.6%
No	35	58.3	19	31.6
Some What	9	15	10	16.6
No Answer	1	1.6	0	0
Do you know how to request a hospital chaplain visit?				
Yes	18	30%	23	38.3%
No	40	66.6	35	58.3
No Answer	2	3.3	2	3.3
If a hospital chaplain was made available to meet your religious/spiritual needs, would you request a visit?				
Yes	50	83.3%	41	68.3%
No	2	3.3	11	18.3
Unsure	7	11.6	7	11.6
No Answer	1	1.6	1	1.6

How often would you like to be visited by a hospital chaplain?				
Daily	12	20%	5	8.3%
Every Few Days	29	48.3	31	51.6
Weekly	15	25	12	20
No Answer	4	6.6	12	20
What need(s) do you have to be addressed by the hospital chaplain?				
Prayer	41	68.3%	31	51.6%
Talk	17	28.3	17	28.3
General Counsel	17	28.3	20	33.3
Ethical Counsel	0	0	3	5
Religious Rites	6	10	4	6.6
Calm my anxiety	6	10	3	5
Comfort	11	18.3	5	8.3
Other	1	1.6	4	6.6
No Answer	2	3.3	12	20
Do you feel that it would be of value if the hospital had a counselling / prayer room for patients and family use?				
Yes	55	91.6%	53	88.3%
No	2	3.3	4	6.6
No Answer	3	5	3	5
Would you object to a general introductory hospital chaplain visit?				
Yes	5	8.3%	2	3.3%
No	54	90	56	93.3
Unsure	0	0	1	1.6
No Answer	1	1.6	1	1.6

Appendix 2: Comparison Questionnaire: Languages

Descriptor	English		Afrikaans		Xhosa	
Sample Size:	NO.	%	NO.	%	NO.	%
Number of questionnaires distributed	30		88		13	
Completed questionnaires	26	86.6%	85	96.5%	10	76.9%
Hospital Breakdown:						
D.E Government Hospital	7	26.9%	44	51.7%	10	100%
P.L Private Hospital	19	73	41	48.2%	0	0.0%
Client:						
Patient	25	96.1%	76	89.4%	9	90%
Family	1	3.8	9	10.5	1	10
Gender:						
Male	10	38.4%	32	38%	5	50%
Female	16	61.5	53	62.3	5	50
Age Group:						
0-12	0	0%	0	0%	0	0%
13-19	2	7.6	5	5.8	0	0
20-30	3	11.5	14	16.4	2	20
31-40	3	11.5	5	5.8	4	40
41-50	2	7.6	14	16.4	3	30
51-60	1	3.8	13	15.2	0	0
60+	14	53.8	31	36.4	0	0
No Answer	1	3.8	3	3.5	1	10
To which population do you belong?						
Coloured	0	0.0%	50	58.8%	0	0%
Asian	0	0	0	0	0	0
Caucasian	19	73	32	37.6	0	0
African	7	26.9	2	2.3	10	100
Indian	0	0	0	0	0	0
No Answer	0	0	1	1.1	0	0
Which area do you reside in?						
Somerset West	10	38.4%	10	11.7%	1	10%
Strand	5	19.2	27	31.7	6	60
Gordon's Bay	5	19.2	5	5.8	0	0
Macassar	1	3.8	13	15.2	0	0
Grabouw	0	0	16	18.8	3	30

Other	5	19.2	14	16.4	0	0
Is your hospitalisation:						
pre-arranged	11	42.3%	35	41.1%	6	60%
Emergency	15	57.6	50	58.8	2	20
No Answer	0	0	0	0	2	20
Is this your first hospitalisation in this hospital?						
Yes	11	42.3%	22	26%	5	50%
No	15	57.6	63	74.1	5	50
Reason for your hospitalisation?						
Medical	9	34.6%	43	50.5%	2	20%
Surgical	12	46.1	31	36.4	1	10
Trauma	4	15.3	8	9.4	2	20
Follow Up	1	3.8	3	3.5	3	30
No Answer	0	0	0	0	2	20
Current duration of stay in hospital?						
1-2 days	8	30.7%	28	32.9%	1	10%
3-4 days	3	11.5	29	34.1	1	10
5-7 days	7	26.9	8	9.4	1	10
1 week	5	19.2	11	12.9	3	30
2 week/more	3	11.5	7	8.2	2	20
No Answer	0	0	2	2.3	2	20
In which manner do you feel the doctor relates to you as a patient?						
Poorly	0	0.0%	0	0%	1	10%
Satisfactory	0	0	2	2.3	3	30
Good	8	30.7	28	32.9	2	20
Excellent	18	69.2	52	61.1	3	30
No Answer	0	0	3	3.5	1	10
In which manner do you feel the hospital staff relate to you as a patient?						
Poorly	0	0.0%	2	2.3%	0	0%
Satisfactory	1	3.8	6	7	2	20
Good	11	42.3	29	34.1	5	50
Excellent	14	53.8	47	55.2	3	30
No Answer	0	0	1	1.1	0	0
How are your physical needs being met in the hospital?						
Poorly	2	7.6%	3	4%	1	10%

Satisfactory	1	3.8	8	9.4	2	20
Good	15	57.6	41	48.2	5	50
Excellent	8	30.7	32	37.6	1	10
No Answer	0	0	1	1.1	1	10
How are your emotional needs being met in the hospital?						
Poorly	0	0%	4	4.7%	0	0%
Satisfactory	2	7.6	12	14.1	5	50
Good	14	53.8	39	45.8	4	40
Excellent	7	26.9	17	20	0	0
No Answer	3	11.5	13	15.2	1	10
What would you say are your greatest needs/concerns in hospital?						
Material	8	30.7%	12	14%	2	20%
Spiritual	5	19.2	12	14.1	0	0
Emotional	6	23	13	15.2	4	40
Other	4	15.3	14	16.4	3	30
No Answer	8	30.7	38	44.7	1	10
What faith group do you belong to?						
Christian	20	76.9%	78	91.7%	7	70%
Muslim	2	7.6	3	3.5	0	0
Traditional African	0	0	0	0	2	20
Non-believer	2	7.6	2	2.3	0	0
Eastern	0	0	0	0	0	0
Other	2	7.6	0	0	0	0
No Answer	0	0	2	2.3	1	10
What denomination do you belong to?						
Spiritualist	1	3.8%	0	0%	0	0%
Pinkster	0	0	4	4.7	0	0
AGS	1	3.8	3	3.5	0	0
NGK	1	3.8	33	38.8	0	0
Apostolic	1	3.8	3	3.5	0	0
Jehovah Witness	0	0	1	1.1	0	0
Moravian	0	0	3	3.5	0	0
Zion	0	0	0	0	2	20
Methodist	3	11.5	1	1.1	4	40
7th Day Adventist	0	0	1	1.1	0	0
Inter-denominational Churches	7	26.9	4	4.7	0	0
Anglican	3	11.5	9	10.5	0	0
Baptist	0	0	1	1.1	0	0
Church of England	1	3.8	0	0	0	0

Muslim	1	3.8	1	1.1	0	0
Presbyterian	1	3.8	0	0	0	0
Catholic	1	3.8	1	1.1	0	0
Die Vrye Gereformeerde Kerke	0	0	3	3.5	0	0
Pentecostal	0	0	1	1.1	0	0
Other	1	3.8	1	1.1	1	10
No Answer	4	15.3	14	16.4	3	30
Are you an active member of your religious church/mosque/institution?						
Yes	16	61.5%	56	65.8%	8	80%
No	10	38.4	26	30.5	1	10
No Answer	0	0	3	3.5	1	10
Do you as a patient have any religious/spiritual needs during your hospital stay?						
Yes	7	26.9%	25	29.4%	4	40%
No	17	65.3	43	50.5	1	1
Uncertain	2	7.6	12	14.1	3	30
No Answer			5	5.8	2	10
If yes (#18), how are those needs met in hospital?						
Poorly	0	0.0%	3	3.5%	1	10%
Satisfactory	0	0	6	7	0	0
Good	6	23	9	10.5	2	20
Excellent	3	11.5	6	7	1	10
No Answer	17	65.3	61	71.7	6	60
If yes (#19), who is meeting your religious/spiritual needs while in hospital?						
Nurse	0	0.0%	2	2.3%	3	30%
Doctor	0	0	3	3.5	1	10
Family	3	11.5	9	10.5	1	10
Friends	1	3.8	3	3.5	0	0
Religious Member	6	23	11	12.9	1	10
Other	1	3.8	5	5.8	0	0
No Answer	17	65.3	61	71.7	5	50
Did any staff member enquire about your religious/spiritual needs?						
Yes	4	15.3%	25	29.4%	0	0%
No	21	80.7	50	58.8	9	90
Unsure	1	3.8	6	7	1	10
No Answer	0	0	4	4.7	0	0

Where do you find your sources of hope (excluding God) in stressful situations?						
Self	10	38.4%	28	33%	1	10%
People	17	65.3	32	37.6	5	50
Tangible Objects	1	3.8	2	2.3	0	0
Religious Community	3	11.5	21	24.7	3	30
Other	2	7.6	6	7	0	0
No Answer	2	7.6	8	9.4	0	0
What importance does your religion/spirituality have to other areas of life?						
Irrelevant	2	7.6%	2	2.3%	0	0%
Some what	4	15.3	6	7	1	10
Important	20	76.9	64	75.2	5	50
Uncertain	0	0	9	10.5	4	40
No Answer	0	0	4	4.7	0	0
Do you believe that your faith can aid in your emotional and physical healing?						
Yes	22	84.6%	78	91.7%	7	70%
No	3	11.5	0	0	0	0
Unsure	1	3.8	4	4.7	1	10
No Answer	0	0	3	3.5	2	20
As a hospital patient, do you feel that it is important for the hospital to meet your religious/spiritual needs?						
Yes	15	58%	61	71.7%	5	50%
No	6	23	10	11.7	1	10
Unsure	5	19.2	11	12.9	2	20
No Answer	0	0	3	3.5	2	20
As a hospital patient, do you feel that you can openly talk about your religious/spiritual needs to staff members.						
Yes	11	42.3%	61	71.7%	6	60%
No	8	30.7	7	8.2	3	30
Unsure	6	23	14	16.4	1	10
No Answer	1	3.8	3	3.5	0	0
Would you appreciate being able to talk to the doctor about your religious/spiritual needs?						
Yes	8	30.7%	58	68.2%	3	30%
No	12	46.1	10	11.7	0	0
Unsure	6	23	14	16.4	5	50
No Answer	0	0	3	3.5	2	20

Would you ever want the doctor to pray with you?						
Yes	11	42.3%	61	71.7%	6	60%
No	8	30.7	11	12.9	1	10
Unsure	7	26.9	10	11.7	2	20
No Answer	0	0	3	3.5	1	10
Do you think that it's…….to discuss your religious/spiritual matters with the doctor?						
appropriate	12	46.1%	65	76.4%	6	60%
inappropriate	12	46.1	15	17.6	3	30
No Answer	2	7.6	5	5.8	1	10
Do you know what a chaplain is?						
Yes	20	76.9%	46	54.1%	3	30%
No	6	23	39	45.8	6	60
No Answer	0	0	0	0	1	10
If no (#28), were you aware that a hospital chaplain can be defined as a 'professional religious worker'?						
Yes	14	54%	51	60%	2	20%
No	8	30.7	33	38.8	7	70
No Answer	4	15.3	1	1.1	1	10
Are you aware of the functions of a hospital chaplain?						
Yes	9	34.6%	33	38.8%	4	40%
No	9	34.6	41	48.2	5	50
Some What	8	30.7	11	12.9	0	0
No Answer	0	0	0	0	1	10
Do you know how to request a hospital chaplain visit?						
Yes	9	34.6%	31	36.4%	2	20%
No	17	65.3	52	61.1	6	60
No Answer	0	0	2	2.3	2	20
If a hospital chaplain was made available to meet your religious/spiritual needs, would you request a visit?						
Yes	12	46.1%	74	87.0%	6	60%
No	7	26.9	5	5.8	1	10
Unsure	6	23	6	7	2	20
No Answer	1	3.8	0	0	1	10

How often would you like to be visited by a hospital chaplain?						
Daily	2	7.6%	14	16.4%	1	10%
Every Few Days	12	46.1	44	51.7	4	40
Weekly	5	19.2	19	22.3	4	40
No Answer	7	26.9	8	9.4	1	10
What need(s) do you have to be addressed by the hospital chaplain?						
Prayer	11	42.3%	58	68.2%	5	50%
Talk	11	42.3	22	25.8	2	20
General Counsel	9	34.6	29	34.1	0	0
Ethical Counsel	0	0	4	4.7	0	0
Religious Rites	0	0	10	11.7	1	10
Calm my anxiety	1	3.8	8	9.4	0	0
Comfort	2	7.6	11	12.9	4	40
Other	1	3.8	3	3.5	0	0
No Answer	8	30.7	5	5.8	1	10
Do you feel that it would be of value if the hospital had a counselling / prayer room for patients and family use?						
Yes	20	76.9%	80	94.1%	9	90%
No	2	7.6	4	4.7	0	0
No Answer	4	15.3	1	1.1	1	10
Would you object to a general introductory hospital chaplain visit?						
Yes	3	11.5%	4	4.7%	1	10%
No	20	76.9	81	95.2	9	90
Unsure	1	3.8	0	0	0	0
No Answer	2	7.6	0	0	0	0

Appendix 3: Sinekamva Chaplain Assessment Note (incl. case study 5)

CHAPLAIN ASSESSMENT NOTE

Sinekamva

JANE MARY* **LOOTS**
75 Flower Street
Strand, 7140

D.E 755201 698
DOB: 12/05/1955
SEX: F
Tel NO: 021851003

Diagnosis: Emotional Support Referral: Sr Britz

Date: 11-04-2010 Time: 14h25

PROBLEM DESCRIPTION:

55♀ Jane recognised as "real pt." Jane's husband undergoing dental surgery when he aspirated. Pt daughter 8/12 preg - staff informed. Jane emotionally stable but anxious at times. Extended family present at time of my visit. Family awaiting pastor's wife to join them.

STRENGTHS & WEAKNESSES

A. Partner relationship X **/ Parent relationship** ____ — Married 35yrs - stable relationship

- [ ] Poor cummunication. Future of relationship uncertain.
- [ ] Relationship relatively stable. Some areas of concern.
- [X] Stable, commitment evident. Sensative to each other.

B. Immediate family

- [ ] Immediate family distant, withdrawing, not supportive. — 1x daughter and son-in-law present.
- [ ] Some immediate members are supportive in various ways. — No further children or grand children
- [X] Strong commitment. Appropriate emotional support.

C. Extended family

- [ ] Extended family distant, withdrawing, not supportive. — Extened family live outside of area.
- [ ] Some extended members are supportive in various ways. — No further mention of them.
- [X] Strong commitment. Appropriate emotional support.

D. Other sources of emotional support — Has some meaningful freindships. Cld benefit from further support systems.

- [ ] Poorly developed networks, patient isolated
- [X] Patients has meaningful but limited network systems.
- [ ] Well developed and diverse network, offering various forms of support.

E. Spiritual support — Family has some church influence - not regular attendees. Pastors wife will visit with family later.

- [ ] Patient connected to a spiritual support system.
- [X] Patient disconnected to a spiritual support system.
- [ ] Patient unconnected to a spiritual support system.

F. Employment ____ **/ Student** ____ — Pt sole breadwinner. Jane housewife. Financial stressor are present.

- [ ] Has been unable to function due to illness, social situation.
- [ ] Has had to take time off due to illness. Future uncertain.
- [ ] Has had a setback but patient willing to seek help.

G. Emotional response — Jane is acting emotionally appropriate to situation.

- [ ] Moods are unstable and reactions inappropriately excessive.
- [ ] There is an increase in emotions, but effect is not great on realtional matters.
- [X] Although emotional at times, patient is able to deal with feelings appropriately.

H. Tasks of daily living

- [ ] Patient has difficulty in attending to most tasks and needs much support.
- [X] Certain tasks are difficult but patient remains possitive. — Anxious at times but stable to continue to function.
- [ ] Patient functions well.

COMMENTS & CARE PLAN:

Provided opportunity for Jane to express her worry that Paul would die and not see his grand daughter. Some feelings of regret are present as Jane & Paul were not able to graduate and live a "full life." Living life through daughter? Prayer support provided.

REFERRAL/FOLLOW UP:

Will continue to monitor situation.

Signed:

DEVIN ATHERSTONE
Chaplain
Council N° ACC 6118

Follow Up Visit:

P.T.O:

Appendix 4: Different Religious Healthcare Beliefs[54]

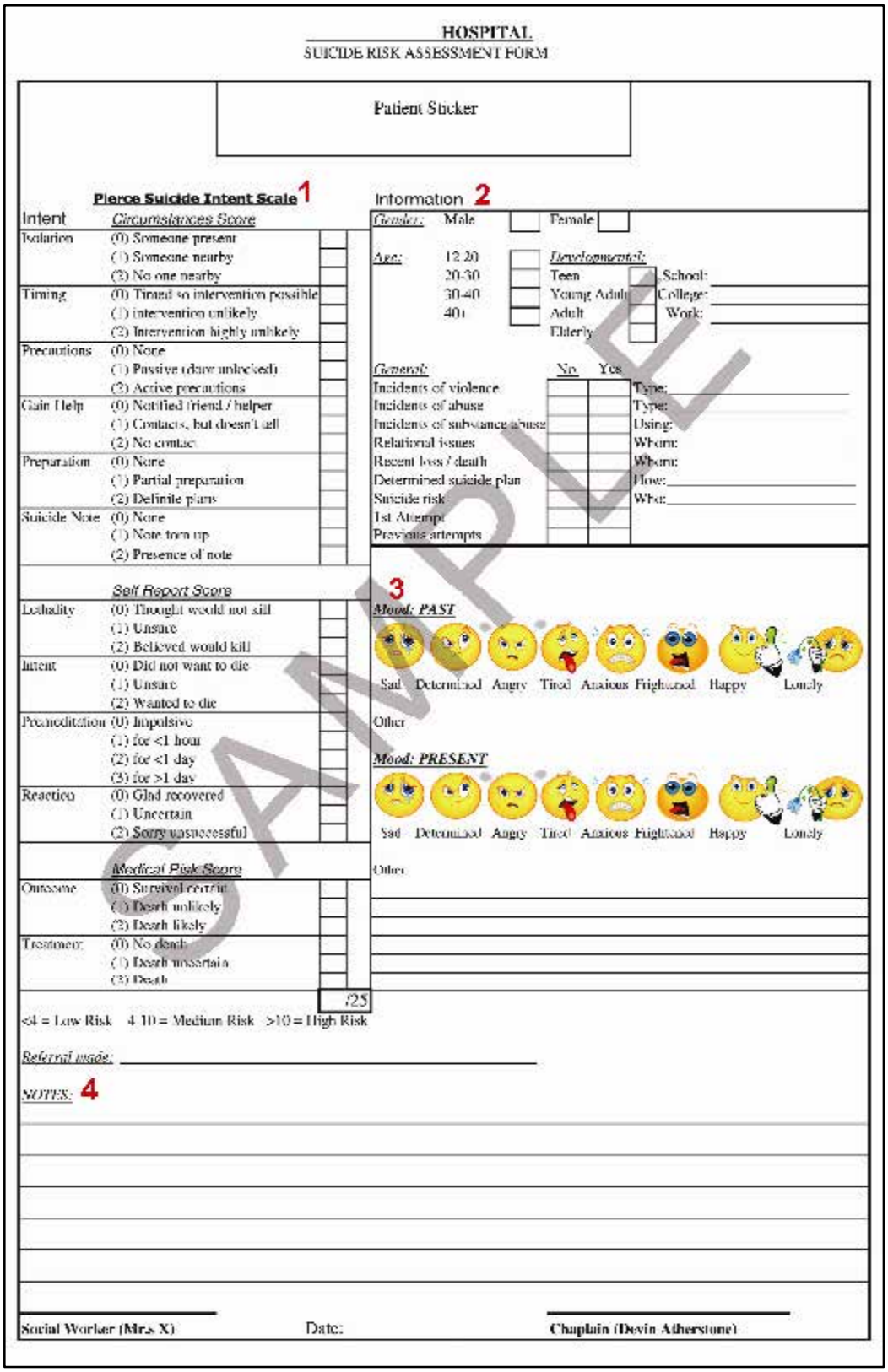
	Catholic	Mormon	Islam	Jehovah's Witness
Abortion	Unacceptable	Unacceptable	Unacceptable	Unacceptable
Autopsy	Acceptable	Acceptable	Acceptable	Acceptable if required by law
Blood Products	Acceptable	Acceptable	Acceptable	Unacceptable (autologous blood transfusion allowed by some)
Diet	Moderation of dietary practices	Prohibit use of alcohol, tea, coffee & tobacco	Prohibit pork & alcohol	Abstain from tobacco & alcohol
Healing Beliefs	Many as part of belief system	Power of God can heal	Varies	Faith healing forbidden
Healing Practices	Sacrament of the Sick	Anointing with oil, sealing, prayer, laying on hands	Some use of herbal remedies & faith healing	Reading scriptures brings comfort
Medications	Acceptable	Acceptable	Acceptable	Acceptable except for blood derived products
Organ Donations	Acceptable	Acceptable	Acceptable	Unacceptable
Surgical Procedures	Acceptable (excl. abortions and sterilisation)	Acceptable	Acceptable	Acceptable, no blood products allowed (except perhaps autologous)
Visitors	Family, friends & clergy.	Elder & Sister, family, friends & church folk	Family & friends	Family, elders & members of church
Beliefs Related to Death	Prayer; sacrament of the sick; communion; mandatory baptism. Wake & burial	Baptism required (adults); body dressed in temple garments; call bishop/elder. Prefer burial	Imam performs specific procedures for washing & shrouding body, with assistance of family; body buried facing Mecca. Bury soon as possible	Eldership visits. cremation is discouraged but not expressly forbidden

	Judaism	Protestant	Seventh-Day Adventist	African Traditional
Abortion	Varies, therapeutic may be acceptable	Varies but mainly unacceptable	Acceptable	Unacceptable, but can be secretly done

[54] Rosdahl CB and Kowalski (2008:82-83, 127) and Lubbe (2010:18).

Autopsy	Acceptable; all body parts must be buried together	Acceptable	Acceptable	Acceptable with very clear explanations
Blood Products	Acceptable	Acceptable	Acceptable	May be acceptable
Diet	Kosher-prepared foods; milk & meat not mixed; prohibit predatory fowl, shellfish & pork products	Varies, moderation encouraged	Vegetarian diet encouraged	Some may have religious restrictions
Healing Beliefs	Medical care expected	Some faith healing, medical care expected	Divine healing	Some faith healing, involve traditional healers
Healing Practices	Prayers offered	Prayers offered	Anointing with oil & prayer	Prayers offered, traditional medicine may be used
Medications	Acceptable	Acceptable	Acceptable	Traditional medicines are often used alongside biomedical drugs
Organ Donations	Acceptable in certain circumstances; practice varies	Acceptable	Acceptable	May have religious restrictions.
Surgical Procedures	Acceptable	Acceptable	Acceptable	Rituals aimed at requesting ancestral protection for survival & retention of life are performed
Visitors	Family, friends & rabbi	Family, friends & minister	Family, friends, pastor & elders	Family, friends & religious and community leaders
Beliefs Related to Death	After death the rabbi or designate cleanses the body. Burial in simple coffin as soon as possible	Prayer; communion; call pastor. Cremation or burial	Prayer; call pastor. Burial	May want professionals to clean body. Some may have religious rituals. Large funeral affair

Appendix 5: Suicide Risk Assessment Key



HOSPITAL
SUICIDE RISK ASSESSMENT FORM

Patient Sticker

Pierce Suicide Intent Scale 1

Intent	Circumstances Score	
Isolation	(0) Someone present	
	(1) Someone nearby	
	(2) No one nearby	
Timing	(0) Timed so intervention possible	
	(1) Intervention unlikely	
	(2) Intervention highly unlikely	
Precautions	(0) None	
	(1) Passive (door unlocked)	
	(2) Active precautions	
Gain Help	(0) Notified friend / helper	
	(1) Contacts, but doesn't call	
	(2) No contact	
Preparation	(0) None	
	(1) Partial preparation	
	(2) Definite plans	
Suicide Note	(0) None	
	(1) Note torn up	
	(2) Presence of note	
	Self Report Score	
Lethality	(0) Thought would not kill	
	(1) Unsure	
	(2) Believed would kill	
Intent	(0) Did not want to die	
	(1) Unsure	
	(2) Wanted to die	
Premeditation	(0) Impulsive	
	(1) for <1 hour	
	(2) for <1 day	
	(3) for >1 day	
Reaction	(0) Glad recovered	
	(1) Uncertain	
	(2) Sorry unsuccessful	
	Medical Risk Score	
Outcome	(0) Survival certain	
	(1) Death unlikely	
	(2) Death likely	
Treatment	(0) No death	
	(1) Death uncertain	
	(2) Death	
		/25

<4 = Low Risk 4-10 = Medium Risk >10 = High Risk

Referral made: _____

NOTES: 4

Information 2

Gender: Male ☐ Female ☐

Age: 12-20 ☐ 20-30 ☐ 30-40 ☐ 40+ ☐

Developmental: Teen ☐ Young Adult ☐ Adult ☐ Elderly ☐

School: _____
College: _____
Work: _____

General:

	No	Yes	
Incidents of violence			Type:
Incidents of abuse			Type:
Incidents of substance abuse			Using:
Relational issues			Whom:
Recent loss / death			Whom:
Determined suicide plan			How:
Suicide risk			When:
1st Attempt			
Previous attempts			

3

Mood: PAST

Other

Mood: PRESENT

Other

Social Worker (Mrs X) Date: Chaplain (Devin Atherstone)

1. Pierce Suicide Intent Scale: This simple 12 part scale looks at the patient's thoughts and emotions at the time of the attempt and the circumstances around the attempt. This scale designed by Pierce (1977) is widely used around the world.

2. Information: This section provides us with a synopsis of the patient's social details. We felt that this is important as the Pierce scale is purely medical focused and did not provide possible insight into the attempt.

3. Mood: This was designed in order to help the patient identify with how they felt at the time of the attempt and how they are presently feeling. The idea behind the picture faces helps those patients who struggle to find words for their moods.

4. Notes: Any additional information, thoughts and concerns are notes in this section.

Appendix 6: History Structure: Association of Professional Chaplains

1939	Chaplain Dick addresses The American Protestant Hospital Association (APHA) on the work of a chaplain in the general hospital. After meeting with Dr Cabot, Dicks was later commissioned to chair an APHA study on religious work in hospitals.
1940-1946	Two surveys conducted by APHA revealed the growth in chaplains working in general hospitals. In 1945, it was recommended to the APHA council to draft a section solely for chaplains. This eventually led to the establishment of the Chaplain's Section in 1946.
1947-1950	President of the APHA, Chaplain Potter suggested that standards and certification be introduced into the association. The finalisation happened in 1950, which included two units of Clinical Pastoral Education (CPE). In 1948, chaplains from psychiatric hospitals gathered at the American Psychiatric Association (APA) conference. It was at this meeting that the Association of Mental Hospital Chaplains (AMHC) formed.
1968	In 1962 the APHA renamed itself to the Chaplains' Division of the APHA. This was later renamed in 1968 to the College of Chaplains. Certification, training & CPE created more opportunities for chaplains. During 1968, the AMHC created standards, certification and CPE training for inter-faith chaplains (Catholic, Jewish & Protestant).
1970	The rapid growth of the AHMC amongst Mental Health Centres, lead to the name being changed to the Association of Mental Health Clergy. Through the sixties and seventies, woman chaplains were encouraged to seek certification. The College of Chaplains and AMHC began to seek validation from the Commission for Hospital Accreditation to create hospital standards for chaplaincy. However this failed to materialise.
1980	Standards for hospital chaplains eventually was passed, thus forcing hospitals to provide some process for meeting the spiritual needs of patients. The reimbursement from Medicare allowed hospitals to include full-time chaplains. CPE was once again introduced as a training and certification process. The eighties saw membership drop by up to 40 percent. This led to the suggestion that common goals and resources need to be shared.

1993	The College of Chaplains invited the AMHC to consider working together.
1996	The College of Chaplains separate from the APHA.
1998	At the annual conference the AMHC and College of Chaplains merged to form the Association of Professional Chaplains (APC).

Appendix 7: C.P.E Outcomes

Level I outcomes

- Articulate central themes of his religious heritage and theological understanding that inform one's ministry.
- Identify and discuss major life events and relationships that impact on personal identity as expressed in pastoral functioning.
- Demonstrate the ability to initiate helping relationships.
- Initiate peer group and supervisory consultation and receive critique about one's ministry practice.
- Risk offering appropriate and timely critique.
- Utilise the clinical method of learning to achieve educational goals.
- Demonstrate the ability to integrate in pastoral practice conceptual understandings presented in the curriculum.
- Formulate clear and specific goals for continuing pastoral formation with reference to one's strengths and weaknesses.
- Recognise relational dynamics within group contexts.

Level II C.P.E Outcomes (two or more units)

- Articulate an understanding of the pastoral role that is congruent with his or her values, basic assumptions, and personhood.
- Provide pastoral ministry to a variety of people, taking into consideration multiple elements of cultural and ethnic diversity, social conditions, systems, and justice issues without imposing one's own perspectives.
- Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources.
- Assess the strengths and needs of those served, based on an understanding of behavioral science and grounded in theology.
- Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate clinical communication.

- Demonstrate competent use of self in ministry and administrative function including emotional availability, appropriate self -disclosure, positive use of power, a non-anxious and nonjudgmental presence, and clear and responsible boundaries.
- Establish collaboration and dialogue with peers, authorities and other professionals.
- Demonstrate self-supervision through realistic assessment of one's pastoral functioning

Appendix 8: Pastoral Images

The following is a list of pastoral images as described in Dykstra (2005).

The Living Human Document by Boisen, chapter one.

Reclaiming the Living Human Document by Gerkin, chapter two.

The Living Human Web by Miller-McLemore, chapter three.

The Solicitous Shepherd by Hiltner, chapter four.

The Courageous Shepherd by Campbell, chapter five.

The Self-Differentiated Samaritan by Moessner, chapter six.

The Wounded Healer by Nouwen, chapter seven.

The Circus Clown by Faber, chapter eight.

The Wise Fool by Campbell, chapter nine.

The Wise Fool Reframed by Capps, chapter ten.

The Intimate Stranger by Dykstra, chapter eleven.

The Ascetic Witness by Dittes, chapter twelve.

The Diagnostician by Pruyser, chapter thirteen.

The Moral Coach and Counsellor by Noyce, chapter fourteen.

The Indigenous Storyteller by Wimberly, chapter fifteen.

The Agent of Hope by Capps, chapter sixteen.

The Midwife by Hanson chapter seventeen.

The Gardener by Kornfeld, chapter eighteen.

The Midwife, Storyteller, and Reticent Outlaw by Gill-Austern, chapter nineteen.

Appendix 9: Four Secular Models of Psychology and Religion

I. Psychology *Against* Religion

1. Science or scientific method is the only valid means to truth.
2. Truth claims other than science are destructive.
3. Religion (as myth) rather than truth is destructive.
4. Religion's destructiveness is its prohibitive or inhibitive effect on its members & society.
5. "Scientific" (valid) psychology is the solution to individual problems.

II. Psychology *Of* Religion

1. Man is a spiritual-moral being (at least in a humanistic sense).
2. Religion, technology, science, or society which denies man's spirit, and thus his nature creates pathology.
3. Most or all religions have recognized the spiritual-human quality of man and thus have the right approach.
4. The particular cultural-social-theological definition of man must be discarded in favor of a truly psychological definition of human functioning.
5. Good psychology translates the valid insights of religion into psychology and uses them for human good.

III. Psychology *Parallels* Religion

1. Religion and psychology are not related
2. Each exists in its own sphere. One is scientific and the other is not.
3. Religion is a personal (and social) matter while psychology is intellectual and academic.
4. Both religion and psychology can be embraced. There is no conflict since they do not interact.

IV. Psychology *Integrates* Religion

1. A Unifying or integration view of truth in religion and psychology is both possible and desirable.
2. The truth or insights from psychology or religion will have some correspondence with the other discipline.
3. The truth or valid principles of religion and psychology are in harmony and form a unity.
4. Religion as socially manifested may be pathological but its intrinsic nature is not.
5. Valid religions and religious experiences are helpful in transcending the pains of existence or in assisting in the maturing process of growth.

Appendix 10: Visitation Guidelines

- *Motivation and prayer*. Before setting out on a hospital visit, determine your motivation for the visit. Is the visit out of guilt or obligation? Out of curiosity? Always ask why are you taking time out of your schedule to visit the person? A simple prayer of asking the Holy Spirit to guide the conversation and open doors of opportunity is always advisable. As Christians we are the vessels that the Lord uses to do His work as we represent Christ to the ill.

- *Understand the hospital rules.* Know what rules and guidelines the hospital has in place and respect those rules. Visiting hours and the number of visitors per visit are just two important guidelines that a visitor needs to obey. Be especially aware of the rules when visiting in any Intensive Care Unit (washing hands, wearing masks and gloves, and what one can bring into the ICU etc.) Most guidelines and rules will be placed on the ward doors.

- *Introduce yourself to staff.* Make yourself known to the staff members of the ward you are visiting. Let them know you are the patient's pastor and whether the visit has been requested. Most hospital staff are easy to work with once you introduce yourself. Explain why you're there, and determine to let them do what they need to do.

- *Hygiene.* Many hospitals germs get passed onto patients through the lack of hygiene. Washing your hands before and after visiting will play an instrumental role in preventing the spread of germs.

- *Don't be a nuisance.* Make an assertive effort not to get in the way of plugs, tubes or machines. Be prepared for nursing staff to come in and out of the room and allow them to carry out the work that they need to.

- *Length of visit.* Dynamite comes in small packages; short visits can have the same effect. A meaningful visit doesn't have to be a lengthy visit. Remember that between medicines, therapies, and other visitors, many patients are too tired to talk. Bear in mind that you may not be the only visitor

the patient receives. This can be tricky as one can make a mistake of leaving to early as some patients require time to “warm up to you.” How long should your visit be? Long enough to meet the need of the patient. In visiting always ask permission to sit down. Sitting down can portray that you are going to have a lengthy visit. Remember to never sit down on the side of the bed.

- *Lend a healing touch*. Sonnenberg points out, “A pastor's touch can represent some of the only non-clinical contact a patient receives” (Blumhofer 2007). Many a healing can come from a sensitive touch, however before initiating any kind of touch, ask permission and beware of cultural differences. A comforting hand on the shoulder while praying or reading scripture can bring reassurance to the patient.

- *Remember the family.* Keep in mind that often the patient belongs to a larger system than just himself. As with family system theory, each individual is interlinked with one another, thus causing a ripple effect on each member. There may be times when other family members require similar pastoral care. In addition visiting at least once while the family is there displays a genuine sense of assurance and desire to serve them as well.

- *Be sensitive.* Bear in mind that hospitalisation raises certain sensitive matters. Retain any information that may be shared between you and the patient, unless otherwise stated. Reassure the patient that all information shared between the two parties is of a private matter and will not be discussed outside of the room. Always ask permission to share any information about the patient to others.

Appendix 11: Visitation Pitfalls

1) *Program orientated.* Much of a hospital visit can be vague. The visitor can plan the visit to the finest detail by preselecting what scripture verse to read, choosing a type of prayer say and knowing what you will say to the patient. However, as Kirkwood suggests, by having a set "programme" one does not take into account the circumstances of each patient, thereby providing ineffective ministry.

2) *Use of silence.* It is said that many people are afraid of silence. Scottish satirical writer, Thomas Carlyle said that "Speech is great; but silence is greater." Due to tiredness, pain, drug effects or discomfort, silence may be necessary for the patient. The patient, recognising the need to open up to something that the pastoral caregiver said, my struggle to find a response if the visitor's uncomfortableness is obvious and continues to talk. Use the act of silence to generate and digest thoughts.

3) *Remain out of the spotlight.* The principle of "your needs not mine" is crucial in chaplain ministry. Nothing said or done should take the focus away from the patient. The idea that the visitor should be the one controlling the visit is overrated. A tendency can be for the visitor wanting to keep control of the conversation, begins focusing on their own personal experiences and in doing so neglects the patient. So much effort can be put into making the visit a success that the real reason for the visit was lost in the parade of self. Kirkwood believes that when self comes to the fore, the wrong motivation becomes evident.

4) *Outtalk the patient.* Many persons sign up for hospital visitation teams because they are fond of talking. The pitfall is that the person can easily talk "at" the patient and not "to" the patient. Kirkwood finds that people with a talkative personality are often open hearted people who are eager to help but their need to be accepted can be greater. Patients may become frustrated when they are not being heard because the visitor is talking all the time. Even if

the patient triggers a memory, don't feel that this is an invitation for you to tell your story, rather listen, be intrigued and bless the person.

5) *Comparison.* Comparing similar illness or stories may have its benefits, although there are cautions in playing the comparison game. Firstly one may not have the full story or medical history to make justly comparisons. Secondly comparing the patient's own situation with another is a dangerous game, as this leads to belittling the patient's own story.

6) *The rescuer and therapist.* Rescuing the patient out of their situation is not the goal of the visitor. This possibly has its roots in the notion that visitors see themselves as therapists, trying to find a solution for the patient. Trying to find solutions only creates further dependence on others and thus prohibits the patient to think for themselves preventing them to change their mental, emotional and spiritual attitude. Milton (2010) advocates this pitfall by stating that when the visitor's ministry has been re-routed from pastor, to dispenser of psychological techniques and starts competing with other care-giving professionals, their ministry becomes ineffective.

7) *Paternal instincts.* Often the patient may seem helpless to the visitor. In trying to alleviate this, the visitor begins fussing over the patient like an old-fashioned matron. Pouring water, fluffing their pillow, calling for staff to do this-or-that for the patient, can all add to additional resentment and stress for the patient. It is suggested that encouraging the patient to attempt something for themselves can often be more helpful.

8) *The Care-provider.* The role of the visitor is not seen in playing the care-provider for the patient. Most patients belong to an external support system. The patient's family members and relatives hold this position. Seeing to a number of things for the patient is the prerogative of family and relatives. In trying to be the spokesperson for the patient, the visitor may cause further stress and can lead to friction between the relatives and the patient. Where the

patient may not belong to an extended support system, such help may be appropriate and appreciated by the patient.

9) *The realist.* The idea of bringing the patient back to face "the reality of their illness" (in extreme cases) is tempting for the visitor. This sensitive matter needs to be dealt with caution as attempting to coerce the patient into accepting their situation prematurely, could mar the patient's will to recover. However if prolonged denial is evident, professional help may need to be sought.

10) *The spokesperson.* Frequently patients look to the pastoral visitor as the spokesperson or defender of the patient. Kirkwood describes this as "taking up the cudgels on behalf of the patient" (2005:83). High expectations of care are placed upon the medical staff from the patient's family and families often see their loved one as the only and most important patient in the hospital. Visitors should not be manipulated into taking up this role, as the patients family's expectations of what should be done may be unrealistic given the nature of the case. Visitors may not know all the medical facts and plan. If the visitor feels that there has been some misunderstanding between family and staff, first be sure of your facts before approaching the medical staff.

11) *The "gossiper".* Prayer chains and bulletins are often the channels of communication of informing the wider church body of so-and-so's illness and hospitalisation. With strict privacy clauses in place these days, the breach of such information without the patient's permission could have legal implications. Although the motive may be helpful, the fact remains that some people don't want their illness broadcast to the church or even pastoral team. Visitors should always bear in mind that confidentiality during hospital visitation is of utmost importance.

12) *The lone-ranger.* Visitors should not assume that they are the only visitor or pastoral caregiver for the patient. The patient may just have a better rapport

with another person then the visitor. In hospital ministry there can be no place for egotism.

13) *Emotional expectation.* It may possibly be that the visitor expects the patient to share their emotions and unless the patient has revealed something of their inner selves, the visit is seen as a failure. The patient is under no obligation to accept any visitor or to divulge any information to them. There are times when the patient may not be in the place to delve their emotions. The journey may take a few days to establish before the patient opens up. Hughes (2009:6) states that it's not about saying the right thing, or about saying something reflective, or about having answers to difficult questions. It's about being present with someone who's going through a difficult season.

14) *Diversion.* Two possible diversions could be present. The first is a calculated plan by the patient to avoid any discussion concerning them. Either because of denial, resentment against God or church or even something about the visitor that the patient is wary of, could caution the patient into sharing. The second aspect of diversion could come from the visitor. The visitor being uncomfortable talking about the patient's illness or an inability to steer the conversation, begins diverting the conversation onto something else.

15) *The evangelist.* Determining the reason for the visit is vital before setting foot into the ward. If the visitors aim is to convert or evangelise the patient, the point of the visit is lost. Trying to force spiritual matters will only lead to a cold-shoulder from the patient which will in turn leave the visitor feeling frustrated.

16) *Authenticity.* Due to hospitalisation being a very unnatural surrounding, the patient expects the visitor to be natural in behaviour. An artificial voice, whispered tones, nervousness all adds anxiety onto the patient. In being one's self, the patient would most likely respond to you. It is important to know your weaknesses. If the visitor is not comfortable visiting a patient with a certain illness, rather refer the matter to someone else.

17) *Persuasion.* Manipulating a patient into speaking or believing something they don't is forcing the patient into a position or meaning which the visitor desires him to adopt and not what may be best. This can be especially seen between a relationship that is strained or where there is unfinished business between two people. Kirkwood suggests that coercion of a dying or critically ill person is morally and unethically wrong and cannot be accepted as Christian behaviour.

18) *Scriptural recluse.* The temptation to hide behind scripture when we don't have answers to difficult questions is evident in hospital ministry. Yet the hospital is the one place to hear questions and doubts about God that are unanswerable. The visitor is tempted to read God's promises as a blanket to cover the challenges of the patient's faith and to question the challenges is a sin. Using scripture in this way is seldom effective as it only brings confusion and guilt. Scripture should be used in a manner that is alive and vital to the patient's circumstances and not just as an avoidance of difficult questions. The underlying principle is to be honest and admit when no answer can be sought.

19) *Promise keepers*. The pitfall of making promises to patients is the opinion of Hughes (2009:13). In making promises to patients, Hughes alliterates that there is always a danger of not following through with your promise. Think carefully before promising the patient anything, even simple promises, such as "I'll be back to visit you." Or "I'll bring you a …… next time." Making promises often happen when we become uncomfortable or run out of things to say. In making a promise, be sure to keep them. And remember that most of the time patients are not expecting you to do things for them. Your presence is good enough.