

Standards for the Work of the Chaplain in the General Hospital

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It has come to the attention of the American Protestant Hospital Association that the spiritual needs of many patients, both in private and public institutions, are not receiving proper attention. In some instances patients are not receiving any spiritual care, in others they are receiving altogether too much. We know of institutions where as many as seven or eight different religious workers may speak to the same patient in a given afternoon while hundreds of other patients in the same institution receive no attention. It has also come to our attention that many religious workers in hospitals attempt to force their own religious views upon the patient whether he desires them or not.

It is our hope that through the following suggestions hospital administrators, board of directors, medical staffs and church authorities will be aided in judging the nature of the religious work going on within their institutions and further, that they may be aided in securing a more adequate type of chaplaincy service.

It is not our thought that all the suggested standards which follow shall be considered minimum standards but that they shall present a goal toward which the institution and the chaplain shall aim in serving the religious needs of their patients. However, there are certain practices which we consider indispensable in the chaplain's work; where such practices are not being followed we suggest that serious attention be given to an investigation of why they are not by someone in authority. *In the list which follows we indicate those which we consider minimum standards by marking them with an asterisk.*

1 The Chaplain Shall Be Responsible to the Administrator of the Hospital*

a—It is preferable to have the chaplain or chaplains employed and paid by the hospital, just as it employs its medical social workers and other regular personnel; thus the chaplain's work and his time are more directly answerable to the hospital administrator. This will in no way conflict

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with the clergyman's ordination vows or his higher loyalties.

In the past when treatment of the soul was considered as apart from medical care of the patient, and was believed to have nothing to do with his health, the hospital and the physician were not greatly concerned with the spiritual condition of the patient, although some medical men have always recognized a close alliance between body and soul.

b—While a chaplain assigned to a hospital may receive his salary from a church or federation of churches he still should be under the supervision of and directly responsible to the hospital administrator, for it is essential that his work be coordinated with the other care which the patient is receiving. Further, the administrator is in position to see that the work of one chaplain does not conflict with or overlap that of another.

The primary reason that the spiritual care of our patients has gone unattended is that various branches of organized religion have not seen fit to cooperate with each other. While this attitude is rapidly disappearing, there still are those who work independently of other recognized clergymen. The hospital administrator is in position to insist that a proper plan be worked out whereby there will be no overlapping of this work. Also, if there is a tendency on the part of the chaplain to be overly aggressive, the hospital administrator may counsel with him or his superiors in regard to such tendencies and thus protect the patient, without endangering the effectiveness of the work of other clergymen whose methods are different.

We consider this point to be indispensable as

has been indicated above, although we recognize that many institutions permit contrary procedures. But it is in just these institutions that crude and ineffective spiritual work is being done.

2 The Chaplain Shall Cooperate with the Other Personnel of the Hospital*

In the past, even in the church hospital the chaplain has been inclined to work independently of other members of the hospital personnel. He was permitted to find those who wanted and needed his attention as best he could which has often meant that he spent his time wandering from bed to bed and room to room while those who most needed the help and encouragement he could give went unattended, simply because the medical and the nursing staff did not direct him to those in greatest spiritual need. We recognize that there were reasons for this lack of cooperation, but we deplore the fact rather than the reasons for it. We believe that where the chaplain is trained and disciplined in his task the reasons no longer hold. Working as a member of the team, at whose head is the physician, the chaplain is able to pass valuable information on to the physician which should be considered in the treatment of the patient. This does not mean that the chaplain, any more than the doctor, does not respect confidential information given him by the patient in the form of confession. But a wise physician needs only a hint concerning the cause of apprehension or worry in order to conduct his treatment of a patient accordingly.

Cooperation with the staff means that the chaplain is available for consultation in regard to his knowledge and ministry to a given patient and that he holds himself responsible for that ministry. The initiative for this cooperation in a specific case may come either from the physician in charge or from the chaplain. It does not mean necessarily that every patient the chaplain sees will be discussed with the physician but it does mean that he shall be available for such discussion if the occasion arises.

Often complaints or requests come to the hospital administrator which he knows can be handled by the chaplain and which may overlie deeper spiritual needs. Further, an alert admission clerk can observe patients who are especially apprehensive upon admission to the hospital and pass the information on to the chaplain. The nurse often knows what is in the patient's mind, sometimes even better than the doctor; she can suggest to the chaplain that he call upon a given patient who is worried, lonely, bored or apprehensive.

This does not mean that the chaplain will see only those persons with especially difficult problems or who are under grave stress but it does mean that such patients will have preference in his attention and that his efforts will be concentrated upon a relatively small number of persons who need help, in contrast to the general practice of spending most of one's time in calling upon patients who may get along quite as well without the chaplain's aid.

If a chaplain is to have a place in the hospital, even to be permitted inside its doors, *he must be of such character and judgment that he can be trusted with complicated human and spiritual problems.* This will mean having the confidence of the staff, for many of these problems must be worked upon by more than one person. A patient's own minister is really in the category of the patient's family. It is noteworthy, in this respect, that few doctors, nurses, or medical social workers, give much thought to the use of a patient's own minister when dealing with a complicated problem. We believe this to be an unfortunate oversight.

We speak of this only to indicate that we are suggesting a new position for the chaplain in the hospital family of workers. If some hospital administrators and medical staffs protest that they have long recognized such a position we commend them but we still maintain that such a recognition and practice is not general. Further, recognition may have existed in many instances and not have gone beyond the recognition stage. We realize that gaining this cooperation is a major task and one which, in general, still remains to be accomplished. We believe, however, that progress is being made in that direction and that such a study as this makes its contributions to that cooperation.¹

3 The Chaplain Shall Have a Rational Plan for Selecting His Patients*

We do not consider that the routine practice of seeing every patient in a hospital, with no preference given to any one person on the basis of need, to be commendable, or that such a practice can be said to be following a definite plan because: We do not believe that there are many chaplains who can call upon a considerable number of patients and make any significant contribution to their spiritual well being due to the amount of

¹In this connection we would call attention to the Committee on Religion and Health of the Federal Council of the Churches of Christ in America. The Committee is made up of physicians, clergymen, and laymen, who are especially interested in the relation between religion and health. The Reverend Seward Hiltner is executive secretary of the Committee; inquiries concerning its work may be addressed to him, at 297 Fourth Avenue, New York City.

time needed for such work, if for no other reason. On the basis of the experience of several well-trained Protestant chaplains who have kept careful records of their work in general hospitals for acute illness, we would estimate that some twenty-five to thirty-five patients at the most, and preferably a fewer number, is all that one clergyman can follow at a given time. This does not mean that he will see thirty in a given day. It may mean that he will see three or four of the number every day during their acute condition; four or five others every second day; a larger number every third day, and the rest once a week. Some of these patients will need work which must be done outside their immediate presence such as consulting with the physician, the social worker, the family, or the patient's own clergyman.

If a chaplain is to follow this recommendation he must have a plan whereby he finds the thirty patients selected from a larger group who especially needs his attention.

The first plan we would suggest is one that consists of several parts. It may be followed in a small hospital with one chaplain or in a large institution which has several, representing various religious groups, if there is close cooperation between the chaplain and personnel.

a—The chaplain should see those patients which the physicians staff request him to see. These will be persons with definite and usually acute need; they will be difficult assignments and may call for intensive and long time contact before the need is met. Despite the stubborn and often disheartening nature of these assignments they are the most important patients the chaplain will see. Gradually a medical staff learns, as does a given chaplain, the nature of the problems with which he can deal effectively. Some physicians will say to a chaplain, "See all my patients. They all need it." That is not selective referral and does not help a chaplain in selecting those who most need his help.

If a chaplain has worked in an institution for any considerable length of time, perhaps one or two years, and still is not receiving requests from the medical staff to see patients, then we suggest that his work be carefully investigated. It may be that because of his personality or his methods he is not effective.

b—There will be some patients who ask to see a clergyman. This number is far greater among Roman Catholics and Anglo Catholics than among Protestants. From the clergyman's standpoint these are not difficult assignments, as the patient will know why he wants a clergyman and when

the minister arrives will tell him why he was called. Beyond the patient's conscious need may be apprehensions or worry or guilty feelings which must be dealt with, but even so the task will not be difficult.

In connection with such requests we know of both private and public hospitals who have called clergymen from outside their institutions to meet such requests for years without so much as a "Thank You." The personnel of a hospital assumes much when it assumes that just any clergyman has either the training or the obligation to deal adequately with the request of persons he has never seen before and of whom he knows nothing, simply because the services of a clergyman are requested.

c—The hospital admission slips will be a third source by which patients will come to the chaplain's attention. However, the usefulness of the admission slips for him will be determined by the information which they reveal. He will be interested in the patient's name, address, age, occupation, religion, diagnosis, and name of the attending physician. He will know that on the basis of his illness one patient faces greater spiritual stress than does another.

It has been observed that patients who are some distance away from home and therefore cannot be visited frequently by their families and friends, are often given to loneliness and restlessness; patients facing major adjustments to physical disabilities following surgical treatment often become depressed; patients facing major surgery, especially if they know something of the nature of the operation, are apt to be apprehensive, for they naturally think of death; patients facing long convalescence may have a hard time accepting the fact in the early days of their illness. Finally, those patients and the families of patients who are facing death the chaplain needs to know about. These are all stress conditions which bring to the surface of the patient's mind thoughts and attitudes with which the chaplain is especially equipped to deal. Many of these situations can be picked up from the admission slips, but obviously not all of them, therefore, there is the need for close cooperation between physician and chaplain.

Another source whereby patients come to the attention of the chaplain is the request made by the patient's own clergyman. These requests may or may not be significant, but the clergyman making the request will usually indicate what he thinks is his parishioner's need. Beyond the call itself the chaplain will be able to serve as an

interpreter of the patient to the physician of information gained from the clergyman as well as interpret the patient, doctor, and hospital to the outside minister who in turn may be of great help to the family with whom he is in contact. This is not as complicated as it sounds—and when one remembers how difficult and critical some families are of administrator, doctor, nurse, and the hospital in general, one welcomes any assistance.

We recognize that the great majority of hospitals will not have chaplains and will be dependent upon the local clergy for a ministry to their patients. In the State of Wisconsin, for instance, of 137 hospitals only nine have over 200 beds and 101 have below 100 beds. This would be generally true of other states. The total problem of the spiritual ministry to the sick in general hospitals must be considered in the light of the small hospital as well as the large.

In the small hospital the administrator may well be the person who will suggest and help set up a plan which will endeavor to meet the spiritual needs of his patients. He should insist that the clergy cooperate with each other in the plan as well as with the hospital.

The most satisfactory plan is simply for the admission clerk to ask each patient concerning his religious and denominational preference upon his admission to the hospital. At the Massachusetts General Hospital of the patients admitted to the general wards some ninety-eight per cent expressed a denominational preference although only some fifty per cent were actually affiliated with a given church. It was further observed that only some one half per cent objected to the question or inquired why the question was asked.

Once this information is gained a postal card to a minister of the preferred denomination giving the name of the patient is all that need be done by the hospital. If there is more than one church of a given denomination in a community the ministers will decide how the cards may be divided over and above their own parishioners.

Attention should be given first to those patients who are under especially great stress, as: patients who are lonely, facing long convalescence, who have few callers, who are obviously worried about something; and then those who on the basis of their physical condition are facing difficulties: serious surgical operations, adjustment to handicap, death, and the families of those facing death. It has been observed on the basis of several hundred cases that because a minister calls the patient does not think he is facing death, where it has

been true the patient was thinking it already. However, we do not believe it is desirable to call the minister just because a patient is dying (unless of course the patient expresses such a desire), unless he is being called for other conditions and thus would be familiar with the hospital and with the attitudes of the sick, so that he may be counted upon to relieve stress rather than add to it.

In following such a plan it is important that the individual clergyman shall see only those patients whose names have been given him. If once in the hospital some of the ministers spend time in making general and miscellaneous calls upon persons of whom they know nothing, the whole plan will break down. This should be made clear at the outset.

(This report may be used as a guide to the administrator of the small hospital adapting the parts that are practical in his particular community.)

4 Records of the Chaplain*

While we do not consider it indispensable that the chaplain shall keep records we recognize that the fact that he does not is the chief reason why a chaplain has not up to the present time been considered a necessary person in a well equipped hospital, but has been someone who was tolerated so as not to offend church people who were or might become givers to the hospital. There are three kinds of written records which the chaplain may keep:

a—The first, which is not generally accepted, is that of writing in the clinical or medical record itself. This is a brief note, similar to that which the consultant writes, which is simply a record of the chaplain's impression of the patient. The chaplain often discovers significant things about a patient which the physician needs to know; these discoveries as well as impressions should be available in the record. Such a note does not reveal confidences which may have been shared with the chaplain nor does it, in any way, infringe upon the sacred nature of the confessional.

b—The second type of record is a notebook or card index which the chaplain keeps for his own use as a check against his memory. These records may be a simple listing of the patient's name, his address, the date of his admission, the name of his doctor and the number of calls made upon him by the chaplain. This should be a daily record. It will be from this record that the periodic reports, referred to below, will be drawn.

c—The third and more elaborate record is one

which is kept in the chaplain's own file and is written in detail. This is a definite method used especially in difficult assignments to help objectify the patient's need in the chaplain's mind and to show him the mistakes and failures he has made in his work.

The ideal system is a combination of b and c. Further, it is important for the chaplain to make periodic reports, preferably written reports, to the hospital administrator, to the board of directors of the hospital, and to the church authorities under whose auspices he is serving.

5 Worship in the Public Hospital

Worship must be interdenominational in character. Illness, poverty and disease know no denominational barriers. Unity, cooperation, understanding and love go hand in hand with health. Friction, misunderstanding, factions and divisions among those attending the sick are unhealthy. Physicians of different schools of thought meet before the patient with but one concern, that of cooperating and of healing the broken body. Whether there be many ministers or priests visiting the institution or not, cooperation and mutual understanding must be in evidence. The chaplain, especially, is called upon to serve those belonging to other denominations than his own.

A hospital or sanitarium must not be thought of as a convenient place where young people's societies and missionary groups are allowed to practice on the patients. Quite often people take the attitude that anything goes especially in the public hospital. The patients are looked upon with pity and the statement, "Inasmuch as ye did it unto the least of these, my brethren, ye have done it unto me," is misunderstood. Ordained men, commissioned workers and those recognized as qualified are the only ones who should be permitted to call upon the individual patients. Fly-by-night missions and missionaries have no place in the hospital or sanitarium.

The hospital is no place for proselyting and for public conversion services. The patient can be challenged to Christian living and Christian ideals without causing emotional strain. Here personal conduct and attitude of the clergyman can do much to prevent such strains on the part of a patient. Each minister or chaplain is responsible for his own personal attitude toward the patients and his conduct should never induce emotional strain. On the contrary, it should produce calm and rest and a spiritual and mental uplift.

The message must be simple, not juvenile; comforting, not self-pitying; dignified, not slipshod;

sane, not sentimental. Talks on propaganda for peace, war, social action and the like have no place in hospitals. Yet the patient can be challenged to trust, kindness, brotherliness, self-control and the other Christian virtues. The Easy Gospel and the Easy Salvation type of preaching is also taboo for the hospital.

The worship service in a *general hospital for acute diseased* is quite different from that in a *sanitarium or convalescent type of institution*. In the former case, the work is with patients who are in the hospital for a short duration of time. The population shifts daily. The worship is usually at the bedside; very seldom does one meet a patient in a public worship service more than once. When the patient can attend a service in the chapel, he is well on the road to recovery. One's worship service in each instant is a unit in itself.

However, in the sanitarium or the convalescent type of institution, the patients are there for a longer period of time, quite often for a period of years. A more constructive program can be prepared. A series of sermons can be preached, for the congregation is stable and the population of the institution changes gradually and slowly. The chaplain knows the patients and they in turn know him. He is called upon more often by them and he becomes their pastor during their stay in the institution. The pastoral work in institutions of this type is more encouraging and the results are more noticeable. The chaplain shares the patients' troubles and their sorrows, their joys and their advancements in the healing process.

6 The Training of the Chaplain*

It is essential that any one who is to serve as a chaplain should have adequate training for that task. Although the training given by theological schools along pastoral lines is improving, it can not be assumed that all ministers, even those with good academic training, are equipped to work as chaplains. Three or four fundamental principles emerge from experience with the training of chaplains.

a—The chaplains should have completed college and seminary courses at accredited educational institutions. This becomes especially important as the educational standards for other hospital personnel are rapidly rising. To be markedly inferior in educational background would place a tremendous obstacle in the chaplain's way, regardless of how great his skill or deep his understanding. It is still true that less than half of all ordained ministers could meet these educational standards. Unless the circum-

stances are exceptional, these educational qualifications should be insisted on.

b—The chaplain should have a course of supervised clinical training. Resources and facilities for such training have been expanded in recent years, and there are probably close to a thousand men who have had some training of this sort within the past fifteen years. The supply is still inadequate, but it will grow in direct proportion to whether hospitals demand it of their chaplains, just as medical internships grew rapidly a few years ago. Such training is obviously the best safeguard the hospital has against getting chaplains, who, with the best will in the world, do not have the skill to do the required job. The essence of such training is found in the medical internship or social case work field experience, namely the securing of training and experience under adequate supervision.²

c—Although a man with experience should have preference over one without experience other things being equal, no adequate statement can be made about a minimum amount of experience required of candidates. One reason for this is that the best trained men are apt to have had comparatively little experience, in terms of years. Another is that many chaplains with years of experience have been working in inadequate stereotype patterns for so long that their experience has had a negative rather than a positive value.

d—Selected Protestant hospitals should consider it a major responsibility to make their facilities available for the training of chaplaincy candidates and other theological students. Not many hospitals are equipped for this, nor would be equipped even if they had competent chaplains to act as supervisors; but some should be made so. It is important also that training be provided not only for those who wish to be full-time chaplains but also to theological students who expect to go into the parish ministry. They will be dealing with the sick, with hospitals, serving on boards, securing funds, and interpreting hospitals to the laity all their lives, the more they can learn about how to conduct an effective ministry in them, and why they are the institutions they are, the greater will be the benefit to hospital, church and community. This should be a cardinal

obligation of a distinctly Protestant hospital, if it is properly equipped to give such training. It is not a happy commentary that to date most of the pioneer work along these lines has been done in state and community hospitals, rather than in church institutions.

7 The Appointment of a Chaplain

There are two important questions in reference to the appointment of a chaplain: what qualifications of personality and training will be sought for; and who will make the selection. The matter of training has already been discussed. The cardinal question about appointments therefore is who will make the selection. This is not a question necessarily of whom will make the appointment itself. That should officially be handled, for Protestant hospitals, like all other hospital appointments, by the administrator of the hospital with the approval of the board.

There are three ways in which a chaplain can be selected, or nominated to the appointing power. For the moment we refer to chaplains who are to be full-time or nearly full-time workers.

a—The administrator of the hospital may find the candidate himself. The danger of it is the candidate selected may not be felt to represent the denomination or the Protestant churches generally, which feeling might limit the chaplain's work. The advantages are that a discriminating hospital administrator may choose a chaplain for ability alone.

b—The second method is to have a chaplaincy committee which is representative of the church interests involved, and which makes its recommendations directly to the board or to the administrator. Such a committee should not be set up by the board or the administrator, as it would be only a variant of (a) above unless the committee represents both the board and the church, which is often true where there are clergymen upon the hospital board of directors. The advantage of this plan is that, while the hospital retains the right of approval or disapproval of a candidate, the church and the church's interests are genuinely served.

c—The third method is to place the power of nomination in the hands of the church. If it is a denominational hospital, then the denominational authority makes recommendations. If beyond denominational lines, the church federation is the proper body. The disadvantage of this lies in the possibility of having cumbersome machinery. But it has the advantage, as (b) above, of relating the chaplain to church authority. The hospital

²This supervision as has been found, should be from two sources: from the physician and administrative officers of the hospital, and from a chaplain who can teach students as well as minister to patients. It is possible that the A. P. H. A. might wish to begin to make a very small list—even privately and confidentially—of chaplains and hospitals equipped to give such training to candidates. This would have a stimulating effect upon securing trained and competent chaplains in other institutions, and would serve as a guide to candidates who wished to know where they might get training under adequate supervision.

board would even here retain the right of appointment.

All of the above recommendations are made on the assumption that the hospital supports the chaplain, which is much the best arrangement. If other methods are used to support the chaplain, or to support him in part, corresponding changes will have to be made in some instances. The cardinal principle is to give the hospital the final voice about the selection, but to give the churches a real part in the matter of recommendation of candidates, assuming certain standards of competence have been accepted.

If a part-time chaplain is being secured, in general the same methods as indicated above should be applied. Control can not be as complete as in the case of a full-time chaplain, but its nature should be the same.

A further question may well be raised about "visiting clergy" in the hospital, assuming that it already has a competent chaplain. Naturally no question is raised about pastors who call upon members of their own congregation. But it is seldom clear what privileges should be accorded to ministers who see patients who are not their own parishioners or what should be demanded of them in return, if any such calling is permitted.

Two suggestions are made. First, a "visiting clergy staff" may be set up somewhat after the fashion of the medical staff. This plan does not need to be elaborate, but guarantees a certain competence on the part of any clergyman placed on such a staff, and assumes that he has certain obligations to the hospital. It would also have all the advantages of the plan described below.

A second plan is for the chaplain to arrange, through a private understanding with representative clergy of various communions that as occasions arise where patients belonging to their communions wish a ministry, which the patient or the chaplain feel the chaplain cannot give, that one of them may be called. This protects both the hospital and the patient, especially in sacramental matters.

Generally speaking, the hospital should not give free right of way to clergy indiscriminately except to call upon members of their own parish or denomination. The plans above protect the hospital administrator from the charge that he is discriminating against any group yet they recognize and accommodate the spiritual needs of the patients.

The problem of selecting and appointment of chaplains in community and public hospitals is

similar to that in Protestant hospitals in that the same caliber of candidate is required. The administrative problems may be somewhat different. Greatest care must be exercised in the public and private community hospital that the group selecting the chaplain is representative of the churches, ideally the church federation is the proper agent to make the nomination for the Protestant group. The Roman Catholic nomination will naturally be made the presiding Bishop or some one he shall specify. Jewish nominations may be made by the Rabbinical association where such an organization exists.

8 Conclusion: It Is Written, "Man Shall Not Live by Bread Alone"

Although it is the main function of the chaplain to minister to individual patients, this by no means exhausts his usefulness to the hospital. A good chaplain will eventually have a marked influence upon the indefinable "atmosphere" of any institution. The attitude of all workers in the hospital has an influence upon this atmosphere; and it is important that it be one which shows visibly that "in quietness and confidence shall be our strength." The chaplain cannot do this alone, but he can help more than any one else except the administrator. If he is given opportunity to teach in the nurses' training school, and is afforded other opportunities of appearing before the staff he can interpret the "spiritual care" of the patient in such a way as to infuse new life into a vital truth to which all too often only genuflections are made.

In these great modern institutions where our sick and suffering and dying congregate we recognize that there is much which goes beyond the realm of the physical. The clergyman in his ministry to the sick and the dying and to the families of the sick and the dying is concerned with aiding in the recovery of health in any way he can, just as the physician is concerned with helping his patient gain comfort and spiritual peace, although he recognizes that that is not his major task. In like manner the recovery of health is not the clergyman's major task. Rather it is to personalize the "far reach" the "distant view" of religion. Through the poise of his person and the authority of the "words" which are his professionally he encourages the one, relieves another of worry, aids still another to accept suffering, breaks the grip of boredom for another, gains quietness for another in the face of death, and comforts another as death comes to claim a loved one. Yes, truly, man does not live nor suffer nor die by bread alone but by the compassion and confidence and poise of those who seek to "do him good."