THE MINISTER AND THE HOSPITAL

(An interview between the Editor of **Liturgical Review,** *and the Rev. Stewart McGregor, Chaplain to Edinburgh Royal Infirmary.)*

Part I — Hospital Visitation

SM: I am happy to have this opportunity of sharing some ideas about the role of the visiting clergyman in hospital and this seems a good way of doing it.

ED: Stewart, I appreciate very much that you have come along to talk with me about this. I have felt I should say something about this to my readers for quite a while, for a lot of them visit hospitals, some very frequently and others from time to time, and I think there are matters regarding the pastoral side and also regarding hospital worship and the whole question of relationship to patients which enter into the work of the ministry in a changing situation.

I begin first by asking you about the situation where the clergyman comes in from outside to a hospital where in a sense his role is there by use and wont rather than by any established legal standing.

SM: Well, first, could I say that the general rule contained in a memorandum of guidance from the S.H.H.D. is that ministers or clergymen should be given access to parishioners who are patients in hospital at any reasonable time. Usually visiting clergymen are welcome in wards. I did a survey some time ago in the R.I. to find out what sisters felt about visiting clergymen. You might be interested in some of the findings.

ED: Yes.

SM: One sister spoke for most of the others, when she said that she thought ministers should be allowed in almost at any time and that they should be encouraged both to visit the sick and to help the patient's family at home. Ministers are regular visitors in hospital. Many of them see hospital visiting as a priority in their pastoral work and most of them, I think, are warmly welcomed when they visit in a hospital like the Infirmary. There are one or two caveats to be observed. As far as possible sisters prefer that ministers should avoid rest hours, meal times and normal visiting hours when patients' relatives who can come and visit only during these hours are present in the ward. They also ask

that ministers should be prepared to wait outside if the patient is being examined by a doctor or for some equally good reason. One or two sisters did comment that they find it very hard to tell a minister that it is not convenient to see one of his parishioners and that ministers resented it very much if a ward sister said that it would be better that he shouldn't visit — but that doesn't happen very often. One does hear occasionally of some sisters who have had unfortunate experiences with visiting ministers. These experiences tend to colour a particular sister's attitude to ministers visiting in her ward. One hears, for example, of ministers (and these are really horror stories) who come in and say to a patient, "My goodness you are looking awful!" or "the flesh is falling off you." One story I was told when I started my ministry was of a country minister who said "Weel, weel, Jock, I've buried a lot o' folk frae this place." Sisters feel that visiting ministers should not distress or upset a patient or burden him with problems more than he can bear, or make life any more difficult for him during his stay in hospital than it is already.

ED: You would feel in other words that the old instruction of the Directory, (of course now over 300 years old), ". . . When anyone is ill, the minister, being sent for," shall more or less prepare the man for his last rites, . . . this is out. . . . Incidentally I think it is important, and I have often found it necessary to remind people that the caveat is "being sent for" and if the relatives haven't sent for him, then they have no right to complain if he doesn't come. But isn't the attitude to the visit as only associated with a terminal case, that of a long-since generation?

SM: It lingers on. There are some patients who see the minister as a bird of ill omen hovering over the hospital waiting for a patient to die.

ED: Well I certainly have had that experience visiting in Edinburgh some thirty years ago when I would get the reaction, "Oh, I'm no' that bad."

SM: This still happens.

ED: Is this the attitude of older people, or is it quite familiar with the younger generation too?

SM: Middle aged and elderly predominantly. Not so much maybe with younger people; but the association between the minister and death is still quite firmly set in the minds of the older generation.

ED: Perhaps the minister's dress doesn't do anything to dispel that?

SM: Not if he comes in like a "black crow". Another point here is that the Roman Catholic Church priest is always sent for when a Roman Catholic patient dies and this does tend to confirm and strengthen the image of the clergyman as a precursor of death.

ED: Would he in fact not normally appear or be sent for in other situations?

SM: The Roman Catholic priest's ministry is largely a sacramental one and he does of course minister communion and absolution to patients. The sacrament of the sick is increasingly being given to patients whether they are dying or not and is seen often as an aid to recovery. But, amongst older priests and in more traditional settings, the sacraments are still associated with death. And so the clergyman becomes firmly linked with death.

ED: We were talking earlier on about the question of giving time to patients in hospital. What factors affect the length of visits, that a minister might be expected to make. I have had the impression myself when I was at the receiving end that perhaps there is a reasonable limit that even a moderately sick patient, as distinct from a really sick patient, can take; — but perhaps my experiences are not normal.

SM: There are no hard and fast rules about the length of time a minister should stay. The main thing is that he is sensitive to the patient's reaction to his presence. The moment he senses that the patient is getting restless and would prefer not to have him there, it is a sign that he has overstayed his welcome. Of course, the length of visit varies from one kind of patient to another. In long-stay wards when patients are resident in hospital, the minister can stay longer. In the intensive care area much shorter visits are usually preferred and the ward staff would prefer that in these units the minister visited *frequently but briefly* rather than at length and infrequently. I think it largely depends on how welcome the minister is and whether the patient wants to speak or doesn't want to speak. If the patient has things that he wants to talk about, I think the minister should be prepared to give time if he possibly can. One of the chief factors inhibiting patients from unburdening themselves is this image of the ministry promoted by far too many ministers, that they're too busy. If they go round telling everyone how harassed they are, how overworked they are, how many patients they've got to visit in that hospital that afternoon, then the patient they are visiting at

that time may feel terribly inhibited about sharing a deep personal problem.

ED: Do you think we would be justified to some extent in transferring Chaucer's picture of the lawyer to the parish ministry — "No — wher so bisy a man as he ther nas,
and yet he seemed bisier than he was."

SM: Right . . .

ED: Well I think I can see your point. This raises the question of the very ill. Now it is obvious that there is intensive care here on the part of the medical profession and I think one has very often just a query as to where the minister stands in this particular situation. I think the old Directory assumed that where people were seriously ill there was no hope for them. That outlook has largely passed, but on the other hand, there are people for whom time is obviously running out and I think that the question of the relationship of the minister to them from the pastoral point of view and from the devotional point of view is an important one. I always remember saying prayers with one of my elders who was nearing his end, and he said very little at the time — he was just conscious and not much more — his wife told me afterwards that the comments he had about the prayers that had been offered showed, that while I thought in a sense, they were meaningless, they had obviously rung a bell with him, and this has made me think very often just about this whole situation.

SM: The task of the modern hospital is to care as well as to cure, but since most of the effort of the medical and nursing staff is directed towards cure, sometimes care occupies a second place. Half the deaths that occur in Scotland occur in hospital, so that the hospital is often a place where the terminally ill are cared for. Generally speaking, members of staff — doctors, nurses and social workers — welcome the support and care which visiting ministers give to the dying. It might be worth observing at this point that some doctors have the greatest of difficulty in relating to dying patients. For some doctors the dying patient is seen as one of their failures. Some doctors, perhaps quite understandably, concentrate their efforts on those who are likely to recover and who will benefit from the therapeutic endeavour and to pass quickly by those who are terminally ill, who are going to die. In this context, (I think) the visiting minister or the chaplain have a great deal to offer. They stand for the fact that death is not the worst thing that can happen to a man. They stand for the

love of God which is stronger than death. I think, often in the minds of patients and staff, they stand for a life beyond this life — a life beyond death. Doctors and nurses welcome the involvement of ministers in the care of the terminally ill — not only for the patient's sake, but also for the sake of the relatives at home who are preparing to lose one of their number and who need the pastoral support which the local minister can give.

ED: I think a good many people realise that in fact they are not likely to recover but it seems to me a very delicate psychological and pastoral problem as to how one handles this. Have you any comments about that?

SM: There is a lot of discussion about the question — to tell or not to tell. I feel that the central question is: how does the doctor share with his patient the knowledge that the patient is terminally ill? What is the best way for him to do that? When speaking to medical students about this I recommend that, as far as possible, the information which the doctor gives should keep pace with the feelings of the patient at that time. It is cruel of a doctor to insist on telling a patient that he is suffering from a fatal illness when the patient isn't ready for it because he is feeling fine.

It is equally cruel of the doctor to keep up a deception with a patient when the patient himself feels that he is not going to recover and that his days are numbered. It is important here that doctors and indeed nurses and ministers also must be open to the feelings of the patient about himself, and must try to relate to the patient at the point where he is.

ED: Do you find this is a situation where relatives have strong views? Are they tending to say "please tell him/her," or "for any sake please don't tell him/her?"

SM: I find that relatives are often in the position of saying "don't tell him/her". And I think in a way they want to protect the patient's feelings. Death has become a taboo subject in our contemporary society, so there are some difficulties in which people find it hard to speak about death openly. My own view is that the staff should not allow their hands to be tied by patients' relatives who would forbid the patient to be told when it is quite clear that it would be in the interests of the patient to know.

ED: You may remember that we had a girl here last year who died under rather sad circumstances. I think it was very clear that the fact that she was aware what was going on made a tremendous impression not only on herself but on

other people and the way she dealt with the whole thing I think was perhaps a very remarkable testimony to her faith. It seemed to me that there might have been other cases where that particular angle had been left in doubt and people's trials had been so much the poorer perhaps as the result of it.

SM: Yes I remember that. It should also be said that denial is one of the stages through which most dying patients go. Some keep on denying right until the time that they die; if they want to go on denying I feel that they must be allowed to. It is also true to say that large numbers of people who know that they are about to die (eventually before death) attain an acceptance of the inevitability of their death and face death with great courage and serenity. They are an example and an inspiration not only to the staff in the ward, but to all who come and visit them during their last days.

ED: You probably have experience as most of us have of those who in this situation would tell you that they couldn't care less. This is almost a misfortune that they've got to tolerate.

SM: There are some patients like that and quite often their words are belied by their feelings. There are not many people who can face death with this spirit, but if this is the way they want to do it, I feel we must not try to break into their feelings and must respect their right to handle this situation in their own unique and individual way.

ED: I've often felt that one of the worries I have about certain activities of the church is that there is what I might call spiritual privacy which I think people are entitled to and nobody is justified in breaking into that if the acceptance is not there on the part of the patient or person visited. I think they have a right . . .

SM: to think their own thoughts. If I could just comment on that in two ways. The first is, that the isolation of the dying patient is a problem to which I think most contemporary writers would want to point; and this sense of isolation is sometimes one which the patient finds extremely painful, so there is a kind of privacy which is definitely harmful and leads to additional suffering for the patient. On the other hand there is a stage of depression which many dying patients go through, where they simply want to be left alone with their own thoughts; they want to be left alone to grieve over this impending separation from the people they have known and loved who have made life rich and worthwhile.

It is a process of disengagement which is very painful and which I think people want to endure silently. I think there is also a necessary privacy in the contemplation of the mystery of death itself and life beyond death. As people look forward to the unknown they often cannot find words to describe it and I think there is a sense in which they do then need this spiritual privacy that you have been talking about.

ED: It is like the kind of adjustment that has to take place when a man loses a limb for example. He has got to start a lot of things all over again, and reorientate himself to a new situation.

SM: There is a grieving, then — a grieving over loved ones — over work, over unfinished tasks and unfulfilled ambitions, over leaving behind the things that are worthwhile and have made life rich and enjoyable.

ED: I think every hospital must have a share of people who have nobody else to care for them. Do you see any special role of the church people for that? I mean we are often told that the church's work has all been taken over by other people nowadays and we can write ourselves off as meaningful contributors. It seems to me there are those without any relatives and friends in the world and I've no doubt a share of them land in hospital too. Is there any point at which the parish minister can supplement the hospital work in this case?

SM: Yes I think a caring minister and congregation can give a lot of help to the lonely and the unvisited in hospital; not only during the terminal stage of life but also during the period of extended hospitalisation. Indeed in the Infirmary we have a number of voluntary visitors from congregations in the city who come in and visit unvisited and forgotten patients. This service is greatly appreciated not only by the patients themselves but also by the staff who look on these visitors as partners in care.

ED: You would in fact have knowledge of people in such a category?

SM: We keep in touch with the staff about this and they let us know. Sometimes we uncover such situations as we go round. Sometimes the visitors go to the same ward week after week at visiting hour and call on patients in the wards who have no visitors of their own. They can thus immediately identify which patients are unvisited.

ED: Then the other thing, I think, that is interesting in this

connection is the image of the church in the hospital. Perhaps too general a question to give a specific answer?

SM: Traditionally (I think) there has been some rivalry between doctors and ministers. This rivalry includes elements of ignorance and of jealousy (I think). There are times when doctors resent the intrusion of a minister especially if the minister's visit is seen to upset the patient or is seen to throw a different emphasis on the treatment or care proposed by the doctor than the one which the doctor himself has given. I mean, for instance, if a doctor is advising sterilisation or a termination of pregnancy and the minister or priest comes in and says this is against the law of God, then we immediately have a conflict of authority. This does not often happen. Usually medical and nursing staff in hospitals see the minister as having something to give. He contributes to the therapeutic endeavour; he's a member of the caring team; he can often explain (for the staff) why a patient behaves in a certain way. If the staff are bewildered about Mrs Jones' depression, about why she is so agitated and so shut up in herself, and won't speak to them and the minister comes in and says that Mrs Jones' son is in prison or her daughter is expecting a baby or her husband has been unemployed or off sick for a long time — this immediately helps to paint in a picture which will assist the staff to do their job more effectively and so, where the minister is prepared to come in and share with the team in the hospital, share his knowledge, share his insights, as well as learning from the team, then I think both the hospital team's work is made more effective and the minister's work is also made more effective.

ED: Could I just take you up on that last point? An interesting question arises when you are talking about sharing knowledge of circumstances. Obviously to some extent this is privileged information. Now, supposing one is in a situation where a knowledge of this kind of information is likely to be helpful, when it is clear from discussion it is unknown to the staff would you think that this is perhaps something that should be confided to the sister or to the doctor or perhaps even to the chaplain rather than to a junior member of staff who happens to be around at the time?

SM: I think there are problems of confidentiality on both sides. Sometimes it is the doctor who is inhibited from sharing the knowledge he has about a patient with a

visiting minister and sometimes it is the visiting minister who is inhibited from sharing the knowledge he has with the hospital staff.

Generally speaking I think we must try to see that we are both basically engaged in helping such people and that we have a lot to learn from each other and a lot to give each other. Where possible I would say that its helpful to all concerned if in the patient's interest there's an exchange of information. One doesn't need to go into a lot of detail but simply outline some of the facts of the case.

ED: I appreciate that, but if I take one of the instances you raised. Mrs Jones' son is in prison and this is affecting her reticence. Perhaps this is something about which you would be justified in saying "Could I have a word with the medical person in charge or a word with the sister?" (if it came out that this wasn't known.)

SM: Certainly, I think whenever a minister visits hospital he should try to see the sister or the nurse in charge of the ward and should before visiting a patient, introduce himself, say who he wants to see and ask if it's convenient and then in a general way ask "How is Mrs Jones today?" — and the sister will, I hope, make a response which will be helpful and in the same way if she is stuck and says "Well we don't know what is wrong with her" the minister can then come in with something which may be helpful to the staff.

ED: Now, would you suggest this kind of contact before every visit or only in the special circumstances? I would be a little anxious myself about perhaps calling a sister from another important job she might be on and I would feel I had to be in a situation where I had to contribute something before I specially asked.

SM: Of course there are limitations.

ED: I've always taken the line that I asked if I could see anybody even if it was quite obvious that I could walk in and see them. I preferred to make some contact with the supervisory staff.

SM: I think this is what I have in mind; that you do make contact with someone on the staff. Very often that person will be the sister, simply because she is more and more becoming an administrator and a kind of master of ceremonies in the ward who regulates the work and endeavours not only of the junior nursing staff, but indeed of the visitors, the minister, and of the doctors themselves

sometimes. *No doctor would go into a ward without first consulting the sister.*

ED: That is an interesting point which I think is perhaps not always appreciated by the ministry. They tend to think . . . Well, the G.P. when he comes to your house door usually walks in, and I'm afraid there are a good many ministers who tend to do the same when they come into a hospital.

SM: I think that is a mistake and anything which conveys an air of self-importance is resented by the hospital staff. Ministers who go in arrogantly demanding information, arrogantly insisting that they have a right to visit here, put people's backs up and it is all so unnecessary.

ED: One can appreciate that this can cause more harm than good.

SM: Yes indeed.

(Part 2—Hospital Worship—will appear in the next issue)