IMPLICATIONS FOR PUERTO RICO OF A STUDY OF THE HOSPITAL CHAPLAINCY IN THE UNITED STATES

A Report of a Type C Project

by

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CHAPTER I

INTRODUCTION

The study is concerned with the function of the hospital chaplains in the United States, the facilities which are provided for their training, and their opportunities for practical experience. The principal purpose of the study is to discover what implications there may be for Puerto Rico in the foregoing situation, and to suggest a program for the training of chaplains to serve in hospitals there.

Interest in ministering to the spiritual needs of the sick must be traced back nearly two thousand years, when Jesus' teachings brought a great impact in the lives of those who came to know Him. Jesus showed great compassion to the suffering and to the distressed, and by His teachings guided them to look forward with hope. The Master and Physician has inspired His ministers to meet the spiritual needs of the sick, when the religious needs of man seem to be stronger. At this moment the help of the minister becomes urgent. Even the man who does not care much about religion feels worried when illness touches him. He fears the unknown power that moves and controls the universe. The minister comes at this critical moment

and if his approach is the right one, he can strengthen the patient's inner drive to live. He can bring peace and happiness to the patient, facilitating recovery if other factors are favorable.

Many doctors appreciate the efforts of the minister in meeting the spiritual needs of their patients. Dr. Elia, a physician, has written about the wholesome and understanding relation which must exist between medicine and religion.

> Distinguished physicians, after making use of all medical skill and learning, discovered that the sole application of pure medical science was not sufficient; and they turned for help to the men of religion and to related fields of human relations.
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> Dr. Richard C. Cabot, a renowned physician of Boston and Massachusetts General Hospital, was one of those men who felt that much more than medicine is required in the restoration of the sick person to healthful and useful living. He considered medicine and religion as an extremely powerful alliance.[1]

Church agencies, such as the Committee on Accreditation of Chaplains, also have testified to the significance of this service of the minister. In the statement of the standards for the work of the chaplain the Committee has said:

> Where sickness and suffering are concentrated, spiritual needs are felt more acutely. In ministering

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[1]Andrew D. Elia, M. D., "Spiritual Needs in the Care of the Patient," American Protestant Hospital Association. Bulletin, 18:1-5, July 1954.

> to patients and their families the chaplain is concerned in aiding recovery if he can; nevertheless, restoration of physical health is not his major field. Rather, his mission is to personalize the vitality of the Christian religion.[1]

Thus, the chaplain can be of real assistance to the physician in the realization of his work. The efforts of both, each one in his own field, are guided by the same objective: the complete health of the patient.

I. NEED OF THE STUDY

Because of the growing importance of the chaplain in the hospital situation and of his contribution to the recovery of the sick, the need for this study has been felt strongly in Puerto Rico. This need is seen particularly from two outstanding points in the field: increased demands for pastoral care, and need for more specialized training. These points will be discussed briefly.

The last two decades have witnessed an increased need for pastoral calls on the hospitalized sick, rather than on the sick in their homes. Families and individuals are coming to realize the advantage of the hospital care, as has been pointed out by Lee and Herrold:

> . . . treatment of the sick seems to be gradually moving from the home and the family. More and more

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[1]Committee on Accreditation of Chaplains, Standards for the Work of the Chaplain in the General Hospital, American Protestant Hospital Association, 1950, p. 2.

> the sick and their family look to hospitals, nursing homes, and other institutions and agencies for care when there is illness, with significant implications for the care of the sick.[1]

In Puerto Rico this trend has been even more significant than in the mainland. There, until a quarter century ago, the sick were usually brought to the hospital only as a last resort. Now, in spite of the growing government hospital construction program, there are not enough hospital facilities to meet the demands. This increase in hospitalization has brought a new outlook in pastoral work. The minister must follow his parishioners to the hospital. Clergymen are coming more and more to regard service to the hospitalized sick as a part of their ministry to their parishes.

At the same time, there is a growing understanding on the part of hospital boards, medical directors, and administrators that more is needed. They see the importance of providing a chaplaincy service in their institutions. In many communities where the services of full-time chaplains are not available, hospital administrators have made arrangement through local councils of churches for the appointment of voluntary chaplains to minister to the sick. An example of this arrangement is the one made

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[1]Dorothy D. Lee and Kenneth F. Herrold, Issue ed., The Journal of Social Issues, 8, no. 4:1, 1952.

by three hospitals in Montclair, New Jersey.[1]

In Puerto Rico, the Church-related hospitals which cannot have full-time chaplains on their staff have appointed clergymen from their respective communities to serve as part-time chaplains. The Council of Churches there has appointed a minister to dedicate his time to serve as chaplain at the State Penitentiary and at three government hospitals: the Tuberculosis Hospital, the Psychiatric Hospital, and the Leprosy Hospital, all in the San Juan area. Church-related hospitals like Ryder Memorial, St. Luke's, Mennonite, and others, have part-time chaplains. Presbyterian Hospital has a full-time chaplain with status of department head. A number of clergymen have volunteered to minister to the sick in government and private hospitals. In some other hospitals clergymen are making hospital calls a part of their parish work. They volunteer to visit patients from their faiths who need spiritual help.

Concurrently with the increased demand for chaplaincy service in hospitals, clergymen came to realize the need for specialized training. The opportunities and responsibilities of the chaplaincy make it necessary for

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[1]Mountainside Hospital Editorial Staff, "Protestant Chaplain Service," Inside Mountainside, 11:2, May 1955.

such a clergyman to grow not only in the knowledge of the field, but also in understanding and insight. They need to undergo carefully supervised clinical training, as has been pointed out not only by Church leaders, but also by well-known physicians and other professionals. Dr. Cabot, a physician, in stating the relation between theology and medicine, says that if the clergyman is to represent religion adequately in this relation he needs to be specially trained for this purpose.[1]

With such specialized training, the clergyman is enabled to give the patient the necessary guidance to develop a positive faith. He can lead the sick person to discover the spiritual possibilities in himself and to use them for his well-being. Only a well-trained chaplain can provide such guidance to the hospitalized parishioner. As Allport states, ". . . customarily it is in the critical periods when desire is more intense, that religious consciousness is acute."[2]

It is this type of specialized training that needs to be organized in Puerto Rico where a number of clergymen are willing to serve but who lack the necessary training.

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[1]Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, New York, The Macmillan Company, 1936, p. 51.

[2]Gordon W. Allport, The Individual and His Religion, New York, The Macmillan Company, 1950, p. 10.

Some of them are giving their services as part-time chaplains, but feel deeply the need of a better preparation. A training program should be planned to meet these needs.

In the implementation of a Puerto Rican program to meet those needs, a series of limitations would have to be faced.

There is only one chaplain in Puerto Rico who has been fully accredited by the American Protestant Hospital Association,[1] and the others, with few exceptions, have not taken special courses beyond their seminary training. The Evangelical Theological Seminary, sponsored by six major mission boards which have developed Church work there, has only one course towards training in the pastoral care of the sick. It was started two years ago and is being taught by the one accredited chaplain in the area. With this exception, there are no facilities available. The churches have depended on the facilities available in the United States, where few interested ministers have come for special training. They have done some graduate work in education, psychology, counseling, and related fields, and have participated in workshops under the auspices of national Church organizations, but have not received any

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[1]Albert G. Hahn, Official List of Chaplains Who Are Paid Members For 1955, Evansville, Indiana, American Protestant Hospital Association, 1955, p. 16.

training in the specific area of clinical pastorate.

In Puerto Rico only one Church-related hospital could meet the requirements set by the Council for Clinical Training for accredited training centers.[1] It is well staffed, has an educational and internship program, and has a full-time accredited chaplain. With additions to be completed this summer its bed capacity will be around two hundred. Besides, it has a big dispensary with a great number of special clinics. It has the facilities of a chapel which was dedicated very recently. It would not have enough room for boarding students for the chaplaincy, and special arrangements would have to be made for providing this facility.

With these pressing needs in mind, recommendations are made in this study for a plan to make use of these very few facilities toward the establishment of an adequate chaplaincy program in Puerto Rico. It is hoped and expected that a great number of clergymen would take advantage of such an opportunity by making use of the facilities which would be provided through the training program. Some of them have already manifested their desire to do so.

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[1]Council For Clinical Training, Inc., Clinical Pastoral Training--Annual Catalogue, New York, The Council, 1955, pp. 15-16.

II. PROCEDURES FOR COLLECTING DATA

The clinical pastoral training movement is a young one and not much literature has been published in this specific area. However, that which was available was studied carefully, including literature on the history of clinical pastoral training, on the relation between religion and health and related fields, and on the facilities for pastoral care of the sick. Also referred to was a great deal of material on counseling which has been of significant help to hospital chaplains in training and in function. All this literature is listed in the bibliography at the end of the report.

Interviews were held with chaplains serving at such institutions as Presbyterian Medical Center, St. Luke's Hospital, Bellevue Hospital, Harlem Hospital, and others in New York City; The Presbyterian Hospital in Philadelphia; Community Hospital, Mountainside Hospital, and St. Vincent Hospital in Montclair, New Jersey; Mendota State Hospital in Madison, Wisconsin; U. S. Public Health Service Hospital in Carville, Louisiana; and The Presbyterian Hospital in Chicago. These interviews provided an interesting picture of the function of the chaplain in general and mental hospitals. Different types of Church-related, community, and government hospitals provided the opportunity of

seeing the chaplain at work in those varied settings.

Still other hospitals were visited and observation was made in relation to their chaplaincy work. Among these hospitals are the following: Fifth Avenue Hospital; Brooklyn State Hospital; Kings County Hospital; Mount Sinai Hospital; Mother Cabrini Memorial Hospital; Knickerbocker Hospital; Doctors Hospital; Joint Diseases Hospital; Lincoln Hospital, New York; John Hopkins Hospital in Baltimore; Community Hospital in Ellwood City, Pennsylvania; Community Hospital in Urbana, Illinois; and Lutheran Hospital in Philadelphia. In Puerto Rico the hospitals visited were: Ryder Memorial Hospital, Mennonite Hospital, Castaner Hospital, Bayamon District Hospital, Psychiatric Hospital, Dr. Ruiz Soler Hospital (Tuberculosis), Aguadilla District Hospital, Ponce District Hospital, Mutual Aid Society Hospital, San Juan City Hospital, Doctors Hospital, Metropolitan Hospital, and other government and private hospitals on the Island.

Officers from training centers and organizations were also interviewed in relation to clinical training programs for chaplains. Among them were Chaplain Armen D. Jorjorian, Senior Chaplain Supervisor at Bellevue Hospital in New York; Chaplain Otis R. Rice, Religious Director at St. Luke's Hospital in New York and former Executive Director of the Department of Pastoral Services of the

National Council of the Churches of Christ in the U. S. A.; the Reverend C. Kuether, Associate Director of Training of the American Foundation of Religion and Psychiatry, and former Director of the Council for Clinical Training; the Reverend James R. Love, Chaplain Supervisor at the Mendota State Hospital in Madison, Wisconsin; and Miss Emily A. Spickler, Administrative Assistant of the Council for Clinical Training. Hospital personnel such as administrators, nurses, social workers, and physicians, were also interviewed. These interviews revealed the scope of the program which different organizations carry on to provide the necessary training for chaplains and prospective candidates. They showed also the high regard which hospital officials have for the work of the chaplain.

The findings point out the needs and opportunities, and the progress and achievements in this important field. Transferred to the Puerto Rican situation, they could give valuable help in meeting the two needs already mentioned, that is, more pastoral care of the sick, and more specialized training of clergymen for the chaplaincy.

III. ORGANIZATION OF THE REPORT

Chapter II contains an account of the development of the hospital chaplaincy in the United States. The philosophy of the clinical pastorate is presented. A

discussion of the appointment, support, and functions of the hospital chaplain follows, with a typical program of the chaplain at the general and the mental hospitals. Some principles which should govern the pastoral call on the sick are stated, and some conclusions are listed.

The third chapter includes a discussion of the training of hospital chaplains in the United States, with a definition of clinical pastoral training, a history of the training movement, and the current facilities for clinical pastoral training offered by different national organizations. A statement of the courses offered is included. The standards for general and mental hospital chaplains and for training centers as set by accrediting organizations are presented in this chapter, and also the qualifications for chaplain supervisors.

The fourth and last chapter contains the implications for Puerto Rico of the study. Specific implications as to the development of the clinical pastorate there, taking into consideration the local situation, are listed and discussed. A suggested program for the establishment of clinical pastoral training is included, with specific recommendations as to the training of a chaplain supervisor, the organization of a training center, the initiation of the program, the number and selection of the students to be admitted, and the evaluation of the program at the end of the first year of work.

CHAPTER II

AMERICAN DEVELOPMENT OF THE CLINICAL PASTORATE

It has been estimated that there are more than sixteen hundred Church-related hospitals and allied healing institutions in the United States.[1] Nearly all the major Protestant Denominations have Church-related hospitals. The desire to carry on the healing ministry of Jesus, and the concern for all who need medical and spiritual care, seem to be the outstanding motives for founding them. Besides providing chaplains to minister to the spiritual needs of the patients in its own hospitals, the Church also provides them in other private and government hospitals. These hospitals include such types of institutions as general and mental hospitals, special hospitals (e.g., for tuberculosis, drug addiction, children, cancer, and so on), Church-related hospitals, public hospitals operated by federal, state, county or city governments, and private non-church-related hospitals.[2]

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[1]Carl J. Scherzer, "More Protestant Hospitals," American Protestant Hospital Association. Bulletin, 18:1-5, October 1954.

[2]Commission on Ministry in Institutions, Standards for Chaplaincy Service in Institutions, New York, Federal Council of the Churches of Christ in America, 1950, p. 1.

To provide this hospital chaplaincy service, the Church and its welfare agencies have developed a training program. Seminarians and clergymen are encouraged to take special training for this work of pastoral care to the sick.

The increasing number of chaplains carrying on a full-time ministry is pointed out by the experience in the Veteran's Administration, where, according to Scherzer,[1] the number of chaplains increased from nine at the close of World War II, to two hundred and forty-one "almost overnight." The membership of the Association of Protestant Hospital Chaplains[2] has also shown an amazing increase, from ten in 1946, to more than three hundred. Of these, two hundred and fifty are fully accredited. The official list published by the American Protestant Hospital Association[3] in 1955, included all chaplains who were paid members for that year and who represented some thirty-eight states, the District of Columbia, Hawaii, and Puerto Rico. The marked increase is also testified to by the Presbyterian

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[1]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, 1950, p. 247.

[2]John Park Lee, "The Association of Protestant Hospital Chaplains," American Protestant Hospital Association. Bulletin, 19:1-3, April 1955.

[3]Albert G. Hahn, Official List of Chaplains Who Are Paid Members For 1955, Evansville, Indiana, American Protestant Hospital Association, 1955, pp. 1-21.

Church in the U. S. A., which has established an Office of Institutional Chaplaincy. This chaplaincy provides counsel and services to all the chaplains, and has set up a lending library of professional books for their free use.

A hospital chaplain is a regular minister of the Gospel, but with a special function--that of ministering to the spiritual needs of the institutionalized sick person. The National Council of Churches has described the chaplain's ministry as being to a special group, in contrast to the parish situation in which he ministers to men and women and children of all ages, degrees of intelligence, and health.

The American Protestant Hospital Association has stated its philosophy of clinical pastorate in the following objectives for training:

> 1. To enable the student to gain an understanding of people--their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.
>
> 2. To help the student develop effective pastoral methods for ministering to people, and to recognize his unique resources, responsibilities, and limitations as a religious worker.
>
> 3. To help the student learn how to co-operate with responsibilities of other professions and utilize community resources for achieving more effective living.
>
> 4. To encourage in the student a desire for that further understanding which is to be obtained by

appropriate and pertinent research.[1]

These objectives have served as some of the criteria for evaluating the work of the chaplain towards his accreditation.

The Council for Clinical Training emphasizes the clinical approach to the problems of religion and life. The minister has privileged relations with his people and he is called and sought out for his special gifts, both in the cure of individual souls and in leading the religious fellowship. The chaplain, in his approach to the sick individual, is able to help him not only in his spiritual needs of the moment but also in his wholesome relations with other people near him: hospital personnel, family members, and visiting friends. The chaplain, in his daily work, endeavors to bring out these positive results. The Council's objectives in clinical training and also its philosophy, are expressed as follows:

> . . . the pastor . . . has needed additional internship experience in dealing with human problems under disciplined and consecrated supervision. Clinical pastoral training provides this additional experience in appropriate clinical centers. . . . The fundamental pattern of training in all these types of institutions has been similar, planned in the belief that a working knowledge of the scientific disciplines in use are

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[1]Commission on Accreditation, Standards for the Work of the Chaplain in the General Hospital, Chicago, American Protestant Hospital Association, 1950, p. 1.

prerequisite to any realistic pastoral work.[1]

This philosophy inspires the training program in all its centers in the country.

The Institute of Pastoral Care is also concerned with clinical training. It has stated its purpose in the following words:

> . . . to organize, develop and support a comprehensive educational and research program in the field of pastoral care, with special reference to the sick, using the opportunities offered by clinical training as a primary means to this end.[2]

The student is given the training and experience necessary for equipping him to do his work effectively as a hospital chaplain. As its primary goal, the Institute seeks through its training program to strengthen religious leadership so that the spiritual needs of the people can be served more adequately. It strives to help clergymen gain insights and skills which will make their ministry more meaningful. In carrying on this purpose the Institute provides a coordinated program which helps ministers meet the clinical pastoral training requirements for certification as professional hospital chaplains.

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training--Annual Catalogue, New York, The Council, 1955, pp. 2-3.

[2]Institute of Pastoral Care, Constitution, Boston, The Institute, 1954, p. 2.

The following paragraph states the objectives of the American Foundation of Religion and Psychiatry in training clergymen to be effective counselors:

> Most importantly they must be made aware of the psychological problems that harass some of the people in their communities. Symptoms and causes of various types of emotional disorders must be understood. As diagnosticians, they should be able to recognize serious illnesses and arrange for proper treatment. They must also become experts in religious therapy. Patience, skill and understanding in dealing with disturbed are very important and come with supervised experience.[1]

Hiltner also points out the need for improving the preparation of the chaplain and says that such preparation should include increased "self-understanding, knowledge of the nature of health and illness. . . . and specialized knowledge, both of illness, of methods used to treat it, and of religious resources in connection with it."[2]

These leaders all appear to concur in the belief that the chaplain must have special training under the leadership not only of an experienced chaplain-supervisor, but also of different members of the hospital staff. They can give him a wide and comprehensive picture of what

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[1]Norman Vincent Peale and Smiley Blanton, A Program of Training in Pastoral Care, New York, American Foundation of Religion and Psychiatry, 1954, p. 4.

[2]Seward Hiltner, Religion and Health, New York, The Macmillan Company, 1943, pp. 248-249.

healing constitutes and of the part played by their various fields in the healing.

I. APPOINTMENT OF CHAPLAINS IN HOSPITALS

The chaplains in Church-related hospitals are appointed by their respective Church bodies. Chaplains for county, city, and state hospitals are appointed by public officials with the recommendation from the various Church organizations. For the City hospitals in New York, for example, the Protestant Commission on Chaplaincy in the City is in charge of nominating the candidates, whom the City government appoints. As to candidates for chaplaincy in state hospitals, which include all mental hospitals, the New York State Council of Churches nominates, and the state government appoints. In all cases the chaplain is administratively responsible to the hospital, but responsible to the Church authority in his ecclesiastical duties. Similar arrangements are followed in the appointment of chaplains from the Catholic and the Jewish faiths.

As to the appointment of chaplains in government hospitals, the Commission on Ministry in Institutions, of the National Council of Churches introduces its statement of policy as follows:

> A statement of policy as to the number of chaplains on full-time service that will eventually be secured shall be adopted by the authorities of the institution

> or institutional system, following the formula suggested below. As indicated previously, "faith groups" is meant, for these purposes in the United States: Protestant, Roman Catholic, and Jewish.[1]

The suggested formula is summarized below.

1. Every institution averaging approximately one hundred and fifty or more persons under its care on any one day shall have one full-time chaplain, representing the major faith group, to minister to persons of his own faith group, and to arrange with other clergy for ministry to persons of other faith groups.

2. An institution having any second faith group represented by two hundred and fifty or more persons, based on an average daily population basis, shall have an additional full-time chaplain of that group.

3. Additional full-time chaplains shall be assigned to an institution for each five hundred persons or fraction thereof, of any faith group based on an average daily population basis.

4. Where the number of persons of any particular faith group is not sufficient, according to such standards, to warrant a full-time chaplain representing that faith group, but is large enough to demand time in religious ministry,

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[1]Commission on Ministry in Institutions, Standards for Chaplaincy Services in Institutions, New York, Federal Council of the Churches of Christ in America, 1950, p. 6.

then a part-time chaplain shall be chosen.

This suggested arrangement works satisfactorily in the United States and there are a great number of chaplains working under its terms. These chaplains make arrangements for pastors to visit and, in some instances, to administer to the patients of their own churches the sacraments and rites of their preference. But the chaplain is responsible for the whole ministry of his faith group and any special arrangement is under his sole authority.

As regards the chaplaincy in mental hospitals in particular, the office of the Department of Pastoral Services of the National Council of Churches has reported that State Councils of Churches frequently ask for suggestions as to clergymen who might become chaplains in such institutions. The candidates are usually recommended by state councils of churches to the corresponding governments. In New York, the State Department of Health[1] has published a booklet in which information is given to clergymen about its mental hospitals. During the last ten years there has been an increasing number of students interested in this type of chaplaincy, and the number of training centers in mental institutions has been increased.

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[1]Herman E. Hillboe, M. D., A Clergyman's Guide, New York, New York State Department of Health, 1954, pp. 32-33.

II. FUNCTION OF THE CHAPLAIN

In planning his program the chaplain must take into consideration the general set-up of the institution he serves and the attitude toward religious activities on the part of all concerned. He must know the facilities available to him and must be familiar with the general program of the institution so that he can integrate his program in the best way. He must be well acquainted with the personnel, specially the staff and the department heads. This will help him to develop his program with all possibilities of success. If he is new in the community he must learn to know it and to discover how to secure cooperation in his mission.

In a report of the conference of Presbyterian Hospital chaplains and administrators held at the beginning of 1955, the Division of the Welfare Agencies of the Church states three important conclusions concerning the function of the chaplain.

> The hospital needs to know some things about the chaplain: that his services are available to patients, to personnel, and to students; that he stands for the doctrines of the Church, personifying them in his life and ministry.
>
> . . . that the chaplain should be a part of the administrative staff with the rank of department head.
>
> . . . the need to educate boards of trustees to the value of the chaplaincy and the need to educate

the ministers about the work to provide more chaplains.[1]

The function of the hospital chaplain is many sided. His daily program represents the work of the Church for the sick, but it also influences the programs of others who are involved in the hospital situation, such as doctors, nurses, social workers, and other personnel. The different approaches he uses in his ministry include work as a member of the health team, various other relationships with the hospital personnel, and all-important work with the patients and their families, and contacts with the community. In many cases he fulfills the function of teaching, through which he can give the needed co-operation to the understaffed School of Nursing. In some instances the chaplain also serves as public relations officer for the hospital, explaining the institution and the chaplaincy to the churches in the community. These functions of the hospital chaplain are discussed in the following pages.

Member of the Healing Team

The principle of the wholeness of personality must be applied by the chaplain in all his hospital dealings.

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[1]Division of Welfare Agencies, Report of Meeting of Chaplains and Administrators, Philadelphia, Presbyterian Church in the U. S. A., 1955, pp. 1-3.

He is a member of the healing team and is very much interested, as are the other members, in the well-being of the patient. Chaplain Ballinger gives an interesting description of the team:

> In the hospital the therapy team includes the doctor, nurse, dietitian, occupational therapist, social service worker, psychiatrist, chaplain, and other professional people who work with the patients. Each member of the team has a particular function to perform somewhat unique and yet somewhat similar to what each of the others performs. The patient and his welfare should have top priority; all members of the team must work together, and help one another toward the common goal of welfare of patient.[1]

Regularly the chaplain tries to do his work of spiritual guidance without infringing on the rights of other professional workers. This attitude wins for him a place of respect among the people responsible for the patient's well-being.

Among others, the doctor is one with whom the chaplain needs to work in close co-operation. They can work together if they understand each other's function in behalf of the patient. Young[2] states that both the doctor and the chaplain have found great advantage in such co-operation. It helps to create a wholesome atmosphere in the

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[1]Malcolm B. Ballinger, Religious Care For Hospital Patients, Ann Arbor, Michigan, University Hospital, n.d., p. 3.

[2]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, 1954, p. 9.

hospital situation. Kemp has described this relationship in significant words which have great relevance:

> The most friendly relations and the highest form of co-operation between the doctor of medicine and the minister of religion can best be secured where both realize that each one has an entirely distinct function to perform for the service of humanity and where both realize that each one can best aid the other by attending strictly to his own specialty.[1]

Through this kind of teamwork the doctor will become more interested in the chaplain's program. The chaplain does not need to feel embarrassed if a number of the doctors attend the religious service he had intended for the patients and students. As long as he has a message of deep faith and love, he will be able to reach all souls, because they come for a spiritual message. The interest and the participation of the medical staff in the religious program is highly desirable.

The trained chaplain will be always a co-operator with the doctor, and never a competitor. A question which has been frequently asked is whether or not the chaplain should receive training in medicine, psychiatry, social work, and other related fields before he is assigned to work in a hospital.

The answer to the foregoing question is that the chaplain needs to understand the importance of each

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[1]Charles F. Kemp, Physicians of the Soul, New York, The Macmillan Company, 1947, p. 236.

discipline represented by the members of the team, and what the relation his work must have with each one of them. During his training, especially his supervised practice, the chaplain participates in frequent meetings with the hospital professional staff. This type of experience helps him to become familiar with the functions of each member of the healing team. Through lectures by surgeons, physicians, psychiatrists, psychologists, social workers, and other members of the staff he learns about the fields which these specialists represent. With this wide knowledge he learns to be an enthusiastic co-operator with each one in the staff. It will lead him to be a welcome and effective member of the team concerned with the same problem--the patient's health.

This awareness of the problems facing the professional hospital staff opens the way for him to work hand to hand with the doctors who will be more likely to welcome his mission in the sickroom. Young[1] states that the doctor and the chaplain have a unique role founded by tradition. But in the interest of treating the patient as a whole person, both must look to the physical, emotional, and spiritual health, each one from his own position.

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[1]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, 1954, p. 30.

Some people have pointed out the possibility of the chaplain's attempting to take on the role of the doctor or other professional worker in the hospital, such as the nurse, social worker, or psychiatrist. This interference might be manifest in different ways. The chaplain, not recognizing the deeper illness of the patient, might wish to continue his therapy when he should refer the case to the psychiatrist. Or, when visiting the sickroom the chaplain might identify himself with the patient's complaints as to some treatment which the sick person might think is not the right one. Generally, however, chaplains are careful not to get involved in this way.

Some conflict or overlapping may be possible in areas which involve the chaplain's and the social worker's duties. He may try to do some things for the patient, such as calling members of the patient's family, helping to solve some economic problem which the patient may express to him, or making referrals to community agencies. These are duties regularly considered to be in the area of the social worker. But in most instances there is mutual understanding and friction seldom occurs.

When the chaplain fully realizes the limitations as well as the scope of his activities, the doctors and the other members of the staff acknowledge his position and appreciate his services. Physicians will frequently refer

him cases which may be helped through spiritual guidance. The co-operation of the chaplain may consist of keeping to his religious duties, giving spiritual help to patients referred to him by the doctors, respecting the physician's and other professionals' position, and trying to understand the patient's complaints without creating a problem to the other members of the team. Effective teamwork can be built up if there is understanding. Dr. Cabot[1] gives some hints for the kind of relation which the chaplain must try to build with the doctor which can be summarized in the following points: 1) Each feels the serviceability of the other if both are sincere and competent; 2) there are instances when the doctor is most needed, others when the minister can do most; and 3) the chaplain works as a minister, not as healer.

Other Relationships with Personnel

A well-trained chaplain always finds it one of his duties to help build up interpersonal relations with the professional staff outside of the team relationship. Also, with personnel who are not necessarily on the health team. As explained by Lloyd-Jones, "the common good can be

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[1]Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, New York, The Macmillan Company, 1936, p. 51.

promoted best by helping each individual to develop to the utmost in accordance with his abilities."[1] This worth of the individual, the freedom to express himself, his opportunity to develop and grow in insight, constitutes the personnel point of view. The chaplain can help to develop this sense of worth in each member of the healing team: the members of the staff, the student nurses, and the technical personnel. He can help build up the permissive atmosphere that will work for the complete recovery of the patient. His daily program can be a living example to all.

The chaplain as a minister of religion is constantly encouraging and promoting the most wholesome relations among persons in the hospital. This status places him in a position of inspiration. A hospital urgently needs a positive religious atmosphere because in many instances the spiritual problems of the sick affect the process of recovery. The chaplain, working together with an understanding and co-operative staff, meets these spiritual needs. There is always a need for more trained chaplains to help hospital personnel adopt this positive point of view in dealing with the sick. It is a powerful tool on hand for the daily task of the chaplain.

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[1]Esther Lloyd-Jones and Margaret Ruth Smith, Student Personnel Work As Deeper Teaching, New York, Harper & Brothers, 1954, p. 5.

In this capacity the hospital chaplain becomes related to the different activities of the staff, and in doing so he comes face to face with their spiritual needs. As persons who also feel the need for a religious experience, they may attend the religious services which the chaplain holds. He may be able to plan special services for them at an hour at which a considerable number of them can attend. He may counsel with them about their religious problems. He may also arrange for Bible studies and help the group with devotional literature which will assist them in their spiritual growth. In this way the chaplain may build wholesome relations with the staff and help them in their religious experience. This relationship will strengthen his position as the specialist in matters of spiritual needs, and will permit him to perform the duties of his unique role.

Although not as a part of his regular duties, the chaplain usually plans some activities with the staff in addition to his counseling with them on their spiritual problems. During his working hours there are frequent opportunities for him to come in contact with the members of this group and to help them in their problems. In some situations he may even arrange for some kind of religious activity for those who live far from their churches and have to limit their attendance only to Sunday. All

these activities are held on a voluntary basis and at the request of the group.

One group asked the hospital chaplain to help them organize a religious activity once a week. They decided to meet every Friday after lunch during their rest period. Their activities consist of short meditations, Bible studies, hymn singing, prayer meetings, and other forms of church activities. These meetings have proved very helpful to the group.

Work with Patients

All other functions of the chaplain are subsidiary to his work with the patients. This fundamental and indispensible part of his work is the core of the entire program. Ballinger[1] has described five ways in which the chaplain can minister to patients. These may be summarized here as follows:

1. The chaplain represents God's concern and care for each individual person. He represents to the person whatever his religion represents to him.

2. The chaplain brings understanding of the patient's feelings. He encourages acceptance of treatment and

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[1]Malcolm A. Ballinger, Religious Care For Hospital Patients, Ann Arbor, Michigan, University Hospital, n.d., p. 3.

co-operation with a friendly therapy team.

3. The chaplain interprets experiences to the patient. The patient may be confused by pain, suffering, necessity for medication or surgery, acceptance of long hospitalization, adjustment to handicaps and disappointments. The chaplain helps relate these experiences to his religious faith.

4. The chaplain discovers the spiritual resources of the patient. He finds out about his religious background and helps him utilize resources which he gained earlier in life and has since neglected or misunderstood.

5. The chaplain also helps the patient develop new spiritual resources. He can encourage and guide spiritual growth.

Pastoral care of the patient is similar to parish work in a regular pastorate. In this case it consists of visitations and counseling; prayer and Scripture reading; administration of Sacraments; conducting religious services; and distributing devotional literature. These functions are described here briefly.

Visitation and counseling. The visit to the sick-room is the way in which the chaplain realizes most of his ministry to the patients, and the daily visitation constitutes his major concern. As soon as possible after the patient has been admitted the chaplain should try to

make his first visit to him. Then he must continue his visits with the frequency which the condition of the patient and other circumstances demand. By means of these frequent contacts with the sick person he comes to know the patient, his worries, his personal problems, and his spiritual needs. The very presence of this "physician of souls" in the sickroon may constitute a motif of assurance and joy to the average patient. He may feel comforted with the visit of the minister of God who brings him a message of peace, love, and guidance. About this phase of the chaplain's work Young makes the following evaluation:

> Since hospital visitation is an essential part of the healing ministry of the pastor, its methodology deserves a great deal of study. The importance of the initial contact with the patient cannot be stressed too strongly. . . . Illness is a frustrating experience, and the sick individual is therefore more likely to be sensitive, irritable, hostile, suspicious, and anxious than when in a state of health. For this reason the simplest sort of ill-timed movement can prevent the pastor from establishing a working relationship with the patient.[1]

The first visit will determine, to a high degree, the effectiveness of the chaplain's work with that patient. It is of extreme importance that he make this visit a warm, accepting, and assuring one. Among the qualifications which Flath and Gilmour have emphasized for persons who

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[1]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, c1954, p. 55.

visit the sick is sincerity. They say, "The light of the sickroom quickly detects sham and artificiality and brings sharp focus on genuine sincerity."[1] Sincerity is and should always be the keynote of the chaplain's interest and work for the patient, and he reflects it even in his gestures during the visit to the sickroom.

An attitude of hopefulness is another requirement for a chaplain's visitations to the hospitalized patients. The modern technique of the clergyman in the sickroom has been discussed by Carrol A. Wise in the following words:

> . . . a clergyman may enter a sickroom with a gravity and solemnity that immediately suggests to the patient that the end is near. . . . Or he may enter in a spirit of enthusiasm so inappropriate to the occasion that it irritates the patient. . . . On the other hand, an attitude of hopefulness, cheer and understanding may be excellent medicine.[2]

Such an attitude on the part of the chaplain helps him to make his visits interesting and meaningful so that the patient is helped by them and expects them with joy and hope.

The chaplain must have a wide knowledge of the techniques of good counseling, and a good command of the

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[1]Carl J. Flath and Monroe T. Gilmour, M. D., When We Enter the Sickroom, Chicago, The Modern Hospital Publishing Company, Inc., n.d., p. 9.

[2]Carrol A. Wise, Religion in Illness and Health, New York, Harper & Brothers, 1942, p. 255.

interview situation. He should have a comprehensive view of the different approaches and of their meaning in the hospital as a setting different from that of other counseling situations. He should know as Young says, that "medical science is pointing out the needs for a total approach to the total person and is teaching the wholeness of personality."[1] He should also know, as Rogers states, that effective counseling consists of ". . . a definitely structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation."[2]

In his counseling the chaplain uses one of the fundamental principles of all counseling; the principle of the acceptance of the individual by the counselor. Rogers has stated that in the emotional warmth of the relationship with the therapist "the client begins to experience a feeling of safety as he finds that whatever attitude he expresses is understood in almost the same way that he perceives it, and is accepted."[3] The chaplain accepts the

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[1]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, 1954, p. 5.

[2]Carl R. Rogers, Counseling and Psychotherapy, Boston, Houghton Mifflin Company, 1942, p. 18.

[3]Carl R. Rogers, Client-Centered Therapy, Boston, Houghton Mifflin Company, 1951, p. 41.

patient as he is with all his problems, and helps him to understand himself and to see his problems clearly, taking steps toward their positive solution. The mastery of this principle provides the chaplain with a valuable help in counseling with the sick.

The chaplain must keep in mind that there is a power in the individual which he can direct toward positive action. Rogers calls this power "the capacity of the individual for self-initiated, constructive handling of the issues involved in life situations."[1] It is the latent power which Sherrill calls "a kind of inward propulsion to grow."[2] He will find great resources hidden in the patient, through which he can help the patient bring about the necessary adjustments in his life. But for the chaplain's ministry, this discovery and the positive direction of this power is not enough. He should bring the patient also to understand that back of this great power in the individual lies religious desire, a manifestation of spiritual power. The main purpose of the religious counseling of the chaplain with the patient is to try to bring into harmony those two

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[1]Carl R. Rogers, Client-Centered Therapy, Boston, Houghton Mifflin Company, 1951, p. 66.

[2]Lewis J. Sherrill, The Struggle of the Soul, New York, The Macmillan Company, 1951, p. 8.

great powers which emerge from the same source--the love of God. When he succeeds in doing this he leads the patient to a hopeful look of his problem.

Hiltner has interpreted the chaplain's counseling as follows:

> Pastoral counseling is the endeavor by the minister to help people through mutual discussion of the issues involved in a difficult life situation, leading toward a better understanding of the choices involved, and toward the power of making a self-chosen decision which will be as clearly bound up to religious reality as the people are capable of under the circumstances.[1]

In the case of the hospitalized sick the chaplain's discussion of the problem with the patient requires special skill because of the hospital situation. With the spirit of understanding and acceptance the chaplain is able to interpret the patient's needs and guide him to take steps for positive adjustments. Schindler links such counseling with the likeness to the ministry of Jesus:

> A Christian ministry will be successful to the degree to which it is modeled after the ministry of Him who came among men as Teacher, Counselor, Physician, and Friend. If we judge men by His standards and deal with them in His spirit, we have proved ourselves not only good interpreters of human nature but have taken that essential step which leads from theory to practice.[2]

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[1]Seward Hiltner, Religion and Health, New York, The Macmillan Company, 1943, p. 167.

[2]Carl J. Schindler, The Pastor As A Personal Counselor, Philadelphia, Muhlenberg Press, 1942, p. 147.

In dealing with the spiritual problems of sick persons, the chaplain has to deal also with their social and psychological problems, often very much interwoven. Dicks emphasizes this many-sided picture of the chaplain's counseling work.

> To be sure we are concerned that suffering shall be relieved. . . . As clergymen we are concerned with what you do with health when you have it. It is the pastor's task to work to relieve suffering and fear and loneliness, but it is also his task to assist people to gain faith and hope and that fellowship with God which encompasses eternity itself.[1]

Prayer and Scripture reading. One of the things which the chaplain is expected to do for the patient during his visitation is to pray with him and read a Bible passage to him. This is customarily done with the Protestant patient, who looks for it as a part of the chaplain's help. Prayer and Scripture reading bring comfort and relief to many patients, and if the chaplain is to leave the room without having done this the patient usually asks for it. If it is done on his own initiative, the chaplain should use his discretion as to whether it must be done during his first visit or not, and as to the most convenient time for it. If the patient is prepared for it, the reading brings him comfort and assurance but the chaplain must

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[1]Russell L. Dicks, Pastoral Work and Personal Counseling, New York, The Macmillan Company, 1945, p. 14.

see that he is not forcing this important part of his ministry.

In the sickroom, the chaplain selects those Scripture readings which may be appropriate and will give the patient a message of comfort and assurance. The Book of Common Worship[1] used by all clergymen of the Presbyterian Church in the U. S. A., contains a section of Scripture selections for use in the visitation of the sick. Among the passages suggested for this purpose are the followings: Psalm 23, Psalm 121, selected verses from Psalms 24, 46, and 91, and St. John 14, Romans 8, selected verses from the fifth chapter of the Epistle of James, and others. Sometimes it may be wise to find out if the patient has some favorite passage which he wishes to have read to him.

The content of prayer in the sickroom is something that the chaplain decides according to his understanding of the factors involved, such as the physical condition of the patient, his spiritual strength or weakness, his Church relations, and his greatest need at that moment. It should lead him to reliance upon God. A short simple prayer can do much during a timely visit to a sick person who believes

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[1]Office of the General Assembly of the Presbyterian Church in the U. S. A., The Book of Common Worship, Philadelphia, Publication Division of the Board of Christian Education, 1946, pp. 180-182.

in the efficacy of a positive religious experience. Such prayer can be also the beginning of a wholesome and understanding relationship between the chaplain and the patient since the first visit. Scherzer states that "prayer should help the patient to overcome worry and fear which are always manifest at the beginning of a serious illness."[1]

Another special moment in which the chaplain should take the initiative of prayer, if the patient has forgotten about it, is the moment the patient is leaving for his home after being discharged from the hospital. He may suggest a moment for expressing gratitude to God for recovery. Scherzer writes about this need as follows:

> We do not want to dwell too much upon the past, but it is well to recall how we hoped and prayed for the day when we should be relieved from pain and illness again. Now that this time has come, it is easy to forget the anxious moments through which we passed. It is to our advantage that God has made it possible to forget. We do not want to dwell indefinitely upon unpleasant things. But at the same time we do not want to forget our resolve to be thankful for recovery.[2]

Administration of the Sacraments. The chaplain will occasionally need to make provision for meeting the sacramental needs of patients, most frequently, to administer

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[1]Carl J. Scherzer, Springs of Living Waters, Philadelphia, The Westminster Press, c1951, pp. 36-38.

[2]Carl J. Scherzer, Springs of Living Waters, Philadelphia, The Westminster Press, c1951, pp. 84-85.

Communion. This varies with the faith of the patient. Even among Protestants, some people need to take Communion more frequently than others, according to the denominations to which they belong. It is the practice of hospital chaplains to administer the sacrament to the sick of their own faith, and to have other clergymen come to administer to their patients.

The request for the Sacrament of Baptism is less frequent, except in the case of children who are very sick and whose parents wish to have them baptized. The different faiths also have their own principles and rules for its administration, and the chaplain tries to follow the same practice used in Communion. Exception to this practice might be a case of emergency in which the appropriate clergyman might not be available. This applies to cases when death is near and the chaplain must act immediately. In the case of some churches, such as the Presbyterian Church where every Communion must be under the authority of some Church judicatory, the chaplain gets the authorization from his local Presbytery which adopts a resolution to the effect. This also applies to the administration of baptism. The chaplain must report annually to the Presbytery all private administrations of the sacraments. All chaplains are notified of this special provisions through the Office of Institutional Chaplains.

Religious services. Regular Sunday morning religious services are held either at the chapel, if one is available at the hospital, or at any designated place set for that purpose. Patients who are permitted to walk or use wheelchairs may attend these services if they wish to. In many hospitals visitors and members of the personnel and students are also invited to attend. Some institutions have intercommunication systems for broadcasting these services to the different wards and rooms, where there are earphones for the use of the patients. Each patient who cannot go to chapel and who wishes to hear the service uses this individual unit which he himself can control. This system prevents interference with other patients who might be critically ill or who do not wish to hear the service.

In smaller hospitals where there is neither chapel nor broadcasting system, services are held in the wards, when condition of patients permits, or in some room which may be prepared on Sundays for this purpose.

In addition to the inspirational and devotional aspects of the chapel, worship services have been found to be of a great therapeutic value to many patients. Their growth in religious experience while at the hospital manifests very positive results in their adjustments to the new situation of the hospital environment. It has been manifest also in their attitudes when they go back to their

homes. There is always a need for a chapel in the hospital. It provides a place for worship which may be the beginning of an adjustment process in the spiritual life of the patient.

Distribution of devotional literature. Every chaplain has on hand a supply of devotional literature to be distributed free among patients who wish to read it. There are some agencies, like the American Bible Society, which provide Testaments, Gospels, Bible portions, and other kinds of religious literature, at the request of the chaplain. Most of the literature sent by Churches and organizations for the chaplain's use is extremely helpful.

In some hospitals a weekly paper or bulletin is published under the direction or with the co-operation of the chaplain. He can help in the whole spiritual life of the institution through this means by writing devotional paragraphs or by editing a column on religious news. He may give publicity to his program by announcing the weekly activities in the bulletin. Many patients enjoy receiving a copy. The following paragraphs are examples taken from a hospital weekly bulletin:

> The Chaplain's Department ministers to the spiritual life of the entire Hospital family: patients, personnel, and staff, in all departments, and of all faiths.

> The chaplains are ready to offer prayer and counsel at bedsides or in their offices, and to administer the sacraments and rites of their faiths to all who so desire.
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> Services of all faiths are held regularly in the Pauline A. Hartford Memorial Chapel. . . . Patients permitted to walk or use wheelchairs are invited to attend any of the Chapel services, and others to listen over the bedside broadcasting system.[1]

(Weekly publications like this are given not only to patients but also to all hospital personnel and to interested visitors. Patients who may so desire will receive the bulletin at their homes upon request that their names be put on the mailing list.)

The chaplain should know all literature distributed by his office, whether from outside agencies or within the hospital, to determine whether certain items are of help in the case of some patients. For example, he may find leaflets containing emotionalized stories which would not be appropriate for certain type of patients. He will use his good judgment in the selection of what is best in each case.

Teaching Function

In hospitals which maintain schools of nursing as part of their program, the chaplain is frequently called to

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[1]The Chaplain's Department, The Weekly Messenger, New York, The Presbyterian Hospital in the City of New York, March 18, 1955, p. 1.

assume a teaching responsibility in addition to the spiritual guidance program for the students. He may teach regular courses such as the social science courses, or lecture students on different allied subjects. Sometimes he is invited to lecture on the chaplaincy work and discuss ways in which the nurse may co-operate in the program. Young[1] affirms that the relation between the chaplain and the nurse is extremely important. His status as teacher gives the chaplain an opportunity to know the students better and to help them grow in their understanding other people and themselves. This understanding is widened through his teaching of general courses such as psychology and sociology.

At some hospitals the chaplain conducts regular religious activities for the students, such as Bible classes and drills, panel discussions on religious and social problems, or services in which the students are taught to take active part. Besides his formal teaching load at the school of nursing the chaplain may conduct forums on the religious needs of the patients and how the nurse may help in meeting these needs.

In a number of general as well as of mental hospitals the chaplains are responsible for the training of

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[1]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, 1954, p. 26.

seminarians and other clergymen in the clinical pastorate. Many supervise the training and practice of prospective institutional chaplains by serving as chaplain-supervisors. One such chaplain is the Reverend Otis R. Rice, who in addition to his duties as Religious Director and his many other responsibilities in the field, supervises the training of a number of seminary students and clergymen at the center established in St. Luke's Hospital in New York City.

Chaplains in other areas carry on teaching responsibilities with local pastors who wish to further their preparation for pastoral care. In addition to their regular duties they organize and conduct seminars and special classes for these pastors. This is a phase of the work of the chaplain as teacher, to help other clergymen in their preparation for pastoral care.

Contacts with Patients' Families

A group which is not frequently mentioned as part of the hospital relationships and with whom the chaplain needs to be concerned is the group made up of the patients' families. It changes as does that of the patients, with discharges and new admissions, but the contacts which the chaplain is able to make through his relations with the patients' families is very far reaching. Many of them wish to join in the religious services at the hospital

while their sick relatives are in the institution. The chaplain can be of great help to them and, through them, to the patients because of the growth in understanding which they can gain in their contacts with the chaplain's program. Frequently the chaplain is called to help in some spiritual problem of a patient's family. In some cases they are referred to him by the patient's pastor. Sometimes he has to interpret for them the reasons for certain limitations in their visits to the patient. If he succeeds in helping them understand, they are willing to co-operate for the well-being of the patient.

Community Relations

Sometimes the chaplain serves as a kind of public relations officer for the hospital, attending meetings of community organizations, such as auxiliary and civic groups interested in helping the institution in some way. Through these contacts he will be able to establish valuable relations which will help his work and the general program of the hospital. Sometimes he will be invited to speak at meetings, or to report to religious groups about the work he is carrying on. These visits to Church groups usually result in promotion work which proves beneficial to his program. There are local groups which may become interested in working out some project to help the hospital as a

result of the chaplain's contacts in the community.

Governing Principles

The following twelve practical principles may be helpful to pastors in their ministry to the sick, and to seminarians and clergymen who are interested in preparing themselves for the work of hospital chaplaincy:

1. Before visiting the patient for the first time the chaplain should try to know about his condition, religious affiliation, home address, occupation, and civil status, as well as his name. The chaplain can get this information from the nurse in charge or from the admission sheet to which he may have access. This prepares him for his introduction if the patient is unknown to him.

2. The chaplain should select the most convenient time for visiting the patient. Sometimes the patient must be alone, for a special treatment or for rest after the treatment. The patient needs time for complete rest each day and this time must be protected from intrusion. During the early morning the patient receives routine care and this is not the appropriate time to visit him, nor should he have visitors at mealtime. Nor should the chaplain go into the sickroom when the doctor and nurse are examining or treating the patient. From ten to twelve in the morning and from three to five in the afternoon have

been found in some institutions to be the most convenient hours for his visits. Of course this does not apply to emergency visits, or to the visit to the patient who has asked the chaplain to come and pray for him before he is taken to the operating room. This and other special visits must be arranged through the doctor or the nurse in charge, so that they may make provision for it, especially in the wards.

3. When entering the sickroom the chaplain must be cheerful and understanding. He must be sincere in his help to the patient trying to make him know that he is interested in his health. This will contribute to the warm and permissive atmosphere needed in the sickroom.

4. The chaplain must make use of his right as a clergyman to hear and keep confidences entrusted to him. The patient expects it, and other persons respect this right. Usually during his conversation with the patient the chaplain receives confidential information that the patient does not wish to share with anyone else. He speaks to the chaplain as spiritual counselor and man of God, representing the Church and its ministry of redemption and love.

5. The chaplain should keep serene and calm before any unusual behaviour, and should try always to accept the

patient as he is. Sometimes a patient may say or do something which may appear discourteous to the chaplain. The chaplain must remember in this instance that the patient may be feeling much pain, or be irritable, or emotionally off balance. He must realize that behaviour which may be unusual in the general hospital may be quite ordinary in the mental hospital, since the feeling of aggression or of hostility may be characteristic of the patient's illness.

6. The chaplain should practice the art of listening, a definite necessity in his daily calls. He should always bear in mind the three conditions underlying listening: 1) suffering on the part of the parishioner; 2) rapport; and 3) the soul-poise of the listener.[1] To stop talking much and to start listening more has been one of the admonitions made to counselors which is extremely important to the hospital chaplain.

7. The chaplain should be always ready to help--there is much that has to be done in the hospital situation at every hour. He can be of great help to the patient not only through direct contact and service, but also through the doctors and nurses. Best relations are established

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[1]Russell L. Dicks, Pastoral Work and Personal Counseling, New York, The Macmillan Company, 1945, pp. 154-155.

between him and the staff by means of this desire to help them and the patient. It also relates him to all the other personnel.

8. The chaplain should make each call to the patient an experience of growth, a meaningful lifting of his life. Each call can be a revealing and reassuring moment. Koewing has described such results and says, "Go into a sick room where there is a patient with both a vital Christian faith and spiritual imagination to see herself wither well or benefited by her illness; . . . she will say things like this: 'I am persuaded that He is able to keep that which I have committed unto Him.'"[1]

9. The chaplain should make short visits, unless there is a special reason to extend them. The shortest visit can be fruitful if it leaves a message of hope.

10. The chaplain should not make too frequent visits to any one patient. There are many who need his help. Sometimes a patient feels lonesome because his family does not visit him frequently, and tries to have the chaplain substitute for his relatives. Others find the chaplain's visit so inspiring that they ask him to come everyday.

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[1]Leland Hoberg Koewing, D. D., Maintaining a Will to Get Well, New York, Board of National Missions of the Presbyterian Church in the U. S. A., n.d., p. 9.

In large hospitals this would be impossible, but even there, some patients try to get more attention than the chaplain can give them. Of course, there are patients whom he has to visit more frequently than others because of their condition and needs.

11. The calls on the patient should be made when he is alone. The chaplain will feel more comfortable in talking and ministering to him without the interference of other visitors. Sometimes this opportunity is difficult to find, especially in the case of a patient who has a member of the family staying with him in the room. In this case, either the patient takes the initiative and asks to be left alone with the chaplain, or the chaplain may make the request. Usually the family tries to co-operate with the chaplain in his ministry to the patient.

12. The chaplain should avoid making any gesture or whisper to any other person in the room. The sick person is always very attentive to all that happens around him, and he may interpret this gesture or whispering in terms of his condition which he might, then, think critical.

The foregoing principles serve to guide the chaplain's work but they are all affected to a large degree by his availability. He is subject to be called in any emergency and almost at any hour. His services should be available at any moment. For this reason institutions

employing chaplains are asked to make provision, if possible, for his housing accommodations on or near the hospital grounds. In this way the chaplain may be able to get into the room or ward, where needed, in a few minutes.

III. TYPICAL PROGRAMS OF THE HOSPITAL CHAPLAIN

Hospital chaplains' programs vary in different institutions, but the two kinds which will be described here are typical. Although they are similar in general aspects, they are different in specific approaches.

General Hospitals

The chaplains' programs in general hospitals comprise the customary daily visitations to the sickroom, counseling, administration of the sacraments to patients of their own faith and provision for this service to patients of other faiths, planning and leading religious services for the patients and personnel, provision of adequate religious literature for patients and visitors, teaching or lecturing to students at the school of nursing, and participating in some community activities. In addition to the foregoing, the program of the chaplain in a general hospital also includes attending staff meetings, keeping the necessary records for reports to Church and hospital administration, writing letters of referral to

other pastors and to community agencies, and answering letters from former patients whom he follows up or who may wish to consult him.

In smaller hospitals, if the services of social workers, are not available, the chaplain is called to counsel with patients' families on social or family problems. In these cases he must know the community resources and make the proper referrals. Sometimes he must interview fellow clergymen in relation to patients from their churches. He must be available at all hours for emergency calls; when going out he should make arrangements with local clergymen to substitute for him.

Mental Hospitals

The program at the mental hospital is different in many aspects although similar in others. Here the chaplain has a very special mission to fulfill in work with the patients' emotions--their anxieties and failures. In addition to a good command of the counseling techniques, the chaplain at the mental hospital must be prepared to understand the illness situation in order to give effective spiritual guidance to the patient. Bruder describes the work and its outcomes as follows:

> In very much the same manner in which the psychiatrist seeks to help the patient deal with his former inadequacies in living, so should the chaplain

> be able to help the patient with his failures in the religious life, and to point out for him a more adequate religious understanding and practice. . . .
>
> For the minister to undertake such a task requires an adequate understanding of the illness situation. This demands special hospital training.[1]

As Hiltner states it, "emotions and interpersonal relationships, body, mind, and spirit, are all involved at all times."[2]

The chaplain in the mental hospital regularly divides his calls into three different types: 1) the visit to the critically ill, 2) the initial interview with the new patient, and 3) the follow-up interview with the discharged patient. Once a week in some institutions, and more frequently in others, the chaplain goes over the danger list and notes the patients that have been added and those that have been removed. As one chaplain reported, sometimes he is called "to break the news to a patient of the death of a loved one, especially a father or mother."

In mental hospitals, more often than in general hospitals, chaplains are required to be present at the

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[1]Ernest G. Bruder, "In the Mental Hospital." Paul B. Maves, ed., The Church and Mental Health, New York, Charles Scribner's Sons, 1953, p. 178.

[2]Seward Hiltner, "The New Concern of Recent Years." Paul B. Maves, ed., The Church and Mental Health, New York, Charles Scribner's Sons, 1953, p. 65.

bedside during a critical illness. This is often as important to the relative who may have difficulty adjusting to the sight of abnormal conduct. Some families seem to forget their relatives in mental hospitals, others cannot visit them as frequently as they would like to because of hospital regulations. In most hospitals for mental illness, the new patient is not allowed any visits from outside the institution during an initial period. His family may ask the chaplain to keep in contact with him.

Another phase of the chaplain's program at the mental hospital which differs from that at general hospitals in his attendance at diagnostic staff meetings. This is a very significant phase of his program and he attends these meetings regularly. During these meetings there are times when the chaplain is consulted concerning the patient's beliefs in regard to whether they are unusual or not in his particular religious group. One chaplain has reported that this is often a determining factor as to whether the patient is to be discharged. Sometimes the chaplain can add to the dynamics of staff discussion by giving his interpretation of the patient's spiritual growth in relation to his progress in the hospital. These meetings help the chaplain to understand the patient and to work better with other patients who have similar symptoms.

In a particular case reported by a chaplain, the graduate nurse, after consulting with the doctor, called the chaplain to help with a patient who was behaving in an unusual way. The patient belonged to a religious group that conducted their services in a very emotional manner. The patient had not attended any service that day nor had any visitor, but all of a sudden he had begun to behave as he would have done in his church. The chaplain stood at the door until the patient looked at him inquiringly and asked him to come in. "Good afternoon, Mr. J., you seem to be holding a service," said the chaplain. Mr. J. answered, "Yes, and I want you to join me." The chaplain said, "What can I do?" Then the patient told him to read a Scripture passage. The chaplain did and a conversation about the Bible and hymn singing followed in which the patient explained to the chaplain how he used to attend church faithfully and take part in the services which sometimes kept on until late in the evening. When the chaplain left the patient was calm, and during subsequent visits continued to improve.

IV. THE CHAPLAINCY COMPARED WITH OTHER PASTORATES

Although the work of the hospital chaplain in some respects is similar to the regular work of any other clergyman in his parish, there are some differences due to the

hospital situation. It is because of these characteristics of his ministry that the chaplain needs to have specialized training and practice in this field. There are three areas in the chaplains' program which present special characteristics, 1) the pastoral call, 2) counseling, and 3) worship.

The Pastoral Call

The pastoral call is the most frequent service of the chaplain to the hospitalized patient. He has to be more careful in the hospital situation than in the regular parish work, because for one thing, the sick person in the hospital is more receptive than he might be at his home where he has constant care of his family. He is also much more sensitive to any over-concern which the chaplain might inadvertently display. A sad appearance will increase the worry and fear which the patient already has because of his hospitalization. Flath and Gilmour[1] state that this may be due to different sources, such as fear of death, invalidism, pain, economic insecurity, or threat of failure growing out of illness.

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[1]Carl I. Flath and Monroe T. Gilmour, M. D., When We Enter the Sickroom, Chicago, The Modern Hospital Publishing Company, Inc., n.d., pp. 4-6.

Nor may the chaplain appear too enthusiastic, giving the patient an impression of insincerity. The patient is able to detect this attitude from the very beginning. In the hoped-for relationship, the patient comes to trust the chaplain as an understanding friend to whom he may speak freely.

Counseling

It is in the area of counseling that the ministry of the hospital chaplain differs most from that of parish work. He has to do much more counseling with the patients and with the staff of the institution. In addition, the difference between counseling in a hospital and counseling in a pastor's office have been stated by Young as follows:

> Three factors make counseling in a general hospital distinctively different from that ministry performed in the pastor's study. First, a pastor in the hospital must necessarily work in relation to other professional people who are legally responsible for the actual life of the patient. Second, the contact in the hospital is more brief than the contact in the study. Third, the environment of the bedside ministry is different.[1]

The moment a patient is admitted, the hospital as a licensed institution is held legally responsible for his safety and all staff members who are to work with him share in

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[1]Richard K. Young, The Pastor's Hospital Ministry, Nashville, Tenn., Broadman Press, c1954, p. 54.

this responsibility. The chaplain, when counseling with the patient, does not work for himself alone. As a member of the healing team he works in co-operation with all its members towards the common goal--the complete health of the patient. His approach to the patient and his counseling technique must be integrated with the efforts of others on the healing team. In the regular parish work the pastor does not have to take into consideration the foregoing hospital situation on his counseling.

Because of his limited time for counseling with each patient who needs this service, and because of the sick-room situation, the chaplain must use the short interview. It prevents the patient from fatigue, and at the same time helps the chaplain to make the best use of his time. Hiltner[1] emphasizes this limitation of time on the part of the pastor as one of the reasons for brief counseling. This factor of time is very important in hospital counseling. Again Hiltner mentions this factor saying that "one of the most important sensitivities we need in counseling is timing. To paraphrase Ecclesiastes there is a time to start and a time to stop . . . a time to keep silence and a time

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[1]Seward Hiltner, Pastoral Counseling, New York, Abingdon-Cokesbury Press, 1949, p. 81.

to speak . . ."[1] Using his time wisely the chaplain finds that the short interview is effective.

The third factor mentioned by Young as being different in the hospital pastorate counseling is the effect of the bedside atmosphere. The problems faced by the patient are not the same as those when he is enjoying good health in the company of his fellow workers and family. As a patient, his emotional and religious problems become more acute. The nature of the strange hospital situation itself contributes to his difficulties. A well-trained chaplain will be armed to circumvent, as much as possible, the complications of the patient's daily routines and his reactions to the complexity of the situation in which he finds himself.

Pain also has its positive values. Dicks[2] reports a patient who had been in the hospital for three years, and during that time had suffered great pain for prolonged periods of time. One day she told him that she would not have missed the experience for the world, and explained that through the experience of being ill and suffering she had found a faith. When she became ill she did not believe in prayer or know how to pray, and now she did. It was

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[1]Seward Hiltner, The Counselor in Counseling, New York, Abingdon-Cokesbury Press, 1950, p. 84.

[2]Russell L. Dicks, Pastoral Work and Personal Counseling, New York, The Macmillan Company, 1945, p. 126.

during this suffering and pain that the religious needs of that patient were met by the hospital chaplain. Through his visitations to her, by listening to her in an understanding attitude toward her suffering, or by sincere prayers with her, he was able to reach deep in her soul and help her to find a faith. With his guidance she had come to believe in the power of prayer. He reports that her quiet endurance in the midst of her suffering verified her statement.

There is another kind of patient whom the chaplain meets in the hospital; the lonely one, to whom he offers fellowship. Cabot and Dicks, the physician and the chaplain who worked together and wrote together, describe how the chaplain becomes a real help to the lonely patient.

> The clergyman can perhaps help more than others because he studies more accurately the nature of the patient's loneliness. As an outsider he may be quicker than others to catch its flavor, and so by giving companionship and affection he may effectively palliate the symptom.[1]

A distinct characteristic of bedside counseling is the emphasis given to emotional problems in general. The chaplain spends a major part of his thought and effort in this aspect of the work. Scherzer gives testimony in this regard, ". . . of vital importance is the counseling technique

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[1]Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, New York, The Macmillan Company, 1936, pp. 61-62.

that enables the patient (in hospitals) to relieve the mind of any stress in the crisis situation that commonly arise in illness."[1]

Worship

Another distinctive characteristic of the hospital chaplain's work is that of the religious services. A church too has this function as a regular and essential part of its program. What, then, is the uniqueness of this phase of the chaplain's work? Three factors must be mentioned. First, worship has a different appeal to the sick in the hospital than it has to the person enjoying health in the normal environment of the community church. Second, the reality of religion is made more clear when illness comes. When he looks deep into his soul, and experiences the reality of God in the presence of pain and suffering, the patient makes a significant discovery which he will never forget. Third, the congregation that worships in the hospital chapel is a changing and heterogeneous group in which patients, as well as doctors, nurses, and other hospital personnel, come together to praise God. Chapel in the hospital is a meaningful experience for the sick.

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[1]Carl J. Scherzer, The Church and Healing, Grand Rapids, Michigan, Baker Book House, 1950, p. 160.

Even the presence of a place of worship in the institution constitutes a call to meditation.

Hospital administrators are becoming more aware of the need of a chapel which may be accessible to patients as well as to personnel and visitors. In some cases, like Bellevue Hospital in New York, each one of the three main faiths has a separate chapel. In others, like Presbyterian Medical Center in New York City, the chapel, which has a movable altar, is shared by the three faiths. Some, like that at St. Luke's Hospital in New York City, are located in a prominent place, thus serving as a constant reminder of the role of religion in the life of the institution. The chapel is always open for meditation. In some institutions, as it has been already stated, the services are broadcast to all rooms and wards, where there are individual earphones for the convenience of patients.

The hospital chaplain who can conduct chapel services so, that they become a real part of the life of the institution, brings hope and assurance to all. He will make of this means a daily spiritual asset to the patient. This atmosphere can contribute in changing the lives of so many sick people by helping them to meet their spiritual needs. It is the atmosphere about which Pratt writes in connection with the all church services. He says, "The Church should see to it that whatever its Sunday services may neglect to

do, it should bring to its worshipers an atmosphere of prayer and a sense of the real presence of the Divine."[1]

V. RECORDS OF THE CHAPLAIN

The chaplain must keep a record of his visits to the patients because it may prove of great help not only to him but to his successor, and to the Church. This record must include such items as patient's name, home address, age, date of birth, room or ward number, date of admission, date of discharge, religious preference, name of pastor, occupation, dates of calls, and other remarks. Chaplains have found it helpful to have printed cards with space for each of these items and others. These cards can be filed in the chaplain's office.

In some hospitals the admissions office keeps a supply of these cards and each day the clerk fills one for every patient admitted the previous day. Then these cards with the corresponding information are sent to the chaplain who completes them as he carries on his work with the patient. In the space for remarks the chaplain may write his observations as his relationships with the patient develop. Usually, after the patient is discharged, his card is filed for possible follow-up and for future reference.

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[1]James B. Pratt, The Religious Consciousness, New York, The Macmillan Company, 1930, pp. 307-308.

As part of their records the chaplains in some hospitals have a form printed on a post card which they use to notify other pastors. When a patient is admitted from one of the churches and wishes his minister to be notified, the chaplain sends him one of these cards with the patient's name, the unit and room number, the date card is sent, and the chaplain's signature. These forms help to keep the best relations between the chaplain's office and the pastors of the different churches in that and neighboring communities. At the same time, they help the patients by informing their pastors about their stay in the hospital and their wish for a visit from them.

It is important too, for the chaplain to keep a file for letters he receives from ministers who refer patients from their churches, and for letters which former patients write to him. He must also keep in his files copies of official letters he sends to pastors, to former patients or their families, and to community agencies.

As to the chaplain's records of his counseling interviews with patients, Dicks describes three types:

> "One is the complete, detailed, verbatim record. . . . This is a study record. . . . There is a second type of record which is a summary of a call with little or no direct quotation listed. . . . This is a work record and is apt to reveal facts more than it reveals emotions, underlying problems or the pastoral process. . . . The third type of record is simply a listing of the persons

> called upon or counseled with and the date of the contact, with no indication of what took place during the conference.[1]

The type of form used by a chaplain would depend upon his work load and the purpose for which he uses such records.

All the records in the chaplain's office contain an interesting history of his work, its progress and its achievements, its difficulties and problems, its promises and possibilities. They bring to him an excellent resource in the preparation of annual reports, and provide him with actual material for addressing different groups about his work. But most important, they enable the chaplain to better evaluate his ministry and the extent and progress of his services. He gets a more complete picture of his achievements and failures, and can plan accordingly. Such records of his interviews with patients and their families, with personnel, with student nurses, and with fellow ministers; of religious services held and the attendance to these services; and of other details pertinent to his wide ministry, all are of immense value in the understanding of the spiritual problems of the sick generally.

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[1]Russell L. Dicks, Pastoral Work and Personal Counseling, New York, The Macmillan Company, 1945, pp. 77-79.

VI. SUPPORT OF THE CHAPLAINCY

As is well known, the chaplains serving in Church-related hospitals are supported by the Church organizations appointing them. The previously mentioned Commission has made a statement as to the support of the chaplain in government and other non-Church-related hospitals and other institutions. Some of these items are:

> 1. Full salary shall be paid the chaplain by the institution at a rate commensurate with what is received by other professional personnel of comparable training including, where possible, housing accommodations on the same basis as these are provided for other comparable professional workers.
>
> 2. Adequate provision for the advancement in salary, by criteria which encourage continued improvement in skill and service, shall be made. . . . The plan should involve opportunities to obtain increases in salary and rise in salary grade commensurate with competency of services performed. . . .
>
> 3. Basic equipment requisite to the chaplain's work shall be made available by the institution, upon selection by the chaplain, including: a) A chapel or other appropriate place for worship, and all necessary ecclesiastical appointments. b) An operating budget for the chaplain's department. Such a budget enables the chaplain to provide materials for religious education, for special holiday seasons, and similar items which are vital to the religious program. c) Adequate office, equipment, and secretarial assistance.[1]

The churches are expected to co-operate with the chaplain in his ministry by providing him such supplementary

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[1]Commission on Ministry in Institutions, Standards for Chaplaincy Service in Institutions, New York, Federal Council of the Churches of Christ in America, n.d., pp. 10-11.

items of equipment as special literature, specially consecrated articles, and other items, all to be selected by the chaplain. Church agencies and other organizations have published information with an excellent and detailed description of religious literature which they can provide without cost. In these lists there are a number of very useful items for the chaplain's program. In addition, there are Church groups who wish to make special donations intended to buy necessary articles which will complete the chaplain's equipment. In Church-related hospitals, many of the items are provided outside the budget. Such items as portable organs, communion sets, record players, and Bibles, have been provided in some hospitals by individuals or groups who have shown a special interest in the work for the sick.

The program which is being carried on by chaplains in the different types of hospitals is enthusiastically supported by the Church in most cases. Other clergymen, as well as the laymen of the Church, upon seeing the many accomplishments in this field, are encouraging an increase in the provision for these services which help so many persons every year.

VII. SUMMARY

The function of the hospital chaplain is a wide

and far-reaching one. It covers a great field, with immense possibilities for helping the hospitalized sick to gain a positive understanding of their situation. This work of the chaplain requires a well-rounded preparation in psychology and its related fields, and in clinical pastoral training, in addition to his theological preparation.

The appointment of chaplains at Church-related hospitals is the responsibility of the Church bodies sponsoring these institutions. Chaplains who work at government hospitals receive their appointment from county, city, or state governments on the recommendation of the respective Church organizations of the chaplains' faiths. The Commission on Ministry in Institutions have issued statements of standards for chaplaincy service and of policy as to the number of chaplains to be appointed.

The function of the hospital chaplain has different aspects, such as his relationships with the healing team of which he is a member and with other personnel, and his work with the patient, the most important part of his ministry. He ministers to the sick through different activities, including visitations, counseling, administration of the sacraments, religious services, and distribution of religious literature. He also has other functions to

perform, such as teaching, relationships with patients' families, and relations with the community.

The sick in the hospital require the joint efforts of a group of specialists which has been called the healing team. The chaplain, as a member of this healing team, must remember always that he should integrate his services with those of the other members toward the health of the patient as a whole. This implies co-operation, understanding, and the best human relationships made possible through the application of the personnel point of view.

The special ministry of the hospital chaplain has unique characteristics which make it different from that of the parish clergyman. Among them are those which distinguish his counseling, the religious services, and the pastoral call which are carried on with approaches different from what is done in the regular parish.

Records are an essential part of the work at the hospital chaplain's office. He must keep records of his contacts and counseling with the patients and of his services to them. These records include printed cards with space for the necessary information about each patient he works with, forms for notifying pastors about their sick in the hospital who wish to have a visit from them, and copies of official letters to former patients, fellow clergymen, and referral agencies.

Chaplains serving at Church-related hospitals are supported by their own denominations or by joint Church organizations responsible for the appointment. The support of the chaplaincy in government hospitals comes from the corresponding government making the appointment, from Church organizations which co-operate in the work, and from groups and individuals who send their gifts to help in the work. The Commission on Ministry in Institutions has issued statements as to salary and provision of basic equipment requisite to the work of the chaplains.

In this chapter principles have been described in relation to the pastoral call which were developed from practical experience in the field. They cover the necessary factors which the chaplain must take into consideration during his calls. They will serve as a guide to the chaplain who is trying to make his calls more effective. They are a challenge to the chaplain who wishes to carry on a successful ministry. They work positively.

CHAPTER III

TRAINING OF HOSPITAL CHAPLAINS IN THE UNITED STATES

Due to the increase in the placement of hospital chaplains in the United States, and the need for training people to meet this growing demand, a number of individuals and organizations have co-operated in the establishment of programs for training institutional chaplains. This new movement started in the second quarter of this century, and has already attracted a considerable number of clergymen who have dedicated their lives to the ministry in hospitals.

A carefully organized training program is being carried on throughout the country by such groups as The Council for Clinical Training and others, many of which have adopted the following definition as a basis for their programs:

> Clinical pastoral education is an opportunity for a theological student or pastor to learn Pastoral Care through interpersonal relations in an appropriate center, such as a hospital, correctional institution or other clinical situation, where an integrated program of theory and practice is individually supervised by a qualified Chaplain-Supervisor, with the collaboration of an interprofessional staff.[1]

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[1]National Conference on Clinical Pastoral Training, "Standards for Clinical Pastoral Education" New York, Council for Clinical Training, Inc., 1952, p. 1 (mimeographed).

I. HISTORY OF CLINICAL TRAINING

Although the idea of providing seminarians with a clinical experience was proposed[1] by the Rev. William Palmer Ladd at the General Convention of the Protestant Episcopal Church in 1913, the real start of the movement came in 1923 through the initiative of Dr. William S. Keller,[2] a layman of the church as well as a physician and leader in community service. In 1922 Dr. Keller had arranged with Dean Samuel B. Mercer of Bexley Hall Seminary, to provide several students with clinical training in Cincinnati. Four students were admitted in the summer of 1923. Dr. Keller housed and fed the seminarians in his own home and placed them as student workers in social agencies and institutions. Fletcher says that Dr. Keller was convinced of the essential role of religion in successful human living, but that "he was fully convinced that ministry in the modern community had much to learn both factually and in terms of skills from the social work,

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[1]Rollin J. Fairbanks, "The Origin of Clinical Pastoral Training" Pastoral Psychology, 4:13-16, October 1953.

[2]Joseph F. Fletcher, "The Development of the Clinical Training Movement Through the Graduate School of Applied Religion," Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 1.

medicine, and community organization."[1] With this start, the Cincinnati Summer School was established. In 1935, after twelve year's development, the program was expanded into a year-round one of four quarters, the summer quarter continuing for seminarians. The three other quarters were devoted to a graduate course of training, taking the form of an internship for those who had finished their seminary training. The name of the school was changed to "Graduate School of Applied Religion," a full-time Dean and Secretary-Librarian were put on the staff, and a building was secured for teaching and dormitory purpose.[2]

The development of the clinical training movement may be related from that year on to five organizations: the Graduate School of Applied Religion; the New England Group; the Center at Worcester, Massachusetts; the Council for Clinical Training, and the Philadelphia Divinity School. These are briefly described here.

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[1]Joseph F. Fletcher, "The development of the Clinical Training Movement Through the Graduate School of Applied Religion." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 1.

[2]Joseph F. Fletcher, "The Development of the Clinical Training Movement Through the Graduate School of Applied Religion." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 2.

Graduate School of Applied Religion

Organized in 1935 as a successor of the Cincinnati Summer School, the Graduate School of Applied Religion became an incorporated non-denominational institution[1] in 1936. From the beginning the Graduate School program sought to provide the students for the ministry with those clinical experiences which would equip them most practically for pastoral service and leadership in the modern community. The idea of specialized ministry or skill played little part in it. Some students were placed in social agencies and others in more specialized programs such as domestic relations and juvenile courts, and in general and psychiatric hospitals. On May 5, 1944, the Trustees of the School accepted the invitation of the Episcopal Theological School in Cambridge, Massachusetts, to join it. With the new program the summer students did a minimum of three hundred and thirty hours of field work, and the winter students a minimum of seven hundred and twenty hours, for the full nine-months' graduate course. On joining forces with the Episcopal Theological School the Graduate School had the

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[1]Joseph F. Fletcher, "The Development of the Clinical Training Movement Through the Graduate School of Applied Religion," Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, National Council of the Churches of Christ in America, 1945, p. 2.

advantage of using the teaching resources at Harvard Divinity School and Harvard University. It also enjoyed the co-operation of the Institute of Pastoral Care in Boston.

The New England Group

The New England Group came into existence in 1932,[1] when a group of chaplains and seminary representatives began sponsoring clinical training in the vicinity of Boston. As a member of this group the Reverend Russell L. Dicks, who became full-time chaplain at the Massachusetts General Hospital, developed note-writing as a particularly effective teaching technique. This is being used widely by students in clinical pastoral training. The program of this group included part-time courses at the Episcopal Theological School; summer courses for ministers doing parish work; monthly evening seminars for ministers, chaplains, and students in clinical training; combined clinical training with allied courses for two full semesters and a summer leading to a master's degree; and practical experience in

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[1]David R. Hunter, The Development of the Clinical Training Movement Through the New England Group." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 5.

general hospitals. For a better picture of its program Hunter outlines ten contributions to clinical pastoral training made by the New England Group. Addressing the National Conference on Clinical Training in Theological Education, held in 1944, he stated these contributions which are summarized as follows:

1. The work and writings of Dr. Cabot and Rev. Dicks, in particular their standard text book "The Art of Ministering to the Sick," led to later experimentation in note-writing, listening, creative assertion, and the evaluation of the resources at the command of the minister in his work with the sick. It was Rev. Dicks who introduced clinical training in a general hospital.

2. It differed in training from other groups, in confining its clinical training to general hospitals.

3. They did an increasing amount of experimentation with new and effective teaching devices, methods which were meant to supplement the note-writing method but not to supplant it.

4. It concentrated upon meeting the needs of ministers no longer in the seminary but who were in charge of parishes. It provided the full-time summer sessions as a way of meeting their needs.

5. It established required part-time courses in clinical training during the school term in the Episcopal Theological School in Cambridge, and provided for elective courses at the same school, and also at Harvard, Boston University, and Andover Newton.

6. It sought to bring clinical training under the control of theological schools, in preference to incorporated or private groups, and organized the Theological Schools' Committee on Clinical Training in 1938 to sponsor and direct the summer courses in clinical training offered at the Massachusetts General Hospital, Boston City Hospital, and the State Infirmary at Tewksbury.

7. It gave strong emphasis, since 1938, on making clinical training a means for preparing men for the general pastoral ministry, not alone nor even primarily for work with the sick.

8. It founded and maintained the Richard C. Cabot Club, a monthly evening seminar for ministers, chaplains, and students taking clinical training during the winter months.

9. It provided, by the Earhart Foundation of winter fellowships to enable selected parish ministers, chaplains, and seminary teachers to give two full semesters and a summer to clinical training, combined with certain allied subjects leading to a Master's degree if desired.

10. It created the Institute of Pastoral Care on the initiative of Rollin J. Fairbanks. The Institute has a Board of Governors representing the four participating theological schools, the Earhart Foundation, the Ella Lyman Cabot Trust, and the Massachusetts and Federal Councils of Churches.[1]

Worcester, Massachusetts Training Center

The Rev. Anton T. Boisen,[2] a graduate of Union Theological Seminary in New York City, after intensive studies at Harvard University and Andover Theological Seminary, started a chaplaincy training project at the Worcester State Hospital, Worcester, Massachusetts. His first class began

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[1]David R. Hunter, "The Development of the Clinical Training Movement Ghrough the New England Group." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, pp. 5-8.

[2]Rollin J. Fairbanks, "The Origin of Clinical Pastoral Training," Pastoral Psychology, 4:13-16, October 1953.

in the summer of 1925 and consisted of only four students, but each year an increasing number of seminarians went there to learn from the experience provided at the center. Referring to this work begun by Rev. Boisen, Kuether[1] states that it was established on a sound foundation and moved toward a slow but steady expansion. Some years later it led to the establishment of the Council for Clinical Training.

Council For Clinical Training

The Council for Clinical Training traces its program directly to the pioneer work of Dr. Richard C. Cabot of the Harvard Medical School and the Rev. Anton T. Boisen.[2] In 1924, Dr. Cabot delivered a lecture at the Newton Theological Seminary entitled, "A Plea For Clinical Training For the Clergy." In December, 1925, "The Survey" printed his article, "A Plea for A Clinical Year for Theological Students." That same year Rev. Boisen established the Worcester, Massachusetts Center which later developed into the Council, incorporated on January 21, 1930 at the home

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[1]Frederick C. Kuether, "The Council For Clinical Training," Pastoral Psychology, 4:18, October 1953.

[2]The Council for Clinical Training, Inc., Annual Catalogue 1955-1956, New York, The Council, 1955, p. 1.

of Dr. Cabot in Cambridge, Massachusetts. It was named the Council for Clinical Training of Theological Students, and by this time it had sixteen students and four training centers. In its catalogue the Council has stated its accomplishments and scope in the following words:

> Since the Council's beginning in 1925 with two students, approximately eighteen hundred men and women have had one quarter or more of training under its auspices. They have come from ninety-eight different seminaries and thirty-six different ecclesiastical bodies including the Jewish faith. They have come from Canada and other countries, as well as from all over the United States. . . . From its beginning in mental hospitals, the program was expanded in 1932 to training in general hospitals and in 1936 to a program in penal and correctional institutions, which in 1940 was broadened to include institutions for juvenile delinquency.[1]

The training program of the Council gives most emphasis to the student's relationships with the patients and consists mainly of supervised experience in an institution, under the direction of a chaplain-supervisor. Kuether describes this emphasis in these words:

> The clinical pastoral training of the Council program centers upon the interpersonal relationships between the student and his patients, and because the student rather than the patient is the one who wishes to learn how to help, the major concern of the training program is with the student.[2]

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[1]Council for Clinical Training, Inc., Annual Catalogue 1955-1956. New York, The Council, 1955, pp. 1-2.

[2]Frederick C. Kuether, "The Council for Clinical Training," Pastoral Psychology, 4:17-20, October 1953.

Bigham[1] has stated that the work of the training of the Council falls into three areas: general hospitals, mental hospitals, and penitentiaries and training schools. The current work of the Council is explained in greater detail later in this chapter.

The Philadelphia Divinity School

The Philadelphia Divinity School is still another organization related to the development of the clinical training movement. The school began in 1937, under the auspices of the Protestant Episcopal Church in Philadelphia. Its program was called the New Plan of Theological Education. In describing it, Howe[2] has stated that for the first time in theological education full-time clinical training became an integral part of the curriculum. In order to introduce ten weeks of clinical training annually into the theological curriculum, it was necessary to lengthen the academic year from eight to ten months. The year was

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[1]Thomas J. Bigham, "The Development of the Clinical Training Movement Through the Council for Clinical Training," Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 10.

[2]Reuel L. Howe, "The Development of the Clinical Pastoral Training Movement Through the Philadelphia Divinity School," Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, pp. 13-16.

divided into four quarters. The entering class pursued the usual theological courses during the first two quarters, received its clinical training in the third, and resumed theological studies in the fourth. The middlers and the seniors also took a quarter of training each year, alternating their programs in such a way that while one class was in training the other two were in academic residence. In 1942, the curriculum was reorganized and the four-quarter system was abandoned. A three-term year was instituted in its place, for three reasons: 1) It was found that a period of ten weeks was not enough for the student to acquire the maximum benefit from the training; 2) the interruption of the classroom work in the middle of the year made continuity of the academic subjects impossible; 3) it was discovered in tests that after training, the students displayed in their academic work a maturity and an interest that was not present before they had had their training experience.

In 1938, the School, under the sponsorship of the Church Training and Deaconess House organized the Department of Women for the purpose of training women for the work in the Church. These students received for the most part the same training as the men.

Institute of Pastoral Care

The Institute of Pastoral Care was organized on January 28, 1944, under the leadership of the Rev. Rollin J. Fairbanks. It succeeded the New England Theological Schools Committee.[1] Its purpose was to organize, develop, and support a comprehensive educational and research program in the field of pastoral care. As Burns[2] has stated, although the primary concern of its program is training for the parish ministry, it also recognizes its responsibility for training in institutional ministry. The Institute is a non-sectarian educational foundation. Its first Summer School of Pastoral Care[3] was offered at the Massachusetts General Hospital in Boston. The primary goal of the Institute is, through its training program, to strengthen contemporary religious leadership so that the spiritual needs of the people can be served more adequately. The Institute seeks to equip pastoral counselors, institutional chaplains, and parish ministers with the necessary knowledge,

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[1]Board of Governors, Institute of Pastoral Care, Boston, Institute of Pastoral Care, Inc., n.d., p. 2.

[2]James H. Burns, "The Institute of Pastoral Care," Pastoral Psychology, 4:21-24, October 1953.

[3]Institute of Pastoral Care, Inc., 1955 Summer Schools of Pastoral Care, Boston, The Institute, 1955, p. 2.

skill, and experience for an effective ministry in pastoral care.

II. CURRENT FACILITIES FOR CLINICAL PASTORAL TRAINING

Various training centers which are currently offering work in clinical pastorates are also offering scholarships for work in their own institutions. In addition, the National Council of Churches, through its Department of Pastoral Services, offers scholarships which permit the recipient to enroll at the school of his choice. Through the director of this department, some of the member organizations of the Council of Churches offer these scholarships not only to prospective full-time chaplains, but to chaplain-supervisors as well.

Training centers which are currently available are operated by the Council for Clinical Training, Institute of Pastoral Care, various theological seminaries, and a few private, local facilities.

In addition to the training centers, a valuable resource for chaplains-in-training is the magazine Journal of Pastoral Care.

Following is a discussion of the facilities for training which are currently available.

Council for Clinical Training Centers

By 1955 the facilities of the Council had been expanded to thirty-nine training centers, in sixteen states and the District of Columbia. Twenty-four of these centers are located in state hospitals and eight in general hospitals. Seven are located in other institutions. (See Table I) Through these centers, the Council offers basic courses in clinical pastoral training.

The Council for Clinical Training is one of the two organizations offering regular clinical pastoral training on a basis of a minimum of six weeks of carefully supervised resident and full-time training in an accredited center or agency. The facilities of the other organization, the Institute of Pastoral Care, are discussed later in this chapter. The goals to which they both subscribe may be summarized as follows:

1. To enable the student to gain a fuller understanding of people, their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.

2. To help the student discover more effective methods of ministering to individuals and groups, and to intensify his awareness of the unique resources, responsibilities, and limitations of the clergy.

3. To help the student learn to work more cooperatively with representatives of other professions and to utilize community resources which may lead toward more effective living.

4. To further the knowledge of problems met in pastoral care by providing opportunities for relevant and promising research.[1]

Some of these goals are similar to the objectives established by the American Protestant Hospital Association.

Miss Emily A. Spickler, Administrative Assistant of the Council, reported that the opportunity for training is offered to theological students and their wives, to clergymen and their wives, and to other religious workers. In the assignments during the summer, preference is given to students and their wives because of their academic schedules.

In some of the centers in-service training facilities are also offered to institutional chaplains. It is an opportunity for those part-time and full-time chaplains who wish to further their training or who are interested in meeting the requirements for accreditation. To facilitate the training and to give enough time to each student, each center admits only six students at a time, under the supervision of a chaplain-supervisor.

The annual catalogue of the Council[2] contains valuable

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[1]Department of Pastoral Services, Opportunities for Study, Training, and Experience in Pastoral Psychology, New York, National Council of the Churches of Christ in the U. S. A., 1955, p. 9.

[2]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, pp. 14-15.

TABLE I

List of Training Centers

Council for Clinical Training, Inc.[a]

Name	Place	Date Accredited	Courses[b] Offered
Austin State Hospital	Austin, Texas	1953	A and B, and I and II
Bellevue Hospital	New York, New York	1940	A and B, and I and II
Boys Industrial School	Topeka, Kansas	1950	B and I and II
Central State Griffin Memorial Hospital	Norman, Oklahoma	1954	B and I and II
Columbus State Hospital	Columbus, Ohio	1951	A and B, and I and II
Connecticut State Hospital	Middletown, Connecticut	1953	B and I and II
Cook County Hospital	Chicago, Illinois	1946	A and B, and I and II
Danville State Hospital	Danville, Pennsylvania	1955	I
District of Columbia General Hospital	Washington, D. C.	1944	I and II
District of Columbia Department of Correction	Lorton, Virginia	1940	A and B, and I and II
Eastern State Hospital	Williamsburg, Virginia	1953	I and II
Episcopal Hospital	Philadelphia, Pennsylvania	1942	A and B, and I and II

TABLE I (continued)

Name	Place	Date Accredited	Courses[b] Offered
Federal Correction Institution	Ashland, Kentucky	1953	I and II
Federal Detention Headquarters	New York, New York	1940	II and III
Federal Reformatory	Keno, Oklahoma	1948	B and I and II
Manteno State Hospital	Manteno, Illinois	1946	B and I and II
Medical Center for Federal Prisoners	Springfield, Missouri	1955	I and II
Mendota State Hospital	Madison, Wisconsin	1953	B and I
Metropolitan State Hospital	Norwalk, California	1952	B and I and II
Modesto State Hospital	Modesto, California	1953	B and I
Napa State Hospital	Imola, California	1952	B and I and II
National Training School for Boys	Washington, D. C.	1940	I
New Jersey Neuropsychiatric Institute	Princeton, New Jersey	1951	A and I
New Jersey State Hospital	Greystone Park, New Jersey	1934	A and B, and I, II and III
New Jersey State Hospital	Trenton, New Jersey	1945	A and I

TABLE I (continued)

Name	Place	Date Accredited	Courses[b] Offered
North Dakota State Hospital	Jamestown, North Dakota	1952	B and I, and II
Osawatomie State Hospital	Osawatomie, Kansas	1953	B and I
Patton State Hospital	Patton, California	1953	B and I
Peoria State Hospital	Bartonville, Illinois	1952	I
Philadelphia State Hospital	Philadelphia, Pennsylvania	1947	I
Rusk State Hospital	Rusk, Texas	1954	I
Saint Elizabeths Hospital	Washington, D. C.	1944	A, B, and C, and I, II, and III
St. Luke's Hospital	New York, New York	1952	A and B, and I
San Antonio State Hospital	San Antonio, Texas	1953	I
South Carolina State Hospital	Columbia, South Carolina	1948	A and B, and I and II
Terrell State Hospital	Terrell, Texas	1953	B and I and II
Topeka State Hospital	Topeka, Kansas	1950	B and I and II
U. S. Public Health Service Hospital	Lexington, Kentucky	1954	A and B, and I

TABLE I (continued)

Name	Place	Date Accredited	Courses[b] Offered
Western State Hospital	Staunton, Virginia	1954	I and II

[a]Council for Clinical Training, Inc., Annual Catalogue, New York, The Council, 1955, pp. 16-22.

[b]Orientation Courses A, B, and C.
Basic Courses in Clinical Pastoral Training I, II, and III.

information as to facilities for admission, and other help for those who wish to apply. Credit for clinical pastoral training is granted through theological schools if the students make arrangements with these schools before entering training. The Council furnishes reports and grades upon request. The fee is one hundred dollars for each quarter but students who are unable to undertake training or complete the clinical year, because of financial reasons may apply for one of the scholarships which are available. These scholarships come from different sources:

1. Funds donated to the New York Protestant Episcopal Mission Society for helping students of religion in the State of New York, available to students of this Church body only. They include not only financial help for beginning

students, but also grants to qualified advanced students for completion of the clinical year.

2. Scholarships offered by the Lutheran Inner Mission Society of Washington, D. C., for the three quarters of the academic year to students of any of the Lutheran bodies.

3. The National Council of Churches in the U. S. A., through its Department of Pastoral Services, offers two types of assistance. One of them consists of a stipend as a fellowship for one year of full-time clinical pastoral training, awarded to ordained clergymen in the active ministry who desire to become chaplain-supervisors in a training center. The other is in the form of grants-in-aid in small amounts provided to ordained clergy or those engaged in theological education, to be able to get approved clinical pastoral training during a stated period. These small grants are awarded for training any time during the year.

Another type of financial assistance is that which comes through stipends and salaries which some of the centers offer. These are provided to students who have completed satisfactorily one or more quarters of clinical pastoral training, and will remain at the institution as graduate students for from six to twelve months. The stipends are offered to chaplain internes, and the salaries to assistant chaplains or residents. Any qualified clergyman

who meets the requirements set by the Council for candidates for the chaplaincy, and becomes interested in this field, may receive the benefits of this program.

Almost all institutions offer complete maintenance, such as room, board, and laundry, while the student is in training. Like the other organizations offering clinical training, the Council does not have all the funds needed, although in 1956-1957 it provided a limited number of full scholarships for the training of chaplain-supervisors.

As can be seen by referring to table I, in the year 1954 the thirty-nine centers of the Council[1] enrolled two hundred twenty-four students for training in their different training periods in Spring, Summer, Autumn, and Winter. This number represented thirty-one Church bodies and sixty-seven seminaries. For the supervision of this wide program the Council has the services of forty-four full-time chaplain-supervisors who are in charge of the centers. These centers are in general and mental hospitals, and in correctional institutions.

The training program. The heart of the Council's training program is the supervised student-pastor relationship. It is a program of internship for the theological

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, pp. 22-24.

students and clergy. It is practiced internship under the supervision of the chaplain-supervisor and other professional staff. After some orientation in the center the student is given opportunity for work with carefully selected patients. In his contacts the student gets acquainted with the patient, tries to understand him, and keeps notes of his interviews with him. Through these recorded notes of the interviews and of the meetings that he leads, the student has the opportunity to study his reactions to the patient, in seminar, with his supervisor and his fellow students. At the same time that the student is helped through his training, the patient also benefits from the student's supervised experience. The whole core of the student's training is to help people grow. Besides seminars, the student's program also includes lectures, readings, and visits to other centers and agencies.

The seminar discussions are conducted by the supervisor and by representatives of the other professions so that the students will be equipped in their later work as chaplains, to be co-operative working members of the healing team. These seminars center on the patient, his growth and development, his present illness and its meaning, and the forces of healing or destruction with which he is dealing. Theory and practice are integrated, and the student's practice is carefully supervised. The four quarters

in which the year has been divided for this purpose begin around June 6, September 19, December 26, and March 21.

For the regular parish minister, the twelve-weeks' or one quarter session is provided. To qualify for a full-time chaplain, the clergyman must take from six months to one year training. The Council recommends one full year of training. The student must be a seminary graduate, be in good standing with his Church body, and have at least three years experience in the parish ministry. He is advised to spread the training in all different types of institutions, under more than one supervisor. But the candidate must spend six months of his training in the type of institution he serves or is to serve as chaplain.

For any one who wishes to qualify to give training, provision is made for his work to be reviewed after one year. He comes before the Commission on Accreditation which, after reviewing his work, recommends or refuses to recommend that the candidate become assistant to a chaplain who is supervising the program. Then, if an individual has been appointed assistant chaplain-supervisor, he works in this capacity for one year after which his work is reviewed again by the same commission. If his work is approved he gets acting supervisor status. This means that he goes to a hospital or other institution as a chaplain of his own, and his students can be assigned to him for

supervision. His work as acting supervisor also is reviewed after one year, and if the commission so recommends, he becomes a regular supervisor. To be enrolled in the Council's program a student must have at least one year of seminary training.

Courses. The courses[1] offered by the Council at its different centers fall into two groups: the Basic Courses and the Orientation Courses. The Basic Courses comprise three divisions or levels. The first division, called Clinical Pastoral Training I, is intended for theological students while still in the seminary, as part of their preparation for pastoral work. It is also open to clergymen who are active in parish work or in institutional chaplaincy, to other religious workers, and to their wives. It deals specifically with the pastoral implications of a religious ministry to people in crisis situations and involves full-time resident training for twelve consecutive weeks in the chaplain's department of one of the accredited centers. The seminary student with at least one year of seminary work may enroll in this course.

The second level of basic courses in clinical pastoral training, is the clinical year, and internship for men

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[1]See Table No. I.

[2]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, pp. 4-5.

seeking to specialize in institutional ministry. It is the prerequisite for those asking accreditation for chaplaincy programs. The internship may be taken in one institution or it may be spent in several institutions or types of institutions. It involves full-time residence in accredited centers for four quarters of twelve consecutive weeks each.

The third level of basic courses is intended for men seeking to specialize further in institutional ministry and the supervision of the theological students and clergymen in training. It offers a second full year of training, following the satisfactory completion of one year as chaplain interne. It provides additional training in the supervision of students in clinical pastoral training which may lead to accreditation as chaplain-supervisors.

The Orientation Courses comprise introductory courses in pastoral care. Some of them are part-time courses intended for theological students, and must be taken in conjunction with the regular seminary classroom courses. Others are part-time courses for parish clergymen or other religious workers who, for one reason or another, cannot arrange for full-time clinical pastoral training.

Orientation Course A is intended for seminarians, and is offered in quarter, semester, or academic year units. It involves visits to patients or inmates, lectures on the

type of illness found in the institution and on related problems, and seminars on the pastoral care of the ill and their families. The student devotes to this course one full day, or two half-days per week for the term of the year. Academic credit must be arranged through the seminary.

Orientation Course B is intended for clergymen active in parish work. Similar to course A, it offers lectures, visits to patients or inmates, and seminars. It involves from one-half to one full day each week for periods ranging from eight to sixteen weeks. Academic credit must be arranged by the student.

Institute of Pastoral Care

The Institute of Pastoral Care,[1] offers facilities for clinical pastoral training during the summer to seminarians and clergymen. It provides them with a coordinated program which helps them meet the following clinical pastoral training requirements: 1) those prescribed for seminary students, 2) the ones specified for certification as a Professional Hospital Chaplain, and 3) those needed for accreditation as a chaplain-supervisor. Enrollment is offered to all seminary students and clergymen

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[1]Institute of Pastoral Care, Inc., 1955 Summer Schools of Pastoral Care, Boston, The Institute, 1955, pp. 1-4.

who wish to undergo the training. In the centers where two sessions are offered during the summer, enrollment in the second session is restricted to persons who had previous training or specialized experience. The Institute tries to admit an ecumenical group, and to insure this practice, not more than one third of the total enrollment in any session shall be from one denomination. Applications can be made to the chaplain-supervisor of the institution where enrollment is sought. It offers six weeks' and twelve weeks' sessions, and the tuition charges are sixty dollars and one hundred dollars respectively.

The Institute also offers the following facilities to its students: 1) In some of the centers living accomodations and board are provided in return for limited service to the institution. 2) The students enrolled in the four affiliated seminaries may apply for scholarship aid through the Institute. The General Service Foundation provides grants-in-aid for teachers of pastoral care and parish clergy who need financial assistance. Also local preaching appointments can be secured by the students as a financial help while in training. Those clergymen who have had previous clinical pastoral training may apply for appointment as Course Assistance Clinical Associates. 3) Upon completion of the courses, and by previously gaining the consent of the faculty advisor at the seminary in which he is

enrolled, the student may receive credit for his clinical training. In this case and upon request, the Institute sends a letter of certification to the official whom the student designates. At each center, the chaplain-supervisor is responsible for the training. He may get as many qualified assistants as enrollment requires, the ratio being five to six students per leader. The Institute also feels the urgent need for more qualified supervisors in training centers. There is the possibility of getting more scholarship aid for preparing these specialists. The General Service Foundation thus provide some, for the training of full-time chaplains.

The above mentioned facilities provided by the Institute help the student himself and also the chaplain-supervisor to discover the student's abilities and interests which qualify him for institutional chaplaincy. Wise indicates the nature of these abilities and interests as including:

> . . . a strong interest in the persons and problems represented in the kind of institution in which he would like to serve, the ability to minister these persons or to learn how to minister to them, and the intellectual capacity to grasp the various human, scientific and religious problems involved.[1]

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[1]Carroll A. Wise, "Clinical Training in Preparation for Institutional Chaplaincy and Clinical Training Supervision." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 58.

The program includes also the opportunity for qualified advanced students to prepare themselves for the position of chaplain-supervisor.

The programs at the different centers sponsored by the Institute[1] vary in content, depending upon the nature of the institution. All centers utilize the clinical approach of actual pastoral work with the sick people. Opportunity for personal conferences is provided. The schedule requires about eight hours of work each day at the center, and also lectures by guest speakers from the institution and community. The student also reads assigned books and articles. Each program of the Institute is an autonomous, self-contained unit under the direction of a chaplain-supervisor.

The Institute of Pastoral Care[2] has eleven centers. Six of them are located in general hospitals, the other five in mental hospitals. They cover a wide variety of geographical areas, as can be seen in the following Table II.

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[1]Department of Pastoral Services, Opportunities for Study, Training, and Experience in Pastoral Psychology, New York, National Council of the Churches of Christ in the U. S. A., 1955, p. 10.

[2]Department of Pastoral Services, Opportunities for Study, Training, and Experience in Pastoral Psychology, New York, National Council of the Churches of Christ in the U. S. A., 1955, pp. 10-11.

TABLE II

List of Centers of the Institute of Pastoral Care[a]

Name	Place	Sessions	Number of Weeks Each
General Hospitals			
Augustana Hospital	Chicago, Illinois	Two	Six
Emanuel Hospital	Portland, Oregon	One	Six
Massachusetts General Hospital	Boston, Massachusetts	Two	Six
Miami Valley Hospital	Dayton, Ohio	One	Six
St. Louis City Hospital	St. Louis, Missouri	One	Six
University Hospital	Ann Arbor, Michigan	Two	Six Applicants may enroll for twelve weeks
Mental Hospitals			
Boston State Hospital	Boston, Massachusetts	One	Twelve
Cleveland Receiving Hospital	Cleveland, Ohio	One	Six
Gowanda State Homeopathic Hospital	Helmuth, New York	One	Six
Westboro State Hospital	Westboro, Massachusetts	One	Six
Worcester State Hospital	Worcester, Massachusetts	One	Six

Each one of these centers is directed by a Chaplain-Supervisor.

[a]Institute of Pastoral Care, Inc., 1955 Summer Schools of Pastoral Care, Boston, The Institute, 1955, pp. 3-4.

American Foundation of Religion and Psychiatry

The American Foundation of Religion and Psychiatry[1] offers clinical pastoral training courses in co-operation with the Council for Clinical Training. These courses are not duplicated in other local institutions of learning. Mention must be made of three of these which are reported to be in great demand. 1) Survey of Therapies--the taking of case histories, the screening process. It includes therapies best suited to different illnesses. 2) Bearing of Psychiatry and Theology on Pastoral Care--a view of man's religious experience. This is a study of experiments in spiritual healing and prayer therapy, and what a pastor needs to know about psychiatry. 3) Procedures in Group Therapy--includes the study of group therapy, principles to be followed, its dynamics and the function of the leader.

The Foundation also offers graduate seminars. Students in training meet regularly in small seminar groups in which consideration is given to cases under treatment. New trends in therapy, important books and publications, and conflicts in theories among professional leaders are also discussed. Two of these graduate seminars are offered

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[1]American Foundation of Religion and Psychiatry, A Program of Training in Pastoral Care, New York, The Foundation, n.d., pp. 5-6.

each summer: A) Introductory Seminar in Pastoral Care, and B) Advanced Seminar in Pastoral Care. The work in the advanced seminar varies greatly from semester to semester.

The Foundation also sponsors summer seminars in Pastoral Care. These consist of a series of lectures, discussion groups and workshops, and consideration of case histories. The summer seminars are held for a full week each, beginning on Monday and ending on Saturday. They are designed for clergy and other religious workers interested in furthering their training but who cannot attend the regular year-round program offered by the Foundation.

The Rev. Frederick C. Kuether, from the organization, reports an increasing interest manifest in these seminars. He also expresses the wish of the Foundation to expand its training program.

Theological Seminaries

One of the joint efforts to widen facilities for training has been the work of the National Conference on Clinical Training in Theological Education, organized recently. This Conference was made possible through the collaboration of the Council for Clinical Training, the Graduate School of Applied Religion, the Institute of Pastoral Care, and the Theological Schools which administer programs of clinical training and sent their representatives

to the Conference. Chaplain Rice has described how the Conference came into existence:

> Theological educators and Church leaders have long concerned themselves with the problem of providing seminarians and clergy with instruction and guided experience in the more practical aspects of pastoral care. During the past twenty years various individuals and organizations have developed programs for clinical pastoral training. . . .
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> A year or so ago the Reverend Professor Philip Guiles, Ph. D., long interested in clinical pastoral training, urged that there be a meeting of minds on the part of all those concerned with the field. . . . As a result, the National Conference on Clinical Training in Theological Education was held at the Western Theological Seminary in Pittsburgh, Pennsylvania, on June 7, 1944.[1]

This movement for an interdenominational program shows the Church's interest in providing adequate chaplain services to the hospitals and other institutions. Fletcher[2] emphasizes the great value of joint efforts in this field.

A number of seminaries sponsor courses in the undergraduate and graduate curricula. An example of the clinical pastoral training program on the undergraduate level is

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[1]Otis R. Rice, "Introduction." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. vii.

[2]Joseph F. Fletcher, "The Development of the Clinical Training Movement Through the Graduate School of Applied Religion." Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 3.

part of the training offered by the Southern Baptist Theological Seminary at Louisville, Kentucky.[1] Its clinical pastoral training is constituted of the following undergraduate courses: 1) Psychology of Religion: The Scientific Basis of Pastoral Care. 2) Pastoral Care and Personal Counseling: A Study of the Literature of Pastoral Care and the Problems of Marriage and Family Counseling. 3) An Introduction to Clinical Pastoral Care.

For graduate work in clinical pastoral training seminaries are making use of the facilities offered them at hospitals having accredited full-time chaplains. These chaplains conduct seminars and other training in connection with the seminary program. Scherzer states the following in this respect:

> . . . some of the chaplains of hospitals are offering seminars on the ministry to the sick to the clergy in the area of the hospital. Such classes offer not only instruction but the exchange of ideas and experiences and help the pastor develop a technique of counseling, interpretation, and reassurance that increases his helpfulness to his sick and troubled parishioners.[2]

Most seminaries offer clinical training to their students through the training centers established by the Council

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[1]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, c1950, p. 245.

[2]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, c1950, p. 246.

for Clinical Training and the Institute of Pastoral Care. There are also institutes and ministers' conferences held in some seminaries during the summer. They stimulate prospective candidates for clinical training by including lectures and courses on pastoral care and on the psychology of religion in their program.

Other Local Facilities

In addition to the training facilities already mentioned, and which operate on a national level, other local facilities are also offered by accredited chaplains to groups of clergymen in certain areas. These chaplains organize special training programs to help clergymen learn better techniques for calling on the sick at their homes and in the hospitals. These short courses are provided for those clergymen who cannot arrange for the six-week periods required by training centers. In 1954 the Committee on National Missions of the Presbyterian Church reported one such instance, saying that the Office of Institutional Chaplaincy ". . . includes provision for a short term of clinical training at the Denver Presbyterian Hospital under the direction of the Rev. Eliot Porter, Ph. D."[1] This

[1]Committee on National Missions, Minutes of the General Assembly of the Presbyterian Church in the United States of America, Vol. III, Part I, Philadelphia, Office of the General Assembly, 1954, p. 157.

kind of program includes courses offered for two or three weeks each during the summer. They have proved to be very helpful to those clergymen who call on the institutionalized sick as part of their ministry.

The program offered at Denver includes courses on improved methods to be followed when calling on the sick. The course has been described as follows:

> Members of the two groups became chaplain externes at Denver Presbyterian Hospital for the period of the course. Instruction was centered on practical methods to be used on calling on hospitalized patients. . . .
>
> Meetings were held with members of the hospital staff, including the chief surgeon, a heart specialist, an obstetrician, an anesthetist, and specialists in other fields. Discussions covered such subjects as death, bereavement, alcoholism, danger-list patients, the use of prayer and Scripture in rooms of the sick, and cooperation with those attending the patient.[1]

Five or Six students attend each course, and plans are made for several groups to benefit. Local ministerial councils seem to be taking advantage of these programs to further their training.

Another local facility for training is that offered by the Rev. A. J. Westmaas at the Harper Hospital in Detroit, who conducts short-term informal clinical training for ministers of the community. His contribution has been able to help a great number of ministers, and through his

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[1]The Editors, "Course Teaches Methods for Calling on Sick," Presbyterian Life, 7:27-28, October 30, 1954.

training efforts they have been given "basic training in hospital procedures, in effective visitation and ministry to their parishioners who become patients."[1]

The Journal of Pastoral Care

An excellent resource for the advanced clinical students is The Journal of Pastoral Care, a professional journal sponsored by the Council for Clinical Training and the Institute of Pastoral Care. It is a quarterly publication. It contains articles on general interest in the field, and covers areas such as the dynamics of human behaviour, the relation of religion to health, and the relation of religion to psychiatry. The Journal contains a section on book reviews which is a valuable contribution to the chaplains in their selection of reading material. It is also useful to the chaplain in the hospital situation.

III. CONTENTS AND METHODS OF TRAINING COURSE

The contents of courses depend upon the nature of the training, and the organization sponsoring the program. Some seminaries are offering courses in psychology and

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[1]Division of Welfare Agencies, Report of Meeting of Presbyterian Hospital Chaplains and Administrators, Philadelphia, Presbyterian Church in the U. S. A., 1955, pp. 1-3. (Mimeographed)

related fields as prerequisites for those seminarians who expect to secure further training for specialized work in institutions as chaplains. The two national organizations sponsoring centers for clinical training, that is, the Council for Clinical Training and the Institute of Pastoral Care, offer courses on different levels.

In the Council for Clinical Training[1] the orientation courses, mainly for seminarians and parish workers, involve: visits to patients or inmates, lectures on the types of illness found in the institution and their related problems, seminars on the pastoral care of the sick and their families, lectures by the different specialists and other professionals dealing with the patients, and readings which are to be reported to the chaplain-supervisor. The student must spend from half a day to a full day per week in the hospital for his practical work.

The basic courses in the various centers conducted by the Council for Clinical Training are divided into three levels which have been already described. In addition to the contents mentioned previously in relation to other courses, the basic courses contain an internship requirement which covers from a quarter to a full year of practical

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, pp. 4-5.

experience in the institution. Courses offered by other organizations include similar contents.

The clinical method of actual work with people is used by all organizations offering some kind of training. The student visits the patients, and during his conferences with the chaplain-supervisor discusses with him his reactions to the sick. The student also must submit to the supervisor reports of lectures attended to. These reports help in the evaluation of the student's work. Meetings are also held in which the students as a group and the chaplain-supervisor join in class discussions on material read and on practical experience with the patients. Review of selected books is also included.

Note writing is a technique which most students on clinical training use when calling on the sick. As soon as possible after seeing the patient, the student writes a complete, detailed, verbatim record of all that happened in the sickroom during his visit. He also writes his interpretation of that contact. During his conferences with the chaplain-supervisor this record constitutes one of the means of evaluating the effectiveness of the methods used by the student. Cabot and Dicks describe this technique as follows:

> Note-writing is primarily a process by which the minister subjects his work with an individual to examination. This examination is the nearest approach

> to an objective check upon the minister's work which we have been able to discover. Note-writing is the development on paper of one's work with a given patient after that work is done. When we reproduce in writing a contact, an interview, a working relationship, we do not merely record it, we rethink it and so develop its meaning.[1]

These authors also state that this note-writing has four values: it is a check upon one's work; it is a clarifying and developing process; it relieves emotional strain for the writer; and the notes stand as a record of one's work.

Cabot and Dicks[2] suggest an outline for this note-writing, consisting of five items which the minister should keep in mind during his call on the patient. In the first place, the notes should contain such information as the name, age, sex, marital status, occupation, religious preference, and physical condition of the patient. Second, they must include the reasons that the minister has to see the patient; how the patient came to his attention. Third, the outline calls for a record of the first impression: description and physical appearance, how he was received. The fourth item is the main body of the notes: the record of what happened. The minister should cite as

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[1]Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, New York, The Macmillan Company, 1936, p. 244.

[2]Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, New York, The Macmillan Company, 1936, pp. 256-257.

many quotations as possible. Fifth, the notes must include a summary of the problem observed, the needs of the patient, and how these needs can be met. This is a valuable teaching and learning device.

IV. STANDARDS OF CLINICAL PASTORAL TRAINING

The National Conference on Clinical Training in Theological Education which met for the first time in 1944, has adopted a set of standards for the training program, the training centers, and the chaplain-supervisors. Hiltner, in evaluating this work of the Conference, states:

> A National Conference on Clinical Training in Theological Education . . . gave special attention to standards for training which have been observed in various centers across the country. The high standards upon which these clinical training groups operate are adapted to special conditions and situations. The Conference has endeavored to compare the standards and has found that the experience of these groups has led them to agree at least in certain respects.[1]

Revised standards, adopted by the Conference during its meeting in 1952, are stated below.

Minimum Work Requirements

The Conference, of which the Council for Clinical Training and the Institute of Pastoral Care are two

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[1]Seward Hiltner, ed., Clinical Pastoral Training, New York, Commission on Religion and Health, Federal Council of the Churches of Christ in America, 1945, p. 56.

constituent bodies, has adopted the following minimum significant essentials on the program of clinical pastoral training:

1. A supervised practicum in interpersonal relations.

2. Writing of clinical notes for consultation with the chaplain-supervisor.

3. A continuing evaluation of the student's experience and growth to be offered during the training period.

4. Frequent association with an interprofessional staff who are genuinely interested and qualified to teach students.

5. Adequate provision for group discussions, seminars, and other group experience for all students.

6. A continuing concern for an integration of psychological, ethical and theological theory with practical understanding of the dynamics of personality and facility in interpersonal relations.

7. A written evaluation of his experience to be made by the student to his chaplain-supervisor at the end of the training period.

8. A final summary evaluation of the student's work and capacities to be written at the end of the training period by the chaplain-supervisor, discussed with the student, and with his knowledge, made available to the appropriate responsible parties.[1]

The same Conference recommended the following minimum program for clinical pastoral education:

1. For the theological student who is preparing for the parish ministry:

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, p. 4.

a. An introductory course to clinical pastoral care during the entire academic year, with one day per week at an accredited center under the direction of a Chaplain-Supervisor who is a functioning member of the staff of the center, and

b. Clinical pastoral education for twelve weeks, full time.

2. For the student who is seeking a Master's degree in pastoral care, at least six months' clinical pastoral education, full time.

3. For the advanced student preparing for the teaching of pastoral theology and pastoral care, an appropriate Doctor's degree with at least nine months, full time of clinical pastoral education, and in addition three months of supervised teaching of pastoral care.[1]

The Conference also adds special consideration intended to help clergymen who cannot be absent from their parishes for a long period. The arrangement is usually made for the summer months:

1. For pastors and other religious workers seeking additional training:

a. Full-time participation in clinical pastoral education for six to twelve weeks is recommended.

b. Where this is not possible, participation in orientation programs at an accredited center is recommended.

2. For chaplains serving full time, at least twelve months full-time clinical pastoral education is recommended, six months of which to be in the type of institution which he serves. Where this standard has

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[1]National Conference on Clinical Pastoral Training, Standards for Clinical Pastoral Education, New York, The Conference, October 1, 1952, p. 2. (Mimeographed)

not yet been attained, Hospital Administrators are encouraged to release their chaplains periodically for the necessary training.[1]

Requirements for Training Centers

The National Conference adopted standards which must govern the establishment of training centers. The following is a summary of these standards:

1. A chaplaincy service which is well established and recognized as a functioning part of the center, with a chaplain accredited as a Supervisor.

2. A progressive institution, oriented toward therapy or rehabilitation, serving an adequate number of patients or inmates accessible to the chaplain's program, maintaining an interprofessional staff available for continuous teaching of theological students. . . .

3. Maintenance should be provided for students in training, or such provisions as may be comparable to the internship programs of other professional groups in the institution.[2]

Chaplain-Supervisors

As to the qualifications which must be met by the head of the training center, the chaplain-supervisor, the following are in operation in both the Council for Clinical

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[1]National Conference on Clinical Pastoral Training, Standards for Clinical Pastoral Education, New York, The Conference, October 1, 1952, p. 3. (Mimeographed)

[2]National Conference on Clinical Pastoral Training, Standards for Clinical Pastoral Education, New York, The Conference, October 2, 1952, pp. 1-2. (Mimeographed)

training and the Institute of Pastoral Care:

> 1. Graduation from an accredited theological school, upon the completion of a three-year graduate course beyond the bachelor's degree or its equivalent.
>
> 2. An adequate period of pastoral experience, with ordination and denominational approval.
>
> 3. At least one year full time of clinical pastoral training, and in addition three months of supervised clinical teaching.
>
> 4. Professional competence including graduate studies, past experience and demonstrated performance. Graduate degrees in appropriate fields with clinical orientation are recommended and may be evaluated as follows: six months credit toward clinical education may be given for an appropriate Doctor's degree; three months' credit may be given for an appropriate Master's degree.
>
> 5. Personal qualifications to be appraised by an accrediting committee in a personal interview.[1]

Each chaplain-supervisor at these training centers must be a well-adjusted person, emotionally and spiritually stable, with the ability to face trying situations calmly and objectively. Other personal qualifications are stated by the Council, such as enthusiasm, high degree of personal insight, and integrity. He should also have interest in training, thorough knowledge of other professions than the ministry, administrative ability, capacity to earn the respect and liking of patients, staff and students, and he

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, p. 6.

must have teaching ability.

V. ACCEPTED WORK STANDARDS FOR HOSPITAL CHAPLAINS

Different institutions and organizations carrying on training programs for the education of hospital chaplains have set up various sets of standards for them to meet. In particular, the American Protestant Hospital Association has set up standards for the chaplain in general hospitals, and the Association of Mental Hospital Chaplains has set standards for chaplains in hospitals for the mentally sick. All of these standards are cited below.

General Hospitals

The American Protestant Hospital Association,[1] organized in 1921, seems to have been the first organization to set standards for the work of the hospital chaplain. In 1939, the administrator of the Presbyterian Hospital in Chicago was so impressed with the work of Chaplain Russell L. Dicks[2] in that hospital that he invited the chaplain to prepare a paper to be read at the next convention of the

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[1]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, 1950, p. 135.

[2]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, 1950, p. 235.

Association in Toronto, Canada, in September of that year. This was an important step in the formulation of standards for the work of the chaplain in the general hospital. Scherzer has described the enthusiasm with which the paper was received at the convention:

> This paper, entitled, "The Work of the Chaplain in a General Hospital," can be regarded as marking the beginning of a new era in hospital chaplaincy. It was received with enthusiasm by many of the delegates and printed in full in the next issue of the American Protestant Hospital Association Bulletin.
>
> One of the results of this presentation was the appointment of a commission of the A. P. H. A. to study the field and formulate a set of standards for the work of a chaplain in a general hospital.[1]

The commission adopted a set of standards, entitled "Standards for the Work of the Chaplain in the General Hospital," which were presented at the Association's meeting in 1940. Their adoption marked another step in the chaplaincy program. The document is divided into eight sections, representing different phases of the chaplain's work. They are summarized as follows: 1) The responsibility of the chaplain to the administrator of the hospital, 2) his co-operation with other personnel of the hospital, 3) his plans for the selection of his patients, 4) the chaplain's need to keep the necessary records, 5) the place

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[1]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, 1950, pp. 235-236.

of worship in the public hospital, 6) the training of the chaplain, 7) the appointment of the chaplain, and 8) his needs for spiritual growth, based on the conclusion: "Men shall not live by bread alone."

Later, a revision of these standards was authorized by the Association in its convention of 1950. This official revision was prepared by the Committee on Accreditation,[1] and follows the same pattern. The section on the selection of patients by the chaplain was changed to read: "Sources of Referral," and was made comprehensive. Two sections of particular interest, A and B, are discussed below:

Section A, The Accredited Chaplain, is introduced by the statement that anyone who is to serve as a chaplain should be properly qualified. It includes the minimum standards for accreditation: 1) College and seminary degrees or their accepted denominational equivalent. 2) Ordination or appropriate ecclesiastical endorsement and evidence of current good standing within a denomination. 3) A significant period of clinical pastoral training such as a minimum of twenty-four weeks, or its equivalent, and a written recommendation by the instructor. 4) Three years of parish experience or its equivalent.

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[1]Committee on Accreditation, Standards for the Work of the Chaplain in the General Hospital, Chicago, American Protestant Hospital Association, 1950, pp. 1-2.

Section B. The Appointment of the Chaplain: The three most common ways presented for the selection of the chaplain to be appointed by the hospital Board of Directors on the recommendation of the administrator are: 1) A Church authority nominates the accredited candidate, it being understood that in a denominational hospital, the denominational authorities make the nomination; 2) a special chaplaincy committee is appointed to nominate an accredited candidate, and the hospital administrator then accepts or rejects the nominee; or 3) the hospital administrator presents a candidate to the Board of Directors who makes the appointment.

Mental Hospitals

The standards set up by the Association of Mental Hospital Chaplains may be summarized as follows:

1. Academic requirements which are similar to those set up by the American Protestant Hospital Association.

2. Evidence of a mature and deepening religious philosophy.

3. Evidence of coordination and of good standing in a recognized faith group, and evidence of a successful period of full-time parish ministry.

4. Evidence of satisfactory completion of a period of specialized training and experience in the mental hospital chaplaincy approved by an accredited organization.[1]

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[1]Association of Mental Hospital Chaplains, Standards for Mental Hospital Chaplains, Washington, D. C., The Association, 1955, pp. 2-4.

VI. SUMMARY

The clinical pastoral training movement, although a young one, has had a rapid growth since its start on the second quarter of the century. Its development is related to such organizations as the Graduate School of Applied Religion, the New England Group, the Center at Worcester, Massachusetts, the Council for Clinical Training, the Philadelphia Divinity School, and the Institute of Pastoral Care. These organizations have contributed toward the establishment of a well organized training program throughout the country.

Through facilities provided by the Council for Clinical Training, the Institute of Pastoral Care, and other organizations and institutions, the seminarian and the clergyman may obtain well-rounded training for the clinical pastorate. The experienced chaplain may add to his knowledge of clinical pastorate through advanced studies, facilities for which are provided by fifty training centers of the two organizations mentioned above. There are other local facilities through which short-term courses are being provided to those clergymen who cannot arrange to be absent from their work to enroll in the six or twelve weeks' periods at the regular centers.

The available training programs offer a variety of courses to meet the needs of seminarians, parish ministers,

hospital chaplains, and other religious workers for their clinical pastoral training. They include actual work with patients, lectures, readings, seminars, visits to different institutions for the sick, reports, class discussions, and other items which help widen the experience of the student. One of the techniques mostly used by students in their work with patients is that of note-writing, which becomes a help in the evaluation of his work.

There have been a set of standards which have been adopted by the different organizations responsible for the training program in the clinical pastorate. Among such organizations are the National Conference on Clinical Pastoral Training, the American Protestant Hospital Association, the Association of Mental Hospital Chaplains, and others. Organizations which carry on training programs, such as the Council for Clinical Training, the Institute of Pastoral Care, and others, have adopted these standards which cover requirements for the training centers, minimum essentials for clinical pastoral education, and the qualifications of the chaplain-supervisor.

Among the accepted work standards for the chaplaincy service are those for chaplains in general hospitals and those for chaplains in mental hospitals. The standards for chaplains in general hospitals were set by the American

Protestant Hospital Association. Those for the chaplains in mental hospitals have been set by the Association of Mental Hospital Chaplains.

CHAPTER IV

IMPLICATIONS OF THIS STUDY FOR A PUERTO RICAN TRAINING PROGRAM

American institutions have exerted a powerful influence in the development of the Puerto Rican culture, especially in the public school and hospital systems. Thus, when Puerto Rico must develop a program for clinical pastoral training she naturally looks to the mainland to discover what policies or practices might be transferrable to the Island. This chapter presents implications for Island practice in the training of chaplains but before stating these implications it might be well to examine briefly the setting for the suggested program.

I. THE SETTING

There are four basic considerations in the Puerto Rican setting which must be kept in mind in any proposed program for clinical training of chaplains. These are: the religious background of the people, the hospitals which are available, the organization of the Puerto Rican family, and the chaplaincy services which are presently available on the Island.

Religious Background

Miller[1] points out that religious freedom was established by the American government on the Island of Puerto Rico in 1898. Still later, when the Island acquired the status of Commonwealth, this principle was maintained and clearly defined in its Constitution. Until the change of Government, the Roman Catholic Church was the established Church but as soon as religious freedom was instituted, the different mission boards in the United States began sending their missionaries. Churches, and educational, medical and social institutions were organized under the Protestant Church auspices.

Every town on the Island now has at least a Roman Catholic and a Protestant church. Both faiths are engaged in a program of expansion in urban and rural areas through schools, community centers, hospitals, and dispensaries.

There are more than three hundred churches of the Protestant faith, and their work shows a continuous growth in activities and influence. Some of their institutions are supported by the respective denominational concerns, while others are supported by the joint efforts of the denominational bodies through the Council of Churches.

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[1]Paul G. Miller, Historia de Puerto Rico (History of Puerto Rico), New York, Rand McNally & Company, 1922, p. 468.

In 1945 an Interdenominational Conference of Evangelical Leaders[1] was held at the Polytechnic Institute, a Church-related Liberal Arts College. The success of co-operation in the development of the work was pointed out in the Conference as one of the major accomplishments of the Church in the Island. In 1905, after all the towns had been occupied by the Church, the Federation of Evangelical Churches was organized. This organization has changed its name and now it is called the Puerto Rico Evangelical Council, affiliated with the National and World Councils of Churches.

There are eight Church-related hospitals in Puerto Rico. Six of these hospitals are under the auspices of the Protestant Church, and two under the auspices of the Roman Catholic Church.

Available Hospitals

At the beginning of this century serious health conditions prevailed in the Island, but since then they have been greatly improved. A wide construction program for hospitals has been developed under government and private auspices, and it has expanded considerably during the last twelve years. According to the Bureau of

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[1]Executive Committee, Findings of the Conference of Evangelical Leaders, San German, Puerto Rico, The Conference, 1945, p. 1.

Hospital Census and Construction,[1] in 1954 there were one hundred and thirty-three hospitals in Puerto Rico. Of this number, seventy-eight were government hospitals, including municipal institutions. As part of this program the Commonwealth has established a number of health centers throughout the Island.

The first missionary medical work in the Island was organized by the Presbyterian Church[2] in 1901. Upon her appointment as medical missionary, Dr. Grace Williams Atkins established a dispensary in San Juan, which led to the organization of the Presbyterian Hospital three years later. Other denominations also organized medical work, which later developed into other hospitals. The last one to be inaugurated was in 1954. With the help of community and Federal government funds, the Presbyterian Hospital has begun a one million dollar project of construction which will increase its facilities still more.

In spite of all the hospitals, the number of beds is entirely inadequate to meet the health needs of a

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[1]Negociado de Censo y Construccion de Hospitales, Servicio Hospitalario en Puerto Rico (Hospital Service in Puerto Rico), San Juan, Health Department, 1955, p. 11.

[2]Department of Educational and Medical Work, The Presbyterian Hospital, San Juan, Puerto Rico, New York, Board of National Missions, 1941, p. 2.

growing population. According to official figures[1] there are now 10,788 beds available for the different services, but 32,793 beds would be needed to meet the need. Distribution is as follows:

Type of Hospital	Beds Available	Beds Needed
In General Hospitals	5,376	9,963
In Tuberculosis Hospitals	2,767	7,332
In Mental Hospitals	2,396	11,070
In Chronic Disease Hospitals	249	4,428

This need for additional beds is due to the annual increase of fifty thousand people in the population on the Island. The government is carrying on a plan to provide large base and intermediate or district hospitals to serve the areas into which the Island has been divided for hospital service, according to Dr. Pons'[2] report. The municipal and other government hospitals refer cases to these base and intermediate hospitals which have more and better facilities, and are better staffed. The map on page 130 shows the different areas served by these hospitals. The

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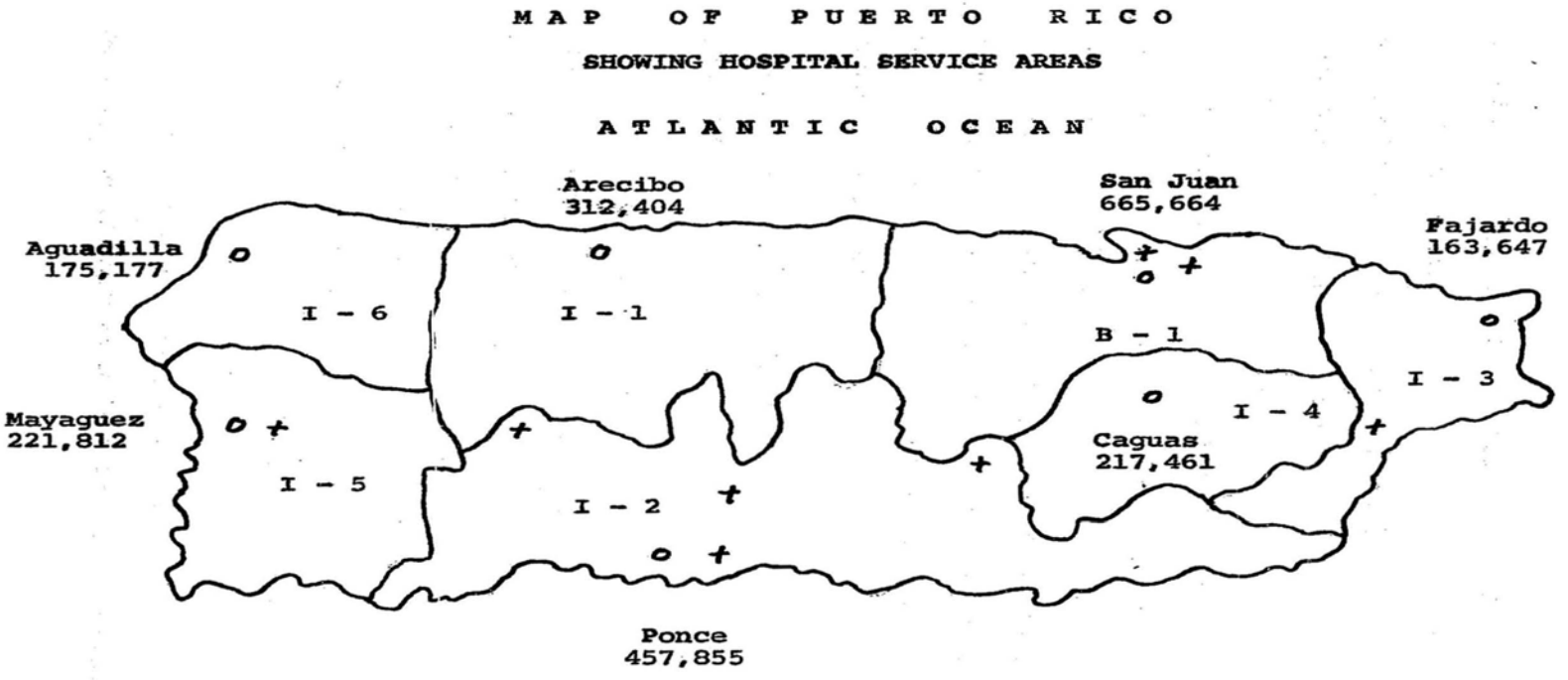
[1]Negociado de Censo y Construccion de Hospitales, Servicio Hospitalario en Puerto Rico (Hospital Service in Puerto Rico), San Juan, Health Department, 1955, p. 15.

[2]Negociado de Censo y Construccion de Hospitales, Servicio Hospitalario en Puerto Rico (Hospital Service in Puerto Rico), San Juan, Health Department, 1955, p. 25.

MAP OF PUERTO RICO

SHOWING HOSPITAL SERVICE AREAS



_____ Service Area Limits

o Area Hospitals

\+ Church-Related Hospitals

B Base Area

I Intermediate Area

Base Area is the largest. Located in San Juan, it serves the city and adjoining towns. The others, called Intermediate Areas, serve the rest of the Island. Each area represents the corresponding part of the population, which at the time the statistics were published, was estimated to have been 2,214,000. There are five of these seven area hospitals working to their full capacity, and the other two are in the planning stage. Although Church-related and private hospitals are distributed throughout the different areas, most of the private institutions are located in the large cities. Each Church-related hospital is marked with a cross in the map.

Organization of the Puerto Rican Family

The organization of the Puerto Rican family builds close emotional ties between its members. This makes them feel that they must stay with the sick member all the time. They wish constantly to express their love to him and their concern for his well-being. They feel that they must not leave him alone in his room nor even in the ward where he is in the company of other patients and of the nurses on duty.

The regulated visiting hours in hospitals sometimes make the family hesitate to hospitalize the patient as the

doctor has suggested. Some families bring a sick member to the hospital only when he is critically ill. The emotions are very strong in most of these cases, the patient's family wishing to keep him at home where they can take care of him personally.

Other factors which must be surmounted are the economic factor, the lack of enough beds, and the great distances which separate many of the rural communities from hospital centers. At Presbyterian Hospital, as in other non-profit hospitals, and in the government ones, any patient needing admission is taken in if there is an available bed. He is admitted regardless of his economic and social status, and of race, color or creed. But even if other factors such as financial difficulties did not exist, there would still be the emotional factor with which to reckon.

An example of this factor follows: One afternoon a mother brought her three-year-old son to the dispensary of Presbyterian Hospital as an emergency case. The child had swallowed a penny which remained in his esophagus. They had tried to take it out but his throat was swollen. A specialist had ordered the child's immediate hospitalization but when the mother was told that she could not stay all the time at his bedside, she refused to have him admitted. The life of that child was at stake and something

had to be done. The chaplain was called and the mother was led to understand the need of her co-operation. Not until a week later was the specialist successful in taking out the penny. He had said that only a miracle could have saved that child's life, and obviously he needed the resources of a modern hospital to help bring about that miracle.

A Puerto Rican patient is particularly susceptible to feeling lonely if his family does not visit him frequently. He also feels anxious if it is the first time he has been hospitalized. For the entire family, the hospital situation is fraught with doubts, apprehensions, and other emotional hazards. The family organization in Puerto Rico has a number of positive factors which in time of trouble can be used to advantage by the hospital chaplain. One of these factors is the tendency of the family to follow in the religious interests of the father when he shows a genuine concern for spiritual matters. A pastor in a rural community was holding the regular Sunday worship when a man he had never seen before came in and listened very attentively to all the service. After the service was over he left immediately and the pastor had no opportunity of greeting him. The next Sunday that same man came in, but this time he was accompanied by his wife and children. Upon greeting him after the service the minister inquired

from him whether he was related to any church. He said that he used to attend Church when he was a child but had not gone back since that time. Then he explained that he had become interested in meeting his spiritual needs while hewas a patient at the hospital where the services had impressed him so much that he did not wish to miss any of them. This experience meant so much to him that he had made the decision to continue attending Church and have his family enjoy this experience with him. Thus he had invited his wife and children to join him for this purpose, and all felt happy about it. This man is now one of the most faithful and active members of the Church, and his family has joined in enthusiastically.

In any picture of the Puerto Rican family there is another factor which must be considered. It is the authoritarian type of discipline which is traditional in the parent-child relationships and which governs a great majority of the families. There are cases in which this factor is reflected in some patients who are referred to the chaplain in the hospital. The chaplain at Presbyterian Hospital was called to help in the case of a young man who had been critically ill and who was emotionally upset. "Good afternoon, how are you feeling today?," the chaplain asked the patient who answered, "Oh, I am too sick and too unhappy." Then the patient went on telling that he could not feel

happy because he was responsible for much of his parents' suffering. He had disobeyed them and had left his home some years ago because they were too strict with him. He said that now he was able to understand that they wished his well-being. He had caused much suffering to them because of his conduct and added that he should have obeyed them. The chaplain could see that his feeling of guilt for having disobeyed the authority of his parents was largely responsible for the young man's emotional problem. He tried to help the patient gain an understanding of the situation, and promised he would come back to see him next day. During the second interview the patient showed some insight in his problem, and during subsequent visits showed significant growth in understanding. When he left the hospital the patient had been able to make a better adjustment and had established better relations with his parents. Supervised clinical training would prepare Puerto Rican chaplains to help in such typical family situations.

Current Chaplaincy Services

With the increase of medical missions in Puerto Rico, the Church became interested in meeting the spiritual needs of the sick in its hospitals. Provisions were made through the medical directors, directors of nurses,

administrators, local ministers, and other religious workers, to minister to these needs. Mellado[1] has stated that the movement has been toward a more liberal interpretation of the religious experience. This has been manifested in the changing attitude of the Puerto Rican sick toward the clergyman's ministry to them. Not very long ago the visit of the priest to the home where there was a sick person was interpreted as an indication that the patient was dying and that the priest was there to administer the last rites. The development of pastoral care to the sick and the regular calls of the clergyman at the home or at the hospital, have led more and more patients to see in him a messenger of hope.

At the Presbyterian Hospital in Puerto Rico spiritual guidance for the patient was at one time taken care of by the medical director and the director of nurses, and at times by the administrator. Local ministers co-operated with the staff in providing spiritual services to patients and to the students. As the hospital grew and the demands for pastoral care of the sick were varied the need for a full-time religious worker to meet these demands became more pressing.

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[1]Ramon A. Mellado, Culture and Education in Puerto Rico, San Juan, Puerto Rico Teachers Association, 1948, p. 62.

In 1935, the medical director asked for the appointment of a full-time religious worker by the Board of National Missions of the Presbyterian Church in the U. S. A., owner of the hospital. The day had come, he said, for the appointment of a worker who could dedicate all his time to meet the religious needs of the Institution. The church decided to meet this need, and in 1937 the first full-time religious director was appointed, with the status of staff member. In 1948, after a year of graduate studies, and according to the new administration in the hospital, the title was changed to that of "Chaplain" with the status of Department Head.

This appointment was the first full-time religious director or chaplain in a Church-related hospital in Puerto Rico. Other Church-related hospitals have made arrangements with local pastors to dedicate part of their time to serve in the institutions. Being regular ministers in their parishes, they cannot be available all day in the hospitals. During the celebration of the Interdenominational Conference[1] these needs were discussed as part of the whole program of the Church. An interest on the part of Church bodies in the Island in making provision for this necessary

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[1]Executive Committee, Findings of the Conference of Evangelical Leaders, San German, Puerto Rico, The Conference, 1945, p. 1.

ministry is increasing. The chaplaincy services have been developed in a spirit of understanding and in harmony with the whole program of the institutions where they have been organized.

The chaplaincy at the Presbyterian Hospital has become an essential part of the program in that institution. Dr. T. D. Slagle, former medical director of the Hospital, has stated:

> Our chaplain has developed a carefully coordinated program with much success. His success is due principally to his ability to introduce his work through all our program in such a way that our technical objectives benefit continually and are never hindered.[1]

Dr. Luis Morales, a well known Puerto Rican psychiatrist and staff member of that same hospital, has said in relation to their work:

> The trend in medicine is to treat patients and not diseases. It is important that the patient understands his situation. The minister is in a position to help. The sick person looks for health but there is a very necessary element which he needs: assurance. The minister can help effectively by helping to solve the emotional and religious problems of the patient.[2]

For many years the Council of Churches of Puerto Rico, as a joint project, has supported an institutional chaplain who serves in the government psychiatric and

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[1]T. D. Slagle, M. D., Annual Report of Presbyterian Hospital, San Juan, Board of National Missions, 1942, p. 3.

[2]Interview with Dr. Luis Morales, Psychiatrist, Presbyterian Hospital, March 7, 1943.

tuberculosis hospitals, in the leper colony, and in the prison, located in the Metropolitan Area of San Juan. The recently revised constitution and by-laws of the Evangelical Council includes the Department of Chaplaincy as an integral part of the organization. Some voluntary part-time service is given by local ministers in private and other government hospitals. None of them has had clinical pastoral training. They are doing good work, but if they could have clinical training they would make a better and more effective contribution in the sickroom. The large area government hospitals do not as yet have hospital chaplains. There is great need for this service and the future possibilities are endless. The experience gained indicates a promising future if a well-organized program for clinical training can be established.

The need for helping the sick person to gain understanding is one of the greatest needs in Puerto Rico. The doctors cannot dedicate much time to counseling with the patients because they are overworked. There are only one thousand six hundred forty-two of them in the Island and this number is short of the standards set for the United States and mentioned by Koos in his book "The Sociology of the Patient."[1] Nor are there enough trained social workers

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[1]Earl Lomon Koos, The Sociology of the Patient, New York, McGraw-Hill Book Company, Inc., 1950, p. 143.

who could render a valuable service in helping to meet this problem. The trained nurses available cannot meet the demand for them and they are not available for counseling with the sick.

II. CONSIDERATIONS BASIC TO ESTABLISHMENT OF A TRAINING PROGRAM

In the establishment of a program for clinical pastoral training in Puerto Rico, for which there are many favorable possibilities, the following basic considerations would have to be borne in mind: 1) the importance for the Island of the separation of Church and State, 2) the need to involve the evangelical Council and its Institutions, 3) the over-all lack of Spanish-language literature in the field, and 4) the preliminary necessity of training one Puerto Rican Chaplain-supervisor to head the on-going program.

Separation of Church and State

The Protestant Church in Puerto Rico insists on the strict application of the principle of separation of Church and State. The appointment and support of chaplains in Church-related hospitals will continue to be made by the sponsoring Church bodies. But the support of those chaplains who would serve in government hospitals and other

institutions would create a difficulty at the beginning, unless the churches take the whole responsibility. If it implies getting funds from the government there would be opposition on the part of the Council of Churches. There is only one solution to meet this situation at the beginning and that is, joint support of the work by the Council itself, or by other Church agencies interested in providing these chaplaincy services. Through the help of the mission boards in providing part of the expenses, the local churches would be encouraged to increase their funds for the chaplaincy.

The opening of the large base hospital and the enlargement of other government institutions will increase the demands for the ministry and the opportunities for providing it through the Church. Later, if an adequate representation is assured for chaplains of both faiths--Protestant and Catholic--in the Island, some kind of arrangement could be worked out by which the government would provide for office and equipment to facilitate the program. But the Church must provide definitely for maintaining the services in all institutions concerned. In government and private hospitals and other institutions, the appointment of Protestant chaplains must be made by the Council of Churches, with the different Church bodies recommending candidates. The procedure would guarantee the fulfillment

of the principle of separation of Church and State in carrying out this program.

Involvement of the Evangelical Council and its Institutions

As in the United States, the development of a clinical pastoral training program in Puerto Rico involves the interests of the Evangelical Council and its institutions. These should include such institutions as the Evangelical Theological Seminary, the Church-related hospitals, the Inter-American University, and other projects and organizations concerned with the program. As has been reported, the Council has a Department of Chaplaincy[1] of which hospital chaplains as well as chaplains in other institutions and in the armed forces are members. A training program would have the backing of the churches through the Council, some of whose officers have already suggested the possibility of organizing such a program in the Island. It would need not only the financial backing of the Council but also its whole-hearted co-operation. This would imply economic help from the local churches and from the denominational boards which help to support the

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[1]Executive Board of Evangelical Council of Puerto Rico, The Constitution and By-Laws of the Evangelical Council of Puerto Rico, San Juan, The Council, 1954, p. 11.

work of the Church in Puerto Rico as a missionary field.

The need of the co-operation from the Protestant Church-related hospitals does not have to be elaborate because these hospitals have already the services of full-time or part-time chaplains. They would be willing to give any help to contribute to the effective training of the students. The facilities of these hospitals would be available for the successful development of the program, including room and board for a few students. Other students would be living in the community where the training center would be established, leaving the room and board facilities in the hospitals for those coming from distant communities.

Many of the pre-theological students get their college education in the existing Presbyterian Church-related University. Some of them would become interested in clinical training through related courses which the University could offer. It could contribute also by helping these students develop the necessary attitude toward the clinical pastorate.

Adoption of American Standards in Hospitals and Clinical Pastorates

Puerto Rican hospitals have adopted the standards of the hospitals in the United States and most of their

doctors are graduates from medical schools on the mainland. Medical, nursing, and other services have been developed according to standards set up by the respective national organizations to which hospitals and their departments were affiliated. The School of Medicine, organized in 1950, was established with a curriculum which meets the requirements of Grade A Schools in the States. The Schools of Nursing have also developed along the American pattern, using the same textbooks in English, and following the same organization of the national schools.

Similarly, the hospital chaplaincy has also grown along the same lines as it has in the United States. There is a full-time chaplain at government institutions whose work is entirely supported by the Evangelical Council and whose program is similar to that of the full-time chaplain at Presbyterian Hospital at San Juan. Most of the ordained Protestant clergymen who perform as chaplains are graduates from the Evangelical Theological Seminary which is supported by five major denominations, or from other theological schools on the Island. Others are graduates from seminaries in the United States. There are also Catholic priests serving as part-time chaplains in government and private hospitals.

The training program on the Island should be developed on the same standards of the national program,

within the needs of the particular situation. Most of the clergymen who serve as full-time or part-time chaplains in hospitals on the Island are Puerto Ricans and therefore have a comprehensive knowledge of the special Puerto Rican situation, the cultural and religious factors, the health conditions, and the family organization in the Island. These are somewhat different from those in the United States, and they have been discussed at length earlier in this chapter.

Provision of Spanish-Language Literature in the Field

The planning for a training center implies the provision of literature and in the case of Puerto Rico, some of this literature must be available in Spanish, since Spanish is the native language of its people. This can be achieved in a number of ways. Some members of the clergy may translate items of literature in the field which has been published in English, while others who have had some experience in hospital chaplaincy can produce more applied literature. The sponsoring agency may get the co-operation of the mission boards for meeting the cost of printing the translated and the new literature. The Council of Churches may help with the facilities of its printing shop.

Almost all the work with patients in hospitals must be done in Spanish, and for this reason much of the training will be conducted in this language. As most of the clergy have a good command of the English language the available literature in English will be used also. Seminars and other activities would be held both in English and Spanish, with the help of the English speaking members of the staff also.

Provision of at Least One Chaplain-Supervisor

One of the implications in the development of a program in the clinical pastorate is the training of at least one chaplain who could supervise the work of a needed training center. This responsibility would have to be met by the local organization sponsoring the program, in this case, the Council of Churches. This would necessitate sending a clergyman, who would meet the requirements, to receive the appropriate training in the United States. He would be trained under the direction of either the Council for Clinical Training or the Institute of Pastoral Care. The arrangements could be made through the National Council of Churches with which the Puerto Rico Council is affiliated.

This clergyman would have to spend at least one year in the States for his training. If he has the necessary

experience and the appropriate degree he could apply for the credit toward the time required for his training. The Council for Clinical Training[1] provides for this evaluation. There are a few clergymen in Puerto Rico who have some training and experience in hospital chaplaincy and who would be available for this opportunity.

The nominating Church organization should be asked to meet part of his expenses in training, and the mission board in the United States should be asked to meet or make arrangements for the rest of the expenses. After the first twelve-week period, the candidate could get a part-time appointment, or he could get a scholarship.

After his training this clergyman would be responsible for organizing and administering the Puerto Rican program. He would be appointed chaplain-supervisor to head the training center which would have to be established for carrying on the program. In such capacity he would supervise the training of the students to be admitted.

III. ESTABLISHMENT OF THE FIRST TRAINING CENTER

The training program for Puerto Rico would imply the establishment of a training center. The sponsoring

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, p. 6.

organization should establish this center, making certain that it meets the standards set up by the organizations and institutions responsible for the program in the United States, as discussed in the previous section. The remainder of this chapter takes the form of a suggested program for action.

Selection of Hospital

The hospital selected for the location of a training center, besides having the required national standards for the medical and nursing services, should be a teaching hospital, with a School of Nursing, an internship program for doctors, a full-time chaplain, and a teaching program for other professional and technical personnel.

There is now a possibility of establishing such center at the Presbyterian Hospital, where facilities can be utilized to insure adequate training and experience for students. It has a full-time chaplain who is an accredited member of the American Protestant Hospital Chaplains Association. Some members of its staff are connected with the School of Medicine as professors in its different departments. It has the services of psychiatrists, surgeons, physicians, obstetricians, other medical specialists as well as non-medical professional personnel who could help in training the students. It could provide maintenance

for some students. The chaplain and the rest of the staff would be willing to co-operate with the program of the center if it were conducted by a properly trained chaplain-supervisor.

This center would be non-sectarian in its set up, as is the hospital, so that it could provide training for clergymen of all faiths. The Church would be willing to help in carrying on the program of the center, by placing at its disposal all available facilities to insure its efficient function. This is indicated in a recent report of a meeting of hospital chaplains and administrators of the Presbyterian Church in the U. S. A.[1] There is every reason to suppose that the other denominations would show the same spirit, thus contributing toward a successful establishment of the center.

Arrangements should be made with the hospital administrator for the maintenance of the students, towards which the Church bodies recommending the students may be asked to help, as has been said. The supervisor should exert every effort to inform the various members of the hospital staff of his problems, to secure from them the maximum co-operation when needed.

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[1]Division of Welfare Agencies, Report of Meeting of Chaplains and Administrators, Philadelphia, Presbyterian Church in the U. S. A., 1955, pp. 1-3.

Accreditation of Center

To be accredited a Puerto Rican training center would have to meet the requirements set up by national organizations with similar programs, such as the National Conference for Clinical Pastoral Training, which has established standards described in the catalogue of the Council for Clinical Training.[1] These standards would be required of a similar center in Puerto Rico. Members of the Council should visit and study the organization and functioning of the center to see whether it would provide a good situation for training. The Accrediting Committee, after a favorable report, would recommend it as a training center.

Physical Aspects of Center

In addition to the regular facilities in the Institution, the supervisor of the center should be provided with the following services and facilities:

a. Office: An office with the necessary furniture is an essential facility for the supervisor. He may spend part of his time there for study, planning, or interviews with students. It must provide as much privacy as possible.

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[1]Council for Clinical Training, Inc., Clinical Pastoral Training Annual Catalogue, New York, The Council, 1955, pp. 15-16.

b. Secretary: The extent and magnitude of the work demands the appointment of a secretary to the chaplain-supervisor. This secretary can help him in all the clerical work and some of the administration details of the center, leaving him more time for supervision and guidance of the students.

c. Library: A library containing books, magazines, journals, and other literature available in the field should be established. It could be a section of the general medical library of the hospital, or in a separate room near the supervisor's office where it could be more accessible to the students. It should be under the care of the secretary.

d. Conference Room: The lectures, conferences, and discussions, which are a part of any training program, require the availability of a conference room. If there is not enough space in the hospital to provide a separate room for this purpose, arrangements could be made with the medical staff of the center to use their conference room. If the center is established at the Presbyterian Hospital, it could use the facilities of the Westminster Fellowship meeting room near the chapel.

e. Place for Worship: If the hospital does not have a chapel, it should have an appropriate room duly arranged for worship. It would also need an organ, a broadcasting

system, a tape recorder, a set of hymn books, Bibles in sufficient number, and comfortable pews or chairs.

Contact with Mainland Hospital

It is suggested that when the chaplain-supervisor has planned the program and the training center is ready to start its work, he invite an experienced director of a training center in the States to give his co-operation in helping to start the work. In such a case, arrangements may be made so that this experienced supervisor may be released from his post during the time he is in Puerto Rico. Contacts can be made through the organization sponsoring the center, to which he is assigned.

Qualifications of Candidates

The training center should be open to clergymen and to seminary students, but especially to those who have had three years of seminary training. Theological education is a necessary background for clinical pastoral training.

One aspect which must be considered most carefully is that of selecting candidates on the basis of the American standards. Some of the supporting denominations require only two years of college preparation from their candidates for admission in the Seminary. Other require completion of a Bachelor's degree. All candidates must complete three

years of training in the seminary before they are ordained. Fully ordained ministers, who are in good standing with their respective Church bodies and who have had some experience in parish work, could be admitted for clinical training if they meet other requirements.

In addition to academic achievement, Church standing, and experience, there are other qualifications which the students should have. Some of these are: emotional and spiritual stability; a positive attitude towards the hospital situation; the capacity to earn the respect of patients, staff, and students; and evidence of a high degree of personal insight and integrity. If necessary, some screening tests, to be determined later, may be used in order to determine a candidate's adequacy and right attitudes. Explorations should be made with the candidates by presenting them some hypothetical situations and asking them how they would react in such a situation. During interviews with candidates their ability as well as their interest in clinical training should be explored. Consideration should be also given to the success which the candidates may have attained in their parish work, if they are pastors.

It is desirable although not absolutely essential that candidates have some previous experience in teaching.

Basic Course

As soon as the appointed chaplain-supervisor has taken the necessary steps in organizing the program, it should be started with a twelve-weeks' summer session, or two six-weeks' sessions. This course would be the introductory or orientation course, providing the fundamentals of clinical pastoral training. It would be the responsibility of the supervisor to see that the course covers all important phases of the work.

The basic course should consist of the following activities:

a. Readings: The students need to get a complete picture of the clinical pastorate, and as part of their training they must do a great deal of reading. Assignments should be given in books, magazines, and journals, for reading and discussion with the supervisor. He should provide method for evaluating this work of the students.

b. Visits to patients: After a period of orientation the student should be given supervised experience in calling on the patients. He must be asked to take notes on his calls, these notes to be discussed later with the chaplain-supervisor. The establishment of a warm and permissive atmosphere in the sickroom must be emphasized during his training.

c. Frequent meetings with the supervisor: The student should meet with the supervisor as frequently as possible to discuss with him the notes he has written about his calls on the patients. Care must be taken not to assign to new students emotionally disturbed persons or others whose cases may be difficult. The supervisor must keep a close supervision of the student's work in the first part of the training period.

d. Group meetings: The student should also meet with the other students and the supervisor to evaluate his work, and at the same time hear about the experiences of his fellow students. These group meetings provide an opportunity for fellowship. The supervisor can use them to help the students in their growth and to guide them in the process of self-evaluation. Any problems which they may have faced can be discussed by the group and possible solutions may come from the discussion. Suggestions from students as to the teaching-learning situation may be expressed also during these meetings.

e. Lectures by interprofessional staff: A series of lectures should be conducted by the different staff members on their respective fields. A discussion can follow each lecture, giving each student the opportunity to ask questions. The lectures should be centered on the types of illness more frequent in the institutions and the problems

to which they give rise. Surgeons, psychiatrists, anesthetists, and other specialists should take part in this series of lectures, providing the student with an understanding of the different fields represented in the hospital.

f. Seminars: Seminars should be conducted under the leadership of the chaplain-supervisor. Other clergymen from the community may be invited to participate. These seminars must center on the pastoral care of the sick, including such subdivisions as the principles of pastoral counseling, the counseling techniques, the administration of the sacraments to patients, the need of the pastor to understand himself and the patient, and the problems of the minister. They include also the topic of how to apply these principles in the regular parish.

g. Visits to community institutions: A part of the training should result in a knowledge of community agencies in which chaplaincy services are provided or are needed. In these institutions, such as psychiatric hospitals, the leper colony, the tuberculosis hospitals, the penitentiary, and detention homes, the students may observe what is done to meet the spiritual needs of patients or inmates. This activity would give the student a varied experience all of which can be offered him in the Metropolitan Area of San Juan.

Some courses such as those pointed out by Scherzer[1] would be offered through the Evangelical Theological Seminary at the graduate level so that the students could have an adequate background before beginning clinical training. The following courses would be included: The Psychology of Religion, Pastoral Care and Personal Counseling, and An Introduction to Pastoral Care. This would imply changes and additions to the curriculum and staff. But the willingness of the Seminary to do it has been manifested already. The chaplain at Presbyterian Hospital has been invited by the Seminary staff to teach a course on pastoral counseling.

Preparation of Candidate
for Role of Teacher

The proposed program should take into account that the chaplain is often called upon to fulfill the role of teacher. The current full-time chaplain in Puerto Rico is expected to take some teaching responsibility in the School of Nursing at the hospital in which he serves. The chaplain at the Presbyterian Hospital teaches three courses: psychology, sociology, and first aid, as part of his program with the student nurses. In the United States very

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[1]Carl J. Scherzer, The Church and Healing, Philadelphia, The Westminster Press, 1950, p. 245.

few chaplains have teaching responsibility as a regular part of their program, but many of them lecture to the student nurses. In Puerto Rico the chaplain needs to help more in this aspect. The candidates should have some experience in teaching, in order to prepare themselves better for the chaplaincy, especially if they plan to render full-time service in this field. The hospitals where they will work may ask them to help in teaching at their respective schools of nursing. As carefully trained workers they will have a contribution to make in the education of nurses. Besides, some of the Schools of Nursing are understaffed, and the help of the chaplain would be greatly appreciated. If he has not any previous teaching experience, this should be provided during his training.

Provision of Chapel Experience

Chapel services are becoming more and more an essential part in the program of the hospital chaplain. This is not only because of the increasing demands from patients for these services, but also because of team relationships which make it desirable for these services to be available to staff and other personnel.

This experience is different from that which the clergyman or the seminarian may have in their local church. In order to provide the students with this necessary type

of experience in a hospital situation, the supervisor and the other chaplains should give the students the opportunity to share with them the responsibility to lead the services. They should prepare short and interesting services with carefully selected hymns and Scripture readings.

At the Presbyterian Hospital, services are held every Sunday morning, and staff and personnel are welcome to attend. The student training for the clinical pastorate should have experience in religious services in the hospital situation and know how to make them attractive to the sick. For some time the morning chapel for the student nurses at the Presbyterian Hospital was held in the open at the hospital grounds. When the service was changed to the nurses' home many patients who had been hearing it asked whether it could be held again, as before, in a place where they could hear. The Board of National Missions of the Presbyterian Church in the U. S. A. has built the Hildreth Memorial Chapel on the hospital grounds. It was named in memory of Dr. Raymond Hildreth, former medical director of the hospital.

The need for the installation of a local broadcasting system, with individual earphones for all patients, has been pointed out. This facility would help to provide the patients with the opportunity of hearing all religious services held in the institution and some services from

outside. It would also provide a wonderful experience for prospective chaplains at the proposed training center.

Student-Supervision

Only six students should be admitted at a time so as to provide each one with the necessary close supervision. This supervised and carefully guided experience would give the student the understanding that in dealing with the patient he must be more careful in his relationships than when dealing with the average healthy parishioner. With only a small number of students the supervisor is enabled to do more efficient work by helping each one individually.

Student Familiarity with Hospital

The student's familiarity with the work of each department of the hospital should be one of the concerns in the training program. This would show him how to co-operate effectively with the doctors and other staff members. Through his experience he would acquire a working knowledge of the scientific disciplines and become more familiarized with the different types of human disorders. As a result he would be more understanding of the spiritual needs of people in crisis, and better able to meet those needs.

Evaluation

At the end of the first period of training, an evaluation of the total program should be made by the chaplain-supervisor as to the accomplishments of this period, to discover the points of strength and weakness, and the areas which need more emphasis. This evaluation can be of great value in planning future periods of training, and in assuring a growing program.

One important kind of evaluation is for the student to look into his written record of interviews with patients, to ascertain what he had been able to accomplish, and wherein he may have failed. Did he do most of the talking, or did he listen most of the time? Was he directive or non-directive in his interview? How did the patient react during the conversation? This will help the student to grow in his understanding of the patient. A glance at his notes just before he re-visits the patient refreshes his grasp of the situation.

Still another type of evaluation, which may be made by both the chaplain-supervisor and the student, concerns the technique used by the student in his regular calls on his parishioners in their homes or at the hospital. Does he use the directive or the non-directive approach in counseling with them? Does he know what to say and what not to say in the sickroom? Is he aware of the condition

of the patient and of the time he should spend with him? Does he do all the talking or does he listen to the patient's complaints? The answers of these questions in terms of the personnel point of view is of great importance to the clergyman, not only in his contacts during his calls on the sick, but also in his relations with the patient's family.

Advanced Training

Advanced training should be offered to those students who have completed satisfactorily a twelve-weeks' session and who wish further study and practice in clinical pastorate, so as to become full-time hospital chaplains.

IV. CONCLUSION

The proposed program has been suggested in the hope that a number of chaplains can be trained in clinical pastoral work to meet the demands for more adequate personnel in this field in Puerto Rico. There are growing needs for such a ministry to the sick on the Island. Experience shows that when these needs are met effectively, many positive contributions are made to the patients.

Here, then, there is an open field of service to humanity in Puerto Rico. It may be one of the most effective ways to influence, improve and support the lives of

people. They can be reached at any age. A young child's deep impressions of suffering may be interpreted by the understanding clergyman. Or it may be an adolescent whom the chaplain may lead to see clearly and positively the problems of illness and pain. Similarly the chaplain may help older people meet the challenges of life more hopefully. The time is ripe for the start of a broad chaplaincy program in Puerto Rico. The prospects are promising.

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APPENDIX A

Form For the Chaplain's Records

PRESBYTERIAN HOSPITAL

San Juan, P. R.

Office of the Chaplain

Patient's Name .....

Address .....

Age ..... **Room** ..... **Hosp. No.** .....

Religion ..... **Minister** .....

Occupation ..... **Calls** .....

Date Adm. ..... **Date Disch.** .....

Remarks .....

.....

APPENDIX B

Form of Application

AMERICAN FOUNDATION OF RELIGION AND PSYCHIATRY

57 Park Avenue, New York 16, N. Y.

APPLICATION

Name ..... Age .....

Address .....

Denomination .....

Seminary ..... Degree ..... Year ....

Present Position .....

.....

Classroom courses in Pastoral Psychology, Pastoral Counseling, or Pastoral Care:

Course	Seminary of Training Agency	Dates

Courses in Dynamic Psychology, Theory of Psychiatry, etc. (not college psychology courses)

Course	Training Agency	Dates

Participation in Clinical Pastoral Training, full time or part time:

Date	Training Agency	Training Center (Institution)	Chaplain-Supervisor

Date: ..... Signature .....

APPENDIX C

PRESBYTERIAN HOSPITAL
San Juan, P. R.

O.P.D. No. .....

Room
Ward ..... History No. .....

Name ..... Date of birth .....

Address ..... Legitimate .....

Age ... Married ... Widowed ... Single ... Divorced ...
Separated ... Reentry ... Yes / No ...

Sex ..... Race ..... Nativity ..... Occupation ....

Nearest Relative ..... How Related .....

Address ..... Telephone .....

Husband or Wife ..... Address .....

Birthplace .....

Father ..... Birthplace .....

Mother ..... Birthplace .....

Date Admitted ..... A.M. / P.M. .... Date Discharged .... A.M. / P.M.

Physician ..... Telephone ..... Service ...

Remarks .....

Religion ..... Minister .....

Name .....

History No. ..... Period .....

Age ..... Physicians No. .....

Sex ..... Resident or Intern's No. .....

Color ..... Service .....

Month ..... Location .....

Day ..... Autopsy? .....

Consultant's No. ..... Discharge Condition .....

Transferred to .....

Diseases and Nos. .....

.....

Operations .....

MED: REC.COM. .....

APPENDIX D

Form For Chaplain's Office

From MRI ST. LUKE'S HOSPITAL, N. Y. C.

Last Name-First-Middle-Room or Ward-Service-Hospital Number

Admission Date and Hour-Discharge Date and Hour-Register No.

Address-No., Street and Apt.-City-Zone Number-Telephone No.

Birthdate Age Sex Color

Birthplace How long in U. S. In City Naturalized?

| M | S | W | D | SEP. |

Occupation Religion Baptized Check Which

Father's Name Birthplace Mother's Maiden Name Birthplace

Nearest Relative and Relation Address Telephone No.

2nd Relative or Friend Address Telephone

Dr.
Recommended Medically by Provisional Diagnosis Special To

Recommended by (Social Agency or Individual)-Address-

Telephone No.

Last Hospital Admission (Service and Date)-Last Visit to P.P.D.

Transferred to Institution and by Whom ordered-Transfer in Hosp.

APPENDIX E

Notification to Pastor

THE PRESBYTERIAN HOSPITAL IN THE CITY OF NEW YORK

622 West 168th Street--New York 32, N. Y.

Wadsworth 3-2500 Ext. 8286

Name .....

from (Church) .....

is a patient here, in (Unit and Room) .....

and wishes to see you.

Date ..... Chaplain .....