HOSPITAL CHAPLAINCY IN THE CONTEXT OF
RELIGION IN CONTEMPORARY AUSTRALIA

HAZEL ELLIOT

A thesis submitted in fulfilment
of the requirements for the degree of
Doctor of Philosophy

Department of Studies
in Religion

University of Sydney

AUGUST 2000
Copyright in relation to this Thesis

Under the Copyright Act 1968 (several provisions of which are referred to below), this material must be used only under the normal conditions of scholarly fair dealing for the purposes of research, criticism or review. In particular no results or conclusions should be extracted from it, nor should it be copied or closely paraphrased in whole or in part without the written consent of the author. Proper written acknowledgement should be made for any assistance obtained from this material.

Under Section 35 (2) of the Copyright Act 1968 'the author of a literary, dramatic, musical or artistic work is the owner of any copyright subsisting in the work'. By virtue of Section 32 (1) copyright 'subsists in an original literary, dramatic, musical or artistic work that is unpublished' land of which the author was an Australian citizen, an Australian protected person or a person resident in Australia.

The Act, by Section 36 (1) provides: 'Subject to this Act, the copyright in a literary, dramatic, musical or artistic work is infringed by a person who, not being the owner of the copyright and without the licence of the owner of the copyright, does in Australia, or authorises the doing in Australia of, any act comprised in the copyright'.

Section 31 (1) (a) (i) provides that copyright includes the exclusive right to 'reproduce the work in a material form'. Thus, copyright is infringed by a person who, not being the owner of the copyright, reproduces or authorises the reproduction of a work, or of more than a reasonable part of the work, in a material form, unless the reproduction is a 'fair dealing' with the work 'for the purpose of research or study' as further defined in Sections 40 and 41 of the Act.

Section 51 (2) provides that "Where a manuscript, or a copy, of material of other similar literary work that has not been published is kept in a library of a university or other similar institution or in an archives, the copyright in the material or other work is not infringed by the making of a copy of the material or other work by or on behalf of the officer in charge of the library or archives if the copy is supplied to a person who satisfies an authorized officer of the library or archives that he requires the copy for the purpose of research or study'.
ABSTRACT

This thesis examines the entwinement of health and religion through the ages, culminating with an assessment of the present day expectations of the role of general hospital chaplains and the actual tasks being performed by chaplains in specialised medical units. The purpose of this analysis is to gauge whether chaplaincy involvement is an asset to patients and staff in these units.

Medical staff, patients and chaplains were surveyed and their replies statistically assessed for comparisons and dissensions. A number of personal unstructured interviews were conducted with medical staff to ascertain their views of the chaplains’ worth, which showed that, whilst many thought chaplains were beneficial to the patients’ well-being, they were not professionally accepted in the same manner as hospital employed allied health staff. This is partly due to the fact that chaplaincy is a marginal occupation, with chaplains being caught between two loyalties; their religious body and the hospital. They have two identities, but are not central to the key groups, being neither medical nor administrative personnel.

The chaplains’ influence in cost-saving measures and alleviation of stress factors in patients and staff were examined. There were clear indications that, where high chaplaincy involvement occurred in hospitals, patients’ recovery and discharge were accelerated and stress levels reduced; this situation creating a cost-saving by quicker patient changeovers.

The final section of the thesis lists recommended changes to a major part of the hospital chaplaincy system, such as, the establishment of a postgraduate degree course to provide ecumenical training for chaplains following the completion of their individual religious/denominational theological requirements; increased involvement of the laity in hospital chaplaincy; changes to the present funding system so that hospital chaplains are internal to the hospital system; and a more extensive role in post-acute care services, nursing homes, day and outpatients’ departments, geriatric and paediatric units, rehabilitation, disability and dementia units.
ACKNOWLEDGEMENTS

Grateful thanks are expressed to Dr. Victoria Barker for accepting the responsibility of becoming my replacement supervisor upon the retirement of Associate Professor Michael Horsburgh, to whom I also extend appreciation.

Thanks are also due to Dr. Colette Rayment for reading the manuscript and for the encouragement and support received from both Colette and Professor Garry Trompf during my research.

Appreciation is expressed to my son Mark Elliot for believing, and finally convincing me, that I could initially obtain a Bachelor of Arts Degree, which has culminated in this present project.

Appreciation is also extended to the Ethics Committees, Administration Staff, Medical Staff and Pastoral Departments of the following hospitals for their cooperation and support of the thesis:

Royal North Shore Hospital, NSW.
Greenwich Hospital, NSW.
Mount Druitt Hospital, NSW.
Royal Prince Alfred Hospital, NSW.
The Austin Hospital, Victoria.
Princess Alexandra Hospital, Queensland.

This thesis is dedicated to Andrew Harrington who has shown by example that life goes on as normal after a transplantation. He is an inspiration to other young recipients and his achievements and strengths have been an encouragement to me during my research.
TABLE OF CONTENTS

INTRODUCTION

1. THE POSITION OF HOSPITAL CHAPLAINS AT PRESENT 1
   a. The Role of Hospital Chaplains with respect to Australian Hospitals 1
   b. The Division of Clergy and Laity in the Christian Churches 6
   c. The Situation of Hospital Chaplains in Respect of the Churches 6

2. DESCRIPTION OF PROJECT 7

3. CHAPTER OUTLINE 10
   a. The History of the Relation of Religion and Sickness/Medicine 10
   b. Methodology 11
   c. The Expectations of the Role of Chaplains in Three Sydney Hospitals 11
   d. The Expectations of the Role of Chaplains amongst the Religious Hierarchy 13
   e. The Tasks Being Performed by Chaplains in Three Liver Transplant Units 14
   f. Conclusions 16

CHAPTER 1 - The History of the Relation of Religion and Sickness/Medicine

INTRODUCTION 18

1. ANCIENT MEDICINE 25
   a. The Earliest Medical Practices 25
   b. Sumer and Babylonia 26
   c. India 28
   d. Egypt 29
   e. Women in Ancient Medicine 30
2. MEDICINE IN JEWISH AND CHRISTIAN CONTEXTS

a. Jewish Medicine
b. The Early Christian Era
c. The Middle Ages
d. The Emergence of Hospitals
e. The Development of Hospitals in the West
f. The Concept of Both General and Lay Hospital Chaplaincy

3. THE DEVELOPMENT OF MEDICINE IN AUSTRALIA

a. The Sydney Hospital
b. Order of the Sisters of Charity (St. Vincent’s Hospitals)
c. Order of the Josephite Sisters (St. Margaret’s Hospital)
d. Development of the Royal Flying Doctor Service
e. Development of Allied Health Care Workers in Hospitals
f. Spirituality in Nursing
g. Secularisation

4. SUMMARY

CHAPTER 2 - Methodology

BACKGROUND TO SURVEYS

a. Project Aims
b. Survey of Related Studies Concerning Chaplaincy in a Hospital Setting
vi. Surveys Conducted at the Lutheran General Hospital, Illinois to Gauge Changes in Perceived Need, Value and Role of Hospital Chaplains, 1971 and 1981.

75

c. Further Studies Concerning the Role of Faith in Healing

78

i. Crisis Intervention in Orthopaedic Surgery Conducted at Evanston Hospital, Illinois

79

ii. University of Virginia Medical Center Research

81

iii. Rochester Methodist Hospital Cardiac Rehabilitation Unit Research

81

iv. General Literary Discussion

82

d. Hypothesis

87

e. Background to Hospitals Participating in the Surveys

87

i. The Royal North Shore Hospital, St. Leonards, NSW.

88

ii. Mount Druitt Hospital, Mount Druitt, NSW.

88

iii. Greenwich Hospital, Greenwich, NSW.

89

iv. The Austin Hospital, Heidelberg, Victoria

91

v. Royal Prince Alfred Hospital, Camperdown, NSW.

92

vi. Princess Alexandra Hospital, Woolongabba, Queensland

93

f. Participation Selection Method

94

g. Statistical Methods

96

h. Questionnaire Format

96

CHAPTER 3 - Results of Survey Conducted at Three Sydney Hospitals as to the Expected Role of Chaplains

INTRODUCTION

102

1. STATISTICAL RESULTS OF PERSONAL DETAILS

103

2. GENERAL SURVEY RESULTS

114

3. RESPONSES TO SPECIFIC QUESTIONS

117

a. General Role Expectations

117

b. Miscellaneous Questions

128

c. Witness Questions

129
d. Ethical Questions 134
  e. Comforter Questions 139
  f. Counsellor Questions 140
  g. Resource Questions 143
  h. Liturgist Questions 144
  i. Overall Assessment Questions 145
  j. Record of Religious Practices 148
  k. Chaplaincy Visits 152


INTRODUCTION 155

1. GENERAL SURVEY OF RESULTS 155
   a. The Question of the Standards of Chaplaincy in Hospitals 155
   b. The Question of the Use of Christian Laity in Hospital Chaplaincy 158
   c. Expectations of the Role of Hospital Chaplains among the Hierarchy 161

2. RESPONSES TO SPECIFIC QUESTIONS 164
   a. ‘Comforter’ and ‘Witness’ Questions 165
   b. ‘Counsellor’ Questions 166
   c. ‘Resource’ Questions 167
   d. ‘Ethical’ Questions 168
   e. ‘Liturgist’ Questions 169
   f. Suggestions for Additional Chaplaincy Tasks 170

CHAPTER 5 - Survey of Three Liver Transplant Units as to the Actual Tasks Being Performed by Chaplains in Australian Hospitals, July 1994-January 1995.

INTRODUCTION 172

1. LIVER TRANSPLANT UNIT SURVEY 173
2. UNSTRUCTURED PERSONAL INTERVIEWS WITH SELECTED LIVER TRANSPANT UNIT STAFF MEMBERS
   a. The Austin Hospital 185
   b. Princess Alexandra Hospital 188
   c. Royal Prince Alfred 190

3. PATIENTS' LENGTHS OF STAY IN THE THREE SURVEYED LIVER TRANSPANT UNITS 196

4. COST SAVINGS TO GOVERNMENTS AND HOSPITALS CREATED BY REDUCING PATIENTS' LENGTHS OF STAY IN HOSPITAL 198

5. LIVER TRANSPANT UNITS' STAFF SICK LEAVE 199

6. MEASURING THE EFFECTS OF STRESS 201

CHAPTER 6 - Conclusions

INTRODUCTION 204

1. COMPARISONS BETWEEN THE PRESENT RESEARCH AND THAT CONDUCTED PREVIOUSLY BY RESEARCHERS IN AUSTRALIA, NEW ZEALAND AND THE UNITED STATES 206

2. OVERALL SURVEY OF RESEARCH 208

3. RECOMMENDATIONS 214
   a. Theological and Pastoral Education Methods 216
   b. Recommendations for Required Training and Qualifications 221
   c. Recommendations for Extended Chaplaincy Involvement 224
      i. Hospital Day Surgeries and Outpatients’ Departments 225
      ii. Speech Pathology 225
      iii. Post-Acute Care Services (PACS) 225
      iv. Long Term Nursing Home Care 226
      v. Home Visits to People with Physical and Mental Disability 226
      vi. Ministry to Dementia Sufferers 226
      vii. Ministry to Obstetric Patients 227
viii. Paediatric and Geriatric Chaplaincy
ix. Ministry to Rehabilitation Patients
x. Ministry to Transplant Patients and Donor Relatives

d. Recommendations for Increased Lay Chaplaincy Input

e. Recommended Funding Procedures
f. Unit and Set Ward Chaplaincy
g. Ethics Committees
h. Pastoral Lectures to Staff

4. RESEARCHER’S CONCLUDING COMMENTS

BIBLIOGRAPHY

APPENDIXES

I Letter from Nursing Research Advisory Committee, Royal North Shore Hospital
II Letter from Royal North Shore Hospital Ethics Committee
III Letter of Research Approval from Mount Druitt Hospital
IV Letter of Research Approval from Greenwich Hospital
V List of Personally Interviewed Religious ‘Hierarchy’

Requested Personal Details forms forwarded with the ‘Expectations of the Role of Chaplains’ Questionnaires:

VI Consultant Doctors
VII Registrars, Residents, Interns
VIII Nurses
IX Patients
X Chaplains
XI ‘Expectations of the Role of Hospital Chaplains’ Questionnaire
XII Statistical Data Relating to Section 2
XIII Liver Transplant Unit Survey Form
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>XIV</td>
<td>Liver Transplant Survey Answers to Questions 1(a); 1(e) ii; 2(b);</td>
<td>276</td>
</tr>
<tr>
<td></td>
<td>2(c); 2(d).</td>
<td></td>
</tr>
<tr>
<td>XV</td>
<td>Interview with Dr. Bob Jones, Director of The Austin Hospital LTU</td>
<td>281</td>
</tr>
<tr>
<td>XVI</td>
<td>Interview with Ann Heydon, Theatre Nurse at The Austin Hospital</td>
<td>282</td>
</tr>
<tr>
<td>XVII</td>
<td>Interview with Pam Wilton, Clinic Nurse, The Austin Hospital LTU</td>
<td>283</td>
</tr>
<tr>
<td>XVIII</td>
<td>Interviews with Senior Nursing Staff of The Austin Hospital Transplant Wards</td>
<td>284</td>
</tr>
<tr>
<td>XX</td>
<td>Comments pertaining to Chaplaincy made by Patients and Relatives of The Austin Hospital LTU</td>
<td>288</td>
</tr>
<tr>
<td>XXI</td>
<td>Interview with Graham Kyd, Transplant Co-ordinator, Royal Prince Alfred Hospital LTU</td>
<td>290</td>
</tr>
<tr>
<td>XXII</td>
<td>Interview with Beth Cambridge, Social Worker, Royal Prince Alfred Hospital LTU</td>
<td>291</td>
</tr>
<tr>
<td>XXIII</td>
<td>Interview with Dr. Ron Gribble, Psychiatrist, Royal Prince Alfred Hospital LTU</td>
<td>292</td>
</tr>
<tr>
<td>XXIV</td>
<td>Interview with Andrew Harrington, Patient, Royal Prince Alfred Hospital, LTU.</td>
<td>293</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lutheran General Hospital - 5 Major Roles of Chaplains</td>
<td>76</td>
</tr>
<tr>
<td>2</td>
<td>Completed surveys returned at Royal North Shore, Mount Druitt and Greenwich Hospitals combined by groups</td>
<td>103</td>
</tr>
<tr>
<td>3</td>
<td>Completed surveys returned at RNSH, MDH, and GH, combined by sex</td>
<td>103</td>
</tr>
<tr>
<td>4</td>
<td>Completed surveys returned at RNSH, MDH, and GH, combined by religion</td>
<td>104</td>
</tr>
<tr>
<td>5</td>
<td>Completed surveys returned at RNSH, MDH, and GH, combined by denomination of Christians</td>
<td>105</td>
</tr>
<tr>
<td>6</td>
<td>Comparison of National Census and the present Survey figures relating to denominations</td>
<td>105</td>
</tr>
<tr>
<td>7</td>
<td>Completed surveys returned at RNSH, MDH, and GH, combined by age</td>
<td>106</td>
</tr>
<tr>
<td>8</td>
<td>Returned surveys per hospital</td>
<td>106</td>
</tr>
<tr>
<td>9</td>
<td>Returned surveys per hospital by groups</td>
<td>106</td>
</tr>
<tr>
<td>10</td>
<td>Returned surveys per hospital by sex</td>
<td>107</td>
</tr>
<tr>
<td>11</td>
<td>Groups’ break-up of all participants by sex</td>
<td>107</td>
</tr>
<tr>
<td>12</td>
<td>Groups’ break-up of all participants by age</td>
<td>107</td>
</tr>
<tr>
<td>13</td>
<td>Groups’ break-up of all participants by religion</td>
<td>108</td>
</tr>
<tr>
<td>14</td>
<td>Groups’ break-up of Christian denominations</td>
<td>108</td>
</tr>
<tr>
<td>15</td>
<td>Cross reference of combined hospitals by Christian denominisations and age</td>
<td>109</td>
</tr>
<tr>
<td>16</td>
<td>Cross reference of Christians by denomination and individual hospitals</td>
<td>109</td>
</tr>
<tr>
<td>17</td>
<td>Cross reference of Christian denominations/no religion and Patients/Doctors/Nurses</td>
<td>110</td>
</tr>
<tr>
<td>18</td>
<td>Cross reference of Patients/Doctors/Nurses by age and no religion/religion</td>
<td>110</td>
</tr>
<tr>
<td>19</td>
<td>Cross reference of Patients/Doctors/Nurses by hospital and no religion/religion</td>
<td>110</td>
</tr>
<tr>
<td>20</td>
<td>Break-up of Chaplains by sex</td>
<td>110</td>
</tr>
<tr>
<td>Table 21</td>
<td>Break-up of Chaplains and Extra Chaplains by hospital</td>
<td>111</td>
</tr>
<tr>
<td>Table 22</td>
<td>Cross reference of Chaplains by hospital and denomination</td>
<td>111</td>
</tr>
<tr>
<td>Table 23</td>
<td>Cross reference of Extra Chaplains by hospital and denom.</td>
<td>112</td>
</tr>
<tr>
<td>Table 24</td>
<td>Cross reference of Chaplains by denomination and sex</td>
<td>112</td>
</tr>
<tr>
<td>Table 25</td>
<td>Cross reference of Chaplains by age and denomination</td>
<td>112</td>
</tr>
<tr>
<td>Table 26</td>
<td>Break-up of Chaplains and Clinical Pastoral Education Students by sex</td>
<td>113</td>
</tr>
<tr>
<td>Table 27</td>
<td>Break-up of Chaplains and CPE Students by religion</td>
<td>113</td>
</tr>
<tr>
<td>Table 28</td>
<td>Break-up of Chaplains and CPE Students by denomination</td>
<td>113</td>
</tr>
<tr>
<td>Table 29</td>
<td>Break-up of Chaplains and CPE Students by age</td>
<td>114</td>
</tr>
<tr>
<td>Table 30</td>
<td>Break-up of Chaplains and CPE Students by hospital</td>
<td>114</td>
</tr>
<tr>
<td>Table 31</td>
<td>Question 2 - Combined Patients/Doctors/Nurses by hospital</td>
<td>119</td>
</tr>
<tr>
<td>Table 32</td>
<td>Question 2 - Combined Patients/Doctors/Nurses by Christian denomination</td>
<td>120</td>
</tr>
<tr>
<td>Table 33</td>
<td>Question 3 - Group percentages</td>
<td>121</td>
</tr>
<tr>
<td>Table 34</td>
<td>Question 5 - Group percentages</td>
<td>122</td>
</tr>
<tr>
<td>Table 35</td>
<td>Question 5 - Patients/Doctors/Nurses percentages by hospitals</td>
<td>123</td>
</tr>
<tr>
<td>Table 36</td>
<td>Question 7 - Overall Groups</td>
<td>125</td>
</tr>
<tr>
<td>Table 37</td>
<td>Question 7 - Patients/Doctors/Nurses by hospitals</td>
<td>125</td>
</tr>
<tr>
<td>Table 38</td>
<td>Comparative figures for Questions 8 and 9</td>
<td>127</td>
</tr>
<tr>
<td>Table 39</td>
<td>Question 26 - Groups</td>
<td>133</td>
</tr>
<tr>
<td>Table 40</td>
<td>Question 26 - Christian denominations</td>
<td>133</td>
</tr>
<tr>
<td>Table 41</td>
<td>Question 34 - Groups</td>
<td>136</td>
</tr>
<tr>
<td>Table 42</td>
<td>Question 35 - Groups</td>
<td>137</td>
</tr>
<tr>
<td>Table 43</td>
<td>Question 23 - Groups</td>
<td>140</td>
</tr>
<tr>
<td>Table 44</td>
<td>Question 41 - Groups</td>
<td>141</td>
</tr>
<tr>
<td>Table 45</td>
<td>Question 42 - Groups</td>
<td>142</td>
</tr>
<tr>
<td>Table 46</td>
<td>Question 42 - Hospitals</td>
<td>142</td>
</tr>
<tr>
<td>Table 47</td>
<td>Question 51 - Groups</td>
<td>146</td>
</tr>
<tr>
<td>Table 48</td>
<td>Question 51 - Denominations</td>
<td>147</td>
</tr>
</tbody>
</table>
Table 49  Question 51 - Combined Chaplains' figures  147
Table 50  Questions 53/54 - Do you/did you ever attend church?  149
Table 51  Questions 53/54 - Groups  150
Table 52  Questions 53/54 - Denominations  151
Table 53  Number of Patients and Number of Days Hospitalised in the Liver Transplant Unit at Princess Alexandra Hospital  196
Table 54  Number of Patients and Number of Days Hospitalised in the Liver Transplant Unit at The Austin Hospital  196
Table 55  Number of Patients and Number of Days Hospitalised in the Liver Transplant Unit at Princess Alexandra Hospital  197
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHWCA</td>
<td>Australian Health and Welfare Chaplains’ Association</td>
</tr>
<tr>
<td>CPE</td>
<td>Clinical Pastoral Education</td>
</tr>
<tr>
<td>DGR</td>
<td>Diagnostic Related Group</td>
</tr>
<tr>
<td>GCRP</td>
<td>Good Clinical Research Practice</td>
</tr>
<tr>
<td>GH</td>
<td>Greenwich Hospital</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immune Deficiency</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IVF</td>
<td>In-Vitro Fertilization</td>
</tr>
<tr>
<td>LTU</td>
<td>Liver Transplant Unit</td>
</tr>
<tr>
<td>MDH</td>
<td>Mount Druitt Hospital</td>
</tr>
<tr>
<td>MREC</td>
<td>Medical Research Ethics Committee</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NRAC</td>
<td>Nursing Research Advisory Committee</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>QLD</td>
<td>Queensland</td>
</tr>
<tr>
<td>PACS</td>
<td>Post Acute Care Service</td>
</tr>
<tr>
<td>PAH</td>
<td>Princess Alexandra Hospital</td>
</tr>
<tr>
<td>RNSH</td>
<td>Royal North Shore Hospital</td>
</tr>
<tr>
<td>RPA</td>
<td>Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>The Austin</td>
<td>The Austin Hospital</td>
</tr>
</tbody>
</table>
## RELIGIOUS DENOMINATION ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANGLICAN</td>
<td>The Anglican Church of Australia</td>
</tr>
<tr>
<td>BAPTIST</td>
<td>The Baptist Church of New South Wales</td>
</tr>
<tr>
<td>CATHOLIC</td>
<td>The Catholic Church</td>
</tr>
<tr>
<td>JEWISH</td>
<td>The Jewish Orthodox Church</td>
</tr>
<tr>
<td>PRESBYTERIAN</td>
<td>The Presbyterian Church in New South Wales</td>
</tr>
<tr>
<td>SA</td>
<td>The Salvation Army</td>
</tr>
<tr>
<td>SDA</td>
<td>Seventh-Day Adventist</td>
</tr>
<tr>
<td>UNITING</td>
<td>The Uniting Church in Australia</td>
</tr>
</tbody>
</table>
INTRODUCTION

1. THE POSITION OF HOSPITAL CHAPLAINS AT PRESENT

a. The Role of Hospital Chaplains with Respect to Australian Hospitals

A brochure produced by the NSW Civil Chaplaincies Advisory Committee the representative Church body which functions as the negotiating body between the Churches, Government and Institutions, sets out the required standards for health services, chaplaincy and pastoral care. This brochure states that ‘chaplains work closely with other members of the health team in particular units and become known to and trusted by staff and patients’. Under the heading of ‘The Chaplain’s Ministry’ there is also a list of requirements of the chaplain’s tasks: ‘staff support’; ‘consultation with staff on pastoral, ethical and theological questions of treatment and patient morale’; ‘fellowship and support programmes’ and ‘pastoral care and counselling for patients and relatives’. The brochure continues: ‘While appointed by their own particular religious bodies, chaplains collectively represent all the faiths and work together to meet the pastoral needs of all patients, staff and others connected with the hospital or health service’. Similar standards have been set by ruling bodies in other states and also by the Australian College of Chaplains. Most hospital chaplaincy Policy and Procedure Manuals include passages concerning additional tasks expected of chaplains, similar to the following, penned by an administrator of Westmead Hospital: ‘The chaplains are also available to be with and support the patient’s relatives and the hospital staff in facing the suffering, trauma and pain that injury and death expose’.

It is difficult to assess generally whether chaplains see themselves as staff. Chaplaincy is a marginal profession with one foot in the medical world and the other in the religious world. The attitude of a specific hospital would influence a chaplain’s view of their own individual staff status. At one Sydney hospital the officially appointed chaplains wear a blazer bearing an insignia of the hospital which identifies them to both the staff and patients. This step would certainly encourage patients and staff to see chaplains as authorised members of the hospital, and so also the chaplains themselves. However, at this same hospital, the trained and experienced voluntary chaplains (both lay and ordained) do not wear the blazers, only an identification tag, and this would surely discourage them from considering themselves as hospital staff, despite the fact that many are performing the same or similar duties to the officially appointed chaplains. These voluntary chaplains would not be as readily recognised by the medical staff and patients and may not be as readily accepted at a bedside.
Chaplains at most other hospitals wear no special uniform (unless an ordained minister) and this may be their preference, indicating a desire to preserve their religious status before a hospital one. In a marginal profession, this failure of self-identification could have a detrimental effect, with one strand of the profession having difficulty in recognising another. Whilst social workers, physiotherapists, and other allied health workers may not wear a uniform, they are employed by the hospital and recognised as part of the hospital team; most chaplains are not. The fact that chaplains are treated differently by different hospitals shows the inconsistency of chaplaincy and adds to the confused status expectations of chaplains in the eyes of patients, staff and the chaplains themselves. The Health and Welfare Chaplains Association and the above-mentioned College of Chaplains hold meetings and conferences at which chaplains have the opportunity to discuss their ministry with each other. However, indications are that more interaction between the chaplains and other medical disciplines is warranted.

b. The Division of Clergy and Laity in the Christian Churches.

In order to understand the situation with regard to lay chaplains, the division of clergy and laity in the Christian Church needs to be clarified. The word ‘lay’ has a number of connotations. In modern secular parlance it tends to refer to a person who is ‘unqualified to speak or judge in various fields of knowledge or science’. However, the expert/non-expert interpretation of lay becomes more complex in relation to religious lay workers, who may have substantial formal training or no training at all. When discussing the religious lay, three aspects have to be considered: the interpretation of the theological word ‘laos’; expert/non-expert workers; and ordained/non-ordained persons.

The terms ‘lay’ and ‘laity’ are derived from the Greek word ‘laos’, which refers to the ‘people of God’. It is difficult to draw a clear distinction between clergy (priests) and the laity in the New Testament, as indications are that they hold one common priesthood as the ‘laos’ of God, though they do have different and complementary gifts and ministries. The universality of ministry, the concept that everyone has a gift, is stated explicitly by Paul in Corinthians 7:7; Ephesians 4:7; 1 Peter 4:10; and most clearly in Romans 12:3. Whilst Paul is concerned that all ministry is universal and that all gifts have the same source, each in its place and of the same value, a number of New Testament passages do refer to the laying on of hands in what could refer to some form of service of ordination or related act (e.g. 1 Timothy 4:14 and 2 Timothy 1:6-7). Other texts in the New Testament, in particular 1 Cor.12,

---

do however indicate that a charismatic type of ministry was being advanced, which suggests that many apostles, prophets, teachers and evangelists were lay people. (Eph.4:11). This supports the view of Hendrik Kraemer that the Christian Church began its journey through the ages by the witness and activity of the laity. 2 There is no doubt that Paul was aided by a large number of ‘common’ helpers and that many of these were women. This is substantiated in Acts 18:18 where Paul speaks of Priscilla; in Acts 21:9 when Paul stayed in Caesarea at the home of Philip the evangelist who had four unmarried daughters who prophesied; and in Romans 16:1-15 which makes mention of Phoebe, a servant of the church in Cenchrea and Priscilla, Mary, Tryphena, Tryphosa, Persis and Julia, all women ‘lay’ workers of the early church. This substantiates the claim that lay people played a significant role in the life and witness of the church in the New Testament, wherein the emphasis is on functions and vocations rather than on offices. 3

With the modern emphasis on titles and degrees, one often overlooks the fact that many of the original theological thinkers, the Great Church Fathers, were actually very knowledgeable laymen. Tertullian, Cyprian and Augustine belong to this category. Kraemer expresses the rarely recognised fact that:

Cyprian and Augustine having become bishops so to speak by surprise were essentially, by their whole education and long secular careers, laymen. Their position as Church Fathers has put them so forcefully in the theological, non-lay category, that the simple truth of their being thinking Christian laymen is entirely forgotten or ignored. 4

Gradually, but unevenly, the laity came to be defined negatively as non-clergy. John Howard Yoder states defensively that this negative definition of the laity did not derive from the original concept of the biblical word ‘laos’:

There is no concept of laity in the negatively defined sense as ‘those with no ministry’. The people (laos) includes all the ministries. The bishop is a member of the laity just like everyone else. The use of the word ‘lay’ to mean non-minister is heretical, and arises only generations later. 5

Although some sects such as the Quakers admit no distinction at all between their members, the most marked distinction between the laity and clergy comes from within Roman Catholicism. The Church of England has been a little more flexible in later years, allowing the laity more deliberation concerning the universal Church

---

2 Kraemer, op.cit., p.16.
3 Ibid., p.20.
4 Ibid., p.20.
administration and financial matters, together with more involvement at a local parish level.6

For many years, the relationship between the laity and clergy has not been a smooth one. Mark Gibbs notes that by medieval times differences between the clergy and lay people had developed, with the functions of the clergy being considered superior to the ministry administered by the lay people.7 The authority of bishops and priests has been questioned by lay people, causing dissension in some churches. This occurred, for example, in 1980 when the laity expressed disagreement with the resolutions of the Roman Catholic National Pastoral Congress in Liverpool, England. The difficulties that clergy and laity have in working together is experienced in both the Catholic and Protestant Churches. It is exacerbated in cases where the laity have received a higher formal education than the clergy. Such a situation obtains in many African churches, for instance.8

Early in the twentieth century, the Church of England began to relax its stance concerning the status of the laity and, by 1919, The National Assembly of the Church of England had been formed to discuss matters pertaining to the church. This Assembly contained a House of Bishops, House of Clergy, and a House of Laity, elected every five years by the representative electors of the Diocesan Conferences. In 1948, a fusion of the former Ecclesiastical Commission and Queen Anne’s Bounty took place and a new form of Church Commissioners were elected to manage the estates and revenues of the Church of England; again members of the laity were included amongst these Commissioners.9

Despite much hesitation and argument, the document Lumen Gentium (The Constitution of the Church), produced by Roman Catholics during the Second Vatican Council which commenced in 1962, strongly endorsed the view that God, clergy and laity are one together. In answer to the question ‘who are the lay faithful?’ the Council considered that they went beyond the predominantly negative interpretations of the past by stressing an intention basically to recognise the laity as fully belonging to the Church, at the same time accepting the uniqueness of their vocation.10 It is widely

8 Ibid., p.319.
10 Second Vatican Ecumenical Council, Dogmatic Constitution on the Church, Lumen Gentium, 31.
held, however, that the document clearly implies that the role of the priests is more important than that of the role of God’s people in the form of the laity.  

In 1987, a Synod of Bishops was held to discuss the topic: Twenty years after the Second Vatican Ecumenical Council. This was attended and recorded by Pope John Paul II, and again a distinction was made between those in Holy Orders and the lay faithful who have been Baptised and Confirmed. This distinction may still be seen as denigrating the laity; it may also be interpreted as giving a clear explanation of clerical and lay roles in the Church. Whilst many of the functions carried out by the clergy may be performed equally as well by a lay person, the role factor must not be forgotten. The clergy, upon receiving their Holy Orders, devote their lives solely to the one purpose of serving the Lord and the Lord’s people; with the exception of Monastical and similar religious Orders, the laity remain in the secular world. This is the world of secular professions and occupations, forming partner relationships, raising and educating children, joining societies and social clubs; the laity are not called to abandon the position they hold in the world.

The Synod of Bishops also discussed the role of women in the Church and, whilst the Catholic belief is that women cannot receive the Sacrament of Orders to become priests, those attending the Synod were reminded of the words spoken in 1975 by Pope Paul VI:

We cannot change what our Lord did, nor his call to women; but we can recognise and promote the role of women in the mission of evangelisation and in the life of the Christian community.

Towards the end of the meeting, the Synod Fathers invited priests and candidates for Orders to be carefully prepared to encourage the vocations and mission of the laity, whilst the laity were asked to do their part in helping priests in their spiritual and pastoral lives. If this principle were to be followed in practice by all Church bodies, there would presumably be less controversy arising at the parish level.


13 Ibid., pp.36/7 & 61.


15 Pope John Paul II, op.cit., p.165.
However, the role of the ordained clergy is ambiguous and diverse, and it is reasonable to maintain that many are not qualified to perform some of the tasks which may be expected of them by present day congregations. It would seem that now, more than ever, members of the congregation should be utilising their specific gifts and educational knowledge. Clear comments on this subject are expressed by Yoder in the following passage:

When in our day the congregation is made up of persons of a host of different educational and professional, social and psychological characteristics, the normal consideration of aptness for tasks should call for a greater scattering of types and assignments of roles, rather than for concentrating most functions in the hands of one person who, by virtue of his own education, and even more by virtue of his unique job, does not share a common background or occupation with anyone in his or her congregation.16

With the congregation performing many and varied tasks associated with the running of a parish, the religious term ‘lay worker’ is often misinterpreted. A person may be an expert at performing a particular task in the church, but may not possess any formal theological training, Whilst another may be extremely qualified, obtaining degrees and specified training, but not receive ordination.

c. The Situation of Hospital Chaplains in Respect of the Churches

The majority of hospital chaplains are appointed by their individual religious bodies to represent that body in a particular hospital, with the approval of the hospital’s administration. A number of these approved chaplains are paid a salary by their religious body, whilst others, minister in a voluntary capacity. Whether ministering in a paid or voluntary capacity, chaplains must attain a required level of expertise set by their religious body before authority to act as a chaplain is granted. A problem with this method of selecting chaplains is that no consistency exists between the required standards of each individual religious body. The standards set by the Australian College of Chaplains and the Health and Welfare Chaplains Association act as a guide for hospital administrators to ensure chaplains are fulfilling their ministry in a satisfactory manner. Membership of the above associations is not compulsory and many chaplains minister comparatively independently of supervision. Some workers in hospital ministry act in a lay or voluntary capacity as assistants and are directly responsible to an officially appointed chaplain of their religious body. It is not possible, however, for hospital administrators or chaplain supervisors to monitor assistant chaplains at all times and it is recommended that respective religious bodies

16 Yoder, op.cit., pp.74/5.
seriously consider appointing additional qualified chaplains. These could be recruited from the laity or from ordained clergy: Hospital chaplaincy requires specific training and whilst, if not ordained, a chaplain is referred to as ‘lay’, this term has a connotation different from that pertaining to theologically untrained church workers or experts in another field who might assist in the church. As in the past, an effective ministry to the sick can be achieved without the need of ordination.

In many cases, individual religious bodies do not allocate sufficient funds to employ the required number of hospital chaplains. The major Christian denominations often allocate only one, sometimes two, paid chaplains to minister in large public hospitals. This could result in patients, relatives and staff not receiving the help they need, or the chaplain being left to recruit the services of voluntary assistants. In a small number of cases, hospitals or, as in the case of the researcher, an individual church may partly or fully finance chaplains, whilst Government funding is also made available for Psychiatric Hospital Chaplains and Prison Chaplains.

2. DESCRIPTION OF PROJECT

The aim of this project is to determine what patients, doctors, nurses and chaplains themselves, expect from the hospital chaplain’s role, then to analyse the results for major differences and try to assess any changes which may be relevant now or in the future. The specific aims are: to assist hospital chaplains to become aware of the expectancies which other relevant groups have of them; to assess how doctors and nurses perceive the overall value of the chaplain’s role to themselves and patients; to assess patient expectancy of the chaplain’s role; to assess how the role definition held by chaplains themselves may differ from the expectations of other relevant groups; and to assess whether chaplains are agreed on their role priorities. Very little research of this type has previously been conducted in Australia and with the world-wide changing climate of medical provision created by advanced technology; the increasing trend by hospitals to utilise the expertise of allied health professionals, such as psychologists, social workers, grief counsellors, special counsellors for medical staff, Aboriginal patients, HIV/AIDS patients and others; more outpatient and short stay wards being utilised in hospitals which has encouraged a move towards community services outside of medical institutions, such as district nursing, home care, meals on wheels, respite aid for family carers, and patient transportation, research into the role chaplains are expected to play, and research into whether they are accepted as a part of the hospital team, is deemed necessary. It is important that the hospital chaplain’s role is
ascertained at this time to determine where it fits into the changing conditions of medical advancement.

This research took the form of three separate surveys conducted at six hospitals in three Australian States. Participants taking part in two of the surveys were randomly selected, regardless of sex, age, race, religion, denomination or church attendance, with the other survey participants being specifically chosen. All the surveys were conducted personally by the researcher, with assistance being given by the chaplains departments attached to the participating hospitals. Authority to conduct this research was obtained from the Ethics Committees of the relevant hospitals. The School of Studies in Religion at the University of Sydney considered that the intensive scrutiny, and ultimate acceptance, by the hospitals for the research to proceed was sufficient and further permission was not sought from the University Ethics Committee.

The first survey was conducted at three New South Wales hospitals to ascertain the expectations of the role of chaplains by patients, medical staff and chaplains: The second survey was conducted in order to obtain both written and verbal views from selected hierarchical members of eight major religious bodies, regarding the chaplaincy situation as it applied to their individual religion/denomination: The third survey was conducted to ascertain from staff how, and to what extent, chaplains were actually involved in three Liver Transplant Units in Victoria, New South Wales and Queensland. The third survey became necessary when the first two did not yield conclusive results as to chaplaincy expectations. In many instances, this was because the groups as a whole and individuals within each group, responded differently to the research questions, indicating confusion and lack of knowledge of chaplaincy. The third survey was conducted to allow the researcher to assess whether the medical staff attached to the three Liver Transplant Units concurred with one another as to what the chaplain in their Unit actually did and the level at which they were accepted as part of the Unit team. The methods used to conduct the above surveys were similar to those adopted by a number of United States researchers, in particular Raymond G. Carey, as outlined in his research on ‘Change in the Perceived Need, Value and Role of Hospital Chaplains’.17

It was expected that the Australian research would indicate differing chaplaincy expectancy from the patients, medical staff and chaplains. The expectation was that patients would concentrate on the relief of fears and anxieties, that the chaplains would make them feel better, with the staff responses being more orientated

---

to institutional aspects, such as the contribution of chaplains to the running of the hospital. The chaplains were expected to place emphasis on intrinsic values, such as representing and creating good in itself. These assumptions were correct with respect to the patients and chaplains, whilst the staff, in most cases, held the view that the chaplains’ value was in comforting the patients rather than in contributing to the general running of the hospital.

The null hypothesis for this study is that there will be no differences between the various groups of respondents in respect of their answers to the questions regarding role expectations for hospital chaplains. This hypothesis is proved correct regarding questions pertaining to the comfort of patients. The majority of participants from all groups considered that the primary role of the chaplain was to show care, compassion and kindness, to discuss patients’ fears and anxieties, also to assist patients and relatives during a crisis and help them to face death when necessary. There was also a high level of agreement concerning the chaplain’s role as a witness of God’s love and concern, and as a prayer intercessor. However, agreement did not follow through to questions regarding ethics, where inconsistency was found between individuals and groups as to their expectancy that chaplains would have access to patients’ medical records, consult with medical staff on ethical issues such as abortion, IVF and life support systems, and to counsel patients on these issues. Inconsistency, to varying degrees, existed in other sections of this ‘Expectations of the Role of Hospital Chaplains’ survey; these will be discussed fully in Chapter 3.

It was anticipated that the chaplaincy expectations held by the religious hierarchy regarding their own religious/denominational chaplains would differ in some areas. The hierarchy were, however, expected to respond in a similar manner to their own chaplains, but this was not the case; the hierarchy frequently answered differently from their chaplains and to participants from other groups. It was further expected that the hierarchy would hold realistic views as to the accepted status of chaplaincy, both in the Church and the hospital structure. It was found, however, that the hierarchy held an exaggerated view of the status of the chaplaincy, a status that was not always reflected by the research results. Indications were that at least some of the hierarchy were confused and unaware, or unwilling to concede, that problems may exist in the present hospital chaplaincy system in Australia.

As the inconsistency and confusion amongst participants of the first two surveys was so high, the final survey was conducted amongst the medical staff of the three specialist Liver Transplant Units, to gain their views of the chaplaincy input and the chaplain’s value to their specific Unit. The intention of this survey was to ascertain the actual ministry being performed by the chaplain, rather than defining their expected role. The expectation was that the three similar units would record similar responses.
This expectation was not substantiated; each of the three units adopted a different system regarding chaplaincy input, giving the researcher the opportunity to compare the methods utilised in each and to assess whether one method was preferable to another. The length of time patients were hospitalised in each individual unit, over a five year period, was calculated, showing that the Unit utilising the highest chaplaincy involvement recorded a considerably better patient discharge rate, irrespective of variables. Recommended changes to the present Australian hospital chaplaincy system have been made by the researcher, based on the successful discharge rate of this Unit, together with recommendations regarding funding, training/qualifications, the formulation of a postgraduate degree course and suggested incentives to raise the status and prestige of hospital chaplains.

3. CHAPTER OUTLINE

a. The History of the Relation of Religion and Sickness/ Medicine

The purpose of this chapter is to show that hospital chaplaincy is not a recent development; religion and medicine have been interconnected since the first mention of the demigod Imhotep in the 28th century BC. It needs to be understood that religion has not simply been an ‘added extra’ in the historical medical process, but accepted as an actual facet of healing. With the increasing changes in technology and medical procedures it is important, for the survival of hospital chaplaincy, that this history is known and the entwinement of religion and medicine continued. The chapter follows the cult of Asclepius, named after the Greek God of healing, and explains the early forms of Greek temple worship. Early medical practices involving magic, totem and tabu and archaic religious rituals performed by tribal societies are discussed, moving on to the history of medicine in Sumer and Babylonia, India and Egypt.

The chapter notes that women were intimately involved in ancient medicine, with three early women healers, Elephantis, Salpe and Sotira, being praised by Pliny the Elder. The works of prominent physicians and early medical writers, such as Hippocrates, Galen, Celsus and Aretaeus, are shown to have been the forerunners to modern medicine, and the progression of medicine in both the Jewish and Christian contexts, covering both the Old and New Testament biblical times, is included to emphasise the involvement of medicine and religion during those periods.

The chapter outlines the emergence of hospitals, noting the many elaborate and advanced medical institutions which were founded in the Byzantine Empire and the 4th century AD medical institutions founded by Basil of Caesarea, Gregory of Nyssa and John Chrysostom, together with the development of hospitals in the west. The
history follows through to the 17th century London hospitals of St. Bartholomew’s and St. Thomas’. The contribution to nursing made by Florence Nightingale was found to have greatly influenced the nursing profession in Australia in later years.

The chapter also covers the history of the Sydney Hospital, outlining the problems experienced by Matron Lucy Osburn when non-Church of England nurses objected to attending services in the Infirmary Oratory. The prominence of Catholic hospitals was found to be largely due to the Order of the Sisters of Charity and the Order of the Josephite Sisters, the former founding a number of St. Vincent’s Hospitals Australia-wide, with the latter being responsible for St. Margaret’s Hospital, Darlinghurst. The chapter gives an overview of the Royal Flying Doctor Service established by Rev. John Flynn in 1928. It was found that there has always been a strong connection between religion and medicine in this Service. The final sections of the chapter deal with the development of allied health care professionals in hospitals, Spirituality in nursing, and secularisation.

b. Methodology

This chapter covers the methodology used for the conduction of all surveys.

c. The Expectations of the Role of Chaplains in Three Sydney Hospitals.

This chapter records the results of the Survey of Three Sydney Hospitals as to the expectations of the role of Chaplains. The survey sought to determine what randomly selected groups of patients, doctors, nurses and chaplains expected from the chaplain’s role. The aims of the survey were plural: to raise the chaplains’ awareness of what others expected from them; to assess how doctors and nurses perceived the overall value of the chaplains to themselves and the patients; to assess patient expectancy of the chaplains; to assess any differences in the role definition chaplains held themselves and that of the other groups; and to assess whether chaplains were in agreement with each other concerning their role priorities. The intention was to make chaplains aware of any indication that changes to their role may be warranted.

The survey was conducted in Sydney at the Royal North Shore Hospital, Greenwich Hospital and Mount Druitt Hospital, with the approval of the respective Ethics Committees. The participants were randomly selected patients, senior and junior doctors, nurses and chaplains from these three hospitals. Additional chaplains being invited to participate from Westmead, Hornsby and St. Vincent’s Hospitals. This was deemed necessary due to the small sample of chaplains available from the original participating hospitals. Of the 601 questionnaires distributed, 461 (76.8%) were returned. The participants were invited to complete a 55 question survey in an anonymous capacity, with questions pertaining to personal details, such as, age, sex,
religion, denomination and position held at the hospital being completely optional. No names were requested and participants’ completion of the questionnaire was considered to be their agreement to participate. Patients who were able to complete the questionnaire by themselves did so; others who had difficulty writing were assisted by the researcher or by a relative. The majority of the medical staff were handed their questionnaires by the researcher personally and collected in the same manner; the remainder were distributed and collected by the hospital chaplaincy departments or administrative staff.

For simpler statistical analysis, the survey questions were categorised into 11 groups, under the following headings:

* ‘General Role Expectations’ - these were questions referring to participants’ knowledge of chaplains, whether they knew that hospital chaplains exist, whether they expected them to be male or female, the type of training they expected chaplains to have received.

* ‘Miscellaneous’ - these were questions which did not apply to other categories, such as, the chaplain’s access to patients, whether the chaplain’s visit was considered advantageous to patients’ well-being.

* ‘Witness’ - questions under this heading reflected the chaplain as a witness of God’s love, covering the subjects of prayer and faith.

* ‘Ethical’ - this covered a range of ethical questions, including whether chaplains were expected to have access to patients’ records, whether they should liaise with staff concerning ethical issues, whether the chaplain was expected to be consulted concerning issues such as abortion, IVF or life support decisions.

* ‘Comforter’ - this encompassed all questions pertaining to the expectation that chaplains would show care, compassion and kindness, that they would be available to listen to patients when necessary, offer help during times of crisis and generally ‘be there’ when needed.

* ‘Counsellor’ - this covered the aspect of the chaplain as a Pastoral Counsellor, incorporating questions relating to staff work and personal problems, and questions concerning whether the chaplain is expected to help examine a patient’s lifestyle, such as smoking, drinking or worrying.

* ‘Resource’ - this covered questions relating to the expectation that the chaplain would act as a liaison person between the patients and medical staff, liaise with a patient’s parish clergy or conduct pastorally related lectures for the staff.
* ‘Liturgist’ - this referred to all questions connected to administration of the Blessed Sacrament, performance of Baptisms in hospital and holding services of worship in the hospital.

* ‘Overall Assessment’ - these questions asked what the participant thought was the chaplain’s most important task and whether there were any other tasks they thought the chaplain should perform.

* ‘Record of Religious Practice’ - this heading relates to whether the participants attend church now or whether they did in the past, and how frequently.

* ‘Chaplaincy Visits’ - questions under this heading asked whether the participant (if a patient) had been visited during their present stay in hospital, or (if not) whether they had received a visit during any previous hospitalisation.

Many of the results of this survey were inconsistent and confusing, with the groups and individual participants of groups often responding differently to the same question or answering similar questions differently. Senior and junior doctors sometimes agreed with each other or with nurses and patients, while at other times their responses were contradictory. This indicated that many participants, from all groups, had little knowledge of chaplains or their expected role. The only questions upon which the majority of participants agreed were those under the ‘Comforter’ and ‘Witness’ headings. Most expected the chaplain to perform a comforting role and to ‘be there’, particularly for patients and relatives.

As this first survey did not achieve more concrete results, further research was conducted, at different hospitals, in an endeavour to ascertain the actual tasks being performed by chaplains, rather than their role expectations.

d. The Expectations of the Role of Chaplains amongst the Religious Hierarchy

The second survey, conducted amongst selected hierarchy of eight major religions/denominations, is discussed in Chapter 4. The purpose of approaching the high ranking clerics or administrators, who were responsible for overseeing hospital chaplaincy in their individual religious bodies, was to assess whether chaplains were performing their ministry in the manner expected by their hierarchy, or whether expected chaplaincy procedures, as seen by the hierarchy, differed from those of the chaplains themselves. The survey was also intended to assess any differences occurring amongst the individual hierarchy with regard to chaplaincy expectations generally and to their own chaplains. In particular it was expected that the diversity of the religions/denominations involved would create differences and that awareness of these differences by religious bodies would create understanding between them and,
ultimately, encourage a closer relationship between chaplains regardless of religion or denomination. The outcome was that, of the 55 questions asked in the written questionnaire, the hierarchy answered 24 identically. However, there was confusion by the hierarchy on many aspects of chaplaincy, particularly where ethical issues were concerned and their expectations frequently did not correspond with the expectations of other surveyed participants. It is reasonable to assume that responses to the ethical questions may have been influenced by the religion/denomination of the hierarchy.

There were two components to this survey: firstly, the hierarchy were invited to complete the same ‘Expectations of the Role of Hospital Chaplains’ questionnaire as the patients, medical staff and chaplains at Royal North Shore, Greenwich and Mount Druitt Hospitals; secondly the hierarchy took part in verbal interviews conducted by the researcher. These interviews were unstructured, with no list of specified questions, although the same or similar questions were asked during each discussion. The participating hierarchy were selected from eight major religions/denominations: The Anglican Church of Australia, The Baptist Church of New South Wales, The Catholic Church, The Presbyterian Church in New South Wales, The Uniting Church in Australia, The Salvation Army and The Seventh-Day Adventists’ Church. Although only a small number of Jewish chaplains and other participants were involved in the surveys, Judaism was included commensurate with its standing as a major religion. Whilst Judaism has no model of organisation corresponding to the hierarchy of Christian denominations’ organisational structures, the long serving Rabbi Apple, a member of the current Beth Din and a well-known Sydney public commentator on Judaism, was approached for his views in a similar manner to the Christian hierarchy. Rabbi Apple explained that there are no full-time Jewish chaplains and professionally they differ considerably from Christian denominations. Jewish Rabbis are selected from the congregation and combine teaching and their Synagogue duties with their chaplaincy work, assisted by lay helpers. Their chaplaincy visits are mainly intended to provide companionship and comfort when necessary. As the general written surveys were randomly distributed to the hospital participants, members of the Jewish faith were included in all the conducted surveys and their responses incorporated statistically; the small sample size, however, and the nature of their chaplaincy procedures, prevented a viable comparison being made with the Christian denominations.

e. The Tasks Being Performed by Chaplains in Three Liver Transplant Units

Chapter 5 discusses the ‘Survey of Three Liver Transplant Units as to the Actual Tasks Being Performed by Chaplains in Australian Hospitals’. This survey was conducted to ascertain the extent to which chaplains were integrated in the hospital
system generally. The survey related the part they played in the three participating transplant unit teams and the actual tasks they were performing. This was to obtain from the medical staff an indication of the value, and considered indispensability, of chaplains to the patients and the operation of the units generally. It was expected that, as the three participating units performed similar functions, the staff’s responses to the survey would also be similar. These expectations were not fulfilled as, although the units were performing similar medical functions, the involvement of chaplaincy input in each unit was different and this influenced the participants’ responses.

With the permission of the individual Ethics’ Committees and Unit Directors, the staff of the Liver Transplant Units attached to The Austin Hospital in Victoria, Royal Prince Alfred Hospital in New South Wales and Princess Alexandra Hospital in Queensland, took part in a short open-ended written questionnaire, distributed by unit personnel, and unstructured personal interviews, conducted by the researcher. Of the 60 questionnaires which were distributed, 20 to each unit, 37 (61%) were returned. The Austin Hospital returned 45%, Royal Prince Alfred Hospital 80% and Princess Alexandra Hospital 60%. The lower figure for The Austin was due to the smaller staff numbers in the Unit compared to the other LTUs and the delegated distributor’s inability to enlist more participants. The consenting participants consisted of: 20 nurses, including some who were generally trained, clinical nursing coordinators, theatre nurses and transplant coordinators; 14 doctors, which included medical, surgical, anaesthetist, pathologist and heptologist participants; one occupational therapist; one physiotherapist and one LTU administration clerk.

Included in this survey was a calculation of the number of days patients were hospitalised in each Unit over a five year period. It was expected that, after allowing for variables, patient lengths of stay would be comparable in the three Units: A comparison of staff sick leave taken in the three Units was also intended but, due to the Hospital’s policy, relevant figures were not obtainable Royal Prince Alfred. A comparison was made of LTU sick leave records of The Austin and Princess Alexandra Hospitals, in an endeavour to assess whether any existing differences in the Units’ figures may have resulted from one Unit operating differently to the other.

The results of this survey indicated that the three participating Liver Transplant Units were operating very differently regarding the involvement of chaplaincy in their team. The Austin Hospital had adopted a program whereby the chaplain was considered an indispensable member of the Unit, her salary being paid from their Unit funding. She was included in all facets of the Unit to the extent that her presence was welcomed in the theatre whilst operations are in progress. She was highly involved with both patients and staff, from a patient’s initial interview to discuss their suitability for transplantation through to their post-transplant treatment.
The average length of stay figures for patients in the The Austin Hospital’s LTU was considerably less than at the other two participating hospitals. The conclusion is drawn that this could reasonably be attributed to the high chaplaincy involvement adopted in that Unit.

The Princess Alexandra Hospital, by contrast, did not utilise chaplaincy to any great extent, preferring to involve a former transplant patient to liaise with patients as a coordinator. This coordinator was not theologically or pastorally trained but, nevertheless, forged close relationships with the patients as someone to whom they could relate outside of the medical profession. As a former transplant recipient, the coordinator had a personal understanding of the patients’ problems and fears. As a coordinator rather than a chaplain, she did not perform the pastoral duties exhibited by The Austin Hospital chaplain, nor was she present in the theatre during operations. However, there were indications that the one to one relationships she fostered with patients influenced their recovery rate. The length of time the Princess Alexandra Hospital LTU patients were hospitalised was slightly less than The Austin Unit, but considerably less than the Royal Prince Alfred Unit, which did not utilise chaplaincy extensively at all, nor did they employ a specific coordinator to relate on such a personal level as Princess Alexandra. The role of the RPA coordinator was more generally orientated.

The conclusions reached here were that, irrespective of variables, the LTU with the highest chaplaincy involvement had the greatest influence on patient recovery, the one which employed the personally involved coordinator was next, whilst the LTU with less chaplaincy or personal involvement recorded longer patient length of stay figures. A number of United States researchers have conducted surveys into the possibility that high chaplaincy input reduces a patient’s stay in hospital; attitudes and beliefs towards the power of prayer can be significant factors in this regard. This research is discussed at the end of Chapter 2.

f. Conclusions

The final chapter of this thesis, Chapter 6, comprises a summary of the research, together with the researcher’s recommended changes to the present chaplaincy system in Australia. The present research has indicated that hospital chaplaincy would benefit generally if more specialised ministry methods were to be adopted. This is not intended as a criticism of chaplains presently ministering in hospitals, but rather as encouragement to future chaplains and their religious bodies to have the foresight and courage to make changes when and where needed.

As shown by a list of proposals prepared by The Australian College of Chaplains, this College is aware of the need to enhance the prestige and standards of
chaplaincy in Australia. It is considered by this researcher that the only way to achieve this end for hospital chaplains is by developing this branch of ministry to a profession in its own right. Hospital chaplains are not generally accepted by hospital staff as being allied health professionals in a manner similar to social workers, counsellors, physiotherapists, psychologists, and so on. Such allied health staff are, in most cases, employed directly by the hospital and have obtained postgraduate degrees to achieve their position. It is recommended, therefore, that in order to raise the status and prestige of hospital chaplains, a comprehensive postgraduate course be initiated, this to be completed after a person has completed acceptable training in the theology of their own denomination or religion. Such a degree course should be designed on an ecumenical basis and be open to both ordained ministers/priests and members of the laity. Suggested subjects to be covered by the course are itemised in this Chapter. It is also highly recommended that, with the increasing fall in numbers of ordained ministers/clergy, more of the laity be encouraged to undertake training consistent with that required for hospital chaplaincy.

Other recommendations include the advantages of unit and set ward ecumenical chaplaincy similar to that conducted at The Austin Hospital, extended chaplaincy involvement in hospital day surgeries and outpatients’ departments, post-acute care services, long term nursing home care, ministry to dementia suffers, obstetric patients, paediatric and geriatric patients, rehabilitation patients, transplant recipients and transplant donor relatives. The introduction of lectures to hospital medical staff on pastoral topics and the purpose of chaplaincy is also recommended, as is the inclusion of chaplains on Hospital Ethics Committees. The question of funding for hospital chaplaincy is a controversial one; recommendations that funding becomes more centralised are made in Chapter 5.

The researcher considers that the most significant indication to emerge from the project is that, when chaplains are accepted members of a hospital team and highly involved with patients, relatives and staff, the patients’ recovery and discharge are accelerated. This is not only advantageous to the patients; it also represents financial cost-savings for hospitals and governments. It is hoped that governments, hospitals, religious bodies and chaplains themselves will consider the feasibility of implementing all, or at least some, of the above recommendations; only by negotiating and working together would changes be achievable.
CHAPTER 1

THE HISTORY OF THE RELATION OF RELIGION AND SICKNESS/MEDICINE

I say, we ought not to reject the ancient Art, as if it were not, and had not been properly founded.

Hippocrates.¹

INTRODUCTION

The concept that religion and sickness/medicine have always intertwined and continue to do so, is one of the major themes of this research. The listing of histories in this Introduction connecting religion and sickness/medicine in various countries and cultures throughout the ages, will reveal comparisons and continuity with modern day practices.

Firstly, faith has been a constant link through time, starting with the Greek God Asclepius and the healing cult to which his followers subscribed, through to the faith healing of the Biblical era, and faith healing shrines of Europe, many of which are still visited by thousands of people hoping to be miraculously cured sickness or disability. In a course conducted at the John Hopkins University in 2000, Kerri Jeffrey and David Bauer discussed faith healing as a bond between sickness and religion, noting that ‘there has always been faith healing since the advent of religion. In some cases, religion was invented specifically as a form of treating the sick or wounded. As time progressed, advances in medicine began to supplant a few of the religious healing practices, but in most cases, religion still played a very large part in the healing process’.² Before and during the Middle Ages belief in the miracles of the Bible was high, but as Jeffrey and Bauer further note, ‘our expanding scientific fields can explain many diseases and disorders, so people are hard pressed to believe that a religion can heal a disease that is logical and rational to humans’.³ Whilst this may cause many to consider the concept of faith healing to be irrelevant to modern medicinal healing, others with strong religious backgrounds may genuinely believe that

³ Ibid., p.7.
their faith will be the most important factor of their healing. This view is supported by the prominent place healing services occupy in many religions today; the researcher’s own Anglican church conducts such a service weekly.

Joseph Ziegler uses the Bible as a support to connect religion with medicine, noting that ‘the Bible is a powerful core text which clearly suggests that medicine and religion converge’. He claims that neither medicine nor physicians could be considered religiously neutral, rather that both derived their high status from their divine origin as written by Ben Sira in Ecclesiasticus 38:1. This verse asks that the people ‘honour the physician because of his essential function’.

Ziegler also comments on a very significant aspect of the connection between religion and medicine, that of ethics. As he notes, ‘Medical ethics are enshrined in a religious structure. There is a fusion between religion and medicine on an ethical level’. A number of major ethical problems have evolved through the ages, not least that of abortion.

Darrel W. Amundsen points out that the practice of abortion is condemned in early Christian literature, for example, in the Didache 2.2, the Epistle of Barabas 19.5 and in the works by Clement of Alexandria. Also, the Hippocratic Oath states that abortion should not be performed and Scibonius Largus, in condemning abortion and stressing that medicine is the science of healing, not of harming, credits Hippocrates with going ‘a long way towards preparing the mind of the learners for the love of humanity. For he who considers it a crime to injure future life still in doubt, how much more criminal must he judge it to hurt a full grown human being’. Among theologians, Thomas Aquinas held that the degree of sin attached to abortion depended on the stage of foetal development, whilst Antoninus, in his Confessionale in 1473 AD, said that mortal sin was committed by physicians who gave medicine to a pregnant woman to kill the foetus, even if the mother’s life was threatened. However,

---

5 Ibid., p.3.
6 Ibid., p.50.
four years later when Antoninus dealt with abortion in his Summa, he revised his view to say that no homicide occurs due to abortion unless the foetus is already formed.\textsuperscript{10}

The ethics of abortion are still causing conflict today in both hospitals and places of worship. Both the Old and New Testaments of the Bible command that ‘thou shalt not murder’\textsuperscript{11} which many believe incorporates abortion. The question of when a foetus receives its’ soul and becomes a human being is heavily debated in many countries, including Australia, and conflict between the Church and the medical profession often occurs. As noted by Jeffrey and Bauer, ‘in recent years the Church has increasingly lost its power over people’s lives’,\textsuperscript{12} This has resulted in legalised abortion being approved in many countries or, at least, performed at a medical practitioner’s discretion.

A further ethical connection between medicine and religion is the painless-death or mercy-killing known as euthanasia. As with abortion, there is much debate taking place today on this subject for similar reasons. Amundsen notes that ‘in the past, what is now referred to as active euthanasia and a moral category unto itself, was regarded as simply homicide on the physician’s part and suicide on the patient’s, assuming willing involvement by the latter’.\textsuperscript{13} Martin Aspilcueta, better known as Navarrus, writes in his 1568 summa that it is sinful for a physician to knowingly give harmful medication to a patient ‘even if he administers it out of pity and in order to please the patient’.\textsuperscript{14} In the majority of countries today, it is still technically illegal for doctors to prescribe lethal drugs to terminate life, although a form of passive euthanasia may be effected by removing a patient from a life support system when it is no longer considered advantageous to prolong such treatment. Euthanasia creates problems for both the Church and the medical profession, with individual opinions on both sides being divided. The kind of questions being asked are whether one human being has a right to play God where another’s life is concerned, adopting the view that through God life began and by God it should be terminated, or is God’s command for compassion and love for others being more faithfully fulfilled by relieving a sick and dying patient from further unnecessary pain and distress? Medicine and religion are


\textsuperscript{11} Exodus 20:13, Matthew 5:27.


\textsuperscript{13} Amundsen, op.cit., p.271. Medicine, Society and Faith.

\textsuperscript{14} Navarrus, \textit{Manuale sive Enchiridion confessariorum at poenitentium}, Lyons, 1574, in \textit{Ibid.}, p.271.
closely intertwined by both the abortion and euthanasia problems, but often in conflict rather than in cooperation.

An additional ethical problem which has arisen in recent times, but was not applicable to the past, is the advances being made concerning DNA research. In particular, scientists have begun extensive genetic manipulation and cloning experiments. Not only can many genetic disorders be detected in a foetus, which may encourage women to seek an abortion, but experiments to scientifically manufacture a baby’s sex, hair and eye colours, I.Q., and other facets are being conducted. The Church is again involved in conflict with the medical profession on this subject as it can be considered that the medical scientists are playing God in trying to produce a perfect person. To the religious a perfect person is not God’s will. As far back as 1921, William Osler was aware of the potential power of science when he wrote that ‘out of the spiritual protoplasm of magic have evolved philosopher, physicist and priest. Magic and religion control the uncharted sphere - the supernatural and the superhuman; science seeks to know the world, and through knowing it, to control it’.\(^\text{15}\)

In the past, the strongest connection between medicine and religion was that the sick and homeless were cared for by religious bodies, these being primarily Orders of monks who considered it their duty to found hospitals and hospices for the dying, poor, and distressed. These early monks were, in effect, the forerunners to today’s nursing profession; similar motives of caring, helping, and doing good for the sick are still relevant. The amount of modern nursing spirituality literature is increasing, with Anne J. Fry writing:

Historically the origins of the spiritual perspective of nursing evolved from the role of medieval Christian religious orders who cared for the sick as a good work necessary for salvation. As such, this tradition incorporated certain values about the nature of humans as spiritual beings.\(^\text{16}\)

Nursing spirituality is discussed further in section 3f. of this chapter.

Initially the monks acted as physicians and surgeons also, but in 1163, at the Council of Tours, Pope Alexander III enacted a canon forbidding monks and other regular clerics from leaving their institutions for the study of medicine or secular law. At the Fourth Lateran Council in 1215, a further ruling was made to the effect that the


practice of surgery was forbidden to clerics in major (holy) orders, such as subdeacons, deacons, and priests, but this this directive did not apply to those in minor orders. It is thought that the reason for this was that a clerical practitioner might be held responsible for a patient’s death. Ultimately these rulings led to more secular physicians in the universities, increasing the laity in areas previously dominated by the clergy. The religious orders continued their work founding hospitals and nursing the patients. The majority of these hospitals were named after Saints and many, such as St. Thomas’ and St. Bartholomew’s in London are still in existence. However, they are now controlled by secular authorities. Although numerous religious and Christian denominational hospitals and nursing homes continue to exist world-wide, they are greatly outnumbered by private and public secular institutes.

Religion and sickness have always been connected through clerical visits to the sick. Although in the past such visits were usually made by a clergyman attached to a certain community, today the clergy are assisted by many lay pastoral visitors, both male and female, who visit the sick in their homes and hospitals. In addition to these casual visitors, some hospitals have the services of fulltime hospital chaplains or a permanent pastoral care team. The assessed acceptance and value of hospital chaplaincy is covered in this present research.

A final point to illustrate the entwinement of religion and sickness is the question of hygiene. As shown below, certain purification rites were practiced by the ancient followers of the Greek God Asclepius, whilst more than 3000 years ago, Judaism taught the necessities of cleanliness and prevention of disease. Ceremonial cleansing rituals were practiced, and there were regulations regarding purification after childbirth, extensive bathing and washing required after infectious skins diseases, bodily discharges, or house mildew. Additionally, strict food regulations existed regarding the classification of animals into clean and unclean. These ancient Judaic methods, emphasising the extreme importance of hygiene for the prevention of infection, can be considered the forerunner to modern day infection control.

Evidence of the relationship between religion and sickness/medicine during different stages of history is recorded below.

A study of the history of medicine indicates that the first physicians were priests, not only during the early Christian era, but dating back to the 28th century BC when the demigod Imhotep emerged as one of the first recorded physicians in Egypt. 

By 600 BC priest/physicians were prominent in Greece. A form of psycho-therapy called ‘incubation’ was being practised in many Greek temples, known as ‘Asklepieia’

17 Amundsen, op.cit., pp.22--44, Medieval Cannon Law.
18 Leviticus, Chapters 11-15.
19 Refer Chapter 1, under 1.d. Egypt.
after the Greek God of Healing, Asclepius, who is said to have often visited and healed patients in the form of dreams. According to the Greek legends, Asclepius was the son of the god Apollo and a mortal woman and is said to have learned his healing art from a centaur known as Chiron. The practice of incubation involved incubants observing strict purification rituals and fasting rules, after which they slept within the precincts of a temple for the purpose of receiving a vision, revelation or relief from disease or pain. The latter were usually induced by faith, but sometimes by a combination of faith and drugs.

Many sanctuaries dedicated to Asclepius existed throughout the Ancient World, with the most famous operating at Epidaurus, Cos, Pergamum, Tricca in Thessaly, and Athens. The sanctuary of Asclepius at Epidaurus survived for almost eight hundred years and much of what is known about these sanctuaries derives from inscriptions found on a stone stelae during excavations at the Epidaurus temple site.

The rituals connected with the Asklepieia created a cult which was both a religion and a system of therapeutics. Dreams of the gods raised particular interest in the Ancient World and opinions on this subject were divided as to whether the dreams were actually sent by the gods themselves, or whether the soul reached upwards while the senses were sleeping, to make contact with higher realities. We know that Plato recognized dreams to be a way in which the gods could convey messages to mortals and that Separis, Isis and Jupiter Dolichenus all encouraged dreams in their devotees. However, it was in the cult of Asclepius that the interpretation of dreams, particularly involving medical procedures, rose to prominence.

The strict purification rites attached to the practice of incubation in the Asklepieia meant that patients who were near death, or women close to childbirth, were not allowed inside the sanctuaries because they had to be kept ritually clean at all times. As Meier states:

Before the actual rite of incubation took place certain rites of purification and ablutions had to be performed. Porphyrius reports an inscription in Epidaurus which runs 'let every man who enters the incense-laden temple be clean, yet he may be called clean who has none but holy thoughts in his mind'.

Ibid, p.16.
Fox, op.cit., p.151.
Pausanias ii, 27, 1 and 6, in Meier, op.cit., p.53.
Porphyrius, De abstenentia ii, 19, in Meier, op.cit., p.54.
Meier also tells of an inscription in the Asklepieia Lamboesis in Africa which runs: ‘Go in good, come out better’. The purification rites before incubation would undoubtedly have included some form of bathing as, according to Plato:

In the ancient world the bath was thought of as having a purifying effect on the soul as well as the body, since it freed the soul from contamination by the body and this set the soul free for communion with the gods.

After completion of the purification rites, fasting and offering of sacrifices, the patient would spend the night in the sanctuary. During their sleep Asclepius would appear to the patient in a dream and give advice. In the morning the temple priests would interpret the dream and explain the god’s instructed cure.

According to Fox, ‘at times visitors struck a bad patch in their own dreaming and had to ask a priest to dream on their behalf’. Meier adds that ‘another person could sleep in the sanctuary as proxy for a sick person who could not be moved’. If a dream was not received by or on behalf of a sick person, treatment was given by the temple priests as the god’s human representatives. Whilst surviving records of dreams of Asclepius talk of miraculous cures, from the first century BC more precise medical practices were recorded as being prescribed by the god.

The priests of the Greek temples of healing appeared to pay great attention to dreams because they saw these dreams as messages from gods such as Asclepius, and these Greek temple priests must certainly be considered amongst the first priest/physicians to have practised healing as their major occupation. Their success in treating insomnia, headaches, paralysis and other complaints, from information derived from the 44 inscriptions on the stone stelae found at Epidaurus, was a major foundation upon which the medical profession was able to build and evolve into what it has become today. Modern day clinics derive their name from the couches (clines) on which Asclepius Sanctuary patients slept and, 2000 years later, psychologists, following Freud’s example, were still utilizing similar analytical couches to perform dream analyses, although the use of couches has now been abandoned in favour of the doctor and patient sitting face to face on the same level. Another significant connection between the ancient and modern medical profession is the insignia or badge by which today’s doctors are recognised: a serpent coiled around a staff reputedly

28 Meier, op.cit., p.54.
29 Ibid., p.54, referring to Plato, Cratybus 405B.
30 Fox, op.cit., p.153.
31 Strabo xvii, p.801 in Meier, op.cit., 55.
33 Fox, op.cit., 152
34 Meier, op.cit., p.56.
associated not only with both the Greek god Asclepius and the Egyptian god Imhotep, but also with the story of Moses when he was told by God to ‘make a bronze snake and put it on a pole; anyone who is bitten can look at it and live’.\textsuperscript{35} This incident is further recorded in the New Testament where John states ‘just as Moses lifted up the snake in the desert, so the Son of Man must be lifted up, that everyone who believes in him may have eternal life’.\textsuperscript{36}

Whilst it will be shown later that Hippocratic principles were directly opposed to magic and ritual, the long-standing success throughout antiquity of the cult of Asclepius shows very clearly that medicine and religion were not divorced. This connection continues into the modern world with the emergence of hospitals as we know them today, which were originally founded by various Monastic Orders as their considered duty to the sick and infirm. The Middle Ages produced the nucleus of our present day hospitals with the foundation of St. Bartholomew’s Hospital, London, in 1123 AD by the monk Rahere and St. Thomas’s also early in the twelfth century in the Priory of St. Mary Overy in Southwark, both under the control of the Church. Saints’ names were frequently given to these early hospitals, enhancing the view that ‘religious and medical duties were intimately intermingled in the past’.\textsuperscript{37} It is from such beginnings that our modern day hospitals have emerged, with most providing some form of chaplaincy or religious involvement. To fully appreciate the standing of hospital chaplaincy in the context of contemporary religion, it is necessary to understand the connection of sickness, hospitals and religion through the ages. This is the purpose of Chapter 1.

1. ANCIENT MEDICINE

a. The Earliest Medical Practices

To the best of our knowledge, primal beings considered that sickness was inflicted through an external magic or evil spirits. With belief that ‘society depended on the inviolability of the totem and tabu, someone falling ill or sustaining an injury was a stern warning that tradition had been infringed’.\textsuperscript{38} By wearing grotesque masks, our primal ancestors endeavoured to frighten away the spirits they feared or to at least hide from the demons which brought ill health. Believing that they descended

\begin{itemize}
\item \textsuperscript{35} Numbers 21:8.
\item \textsuperscript{36} John 3:14-15.
\item \textsuperscript{37} Guthrie, Douglas, \textit{A History of Medicine}, Thomas Nelson & Sons Ltd., Edinburgh, 1958, p.10.
\item \textsuperscript{38} Leff, S. and Leff, V., \textit{From Witchcraft to World Health}, The Macmillan Co., N.Y., 1958, p.17.
\end{itemize}
from animals, primal societies created totems that were often symbols of such animals. The term ‘totemism’ is credited to John Long in his book *Voyages and Travels of an Indian Interpreter and Trader* in 1791, and the topic was very popular amongst writers during the nineteenth and early twentieth centuries, but less so now. Samuel and Vera Leff write:

> Wishing to share the strength and agility of the totem-animal, members of the tribes dressed in the animals' skins and imitated in song and dance the habits and movements of the object of their worship. By similar logic, the characteristic movements of some diseases such as epilepsy inspired religious dances intended to appease the angry spirit.

For the earliest tribal societies across the globe, the treatment of illness involved archaic religious rituals; their aim was to transfer the illness causing spirits to the human world and then devise their own magic to counteract that of the spirits.

From this non-rational approach, religion, medicine and magic became completely intertwined and the specialist in the treatment of disease was something more than a healer; he was divinator, intermediary, appeaser and sometimes avenger; and he frequently cured the patient.

### b. Sumer and Babylon

Sumeria was one of three great ancient civilizations, the others being Egyptian and pre-Aryan Indian. The city of Ur, capital of Sumeria, was situated on the Euphrates about 100 miles west of the Persian Gulf and early excavations by Sir Cyril Woolley show that craftsmanship and art produced by the Sumerians reached a high standard. Cuneiform writings found on clay tablets indicate that a medical profession was practised in Ur with reasonably high ethical standards being observed.

---

41 Leff, *op. cit.*, p.18.
The oldest medical document is a clay tablet from Nippur of 2700 BC, which was excavated by Sir Leonard Woolley during an archaeological expedition of 1922 to 1934. The text is the pharmacopoeia of the Sumerian physician Lulu. Medications for both internal and external use were listed in this document, with a variety of ingredients. Sodium chloride (salt) and potassium nitrate (saltpeter) were utilized with milk, snake skin, turtle shell and numerous botanical properties, particularly cassia, myrtle, thyme, willow, pear, fir, fig, and date. The medications were prepared from the seeds, roots, bark, branches or gum and used in both solid and powdered form. Whilst the prescriptions in the document clearly state the required ingredients, they do not specify the required quantities, nor do they advise the frequency of usage. Furthermore, the diseases for which the medications were used are not named in the text, so the therapeutic value of the medications cannot be verified.46

The Sumerian concepts of health and healing were related to their theology of creation. This theology held that man was created to serve the gods who were, in turn, responsible for the health and welfare of their servants.47 The religious beliefs and practices of the Sumerians influenced their theories of disease and sickness. Disobedience, misdeeds and the non-observance of religious taboos all required punishment by the gods. The sin could be punished individually or as a community.

The Sumerian myth of Inanna and Shukalletuda describes the sin of an individual who angered the deity and attracted community punishment in the form of a plague which devastated the land and its people.48 However, within the Sumerian theology the nature of their gods appears unpredictable; sickness would seem to have been attributed, on some occasions, to the influence of a demon and, on others, to punishment by the gods. In her Religion and Healing in Ancient Sumer, Wendy Brown argues that medical practices were inseparable from religious ritual, citing the following among the range of treatments adopted by the ancient Sumerians to appease the gods:

Repentance for sins through confession, supplication
Expiatory rituals, purification ceremonies
The offering of sacrifice to the gods
The offering of other foods to the gods including bread, wine, milk, honey, beer
Exorcism of demons
Trephining of the skull to let an entrenched demon escape as quickly as possible
The application of folk medicines. Herbal medicines picked at night under the

48 Ibid., p.9.
The Sumerian civilization was replaced by Assyria in the north and Babylon in the south around the year 2000 BC. The Louvre in Paris now houses a code of laws, engraved on a pillar of hard black stone, drawn up and recorded by command of the Babylonian ruler Hammurabi (18th century BC, the Hammurabi Code). Amongst these rules were regulations on the subject of professional fees and mention of abscess lancing with bronze knives and the preservation of eyes. This indicates the existence of a medical profession, but does not specify the actual status of the practitioners. Although the Code of Hammurabi does not contain laws to do with religion, the ruler is depicted as receiving commands to formulate the code from the sun god Samas, thus emphasizing the divine origin of the written law and a connection between religion and the medical profession.

c. India.

Early Indian medicine and surgery also had its roots in religion, with the Rig Veda (1500 BC) and the Ayur Veda (700 BC) being the earliest Sanskrit documents to record information of medicine. However, the priestly caste of the Hindu Brahman did not supply the physicians of the Vedic Age. Instead this duty fell to the lower Vaisya caste of merchants and farmers. There was good reason for this as, according to the ancient laws of Manu, the physicians were regarded as unclean and hence were not allowed to attend funeral feasts. Whilst not being one of the 4 great Indian religious Vedas, it is regarded as being knowledge revealed by the divine healer Dhanwatari himself, or by some other great ‘rishi’ or teacher, to the great physicians Charaka and Susruta.

Whether Buddhism is referred to as a religion, a form of faith or a philosophy, it has, like ancient Hinduism, an association with sickness founded on its own religious culture. According to W.A. Glaser’s research, hospitals existed in Ancient India by 244 BC as a result of King Asoka’s administrative policies, which created government, town and monastery administered hospitals as a function of

49 Ibid., p.11.
53 Ibid., pp.26-27.
Buddhist charity.\textsuperscript{54} And although the Indian hospital today is a very different and westernised institution, introduced by the English military organisation, a religious element was retained through missionary involvement of Buddhism across the globe from Europe and the United States.\textsuperscript{55}

d. Egypt.

As in other ancient civilizations mentioned, the entwinement of religion and sickness is clearly apparent in ancient Egypt. Here we find medical practices monopolised by the priestly class and closely tied to theology. Discussing the Egyptian gods and demigods who presided over medicine, Kenneth Walker notes:

Imhotep became the Egyptian god of healing and he had therefore the unique distinction of being the only medical man ever to achieve deification. Imhotep is also one of the earliest doctors known to us by name and no name could have better befitted a great physician, meaning as it does, he who cometh in peace.\textsuperscript{56}

Two valuable pieces of Egyptian papyri are the Ebers and the Edwin Smith papyri, found together in a tomb at Thebes in 1862. Both of these show that clinical medicine was beginning to emerge during the later Egyptian epochs, with the priest/physicians having learnt to examine their patients to discover their physical problems. Although charms and rituals were still being used, considerable medical advancement was evident from the Ebers and Edwin Smith papyri.\textsuperscript{57} The Ebers papyrus is in particularly good condition; it was written about 1500 BC, probably close to the time of Moses, but the contents were copied from texts or books which had been written many centuries earlier.\textsuperscript{58} The main part of the book consists of prescriptions for ailments and is a curious mixture of magic and quackery. The general idea was that disease was due to possession by an evil spirit, which must be driven out by an incantation or magic formula and then the harm already done must be repaired by a medical prescription.\textsuperscript{59} The Edwin Smith papyrus, although written about the same time as the Ebers Papyrus, interestingly is very different. It discusses the treatment of wounds and injuries free from magic and incantations.\textsuperscript{60}

\begin{flushleft}
\textsuperscript{55} Kirkpatrick, op.cit., p.3.
\textsuperscript{56} Walker, op.cit., 27.
\textsuperscript{57} Ibid., p.28.
\textsuperscript{59} Ibid., p.13.
\textsuperscript{60} Ibid., p.14.
\end{flushleft}
explanation for this could be that it was a surgical rather than a medical document, describing the treatment for fractured, broken or dislocated bones and similar injuries. Such injuries may be attributed to the numerous battles fought between the Egyptians and Babylonians, many of which are noted in Biblical passages, particularly Jeremiah and Ezekiel. Samuel and Vera Leff support this view as to why the Edwin Smith papyrus does not refer to magic or incantations, stating:

The Hittites, Assyrians, Israelites and Egyptians seemed always to be smiting one another, and the thrusting of bronze spears and swords could do much damage; so surgeons had a large amount of material for checking theory and practice. Embalmed bodies show many examples of fractured bones, almost always in the forearm near the wrist - which suggests the arm being raised in battle to ward off a blow to the head. There was clearly no time on the field of battle for long-winded spells, and the Edwin Smith papyrus shows that surgeons treated wounded persons with skill.

The strong entwinement of religion and medicine can be seen from the medical training received by students during the reign of Rameses the First (1320-18 BC). At Heliopolis Medical School and the Sais Gynaecological School, the students were taught by Temple Priests and Divine Mothers. A mixture of medicine and magic was taught; the underlying philosophy could be compared not unfavourably to the present-day psychosomatic schools of medicine. Kenneth Walker gives an imaginative description of the qualifications of a medical student during Rameses the First’s reign:

I have come out from the school of medicine at Heliopolis, where the venerable masters of the Great Temple have inculcated their remedies within me. I have come out from the Gynaecological School of Sais, where the Divine Mothers have given me their prescriptions. I am in possession of the incantations composed by Osiris personally. My guide has always been the God Thoth, the inventor of speech and writer of infallible prescriptions.

It is Kate Campbell Hurd-Mead’s belief that this student was a woman.

e. Women in Ancient Medicine

Written records of women’s medical prowess in the ancient world are sparse compared to records of the men. Early historians were mainly men and it appears that they were interested in other prominent men of the public world and not in women or lower class men. Women appear to have played a prominent role in

61 See Jeremiah 43:10-13; Ezekiel 29:19-20; Ezekiel 30:10-11.
62 Leff, op. cit., p.36.
63 Walker, op. cit., p.29.
64 Walker, op. cit., 29.
Egyptian medicine; Kate Campbell Hurd-Mead claims that the first records of women doctors are of those practicing during the reign of Queen Nefertirka-ra in Egypt about 2730 BC. A medical school existed at Memphis, where Ptah and Imhotep were revered as gods and teachers, to which women may have been admitted; there was also a women’s college at Sais where gynaecology and obstetrics were specialities.66 As early as 1500 BC women students are believed to have been accepted at the medical school in Heliopolis. Hurd-Mead maintains that ‘women had always been admitted to the Royal Medical Schools (Egypiteas)’.67

Paintings in tombs and objects found in graves indicate that there were indeed women healers in Ancient Egypt and elsewhere. One of these paintings depicting the goddess Isis healing with her priestess helpers, was found in the tomb of Rameses the Third (1166 BC).68 Whilst the early priestesses attributed their healing powers to the goddesses, any success they achieved probably arose from the patient’s faith in the healing powers of the priestesses and goddesses rather than any form of medication. This is substantiated by the Ebers Papyrus of c.1560 BC, which records the following recipe prescribed by the goddess Isis as a headache cure for the god Ca: 69

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Quantity</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coriander berries</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Berries from Xaset plant</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Wormwood</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Berries of the Sames plant</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Juniper berries</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Honey</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

To be mixed and smeared on the head.

It is improbable that the ingredients used in this recipe would medically benefit a headache.

Despite the widespread changes which occurred in medical ideas under Hippocrates’ influence, few people in the ancient world could afford the services of professionally trained physicians.70 Most relied on home healing by a ‘wise woman’. These ‘wise women’ often learned their trade by experience and by watching others work their cures rather than from books. They used mainly herbal medicines to treat their patients.71

It appears that women of lower status also performed surgery in the presence of men. Evidence of this is provided by a picture of a slave girl of about 1420 BC in a

66 Ibid., p.16.
67 Ibid., p.15.
69 Ibid., p.6.
70 Ibid., p.5.
71 Ibid., p.5.
Thebes mortuary chapel. This picture depicts the male relatives of a woman patient watching the slave girl skilfully perform an operation on the woman’s foot.\textsuperscript{72}

Midwifery was similarly considered a skill which could be learned. It was treated as a women’s function, but was viewed differently from the powers the priestess-healer needed to treat illnesses. However, prayer and charms were still used by the midwives to ward off demons from the mother and baby.\textsuperscript{73}

\section*{2. MEDICINE IN JEWISH AND CHRISTIAN CONTEXTS}

\textbf{a. Jewish Medicine}

The Old Testament period is generally considered to cover the period from the Exodus, past the Exile, to the writings of the latest work in the Old Testament, probably Daniel. That would place it from approximately 1250 BC to 167 BC, the time of the Maccabaean revolt. The Old Testament writings were produced by and for a people leading a settled existence in the towns and villages of Palestine, who adopted many of the everyday patterns established by the Canaanites who had previously inhabited the land. The religious leaders of Israel did not, however, allow the settlers to forget that their forefathers had been nomadic shepherds; part of the desert outlook lived on in the strong traditions of Hebrew life.\textsuperscript{74} Whilst the stories of Abraam, Isaac and Jacob indicate a semi-nomadic existence, archeological excavations have shown that cities existed. According to excavated city plans, the houses of the poor inhabitants were built of mud and brushwood and indications are that they lived in an overcrowded and impoverished state. Many of these houses consisted of one room in which the family lived, ate, slept, and worked. The houses had no chimneys for the fire, little lighting and would have been infested with insects during the summer months. The climate would also have necessitated the family’s sheep and goats being kept inside for part of the year.\textsuperscript{75}

The living conditions would not, however, have been blamed for the sickness contracted by the occupants. Although during this period medicine in the ancient Near East was divided between actual cures and rank superstitions, E.W. Heaton writes:

The Israelites’ dominating belief in a single all-governing God had a profound influence in reducing the magical element. As every condition of man, whether in sickness or in health was directly ascribed to the action

\textsuperscript{72} Ibid., p.18.
\textsuperscript{73} Ibid., p.7.
\textsuperscript{75} Ibid., p.71.
of God, this belief also tended to hold up the development of professional medicine on a rational and scientific basis. 

In Old Testament times the physician was almost non-existent, with disease being regarded as God’s punishment for sinful behaviour. As sin was the domain of the priests, the sick were expected to seek the priests’ aid for treatment.\(^{77}\) The belief was that if a man abided by the law of Moses he would not become sick. ‘I will not bring on you any of the diseases I brought on the Egyptians, for I am the Lord, who heals you’. (Exodus 15:26). However, as Walker points out, Exodus refers to large epidemics and in this field ancient Jewish medicine excelled. In an effort to prevent large scale disease, the priests laid down clear and efficient instructions in the Book of Leviticus on consumption of proper and improper food, clean and unclean objects, the hygiene of childbirth and the prevention of contagion.\(^{78}\) Of course, the author of the Book of Job courageously challenged the belief that sickness was a punishment and insisted that some sufferers were undoubtedly innocent. It is made clear in Chapters One and Two of the Book, however, that Job’s affliction was the work of Satan, allowed by God as a test of Job’s faith. In the final chapter Job is praised by God for his faithfulness and made prosperous by God giving him twice as much as he had before his affliction.

Although very few physicians or midwives are named in the Bible, there must have been many in each community. A midwife is recorded as assisting with the birth of Rachel’s child in Genesis,\(^{79}\) and another in delivering Tamar’s twins.\(^{80}\) In Exodus the midwives Shiphrah and Puah are specifically named,\(^{81}\) whilst we are also told that the Midianite Zipporah, wife of Moses, took a flint knife and cut off her son’s foreskin, thus performing the medical/religious act of circumcision. Apart from these obstetrical and circumcision references, the only other direct medical procedure mentioned in the Bible is a form of bandaging. Ezekiel records that the broken arm of Pharoah, King of Egypt, had not been bound up or put in a sling to aid healing.\(^{82}\)

In the period between the two Testaments, the accredited author of Ecclesiasticus, Jesus Ben Sira,\(^{83}\) writing in about 190 BC, advised the people of

\(^{76}\) Ibid., p.192.

\(^{77}\) Walker, op.cit., p.31.

\(^{78}\) Ibid., p.31.

\(^{79}\) Genesis 35:17.

\(^{80}\) Genesis 38:28.

\(^{81}\) Exodus 1:15-21.

\(^{82}\) Ezekiel 30:21.

\(^{83}\) Accredited author of Ecclesiasticus. This is one of the deuterocanonical books originally written in Hebrew. In Greek it became known as the Wisdom of Jesus Ben Sirach, later becoming Ben Sira or Sirachides. The Jerusalem Bible, Darton, Longman and Todd, London, 1966, p.1034.
Jerusalem to honour the physician and to use his skill in their need of it. His emphasis on the Divine origin of the art and the high place of the profession among great men, read like an argument against objections to the introduction of a foreign practice. In that period, religious men had no objection to medicine in itself and a number of healers or physicians were apparently practising, with many remedies already being adopted by the people. However, on the part of the orthodox, a strong feeling existed against physicians who did not associate their healing with the ceremonies enjoined by the Law; it is clear that the priests were regarded as experts in medicine.

b. The Early Christian Era

Greek physicians were probably the first in Jewish experience to use fewer or no religious formulae in their art. Hippocrates, the so-called Father of Medicine, born on the Greek island of Cos in about 460 BC, did much to separate medicine from magic and the supernatural. Short writes:

He stressed the importance of careful bedside observation, honest thinking and honest practice, and he set the profession a high standard of medical morals, including the famous Hippocratic Oath. He denied that even epilepsy, previously known as the sacred disease, was caused by God or devil.

Although about seventy books were written by Hippocrates and his followers, it is not known how many were actually the work of Hippocrates himself. They do, however, reflect Hippocrates’ approach to medicine and can be considered the start of medical practices as we know them today. His treatments were based on simple, commonsense ideas such as rest, diet, fresh air, massage, and blood-letting; his bone dislocation methods were excellent; his practice of keeping wounds dry, apart from treating them with wine or boiled water as a forerunner to antiseptics, was an early attempt to prevent infection.

Arguably the most influential physician after Hippocrates was Galen, born in 129 AD at Pergamum. It is thought that, whilst very young, Galen became a *therapeutes* of Asclepius in the cult’s Pergamum sanctuary. Galen then furthered his education at Smyrna, Corinth and Alexandria. Being born into the cultural governing

---

85 Jeremiah 8:22; Chronicles 16:12; Isaiah 1:6, 28:21.
86 See the various Levitical laws on leprosy, with the implication that the priests could distinguish the various kinds of it, cf. 2 Chronicles 16:12.
87 Smith, *op.cit.*, p.404.
class, Galen’s father had planned for him to study philosophy or politics. However, the god Nicon spoke to Galen’s father in a dream telling him to allow his son to study medicine. He was rich and independent and upon returning to Pergamum he gained the prestigious appointment of physician to the gladiators. This position gained Galen invaluable practical experience in trauma and sports medicine. He later practised in Rome, giving public lectures and anatomical demonstrations which brought him to the attention of the Emperor Marcus Aurelius; both Marcus and his son Commodus became patients of Galen. Many of Galen’s manuscripts were destroyed by fire in 191 AD; however, the remains of his work fill some twenty volumes in Greek, with other works surviving only in Arabic or medieval Latin translations. Galen’s medieval writings cover most aspects of medical theory and practice in his era, including anatomy, physiology and therapeutics. Galen died in Rome sometime after 210 AD. His importance to European medical thought from the fall of Rome to modern times, cannot be overstated.\footnote{91} As Lee Pearcy notes:

> Even as late as 1833, the index to Karl-Gottlob Kuhn’s edition (still the only nearly complete collection of Galen’s Greek works) could be designed for working medical practitioners as well as for classical scholars. Galen absorbed into his work nearly all preceding medical thoughts and shaped the categories within which his successors thought about, not only the history of medicine, but its practice as well.\footnote{92}

As to reputable writers close to New Testament times, we know of Aulus Cornelius Celsus, born about 10 AD in Rome, and Aretaeus of Cappadocia. Celsus, who was not himself a physician, wrote an encyclopaedia which included agriculture, military art, rhetoric, philosophy, law and medicine; however, the medical portion known as \textit{De Medicina} is all that has survived. \textit{De Medicina} was discovered by Pope Nicholas V (1397-1455) and in 1478 it became one of the first medical works to be printed. Celsus depicted an advanced state of medical practise at the time, recommending cleanliness, use of vinegar and thyme oil as antiseptics, and describing plastic face surgery by using skin from other parts of the body. The Celsus Treatise was divided into three parts: dietetic, pharmaceutical and surgical. It describes heart disease, insanity, the use of ligatures to stop arterial bleeding, extraction of goitres, tonsils, and nose polypi, as well as hydrotherapy and lateral lithotomy. The first account of dental practice was also offered. The work of Celsus has become

\footnote{91}{Pearcy, Lee T., “Galen’s Pergamum”, in \textit{Archaeology}. 38.6 November/December, 1985, pp.33-39.}
\footnote{92}{Ibid., p.39.}
historically important, being responsible for much of what is known about Hellenistic medicine and Alexandrian anatomy and surgery.\textsuperscript{93}

Aretaeus (about 150 AD), a Greek physician from Cappadocia, practised in both Rome and Alexandria. Aretaeus held that good health was maintained by pneuma (vital air) and that an imbalance of blood, phlegm, choler (yellow bile) and melancholy (black bile) disturbed the pneuma. Two of his manuscripts, in the Ionic dialect, were discovered in 1554; they discussed tuberculosis, pleurisy, diptheria, tetanus, pneumonia, asthma, epilepsy, and spinal and cerebral paralysis.\textsuperscript{94}

We learn from Homer’s epic poem \textit{The Iliad} that women also played a part in Ancient Greek nursing and healing. The poem describes how women washed the injuries of the wounded and covered them with sedative dressings. Homer also mentions a healer named Agamede, describing her as ‘A leech (healer) was she, and well she knew, all herbs on ground that grew’.\textsuperscript{95}

Other evidence of women involved in healing was found on a number of tombstones erected during both the late BC and early AD periods. The following examples indicate that women were not limited to midwifery duties alone, they also practiced as physicians:

Phanostrate, a midwife and physician, lies here. She caused pain to none and all lamented her death.

\textit{Athens 4 BC.}\textsuperscript{96}

To my Holy Goddess. To Primilla, a Physician, daughter of Lucius

\textit{Vibius Melita.}

\textit{Rome, 1st/2nd Century AD.}

You guided straight the rudder of life in our home and raised our common fame in healing - though you were a woman, you were not behind me in skill. In recognition of this, your bridegroom Glycon built this tomb for you.

\textit{Panthia, Pergamum, 2nd Century inscription by her husband.}\textsuperscript{97}

During the first century AD women healers gained popularity amongst the Romans, with Pliny the Elder praising three by name: Elephantis, Salpe and Sotira,


\textsuperscript{94} Gordon, \textit{op.cit.}, pp.476, 495, 539; \textit{The Oxford Classical Dictionary}, \textit{op.cit.}, p.86.

\textsuperscript{95} Homer, \textit{The Iliad}, X1, 740C. (Sixth Century B.C). in Bourdillon, \textit{op.cit.}, p.8. See also Purves, John (trans,) \textit{The Iliad of Homer}, (ed. and intro.) Abbott Evelyn, Percival and Co. London, 1891, p.199.

\textsuperscript{96} Bourdillon, \textit{op.cit.}, p.8

\textsuperscript{97} Ibid., p.9.
who were not only midwives but also skilful at curing many diseases.\textsuperscript{98} Salpe and Elephantis appear to have been quite prominent women; Salpe wrote on the diseases of women\textsuperscript{99} and Elephantis composed poems which were admired by the Emperor Tiberius.\textsuperscript{100} Pliny discusses Salpe quite extensively, saying that she believed sensation could be restored to a numbed limb by spitting into the bosom, or by touching upper eyelids with saliva.\textsuperscript{101} She used urine as a foment to strengthen eyes and also as a cure for sunburn, for which she would mix the fomented urine with an egg, preferably that of an ostrich, and apply it to the sunburn for a period of two hours.\textsuperscript{102} Salpe held that the flux on wool of a black ram, enclosed in a silver bracelet, would cure tertians and quartans, both forms of malaria,\textsuperscript{103} and mad dog bites.\textsuperscript{104} According to Pliny, Sotira also considered flux to be an efficacious remedy for tertians and quartans, her method being to smear the soles of the patient’s feet with the flux. Sotira further believed that this same procedure would revive an unconscious epileptic patient.\textsuperscript{105}

During the time of the Gospels and early Christianity, the walled city of Jerusalem was the Jerusalem of Herod. The Romans appointed Herod the Great to be king of Judea in 40 BCE. His sovereignty was established three years later with the capture of Jerusalem. Tombs of Herod the Great’s family and of the high priest Caiaphas have been located in cemeteries bordering the north and east of the city. Security was of the utmost importance and Herod built the Antonia fortress on the site of the Hasmonean Baris at the northwest corner of the Temple. Named for Mark Antony it must have been completed prior to the latter’s defeat in 31 BCE. According to Acts 21:27 - 22:30 Paul was at one time imprisoned there. A Roman garrison was based there after 6 CE. This may have influenced the growth of the healing shrine outside the city walls which is mentioned in John 5:1-9. Herod built a theatre and an amphitheatre and erected a podium at the highest point of the upper city to elevate his splendid palace. This was protected by three great towers, Hippicus, Mariamne and Phasaelis. The great base of Phasaelis, part of today’s Citadel, is the only element of the palace which remains. The Sanhedrin was seated in the Temple, with religious and

\textsuperscript{98} \textit{Ibid.}, p.9.
\textsuperscript{100} \textit{Ibid.}, p.59.
\textsuperscript{101} \textit{Ibid.}, p.29.
\textsuperscript{102} \textit{Ibid.}, p.49.
\textsuperscript{103} Tertians is a serious form of malaria with an onset every other day. Quartans is a milder form with longer interval between each bout of the disease.
\textsuperscript{104} Pliny, \textit{op.cit.}, p.59.
\textsuperscript{105} \textit{Ibid.}, p.61.
civil jurisdiction over Judaea and was a great influence in Galilee and elsewhere.106 There were also the Sadducees and Chief Priests, an ecclesiastical but unspiritual aristocracy, arrogant and unscrupulous. There were also the Pharisees and Scribes, zealous in education, patriotic and religious in their ideals, and influential with the multitude. Added to this were an army of priests, Levites and Temple servants with a warlike as well as a spiritual discipline. There were many wealthy families and a considerable volume of commerce and industry, but also swarms of idlers and mendicants. Nevertheless, because of the comparative sterility of the surrounding poverty, a general precariousness of existence prevailed, which under drought or invasion rapidly became famine, especially if this coincided with a Sabatic year.107 This was the society which existed at the start of the Christian era and the way of life into which Jesus Himself was thrust.

A number of Biblical passages written during or regarding this time emphasize God’s involvement in illness and physical handicaps through the ministry of Jesus. Mark tells of the healing of a demon-possessed man (5:1-20) and the healing of a deaf and mute man (7:31-37) whilst Mark (8:22-26) and John (9:1-7) record the healing of a blind man. In Matthew 25:31-46, Jesus reminds us that God expected His people to visit the sick. Adhering to this directive, the Apostolic Constitutions state that ‘the early bishops were to look after the sick among their flock in fulfilment of Christ’s command’,108 whilst ‘the apostle John's student, Bishop Polycarp of Smyrna also listed the care of the sick among the primary responsibilities of Church Elders in the early second century’.109 Rules also emanated from Rome obliging the bishop to seek out the sick in their own houses.110 This directive came from Hippolytus (r.217-35 AD.) who has the distinction of being the only antipope to be canonized, thus becoming Saint Hippolytus. It is also understood from Hippolytus, that the deacons took the Blessed Sacrament to the sick or homebound each Sunday following the Eucharist.111 During Hippolytus’ time, there is also evidence that deaconesses were

---


107 Smith, George Adam, Jerusalem - From the Earliest Times to AD. 70, Vol. 2.


ministering to the sick. Pope Innocent the Second decreed in 417 AD that the sick in every congregation must be anointed with oil and deaconesses commonly performed this duty. On this subject, Carl Valz states that ‘by this time such visitations were made either by the pastor or by others who were designated for this purpose, both men and women’.\(^{112}\)

By the 4th century AD the Greek Fathers had become prominent in caring for the sick in a loving Christian way as commanded by Christ. St. Basil, or Basil the Great, bishop of Caesarea, led by example in ministering to the sick in imitation of Christ,\(^{113}\) whilst Gregory of Nyssa succeeded in raising care of the sick to an important level in Christian conduct.\(^{114}\) Gregory of Nazianzus similarly stressed the need for mercy towards the sick in his sermon on \textit{philanthropia}., a word used to describe love and practical benevolence towards mankind.\(^{115}\)

All this has continuing relevance to this present day: the Christian sick and housebound are, when necessary, still ministered to in their own homes in the name of the Lord. Such visits are made by parish clergy and lay assistants of most denominations and also, on occasions, by hospital chaplains, who feel a patient would benefit from post-hospital ministry.

c. The Middle Ages

In the Middle Ages magic akin to that recorded in the Ebers and Edwin Smith papyri reasserted itself in medicine. This took the form of church ceremonies to rid a patient of devils and the exhibition of holy relics of the saints which were believed to possess healing powers.\(^{116}\) Keith Thomas states:

\begin{quote}
the ability to perform miracles soon became an indispensable test of sanctity. The Medieval Church found itself saddled with the tradition that the working of miracles was the most efficacious means of demonstrating the monopoly of truth.\(^{117}\)
\end{quote}

On the eve of the Reformation in the 16th century AD, the Church as an institution did not claim the power to perform miracles, nor did it advocate that the saints as intercessors would cure all who entreated them. It did, nevertheless, receive

\(^{112}\) Valz, \textit{op.cit.}, p.152.
\(^{116}\) Walker, \textit{op.cit.}, p.23.
much prestige when any member of the Church was considered to be blessed by God with miraculous gifts. Thus, when the sick could not find relief from any other source, many made pilgrimages to holy shrines in the hope of a supernatural cure. Glastonbury, Walsingham and Canterbury were popular English shrines, with others in France, Italy, Jerusalem and Spain. The shrine of St. James of Compostella in Spain became particularly famous for the cure of leprosy. The bay of Compostella was famed for fish and shellfish, and the leper pilgrims who came to pray at the altar of the Saint and to bestow gifts at his shrine were fed on those and were healed, according to the belief of the period, by the miraculous intervention of the Saint. As the palm was the badge of the pilgrims to Jerusalem, the scallop shell was the badge of the pilgrims to Compostella. Crowds of leper pilgrims from across Christendom resorted to this shrine and many of them were healed, to the glory of the Saint and the enrichment of his shrine. In their gratitude, pilgrims offered costly oblations of silks and satins, of raiments and vestments, of silver and gold, of pearls and precious stones, so that the shrine of St. James of Compostella became famous throughout the world. Many shrine pilgrimages still occur today, with a number of cures being reported both in the past and the present.

d. The Emergence of Hospitals

Some authorities claim that, as long ago as 4000 BC, temples of the ancient gods were used as houses of refuge for the sick and infirm. Kenneth Walker relates the legend of Asclepius, the aforementioned Greek god of healing, explaining that his success as a healer in averting death and performing miracles created jealousy in Pluto, ruler of the underworld. Pluto complained to Zeus, father of the gods, that the supply of new souls to the shades was being endangered by so much healing and Asclepius was slain with a thunderbolt. This legend resulted in the many temples known as Asklepieia being erected to the slain god’s memory, to which the sick were brought for treatment. The ruins of the most famous of these Asklepieia are still to be seen at Epidaurus.

Paul Starr claims that the prime purpose of the early hospitals in pre-industrial societies was to provide a religious and charitable haven for the sick to rest, rather than to provide medical institutional type cures. Henry Sigerist has a similar view:

Only in the second half of the nineteenth century did hospitals become anything more than the last refuge of the desperately poor and although Christian philanthropy had given birth to hospitals as early as the

119 Walker, op.cit., p.35
fourth century AD, these institutions had failed to evolve into centres of scientific medical treatment.  

Timothy Miller, however, argues that Starr and Sigerist are referring only to the situation in Western Europe and have ignored the medical facilities available in the province of the East Roman Empire, now referred to as the Byzantine Empire. Many elaborate and advanced medical institutions were founded in this region. These Byzantine medical facilities operated as general hospital, leprosaria, maternity clinics, ophthalmological dispensaries and foundling institutions. Unfortunately, as Demetrios Constantelos states, not much is known about the hospitals in popular cities such as Antioch and Alexandria and only a few hospitals can actually be named, mostly those in Constantinople. Hospitals, clinics and hospices, known as xenones, were erected under the auspices of the Church, the emperor or the State in general and even, at times, by wealthy lay benefactors as a recognition of their piety. Whilst these ecclesiastical institutions were considered as places of healing for the human body, so the Church was thought of as a hospital for the human soul. This thought resulted in most of the ecclesiastical institutions being attached to a place of worship. Like the Ancient Greeks, the Christian sick followed the practice of invoking divine healing; not by Asclepius, but by God, Jesus and the Theotokos, or a saint. Theotokos, meaning God-bearing, is a theological attribute of the Virgin Mary from the Eastern tradition.

The Greek Fathers, Basil the Great, Bishop of Caesarea in Cappadocia and John Chrysostom, the Patriarch of Constantinople, both built hospitals in the fourth century. Basil established a general philanthropic institution, including a hospital known as the Basileisas in honour of Basil. This institution was founded about 372 AD and is thought to be the first organised charitable system in the Christian Greek East. When Basil opened his ptochotrephion outside Caesarea, he saw its medical services as the deepest possible expression of philanthropia. In its literal meaning a ptochotrephion is a poor house which could designate a place designed to shelter and feed the destitute. It was described by Gregory of Nazianzus as being a place where ‘one could see love put to the test in the treatment of disease’.

---

122 Miller, op.cit., p.3.
125 Miller, op.cit. p.26
126 Gregoire de Nazianze In laudem Basili, Chap.63.1 (PG36:577). In Miller, op.cit., p.61.
Whilst Basil was responsible for the first Byzantine philanthropic institution, a Roman woman known as Fabiola was, according to St. Jerome, the first person to establish a Christian hospital in Rome. This was described as 'a place where she might gather sufferers out of the streets and where she might nurse the unfortunate victims of sickness and want'.\footnote{Jerome, 'Letter 76.6 Nicene and Post-Nicene Fathers of the Christian Church'. 2nd Series, VI., New York, 1893, p.160. Constantelos \textit{op.cit.}, p.154.} Fabiola was twice married, having divorced her first husband, and on the death of her second husband she embarked on a life of austere penitence by joining the Patrician gens Fabia Order. In 395 AD Fabiola spent time in Bethlehem where she became associated with St. Jerome, before returning to Rome to continue her charitable works until her death in 399 AD. Fabiola was ultimately canonised by the Catholic Church as a saint.\footnote{Cross, \textit{op.cit.}, p.490.}

With the prominence of the Army in Rome, many well-equipped camp hospitals emerged, with permanent hospitals being founded in towns where the Roman army became an occupying force. These hospitals not only treated the Roman soldiers, but also their families and other prominent civilians. Gradually the Romans allowed the poor sick, athletes and gladiators to be treated in these military hospitals. A reconstruction from plans of one Roman hospital situated on the Rhine shows it could accommodate two hundred patients, with indications of good ventilation, hygienic drainage and excellent water supplies.\footnote{Leff, \textit{op.cit.}, p.77.} The ruins of a large Roman military hospital can also be seen at Novaesium which contained about forty wards, administration offices, a kitchen and a dispensary.\footnote{Walker, \textit{op.cit.}, p.62.}

About the time Basil and Fabiola were founding their hospitals in Caesarea and Rome, John Chrysostom built his hospitals in Constantinople as a glorification of Christ. Since tending the sick was considered a religious duty by the ascetics, John Chrysostom was able to recruit many of them to staff his hospitals.\footnote{‘Palladii dialogus de vita, S. Joannis Chrysostomi’, ed. Paul R. Coleman-Norton, Cambridge University Press, 1928, p.32. In Miller, \textit{op.cit.}, pp.61.62.} According to Constantelos, however, the oldest known hospital in Constantinople was that built by Hosios Marcianos near the Church of St. Irene at the Perama during the reign of Marcian, although very little is known about it.\footnote{Constantelos, \textit{op.cit.}, p.156.} Again following Basil's example, Bassianos, the fifth century Bishop of Ephesus and a participant in the Council of Chalcedon, established a hospital in his diocese for seventy or eighty patients, followed by Theodosios the Coenobiarches who founded a house for sick monks,
another for important lay personages and yet another for the poor and needy, which also served as a home for elderly monks.  

When Emperor Justinian came to power in the sixth century, he was petitioned by St. Sabos to build several hospitals in Jerusalem to cater for the needs of foreigners and strangers who became sick whilst visiting the Holy City and its monastic community. One complex, next to the Church of the Theotokos in Jerusalem, comprised two institutions, one of which was a large hospital for the poor supported by an annual revenue from the State. Justinian, with the co-operation of his wife Theodora, also built and expanded hospitals in Constantinople and, when special leprosariums fell into disrepair, Justinian restored or replaced them.

By the twelfth century, the Byzantine hospital situation had improved dramatically. In 1136 the Emperor John and his wife Irene established a monastery known as Pantocrator which housed a hospital. The significance of Pantocrator lies in the fact that it was a medical centre in the modern sense of the term. Many staff were employed and the hospital included a chapel divided into two sections, one for men and one for women, with regular religious services being held. The subsequent rise of the monastic orders also resulted in the creation of hospitals which, together with hospices and schools, functioned as an integral part of the monasteries. Religious orders continued to care for the sick, founding a number of hospitals in the Mediterranean area, particularly during the Crusades. The best known of these orders was the Knights of St. John of Jerusalem. By the eighteenth century individual physicians had begun to operate private hospitals; independent public hospitals also began to appear by then, but the Churches still maintained their monopoly.

e. The Development of Hospitals in the West

In France, the seventh century Church founded the independent hospital Hotel-Dieu in Paris under the direction of Saint Laudry, the Bishop of Paris. The thirteenth century statutes of this hospital refer to the dormitory for patients as ‘the infirmaria pauperum (the infirmary of the poor)’. According to these statutes the religious community of lay brothers and sisters attended to the bedridden patients; no regular medical staff were maintained. In fact, it appears from the statutes that, before the fourteenth century, physicians and surgeons only treated patients occasionally at

133 Symeon Metaphrastes: Vita S. Theodosii, Ch.33. MPG, CXIV, Col. 501A., in Ibid., p.157.
134 Constantelos, op.cit., p.159.
135 Ibid., pp.171/5.
137 ‘Statua domus Dei Pariensis’ Chap.22, Statuts 46. In Miller, op.cit., p.5.
this hospital.\textsuperscript{138} During this same period, the Hospital of the Holy Spirit in Rome was also designed ‘solely for receiving patients who suffered both from poverty and disease’.\textsuperscript{139}

Santa Maria Nuova was founded in Florence by Folco Portinari (1288 AD), together with the Santa Maria della Scala in Siena. These latter two hospitals became models for others, as can be seen from a Bull of 1449 which ‘gave the confraternity of S. Matteo in Pavia papal approval to erect a hospital in the city which was to be designed ‘with a chapel, bells and cemetery for the poor...in the likeness of the hospitals of Florence and Sienna’.\textsuperscript{140}

In London, after visiting St. Bartholomew’s Hospital in 1316 AD, the Bishop of that city ‘enjoined the master to order the brothers or sisters of the hospital who were responsible for admitting the infirm, to give preference to those who were most in need and not to send them away until they were restored to health’.\textsuperscript{141} This would seem to indicate the continued entwinement of religion and sickness in England. The reign of Henry VIII (1509-1547 AD), however, saw the demise of a considerable amount of the power and influence which had been wielded by the monasteries; at this time, in the words of Samuel and Vera Leff, ‘the noble order of nursing was established on a secular basis’.\textsuperscript{142} It could reasonably be expected that by the seventeenth century the medical profession as a whole would have progressed to a fairly acceptable standard. This was not the case in London, however, as only two hospitals of any importance for the physically ill existed there at the end of the seventeenth century, these being St. Bartholomew’s and St. Thomas’.\textsuperscript{143} Upon founding St. Bartholomew’s in 1123, the monk Rahere became its first Master, retiring in 1137 to denote himself to the Priory. Both the Priory and the hospital were desolved in 1539 and refounded by Henry VIII in 1547. Whilst St. Bartholomew’s still remains one of London’s busiest hospitals, it has not gained the fame afforded to St. Thomas’, which subsequently played an historial part in the training of Florence Nightingale’s nurses. Saint Thomas’ was founded in the twelfth century in the Priory

\textsuperscript{138} Miller, \textit{op.cit.}, p.5.
\textsuperscript{139} ‘Regula ordinis Sancti Spiritus in Saxia’ Capp.40, 42, 43, Pl.217:1145-46. In Miller, \textit{op.cit.}, p.5.
\textsuperscript{142} Leff, \textit{op.cit.}, p.90.
\textsuperscript{143} Thomas, \textit{op.cit.}, p.13.
of St. Mary Overy, Southwark. The Priory is thought to have been founded in 1106, although the exact date on which the hospital, or hospice, was created is not known. The Augustinians of the Priory would doubtless have followed their Order's tradition of tending the sick. In 1212 the building, except for the refectory, was destroyed by fire and rebuilt close by. However, the rebuilt hospital was separated from the purely religious side of the Priory. The original hospice was known as the Priory Hospice of St. Thomas the Martyr, the forerunner to St. Thomas' Hospital. Southwark Cathedral now stands on the site of this early Priory. The Priory Hospice was rebuilt on the eastern side of Borough High Street, after which many changes occurred. In 1539, Henry VIII, was on the throne and he dissolved St. Thomas', accusing the Roman Catholic Brothers of immorality and maladministration. It was not reopened until 1552 by Henry's son King Edward VI, as a secular hospital. At this time the name was changed from the Priory Hospital of St. Thomas the Martyr to the Hospital of St. Thomas the Apostle. In 1862, the hospital was again closed, this time for an expansion of Charing Cross Railway. The Hospital was moved to Lambeth, adjacent to Lambeth Palace, the London home of the Archbishop of Canterbury, and reopened in 1871. After extensive bomb damage during World War Two, the hospital again needed much rebuilding. St. Thomas' had its coat of arms granted only in 1950, summarising the 800 year history of the hospital by remembering St. Thomas a' Beckett, St. Thomas the Apostle, King Edward VI, Florence Nightingale, and the City of London. In 1993, the Guys and St. Thomas' Hospitals' Trust was created, formally bringing together the two hospitals which have had a long connected history. This connection originated by the election of Thomas Guy as a Governor of St. Thomas' Hospital in 1704 and the subsequent founding of Mr Guy's Hospital opposite St. Thomas' in 1725.\textsuperscript{144}

In his book \textit{The Story of England's Hospitals}, Courtney Danton notes that St. Thomas' Hospital appointed its first chaplain in 1726 and that such was the estimate of the chaplain's office that the authorities paid him 80 pounds a year, which was double the salary of a physician or surgeon.\textsuperscript{145} However, more extensive research shows that a precursor to the office of chaplain was that of the hospitaller. The hospitallers were members of various religious bodies, with their primary duty being to care for the sick or needy in a hospital. The first recorded St. Thomas' hospitaller was the Protestant Sir William Morsette in 1552, followed by Sir John Mirriall in 1553 and Sir Henry Boston in 1557, both of whom are believed to have been Roman Catholic; this was during the five year reign of Mary Tudor whose zeal

\textsuperscript{144} Sawyer, Richard, \textit{The History of Guy's and St. Thomas' Hospitals}, unpublished Seminar Paper, 20 Oct., 1999. This paper was written by Richard Sawyer as Administrator of Special Trustees of St. Thomas' Hospital.

for Roman Catholicism may have influenced the election of these two latter hospitallers. Much changed at St. Thomas’ when Elizabeth I, became queen, with the old faith of Mary’s reign being replaced with a more Protestant one. Following William White’s election as a Protestant hospitaller in 1564, all subsequent hospitallers appear also to have been Protestant. Upon William White’s election a formal duty list was drawn up for him on June 26, 1564, penned in Latin. These duties were extensive and showed the position of the hospitaller to be one of the busiest in the hospital. He was expected to read to and teach the poor, lame, sick and diseased daily within the hospital, conduct a common religious service and administer the sacraments to the poor, and bury the dead. In addition to these spiritual duties, the hospitaller was required to collect one shilling a week from those inmates who could afford to pay; keep records of payments; distribute coals and billets of wood to the poor; allot new cases to respective surgeons; distribute leaden tokens to inmates who were allowed to go out; receive and tally the names of all night layers (lodgers).  

The night layers had been cared for at St. Thomas’ since it was refounded in 1553 and the practice was still in existence in the mid-1600s. This care was in the form of night shelter for the homeless. Parsons notes that:

> Since I have found no record that the shelter was furnished with beds, I fear that all these people received was shelter, some straw upon which to lie and a warm, foetid atmosphere to breathe. If they liked they could earn a few pence grinding corn at the mill, but they were not actually made to do any work. By the eighteenth century Hospital Minutes, nothing further is said about these night layers.  

After 1565, the hospitalller was given the added duties of receiving and storing the clothes of all males dying in the hospital until the court decided what to do with them. He was also required, with the matron, to present all cases of offence at the governors’ weekly meeting and, in addition, the hospitalller was ordered to administer the sacrament to the Sisters and receive their offerings which had previously been attended to by the church curate. All these duties were performed for ten pounds a year, plus burial fees, a place to live, and four pints of beer per day. In 1650, the hospitalller’s spiritual duties were changed to praying and expounding a piece of the scriptures daily, preaching twice on Sundays, and visiting the sick and weak. He was no longer to bury anyone alone and was not to marry or baptise anyone in the chapel. Parsons considers this was done to free the hospitalller from the need to use the Book

147 Ibid., Vol.2, p.41.
148 Ibid., Vol.1, pp.196/7.
of Common Prayer because of its translations of earlier Catholic canticles and prayers.\textsuperscript{149} By the nineteenth century the hospitaller’s duties had become primarily religious, with the added task of running a small patients’ library.

No reference is made by Parsons that the first chaplain was appointed to St. Thomas’ Hospital in 1725. Similarly, on contacting St. Thomas’ direct, they stated that they had no knowledge of this in their records, a new hospitaller was not even appointed during that year. The present St. Thomas’ Hospital library does, however, hold a copy of Septimus Vaughan Morgan’s reproduction and translation of a manuscript written by John Howes in 1582,\textsuperscript{150} which records that ‘Gardiner, Bishop of Winchester, who was then Lord Chancellor, forced the governors of St. Thomas’ to erect a chapel, to appoint a mass priest for their hospitaller, and to have mass said daily’. Unfortunately, Howes did not supply specific dates and no Minutes were recorded until 4 January, 1557. If the information is correct, however, this would probably have occurred during the reign of Mary Tudor.\textsuperscript{151} Although this manuscript was not written until 30 years after the events it discusses, Parsons considers that, as private secretary to Richard Grafton, the first Treasurer General of the Royal Hospitals, Howes would have had access to authentic records from which to compile his manuscript.\textsuperscript{152}

In the appendixes of each volume of his \textit{History of St. Thomas’ Hospital}, Parsons lists the presidents, treasurers, physicians, surgeons, hospitallers and matrons from 1215 A.D. onwards, but not chaplains. However, when referring to the hospital staff during Mary Tudor’s reign, Parsons lists the hospitaller as ‘the hospitaller (chaplain)’.\textsuperscript{153} From the above, it would appear that ministry to patients and staff in the past was performed by a combination of the hospitaller and clergy from the adjoining St. Thomas’ Church and that such ministry was far removed from the present day hospital chaplain.

St. Thomas’ Hospital became renowned for the part Florence Nightingale played in its history, which culminated with the opening of the Nightingale Training School for Nurses in 1860.\textsuperscript{154} This school established England as a leader in training women for the nursing profession; England had not been prominent in early times in training women for the medical profession. Women in Italy were accepted into medical schools by the Middle Ages, whilst most of Northern Europe, France and

\begin{thebibliography}{9}
\bibitem{149} \textit{Ibid.}, Vol.2, pp.78/9.
\bibitem{150} Howe, John, \textit{The Order and Manner of the Proceedings in the First Erection of the Three Royal Hospitals of Christ, Bridewell and St. Thomas the Apostle, 1582.}
\bibitem{151} Parsons, \textit{op.cit.}, Vol.1, p.164.
\bibitem{152} \textit{Ibid.}, Vol.1, p.129.
\bibitem{153} \textit{Ibid.}, Vol.1, p.182.
\end{thebibliography}
England still did not allow women into their universities and the bishops issued medical licences as opposed to the City Authorities. Monastic chronicles and Parliamentary rolls indicate, however, that some women were practising medicine in England.\textsuperscript{155} Midwifery also became increasingly under the control of the Church in England; Bourdillon notes that a law was passed in 1512 forcing all midwives to obtain a licence from the bishop before they could practice.\textsuperscript{156} 

By the Middle Ages, there is evidence of medical licences being issued to women in major Italian cities, such as Venice, Rome, Naples and Florence. One early fourteenth century licence mentioned by Helen Bourdillon is quoted below:

\begin{quote}
Since then, the law permitted women to exercise the profession of physician and since, besides, due regard being had to purity of morals, women are better suited to the treatment of women’s diseases. After having received the oath of fidelity, we permit ............(name).\textsuperscript{157}
\end{quote}

Florence Nightingale was revered for many years as a compassionate and dedicated carer of the sick and suffering. As the nursing profession developed, requiring education and training, Nightingale also began to be seen as an efficient administrator, researcher and scholar.\textsuperscript{158} Born in Florence in 1820, Nightingale claimed that God spoke to her at the age of seventeen calling her to his service, but she was 33 before this began.\textsuperscript{159} Nightingale had become interested in nursing some time before this, but her upper class English family had raised objections. However, she was determined and decided that even if she could not work in a hospital she would learn all she could about hospital administration, desired improvements and the causes of mortality.\textsuperscript{160} This proved to be an advantage. In 1853 Nightingale became Superintendent of a London charitable Institution for the Care of Sick Gentlewomen. Although this Institute was originally for members of the Church of England, Nightingale insisted on admitting women of all faiths who were in need of help. Her main problem during this time was the lack of properly trained nursing staff.\textsuperscript{161}

With the advent of the Crimean war in 1854, Nightingale was asked to command a party of female nurses being sent to Scutari to assist the wounded and the many hundreds of cholera stricken soldiers. Her official governmental title was

\begin{flushleft}
\textsuperscript{155} Ibid., p.12. 
\textsuperscript{156} Ibid., p.24. 
\textsuperscript{157} Bourdillon, op.cit., p.12. 
\textsuperscript{159} Huxley, op.cit., p.16. 
\textsuperscript{160} Ibid., pp. 30 & 38. 
\textsuperscript{161} Ibid., pp.47 & 50. 
\end{flushleft}
Superintendent of the Female Nursing Establishment of the English General Hospitals in Turkey. Nightingale and her party were the first women to nurse wounded soldiers in the jealously-guarded male preserve of war and medicine. Perhaps not surprisingly, difficulties arose in recruiting suitably experienced nurses for Scutari, with only fourteen applying. But Cardinal Manning influenced the Roman Catholic Church to send 10 nuns, whilst the Church of England provided another 14 sisters.\textsuperscript{162} The state of the Barrack Hospital at Scutari and the prejudice against the women, created tension amongst them, many of whom began to drink excessively. When the wounded from the battle of Balaclava arrived, the doctors boycotted the nurses, refusing to utilise their nursing skills. Nightingale did not force the issue, setting her women the tasks of sorting linen and feeding patients to keep them occupied. However, the time came when the doctors could no longer cope alone and turned to the nurses for help. Despite the horrendous conditions under which the women were working, at no time did Nightingale relax her strict code of discipline; she did not hesitate to send nurses home for flaunting the rules.\textsuperscript{163} It was during her time at Scutari that the now famous description of Nightingale was initiated. Each night she would go around to the sick and wounded carrying a Turkish lantern which held a single candle inside a circular collapsible shade; from this, the phrase ‘the Lady of the Lamp’ was born.\textsuperscript{164}

When the war ended, Nightingale returned to England, turning her attention to army health. In 1860 an Army Medical School was opened primarily through her efforts. She was also involved in the planning and building of new hospitals, most notably, that of the new St. Thomas’ hospital in Lambeth. This was completed in 1871 becoming, and remaining today, one of the world’s most renowned hospitals. After the planning of hospitals, Nightingale moved on to creating an efficient nursing service to work in them. She used the proceeds from the 1855 Nightingale Fund, a tribute to her own services, to open a training school for female nurses.\textsuperscript{165} In Elspeth Huxley’s words:

\begin{quote}
The Nightingale Training School for Nurses at St. Thomas’ Hospital was opened on 24 June, 1860, adhering to Florence’s strict views on hygiene and discipline, and the best technical training available given by senior sisters, surgeons and physicians. At the end of the course the names of the trainee nurses were to be placed on a Register of Certified Nurses, which ultimately became the Roll of State Registered Nurses.\textsuperscript{166}
\end{quote}

\textsuperscript{162} Ibid., pp.62/3 & 70/1/2.
\textsuperscript{163} Ibid., pp.76/7/9 & 83.
\textsuperscript{164} Ibid., p.88.
\textsuperscript{165} Ibid., pp.173 & 186/8.
\textsuperscript{166} Ibid., p.191.
Despite recurring ill health, Florence Nightingale lived until 1910. Her death notice in *The Daily Graphic* stated that behind the legend of the lady with the lamp lay one of the most astonishingly analytical minds of the nineteenth century.¹⁶⁷

Despite the best efforts of Nightingale to improve hospital standards in the nineteenth century, it can still be argued that the early progression of the medical profession had been slow, with the sick of the 17th century not being a great deal better off than those of the medieval period. Bethlem is a case in point. Thomas points out:

Even less could be done for sufferers from mental illness [...] A number of low grade practitioners were licensed as 'curers of mad folks and distracted persons' and placed them in private mad houses. Even the Royal Bethlem Hospital in London, which came to be known as Bedlam, discharged its inmates as incurable if they had not recovered within a year.¹⁶⁸

It was 1856 before Bethlem had its own chaplain, before which time prison and school chaplains were utilised.¹⁶⁹ As spiritual aid does not appear to have been lacking during that period, it can be assumed that there was an organisational or financial reason for the late appointment of a specific hospital chaplain.

By the 1800s, however, scientific medicine had appeared. The anaesthetic nitrous oxide had been discovered by the British chemist Sir Henry Davy in 1800, the stethoscope by the French physician Rene·Laennec in 1819, X-rays in 1895, radioactivity in 1897, and radium in 1898. With antiseptics and the ultimate discovery of anti-biotic medicine, 'the priestly intruder is banished as medical men become more and more materialistic in their outlook'.¹⁷⁰

f. The Concept of Both General and Lay Hospital Chaplaincy.

An important fact emerges when hospital chaplaincy is examined, this being that no major Australian, American or English dictionary understands chaplaincy as a lay activity; it is always linked to the duties of ordained ministers in a chapel. Even theological references do not usually apply the term chaplain to lay pastoral workers. Clearly the practice adopted by some hospitals to refer to lay pastoral workers as chaplains is ahead of lexicography and theological writing in this area and the Catholic

---

¹⁶⁷ Ibid., p.247.
¹⁶⁸ Thomas, op.cit., 13.
¹⁷⁰ Walker, op.cit., p.23.
Code of Canon Law still insists that the term ‘chaplain’ may only be applied to a man in priest’s orders, stating:

A chaplain is a priest to whom is entrusted in a stable manner the pastoral care, at least in part, of some community or special group of Christ’s faithful, to be exercised in accordance with universal and particular law.\(^{171}\)

During recent years, however, an increasing number of theologically trained lay workers, both men and women, have emerged who offer a comparable hospital ministry to ordained ministers. Because of this, some hospitals refer to all their pastoral workers as chaplains, whilst others prefer to use the term pastoral assistants. The Sydney located St. Vincent’s Hospital has a Pastoral Care Department of hospital paid ‘pastoral assistants’, who minister to all patients when required, plus individual ‘chaplains’ placed at the hospital by their religious bodies to minister primarily to their own denominational patients and staff members. If, as recommended in Chapter 5, a comprehensive degree course were to be established for chaplaincy training, wherein participants would graduate with a specific title, this would encourage consistency amongst hospitals when referring to their chaplains/pastoral assistants.

3. THE DEVELOPMENT OF MEDICINE IN AUSTRALIA

The development of hospitals and medical facilities in early Australia was a slow and often difficult process. Finance and religion were two areas which caused many problems, particularly for charitable institutions, with the work performed by Women’s Religious Orders often receiving little or no support from either government or church sources. On a governmental level, the first New South Wales medical and hospital services were established in 1788 and hospitals were built in accordance with the population increases. These early institutions provided inadequate health facilities and, with the shortage of food and medical supplies, they did little more than aggravate disease. It was not until 1896 that the Public Health Act gave the Board of Health of New South Wales a higher status. This Board was concerned primarily with investigating the causes and means of preventing outbreaks of smallpox and diphtheria. A further step was taken in 1912 when a Tuberculosis Advisory Board was created. The first Venereal Disease Clinic in New South Wales was opened at the Health Department’s Admission Depot in 1914, but was transferred to the Royal Prince Alfred Hospital a year later. The Hospitals Commission was entrusted with the

supervision of public hospitals and of charities and benevolent organisations by Act of Parliament in 1929.172

a. The Sydney Hospital

The history of the Sydney Hospital, however, can be traced back to 1788 when surgeon John White, a naval officer, arrived in Sydney with the First Fleet aboard HMS *Irresistible*, heading a small team of four doctors. Immediately the convicts were landed, epidemics of scurvy and dysentery broke out and a small hospital was hastily built on the western slopes of Sydney Cove on an area called Dawes Point. It was little more than a rectangular cabin made of rough hewn logs, with unlined walls and a dirt floor. As subsequent fleets arrived with many sick, tents were pitched around the hospital. It was only after much suffering and needless death that the crisis of the first years of settlement receded; crops began to grow and store ships chartered by the government finally arrived. In 1794, John White, as the Colony’s first doctor, returned to England to continue as a naval surgeon,173 but the makeshift wooden building and surrounding tents which constituted the Colony’s first hospital remained for a further two years. In 1796, a stone general hospital was built to replace the wooden construction, which was used until Governor Lachlan Macquarie decided a more elaborate institution was needed. This decision by the Governor brought Sydney Hospital, as we know today, to its prime position in Macquarie Street, Sydney. Governor Macquarie’s methods of achieving his goal could be considered a ‘rum do’. In 1809 he called for tenders for his new general hospital and struck a deal on a rum monopoly for the chosen developers which gave the builder the right to import 45,000 gallons of rum for resale over three years. All the Government had to do was supply 80 oxen, 20 draught bullocks and 20 convict labourers. The hospital was opened in 1816, but it was too elaborate for the Colony’s needs at that time and many parts of it were allocated for different purposes.174

Initially some measure of responsibility for pauper patients other than convicts was taken by the early Colonial Government of New South Wales. However, as convict numbers lessened and the free population grew, the Government disengaged itself from direct responsibility for the ‘respectable poor’. As a consequence, the Hospital’s Board of Directors moved into a charitable mode.175 With the changing

population, the Sydney Dispensary was created in 1826 to provide outpatient care for free persons unable to pay for medical attendance. At the same time the institution expanded to serve inpatients and changed its name to the Sydney Infirmary and Dispensary, a title officially approved in 1844. Convict inpatients continued to be treated in the separately managed hospital next door. With the dissolution of the Convict Hospital System, the Sydney Infirmary and Dispensary took over the occupancy of the entire middle section of the Rum Hospital complex in 1848 and in 1881, when building renovations were commenced, the institution changed its name to the Sydney Hospital which remains today on the same site. The Sydney Hospital also conducted dispensaries located in the densely populated areas of Redfern and Paddington, and today's Sydney Eye Hospital is a surviving part of this off-site tradition.

The threat of closure dogged the Sydney Hospital for many years and in the early 1900s, a motion to join the electric light was denied on the grounds that the hospital would shortly close. This obviously did not eventuate and the Sydney Hospital continued to thrive. Much of Australia's medical history had its roots there. William Redfern, the Hospital's first medical officer, was transported to Sydney as a convict on 1801, but was soon pardoned and, as he had received medical training in England, subsequently passed an examination set by a specially constituted board of examination. Redfern became the first person to hold an Australian medical diploma, whilst his assistant, William Cowper, was the first student of medicine in Australia. In 1909, Sydney Hospital became a teaching hospital for the University of Sydney.

The first Nursing School in Australia was also founded at Sydney Hospital, housed in the oldest building now standing on the present site of the hospital, the Nightingale Wing built in 1869. This building has now been classified by the National Trust and has been faithfully restored. In 1866, Sir Henry Parkes, Colonial Secretary, realised the need for a trained nursing staff at the Sydney Hospital which was being run by a team of old and untrained women, usually promoted from the domestic servants of the Hospital. He wrote to Florence Nightingale for advice and in March 1868, Lucy Osburn arrived with five other nursing sisters to take charge of the infirmary. They met with prejudice and ignorance in their efforts to reform the infirmary, the old Rum Hospital, which they found infested with bugs and rats, the

176 'The Rum Currency', The Illustrated Sydney Hospital Gazette, op.cit., p.1.
177 'Australian Post Stamp for Sydney Hospital - One of the Direct Links to 1788', The Illustrated Sydney Hospital Gazette, op.cit., p.3.
178 'Editorial', The Illustrated Sydney Hospital Gazette, op.cit., p.2.
179 Robinson, Robin, 'Doctors and Sydney Hospital in the 1800's', The Illustrated Sydney Hospital Gazette, op.cit., p.3.
180 'The Historic Nightingale Wing - Sydney Hospital's Oldest Building', The Illustrated Sydney Hospital Gazette, op.cit., p.1.
mattresses rotting away under helpless patients and the sanitary conditions appalling. The idea of gentlewomen working as hospital nurses was still unacceptable to many people.181 Eventually the nursing staff was given total control of the internal administration of the Hospital and were instrumental in the demolition of the old centre block of the Rum Hospital and the construction of a more sanitary and well-ventilated building. With the exception of the Nightingale Wing, the hospital site was cleared in 1881, with the present buildings being completed in 1894.182

Whilst the present Sydney Hospital contains a chapel known as the Chapel of St. Luke the Physician, the internal religious provision during Lucy Osburn’s time was quite contentious. She experienced a number of difficulties with the administration of the Hospital and with the medical officers, although most investigations into her actions vindicated her. The most serious allegations directed towards the Sydney Infirmary and Lucy Osburn occurred in 1870 when a sub-committee was appointed by the Directors of the Infirmary to inquire into the allegations made by the Protestant Standard concerning the management of the institution. These allegations included the improper use of the Infirmary Oratory and Lucy Osburn’s insistence that her nursing staff attend Church of England services irrespective of their own denomination. Extracts from a New South Wales Legislative Assembly Sub-committee Report (Votes and Proceedings, 1870) state that the Oratory took the form of a small room at the top of Nightingale Wing which was used for family worship. It contained chairs and a small raised table covered with a red cloth. This did not represent an Altar, but was placed there to give the room a church-like appearance. The called witnesses, Wesleyan and other Protestants, unanimously attested that nothing but family worship from the Church of England Liturgy, scripture readings and hymn singing took place in the room.183 A Sister Eliza, however, who acted as the accountant, gave evidence to the effect that she knew the room as an oratory or chapel. She elected not to attend for the Church of England prayers and was censured by the Lady Superintendent for her absence.184 Similar evidence was given by a Sister Anne, who considered there was nothing offensive about the room, but considered her religious freedom was affected when forced to attend services in the room. In addition, she felt the prayer times coincided with the patients’ breakfast period when nurses were needed on the

182 ‘Historic Nightingale Wing’ The Illustrated Sydney Hospital Gazette, op.cit., p.1
183 New South Wales Legislative Assembly, Report from sub-committee relative to charges against the management of Sydney Infirmary (Votes and Proceedings, 1870), p.5 (p.127 of the bound volume).
184 Ibid., p.11 (p.135 of the bound volume).
wards.\textsuperscript{185} Many other witnesses gave evidence before the investigation finished, at which time Lucy Osburn was found innocent of all complaints against her.

The concluding comments of the Sub-committee read:

> On review of the whole evidence, the committee would express their opinion that there have been no sectarian predilections manifested by the Lady Superintendent to affect injuriously the interests of the institution.\textsuperscript{186}

Lucy Osburn stayed in Australia for almost 17 years, most of her Sisters becoming Matrons at various other hospitals. The Nightingale teaching and standards became accepted practice in the hospital system of the Colony and, by the time Lucy Osburn returned to England, the foundations of modern nursing had been laid in New South Wales.\textsuperscript{187}

The Sydney Hospital appears to have placed importance on religion and chaplaincy in the 1900s. A passage from the 1916 Sydney Hospital Annual Report states:

> Mention should be made of the clergymen and members of the various denominations to whom the Board, together with the patients, are indebted for their kindness and for unfailing promptness in answering the many calls made upon them.

There is also mention in most of the early Annual Reports of a ladies' choir which sang each Sunday in the chapel, and, in the nineteenth century rules to be observed by patients at Sydney Hospital, it is stated that ‘all patients who may be able, are expected to be present at Divine Service on Sundays’.\textsuperscript{188} The Bicentennial Edition of the Sydney Hospital Gazette listed, amongst its bicentennial events, a church service to be held on the 18th October, 1987, at St. James Anglican Church for thanksgiving during the Festival of St. Luke the Physician, after whom the Hospital chapel was named. As the St. James Church clergy are specified as being the present authorised Anglican chaplains for the Sydney Hospital and the Sydney Eye Hospital, it appears that a strong link exists between these two Hospitals and St. James.

During the nineteenth century, The Royal Women's Hospital in Paddington developed from an asylum for the care of indigent persons, foundling children, aged people, and poor mothers requiring confinement. It was originally founded on what is now the site of Central Railway Station, Sydney. This asylum was the product of the first voluntary charitable organisation formed in Australia. At a meeting held on the

\textsuperscript{185} Ibid. p.13 (p.135 of the bound volume).
\textsuperscript{186} Ibid. p.15 (p.137); p.19 (p.141); p.21 (p.143); p.25 (p.147).
\textsuperscript{187} MacDonnell, op.cit., p.1.
\textsuperscript{188} The Illustrated Sydney Hospital Gazette, op.cit., p.6.
8th May, 1813, *The New South Wales Society for Promoting Christian Knowledge and Benevolence in these Territories and the Neighbouring Islands* was formed, with its primary objects being to relieve the distressed and enforce the sacred duty of religion and virtue in New South Wales. The title was ultimately shortened to *The Benevolent Society of New South Wales* and in 1818 this Society received the Governor’s approval. Two years later the asylum was established, planting the seeds for the eventual growth of the Royal Hospital for Women.\(^{189}\)

**b. Order of The Sisters of Charity (St. Vincent’s Hospitals)**

Women of the Catholic faith were similarly extremely instrumental in the foundation of many Australian hospitals. The unenclosed Order of the Sisters of Charity were the first body of religious women to arrive in Australia in 1838, only 23 years after Mother Mary Aikenhead (1787-1858) had founded her Congregation in Dublin. Their reputation for service to the poor was well established in Ireland.\(^{190}\) The poverty in Ireland prompted Daniel Murray (1768-1852), coadjutor assistant bishop to the Catholic Archbishop of Dublin, to found a group of religious women who would go wherever they were needed.\(^{191}\) Based on the Daughters of Charity instituted in France by St. Vincent de Paul (1581-1660), Murray chose Mary Aikenhead from Cork as the nucleus of the new Irish Daughters of Charity.\(^{192}\) The first St. Vincent’s Hospital established by the Sisters of Charity was in Dublin, accepting its first patients in 1835. Mother Mary Aikenhead had been determined to establish a hospital ‘where the poor could be given for love what the rich obtained for money’, open to patients of all creeds.\(^{193}\) This hospital still survives today as one of the Republic of Ireland’s most respected hospitals, although now operating in new modern premises.

A pioneering band of five Irish Sisters of Charity arrived in Sydney on the 31st December 1838 and took up residence in Parramatta where they regularly visited the local hospital for females.\(^{194}\) Despite the problems of belonging to a new Order, by the end of 1842 there were twelve Sisters of Charity in Australia\(^{195}\) and a second convent had been established in Sydney itself. The Sisters became regular sights in the streets of Sydney, visiting gaols, the poor and sick, and giving religious

\(^{189}\) Deveraux, Richard, *Small Beginnings*, The Balmain Hospital, 1979, p.123.


\(^{193}\) Longhurst, *op.cit.*, p.2.


\(^{195}\) O’Sullivan, *op.cit.*, p.46.
instruction in Catholic Schools. A separate Colonial Congregation was established in 1842 and in 1857 an Australian St. Vincent’s Hospital was established at Potts Point in Sydney. In 1870 a new hospital was constructed in Upper Victoria Street, Darlinghurst, where it still exists today encompassing a public hospital, a private hospital and a hospice. An extension, St. Joseph’s Hospital for Consumption, was opened at Parramatta in 1886 and transferred to Auburn in 1892.\textsuperscript{196} St. Joseph’s still exists today as a palliative care and rehabilitation hospital.

In 1893 a small St. Vincent’s Hospital was established in Melbourne, with a more elaborate hospital opening in November, 1905. This contained a University Clinical School within the hospital in conjunction with the new pathology wing. In 1914 the Sisters of Charity opened the nearby Mount St. Evin’s Private Hospital from the Congregation’s own funds.\textsuperscript{197} Saint Vincent’s Hospital at Darlinghurst, New South Wales and St. Evin’s, Victoria, were the only private hospitals operated by the Sisters of Charity until the opening of St. Vincent’s at Lismore, New South Wales, in 1921.\textsuperscript{198} The highly accredited Darlinghurst Private Hospital passed into the hands of a lay management team in 1991, but the Sisters of Charity, whose property the hospital remains, retain a continuing presence in the complex.\textsuperscript{199} Queensland was not forgotten and in 1860, St. Vincent’s Toowoomba was opened, moved premises in 1881, and became a nursing training school in 1889.\textsuperscript{200} In 1922, a new St. Vincent’s Toowoomba was opened on its present site, with many subsequent extensions and additions, the most recent being the Mary Aikenhead Wing in 1997 in honour of the Sisters of Charity Foundress. There are now further St. Vincent’s Hospitals at Launceston, Tasmania and in Fitzroy, Victoria.

With the successful opening of so many hospitals, it could be assumed that the Sisters of Charity experienced a fairly trouble free existence over the years. This, however, is far from the case. All of the original Sisters who arrived in Sydney in 1838 had left by 1859, claiming that the Benedictine hierarchy had made it impossible for them to live according to their Constitutions as Irish Sisters of Charity. On the 20th June 1859, Archbishop Polding of Sydney wrote to his fellow bishop Alipius Goald of Melbourne that, ever since their arrival in Australia, the Sisters of Charity had been ‘a cause of trouble’.\textsuperscript{201} When the Sisters, led by founding Sister Baptist De Lacy, sought public support and money for their Catholic Hospital in Sydney,

\begin{itemize}
\item \textsuperscript{196} Longhurst, \textit{op. cit.}, p.4.
\item \textsuperscript{197} \textit{Ibid.}, p.7.
\item \textsuperscript{198} \textit{Ibid.}, p.8.
\item \textsuperscript{199} \textit{Ibid.}, p.ix.
\item \textsuperscript{200} \textit{Ibid.}, p.12.
\item \textsuperscript{201} O’Sullivan, \textit{op. cit.}, p.1.
\end{itemize}
Archbishop Polding, a Benedictine, initially opposed the venture.\textsuperscript{202} The Archbishop’s attitude may have been influenced by the Catholic Church’s rigid distinction between clerics and the laity, the Sisters being classified as the latter. This meant that the Sisters had no jurisdiction in the Church. The official stance of the Catholic Church towards the laity was, in general, most intransigent during the nineteenth century. The religious orders these came under the jurisdiction of the local bishop or of its own hierarchy, often overseas.

The philosophy of the Sisters of Charity had always been that healing involved both the physical and spiritual welfare and that all clergy, regardless of religion or denomination, would be welcome at their hospital. However, the spiritual welfare of all patients at the Darlinghurst Hospital was challenged in 1859 when questions arose over the availability of Protestant Bibles for Protestant patients. In May 1859, when the Catholic chaplain was doing his rounds, he noticed these Bibles in the wards and removed them, offending many staff, patients and benefactors. The incident was reported in the \textit{Sydney Morning Herald} and \textit{The Freeman’s Journal}. Archbishop Polding intervened and the chaplain returned the Bibles to the wards. However, the damage had been done. As a consequence, Dr. Robertson, a Protestant and the only surgeon, resigned, as did John Hubert Plunkett, Trustee and Treasurer of the Fund Raising Committee; seven non-Catholic patients asked to be removed from the hospital. It is believed that this was one of the reasons which led to Mother Baptist De Lacy’s resignation as Rectress of the Hospital and her return to Ireland. The incident caused considerable loss of public support, but the Sisters eventually overcame the crisis and continued their work.

After Plunkett’s resignation as Treasurer, the Rev. Austin Sheehy, a Benedictine priest, was appointed on Archbishop Polding’s recommendation. More problems followed: Father Sheehy attempted to have an altar erected in the large ward so that Mass could be said there. Mother Veronica O’Brien, who succeeded Mother Baptist De Lacy, refused to agree, claiming that it could frighten the Protestant patients and pointing out that the Hospital’s plan included provision for a room as an Oratory, where Mass could be said. Mother Veronica affirmed that it was appropriate that the wards be used as places of nursing care, not as places of worship. The Rectress again came into conflict with the Catholic clergy in upholding a fundamental principle of the Hospital.

In July 1869, the Hospital had to defend itself once again against the accusation of proselytism brought by Dr. John Dunmore Lang. In this instance, St. Vincent’s was defended by a number of clergy of various denominations. The Anglican minister, the Rev. W.M. Allworth, stated that he had never experienced any

\textsuperscript{202} Longhurst, \textit{op.cit.}, p.4.
hindrance in the exercise of his ministry to Anglican patients, whilst the Rabbi Davis wrote to the *Sydney Morning Herald* refuting Dr. Lang’s claims and giving details of the freedom which he was given to visit the Jewish patients, and to pray with them, especially at the time when they were close to death.203

The philosophy of encouraging clergy of all denominations has continued through the years. The Darlinghurst St. Vincent’s Hospital Review of November, 1967 contains a list of chaplains and visiting clergy including, Anglican, Catholic, Methodist and Presbyterian, plus Jewish rabbis. Today there is a Pastoral Care Team employed by the Hospital, in addition to individual chaplains appointed and employed by their own religious bodies.

The St. Vincent’s Darlinghurst complex is considered one of the best in Australia and is renowned for its association with the Garvan Medical Research Institute and its pioneering heart surgery, led in the past by Dr. Victor Chang and continued today by others from his team.

c. Order of the Josephite Sisters (St. Margaret’s Hospital)

A new Order of religious women was founded in 1866/67 at Penola, South Australia and then in Adelaide, by Mary Mackillop and Father Julian Tenison Woods. These women were to become the Sisters of St. Joseph. The Josephites were the first nuns in South Australia and numbered over one hundred within three years. Instead of leading enclosed lives in a convent, the Josephites lived in groups of two or three, often in small rented cottages. Like the Sisters of Charity, they walked the streets, visited the sick and needy, and collected provisions from shopkeepers for their elderly or orphan charges. An unsuccessful attempt was made to excommunicate Mary and disband the Order in 1871.204

After a group of Josephites transferred their residence to Elizabeth Street, Surry Hills in New South Wales, they began to care for the children who were running wild in the area. The Catholic Church hierarchy nevertheless strongly advised that a maternity hospital conducted by Catholics was the most urgent necessity for the city, adding that by taking the unmarried and destitute mothers, they should thereby save the children also. Thus the work began and, on the 19th March 1894, the first patient was received, brought in sick from the park, totally destitute, dirty and intoxicated. Saint Margaret’s Hospital was on its way.205

---

203 From notes supplied by the archivist of St. Vincent’s Hospital, Darlinghurst.
205 Ibid., p.16.
In 1896, a further residence was leased in the Newtown area ‘to provide shelter for mother and child when relatives or friends refused to take them home’. A few months later a more suitable house in Surry Hills was obtained and it operated there until the Sisters of Mercy opened their foundling home, first at Lane Cove, then at Waitara, in 1898. By this time the Hospital had stretched to a row of terrace houses, still in Elizabeth Street, and became St. Margaret’s Maternity Hospital. By 1905 it became St. Margaret’s Maternity Hospital and Hospital for Women and became a midwifery training school. By 1910 St. Margaret’s had expanded and moved to Bourke Street in Surry Hills. Many benefactors gave donations as no government subsidy was received and future expansion depended on voluntary fund raising. Many patients were treated free and, in addition, often received clothing and money. By 1932 the Bourke Street property loan was finally repaid and St. Margaret’s began to look to the future. Fees paid by student nurses made up a vital component of the Hospital’s income and, in 1946, it was decided to build a private hospital to generate finance for the building of a large public hospital. The intention was to ensure that the neediest patients could, if necessary, be admitted without payment in keeping with St. Margaret’s policy. The Private Hospital building had five floors, standing parallel to Bourke Street, with 44 single rooms. It was blessed and opened in May 1946 by Archbishop Panico. In 1951, an eight storey public hospital for obstetric and gynaecological patients was blessed by Cardinal Gilroy in the presence of Sir Earle Page, the Federal Minister for Health.

In 1959 a convent was built to house the nursing staff Sisters as the villa in which they had been housed was no longer adequate. A circular chapel building which could seat 200 Sisters, hospital staff and patients was erected between the convent and the private hospital. No application was made for government funding, the usual interest-free loan being forthcoming from the Josephites. In 1964 the first group of medical students arrived from the University of Sydney for training and following negotiations with the College of Obstetricians and Gynaecologists, postgraduate training was also possible after 1972. Unfortunately, after such an impressive history, St. Margaret’s closed its doors in the late 1990s due mainly to the diminishing number of city-living families moving to the outer suburbs of Sydney, thus creating financial difficulties. The present method of government funding is assessed on bed numbers and the expanded facilities offered by St. Margaret’s were

---

206 Ibid., p.25.
207 Ibid., pp.25, 26, 27.
208 Ibid., p.29.
209 Ibid., pp.31 and 49.
210 Ibid., p.51.
211 Ibid., p.54.
not considered warranted. It was suggested that a small obstetric and gynaecological unit be incorporated into St. Vincent’s Hospital Darlinghurst in the future. With the planned extensions to St. Vincent’s commencing in the year 2000, it is hoped that this will eventuate.

**d. Development of the Royal Flying Doctor Service**

The history of Australia’s medical/religious relationship was not, confined to the hospital situation. In 1928, the Reverend John Flynn, an ordained Presbyterian minister attached to the Australian Inland Mission, founded the Royal Flying Doctor Service of Australia. Flynn’s passion was to eliminate the loneliness and isolation of the outback as well as to provide a physical medical service.\(^{212}\) Flynn was influenced by talking to legendary patrol padres of the Australian Inland Mission, such as Padre Jim Stephens of Pilbarra, whose accounts of the difficulties and tragedies of the families living along remote outback tracks helped inspire John Flynn to establish inland nursing homes and, eventually, the Royal Flying Doctor Service.\(^ {213}\) In Alice Springs, The John Flynn Memorial Church stands close to Adelaide House, one of fourteen bush hospitals and hostels built by the Australian Inland Mission at Flynn’s instigation between 1911 and 1939.\(^ {214}\) Although the Flying Doctor Service is a non-sectarian organisation, within six years of founding the Service, Flynn had persuaded the Presbyterian Church to establish it as a national institution with financial assistance from government sources.\(^ {215}\) After his collapse in a Sydney church on the 5th May 1951, dying a few hours later, John Flynn’s ashes were laid beneath a memorial stone in the outback Alice Springs where his work was so important. Another Presbyterian Padre, Fred McKay, successfully took over the reins of the Service after Flynn’s death and, it has continued to expand.

Work of the Royal Flying Doctor Service of Australia is as relevant today as ever, with its services extending throughout the whole country. In a typical year, the flying doctors and nurses make 154 000 patient contacts, 14 000 emergency evacuations, conduct 5000 clinics in remote places and fly more than 8 000 000 kilometres. The Service is a charitable organisation and most of its services are provided free. About 80 per cent of funding comes from the State and Federal


\(^{213}\) Ibid., p.14.

\(^{214}\) Ibid., p.157.

\(^{215}\) Ibid., p.19.
Governments, with the remainder being obtained from public donations, tourists and the corporate sector.\textsuperscript{216}

e. Development of Allied Health Care Workers in Hospitals

During recent eras, as number of allied health care professions have developed and expanded in the hospital setting. Social workers, psychiatrists, psychologists, grief and general counsellors, dietitians, patient advocates, physiotherapists, radiographers, diversional therapists, and speech therapists all have direct contact with patients and relatives. From his early research into the role of hospital chaplains, Lindsay B. Carey concluded that ‘the role of the clergy seems predominantly to be very much accepted and professionally appreciated by medical practitioners, nursing staff and allied health professionals within health care institutions who have the services of chaplains’.\textsuperscript{217} Further research was conducted by Carey between 1992 and 1994, approved by the ethics committees of the Lincoln School of Health Sciences at La Trobe University in Melbourne and the Royal Children’s Hospital, Melbourne, to further assess the personal value staff members placed upon the chaplain’s role. The results indicated that ‘the majority of clinical staff affirmed the place of resident chaplains for the care of patients and their families as part of the provision of hospital services’.\textsuperscript{218} In the case of personal hospitalisation, the majority of the staff appeared open to general visits by chaplains, but did not consider any one specific chaplaincy role task to be very personally important to themselves. Although staff members from across all occupational groups indicated their acceptance of the chaplains in the hospital, the following suggestions were made by some as to possible ways in which future chaplaincy could be enhanced; ‘that chaplains increase their profile; explore more productive ways to promote teamwork between chaplains, social workers, psychologists, and other allied health care professionals; be involved to a greater extent in hospital ethics; improve social interaction, flexibility, and a broad minded capacity to listen; and effectively increase the number of available chaplains’.\textsuperscript{219}

In general, the role and task differences among the allied health care professionals are clearly defined in relation to chaplaincy. However, in the case of chaplains and social workers the territorial lines are not always clear due to the similarity of tasks and the areas in which they function. Arthur W. Combs, et al, note

\textsuperscript{216} Ibid., p.7.
\textsuperscript{218} Carey, Lindsay, B, ‘The Role of Hospital Chaplains: A Research Overview’, in Ministry, Society and Theology. Vol.9, No.2, November, 1995, p.43.
\textsuperscript{219} Ibid., pp.48-51.
that ‘85% of the tasks of the chaplain and social worker overlap’ 220 which can lead to communication, cooperation or referral problems. Robert B. Webb, Jr claims that the relationship between some United States Pastoral Care Departments and the Social Services Departments has been described as a continuing war, adding that, although it may not be war, there is little or no communication between these departments.221 From this current research and the personal experience of the researcher, the attitude existing between chaplains and social workers in Australia, and the extent of interaction, varies according to their relevant hospitals, (see Chapter 5 and Appendix XXII).

Whilst most of the allied health care professions do not overlap with chaplaincy, grief and general counselling most certainly can do so, together with patient advocacy, psychology and social work. Grief counselling was, in the past, the domain of the clergy/chaplains, but is now, very often, considered to be a lay counselling discipline. Similarly, this present research shows that many hospital staff members seek the guidance of a psychiatrist rather than the chaplain when they have problems. There needs to be an awareness of this in the future to prevent the risk of allied health care professionals extending their roles to include tasks presently performed by chaplains. As an alternative to the possibility of this happening, the conclusions chapter of this research offers recommendations for chaplaincy role expansion. Chaplains need to convince hospital administrators that, when fully integrated into the hospital system, they are a significant factor in the overall care and faster recovery of patients which, in turn, becomes a cost saving measure. Research into this aspect is discussed in Chapter 5.

f. Spirituality in Nursing

Allied health care professionals are not the only threat to the chaplain’s position, the question of spirituality in nursing may also become an issue. In the past, there was little reference to spirituality in nursing theories and models; this is now changing. As Anne J. Fry notes, ‘In the 1970s, Betty Neuman’s systems theory omitted the concept of spirituality, but in the late 1980s it was included in a revised version of the theory’.222 Fry writes that spiritual care may be seen as the realm of the chaplain or other pastoral workers and outside the role of nurses. She

notes, however, that patients' spiritual needs are sometimes referred to chaplains through partial lack of confidence by nurses to provide such spiritual care.223

Jacqueline Kinsey Bambery thinks that when nurses speak of the spiritual needs of a patient, they are referring to the needs of the whole human/spirit person, which differs from any religious needs the patient may or may not have. For religious needs, Bambery feels it is appropriate to involve a pastoral worker, but also considers that 'in the day-to-day life of client and nurse, what exists is unique. The relationship is, for both of them, a lived experience'. It appears that the point being made by Bambery is that any spirituality which may exist between a nurse and a patient may not have any connection to religion.224 Similarly, Frank Lopez agrees quite clearly that spirituality and religion are not synonymous, with spirituality existing before religion. In Lopez's own words, 'Spirituality is a human reality, it focuses on the human spirit of both believers and non-believers and on their lives as a whole .... spirituality may or may not include God ....may or may not be explicitly religious or Church-related'.225

Tony Bush discusses the terms 'spiritual care' and 'religious care' and notes the confusion which may be caused to nurses by these terms. He writes that 'spiritual care is often interpreted by carers to mean religious care, and therefore comes under the domain of formally prepared religious persons, such as ministers, rabbis, or priests'.226 To illustrate spiritual dimension, Bush quotes a definition penned by L. Renetzky in 1979:

* the need to find meaning, purposes and fulfilment in life, suffering and death
* the need for hope/will to live
* the need for belief and faith in self, others and God.227


225 Lopez, Frank, 'Pastoral Care in an Emerging World' Marist Centre for Pastoral Care, 1994, pp.128/9, in Ibid, p.64.


Elizabeth Mackinlay, herself both a nurse and a priest, believes that the Clinical Pastoral Education model used widely in clergy and pastoral care training, is a good one for nurses to follow.\textsuperscript{228} Mackinlay also lists a number of spiritual issues with which people may require help, including grief, guilt, anger, anxiety, depression, fear, need to receive and to express love, the need for reconciliation with God and in human relationships, and in coming to terms with diagnosis and living with terminal illness. She then adds that ‘these needs are unlikely to all be met by clergy or pastoral carers due to their not being present at the time of need. The obvious group who have the potential to be able to provide spiritual care are the nurses’.\textsuperscript{229} Whilst it is conceded that clergy and pastoral care workers will not always be available during times of patients’ needs, and that some nurses provide invaluable help to patients during traumatic and stressful situations, it is important, for the future of chaplaincy, that the nurses’ help does not overlap beyond a reasonable level into the chaplain’s role.

From the above, it can be seen that there is strong support for the holistic method of caring for patients. However, holistic care does not necessarily mean that such care has to be executed by one person. Holistic means caring for the ‘whole’ person in every way, physically, emotionally, and spiritually. This can, and in most cases should, be a team effort comprising doctors, nurses, allied health professionals and clergy/pastoral care workers. The operative word is ‘team’ and whilst it is recommended that each team member is conversant with the contribution of the other team members, each must work together without extensive overlapping. There is a risk that a general encouragement for nurses to spiritually assist patients, could be detrimental to the patient. Without sufficient knowledge and experience of what they are doing, nurses may further traumatised a patient. For some, both nurses and patients, spirituality and religion may have the same meaning, causing confusion for the nurse as to what may be expected of him/her. Much of the chaplain’s role is involved with spirituality and efforts should be made to educate members other hospital disciplines as to what chaplaincy involves and how/where excessive overlaps may occur.

In some organisations, pastoral care services have expanded to include parish nurses. As Irene Coulson and Sue Ronaldson note:

\begin{quote}
Historically, the Church has been involved in important transitions in people’s lives. A parish nurse is an experienced university prepared
\end{quote}


\textsuperscript{229} \textit{Ibid.}, p.108.
registered nurse with an advanced understanding of the healing ministry. They can provide faith and health-promoting services to religious and non-religious persons in the context of strengthening the person in difficult times'.

Chapter 6 of this present research suggests that, rather than nurses and other disciplines becoming over proficient in chaplaincy duties, that the chaplains extend their role to include an insight into other disciplines in an attempt to raise their own profile in the minds of administrators. This would appear necessary when comments are made to the effect that 'a priest would not understand a patient’s unbelief and may try to force religion on to them which they do not want'. This is in reference to a dying patient who, in the last weeks of life, may indicate a desire to speak of spiritual matters which have not previously concerned them. Rosemary Lancaster notes that these patients very often turn to a nurse who is seen as ‘available and approachable’. However, it is the belief of this researcher that a qualified and experienced hospital chaplain, whether an ordained minister or a lay person, would not only know how to minister ecumenically, but also understand the needs of agnostic or atheistic patients. A correctly trained chaplain would know how to put such a patient at ease and attempt to be where the patient is spiritually at that time.

It should be understood that it is not been the intention of the researcher to discourage experienced, spiritually-minded nurses from helping patients, but it is considered important that chaplains are not supplanted or by-passed in anyway by nurses confusing their role with that of the chaplain.

As stated previously, Chapter 6 of this research contains recommendations to raise the profile of chaplaincy.

g. Secularisation

Secularisation is defined as ‘the process by which sectors of society, its people and their culture are removed from the domination of religious institutions and symbols’. The groups which adopt this process are known as secularists and, although small, these secularist groups are far from unimportant and insignificant. John Drane considers the secularists are not only the least likely to be able to hear the

---

230 Coulson, Irene and Ronaldson, Sue, ‘Spiritual Care in Dementia: Nurturing the Human Spirit’, op. cit., Ronaldson, pp.139/40.
232 Ibid., p.148.
Gospel, but they are also highly influential. Peter Berger writes that they constitute ‘a globalized elite culture’. In Drane’s view, secularists are generally highly educated academics or high-flying professionals, especially in the humanities, who still defend the conventional ‘liberal’ beliefs of an Enlightenment world view. Their usually high positions play a large part in ‘determining the officially sanctioned definitions of reality and meaning that are reflected in the Western education systems, in the media, and in certain sections of government’. They appear not to believe or understand the spiritual concerns of the world because they do not belong to the popular culture in which such concerns occur. Instead, they have formed a powerful subculture of people who basically relate only to each other. They believe that the progress of modernity will inevitably annihilate spirituality and, in their limited circles, that is exactly what has happened. Drane considers the influence of the secularists has affected the Church more than is realized. For the years between 1940 and the mid-1980s, the Church vainly attempted to appease the secularists. At times the Church leaders actually joined forces with them, underplaying the spiritual dimensions of the Gospel and ‘presenting the Christian faith as some kind of programme of social improvement or personal therapy’. Whilst the Western Churches are ill-equipped to know how to relate to the new popular spirituality of today, the secularists resought to deconstruction methods to highlight the failures and weaknesses of Christians from the past. In Ziauddin Sardar’s words, ‘not only do secular elitists pose a particular threat to the Church, but they are also at the vanguard of the continued exploitation of other world cultures’.

The results of the present research indicates a significant increase in the number of Australian citizens who claim to have no religion. This corresponds with the Census figures issued by the Australian Bureau of Statistics between 1947 (0.3%) and 1996 (16.5%). It appears, therefore, that the secularists have succeeded in influencing religious beliefs both globally and in Australia.

236 Drane, op.cit., p.76.
4. SUMMARY

As the above history shows, although hospital methods and administration have changed over the years, the entwinement of religion and sickness has never been severed and the work of the ordained clergy and lay associates continues in hospitals today, albeit in an entirely new guise. Modern day hospital chaplains do not tend patients physically, as did members of religious orders in many of the early hospitals; rather, they now concentrate on the spiritual and emotional aspects of sickness. Unlike the past, when religious bodies held significant control over hospitals and hospices, the present religious involvement in most hospitals is classified as an optional allied health care which patients may choose to accept or decline.
CHAPTER 2

METHODOLOGY

Though this be madness, yet there is method in it.
William Shakespeare

BACKGROUND TO SURVEYS

Prior to the commencement of the surveys, extensive research was undertaken into various methods of questionnaire design and analysis. From the numerous publications available on this subject, D.A. de Vaus’ *Surveys in Social Research, together with a Technical Manual Series* issued by Social and Community Planning Research in London, proved to be informative. These Manuals included the titles *Sample Design and Selection,* *Interviewers’ Guidebook,* *Depth Interviews and Group Discussions,* and *Questionnaire Design.* A comparison with a number of other publications showed that the basic pattern being followed was similar to that suggested by the Social and Community Planning Research publication. Therefore this present research has been conducted in accordance with the suggestions made in these publications. The correct interpretation of ‘hypothesis’ was also researched in an endeavour to correctly formulate one for this thesis, and a general concept of role,

---

6 Ibid., Manual 5.
role conflict, and psychological function of roles was examined.⁹ Put broadly and simply, Peter Kelvin considers that ‘roles are norms associated with differences of functions among members of the same group. Roles are fundamentally categories for functions within the group. (e.g. of the “mother” in the family)”.¹⁰

Population, random and stratified sampling techniques were explored¹¹ and the method chosen is explained under ‘Participant Selection Method’ below.

**a. Project Aims**

The aim of the first survey is to determine what various groups expect from a hospital chaplain and to analyse then the results for major differences. The specific aims are these: to assist hospital chaplains to become aware of the expectancies which other relevant groups have of them; to assess how doctors and nurses perceive the overall value of the chaplains’ role to themselves and patients; to assess patient expectancy of the chaplains’ role; to assess how the role definition held by chaplains themselves may differ from the expectations of other relevant groups; and to assess whether chaplains are agreed on their role priorities. The second survey was initiated in an endeavour to assess the actual tasks being performed by chaplains as perceived by hospital staff.

Studies conducted in Australia, New Zealand and America into chaplaincy methods has indicated that more intensive research is needed to assess reasons for some participants’ responses. These studies suggest that whilst many participants have stated that a chaplain’s visit has had a positive effect, they did not themselves initiate the visit. Many also expected the chaplain to be a minister/priest, but placed the availability of the Blessed Sacrament low on the list of important services. Participants were not commonly aware of the availability of chaplaincy services, chapel services, headphones to hear recorded religious services and many stated they had not been visited by a chaplain. Indications of declining church attendances were also shown in these studies. Some differences were noted in the American research in that the expectation of liturgist services was higher than in the Australian surveys. American chaplains are employed directly by the medical institutions, whilst in Australia and New Zealand they are employed primarily by individual religious bodies. It is felt that the present research is necessary to find out whether similar participant responses are recorded and, if so, to analyse their reasons and determine possible ways to improve chaplaincy methods generally.

---


¹⁰ Ibid., p.16.

b. Survey of Related Studies Concerning Chaplaincy in a Hospital Setting

A selection of the Australian, New Zealand and American studies are considered as background to the survey:

i. Report on Survey of Chaplaincy Services at Westmead Hospital, 22nd February, 1990.

The Westmead survey involved 516 questionnaire forms being issued to patients for optional completion. Of these, 333 (64.5%) were returned and in 292 cases, the form had been partly or fully completed. A number of the questions in this Westmead survey were similar to the present survey. The Westmead participants with no religious affiliation were asked if they would appreciate a visit from a hospital chaplain. Their replies were 51.5% ‘yes’ and 48.5% ‘no’. These figures are close to the those obtained in the above survey, with 44.4% of those indicating ‘no religion’ stating ‘yes’ and 78.8% of those indicating ‘no denomination’, also stating ‘yes’.

A fairly high percentage of Westmead patients (66.7%) indicated that if they wished to see a member of their church/faith whilst in hospital, they would expect such member to be an ordained minister/priest, with most of the remainder opting for a lay visitor. In this thesis survey only 44.3 of the patients expected the chaplain to be specifically a minister of the church, whilst 38.0% expected that chaplains would be either an ordained minister or a lay person who has not received the office of ordination, but has been suitably trained to perform chaplaincy duties. The Westmead patients were not given the ‘either’ option.

Westmead patients who had received a routine pastoral visit from a chaplain of denomination/religion, other than their own, were asked if they had welcomed the visit anyway. The large percentage of 83.7% said ‘yes’. The thesis survey patients recorded a similarly high result of 88.5% ‘yes’.

When the thesis survey patients were asked if they would expect the chaplain to hold services of worship in the hospital, 83.3% said ‘yes’. However, when the Westmead participants were asked if they knew about the ecumenical service which is held in the chapel on Sundays, only 41.3% were aware of this. Only 10.9% of those who were aware of the service said that, in the event of not being able to attend in person, they would have utilised available headphones to hear a relay of the service. Of those who were not aware of the service, 42.8% stated that they would have listened on the headphones if they had been told. It was not asked if any of them had actually attended the service. It would appear, therefore, that although hospital services of worship are part of the expectations of the role of chaplains, interest in and attendance at such services are poor.

This survey was conducted with the co-operation of 10 patients, 10 relatives and 10 visitors, of varying denominations, ages and genders. All participants were asked: ‘If you wanted a chaplain to visit, how was the visit initiated?’ The outcome was that 34.6% of the visits had been the result of a personal request, whilst 65.4% occurred by the chaplain’s normal routine ward visits. All of the respondents who indicated that they initiated the chaplain’s visit by way of their personal request reported that the services of the chaplain had a positive effect on their experience while in or visiting the Brain Injury Unit. Of the 65.4% who indicated that the chaplain had initiated their visit, 82.5% reported a similar positive effect on their experience.

The conclusion that may be drawn is that, had the visits been restricted only to those respondents who initiated the visit by their personal request, then those respondents reporting a positive effect on their experience as a result of Pastoral Care would have been limited to only 34.6% of the project response group. With a request policy in place, 53.8% of the project respondents would be denied even the possibility of experiencing the positive effect reported. This would indicate that the chaplain’s visit should not be considered an ‘optional extra’ that is acted upon only after a request from a patient, relative or visitor. Whilst the thesis survey showed that participants did not expect that chaplains would routinely visit all patients, nevertheless the majority stated that they would indeed welcome such a visit. The thesis survey also shows that, for varying reasons, large numbers of patients are not being visited and, as stated under Question 8, it would appear that more chaplains are needed to ensure that as many patients as possible, in all hospitals, are afforded the opportunity of a routine chaplaincy visit.


Anglicare conducted a survey of the role and function of chaplains in hospitals and prisons comprising 38 patients, 46 prisoners, 69 hospital staff, 18 prison staff, 54 clergy, 137 parishioners and 12 chaplains. This survey report states that ‘surveys had already been conducted at Gladesville/Macquarie Hospital and Westmead Hospital and a graduate student at the University of Sydney was also conducting research on expectations of chaplains so it was decided where possible not to duplicate the survey in those facilities’.12 The University of Sydney research refers to the survey conducted for this thesis.

One significant aspect of this survey, taken in conjunction with this thesis survey, was the ranking of the top ten requirements seen to be the most important in identifying the chaplains’ role.

The top ten requirements as listed by the total group are:

- Listener
- Christian Presence
- Person of Prayer
- Pastoral Carer
- Representative of God
- Spiritual Guide
- Friend
- Care Giver
- Counsellor
- Religious Presence

Whilst the chaplains themselves listed:

- Pastoral Carer
- Listener
- Christian Presence
- Person of Prayer
- Representative of God
- Care Giver
- Friend
- Counsellor
- Spiritual Guide
- Evangelist

In both the above cases, the top ten list for Parish Clergy included ‘Celebrate Communion/Sacraments’ in ninth position. The combined hospital staff, patients and parishioners placed Celebrate Communion/Sacraments in tenth place for chaplains and ninth for parish clergy. These results suggest that there is a particular role and function of the chaplain and this is distinct from that of parish clergy. The above lists agree completely with the conception in the thesis survey that the ‘comforter’ and ‘witness’ tasks are considered the most important facets of the chaplains’ role. Survey iv. below is also relevant to this subject.


This survey was conducted by a chaplain who was employed for the specific purpose of ministering to the patients, relatives and staff of the Liver Transplant Unit. Patients (40) and primary support persons (37) were involved in the research. Both
client groups were asked: firstly to rate the tasks pertaining to the chaplain’s role, and then to rank such tasks in order of importance. This ranked order is listed below:

**Patients**
- Comfort at time of illness/death 70%
- Coping with fears/anxiety related to illness 70%
- To be present at transplant time 65%
- To be part of the team 65%
- Help in facing illness/death 65%
- To visit patients regularly 55%
- To facilitate sacraments 15%
- To pray with patients/family 15%
- Private prayer for individuals 15%
- To provide special worship 7%
- To help patients in their own prayers 5%

**Primary Support Person**
- To be present at transplant time 62%
- Comfort at time of illness/death 62%
- To be part of the team 59%
- Help in facing illness death 57%
- Coping with fears/anxiety related to illness 54%
- To visit patients regularly 46%
- To facilitate sacraments 19%
- To provide special worship 16%
- To pray with patients/family 13%
- To help patients in their own prayers 11%
- Private prayer for individuals 5%

* Percentages are recorded to the nearest round figure.

As stated by the Austin Hospital Liver Transplant Unit chaplain:

While each of the roles listed received significant recognition as important it is noted that in both the rating and the ranking of perceptions those tasks most readily identified as the ‘role of the Chaplain’, i.e. prayer, sacrament and special worship, were lowest in priority. .... The study also clearly indicates that helping patients and support people to cope with the fear and anxiety related to illness and death, and helping them to face death are primary and basic to the Chaplain’s role. In focussing on the two groups - patients and primary support people, the study demonstrated some differences in their ratings of importance of the Chaplain’s role.

There is consistency between the results of this survey, the Anglicare survey and the thesis survey. They show that, whilst the sacraments are an expected task of the chaplain’s role, it is not in practice considered as important or relevant as many of the comforter tasks. To a lesser extent, this also applies to the ‘prayer’ questions. This topic will be addressed further in Section 4 of this thesis.
v. The Horizontal Perspective: A study of New Zealand Patients’ Attitudes Towards Hospital Chaplains, 2 June, 1976.\textsuperscript{13}

A number of questions addressed in this New Zealand survey were similar to questions of the thesis survey. Answers to questions were very close in both surveys, especially to those relating to availability of chaplains; chaplains as part of the hospital team; praying or reading the Bible at every visit; confidentiality; and the availability of chaplains to minister to denominations, not only their own. However, with regard to the expectation of a chaplaincy visit before an operation, the thesis survey recorded 79.0% affirmatively, whilst the New Zealand survey showed that only 30.3% held or strongly held such an expectation. When the same question was asked in New Zealand surgical wards only, the percentage increased slightly to 40.0%. The New Zealand researchers state that a number of patients did not see value in such a visit, and some saw it as a prelude to death, whilst others considered the chaplains visit to be embarrassing at that time.

In general, however, when the New Zealand survey asked if ‘a visit from the parish minister or priest would be of more help than a visit from the chaplain’, more than half of the recipients disagreed, with a further quarter being undecided. The thesis survey recorded 72.5% of recipients saying that they would welcome a chaplain’s visit; the conclusion therefore can be drawn that, whilst visiting clergy are sometimes necessary and comforting to a patient, a specialised ministry is still expected from chaplains.

vi. Surveys Conducted at the Lutheran General Hospital, Illinois, to Gauge Changes in Perceived Need, Value and Role of Hospital Chaplains, 1971 and 1981.\textsuperscript{14}

The methods utilised in the above research were adopted as a pattern for the thesis survey and will now be used as a comparison. Two surveys were conducted at the Lutheran General Hospital Illinois, the first in 1971 and the second ten years later in 1981. As in the thesis survey, patients, doctors, nurses and chaplains were utilised.

The key findings from the 1971 survey were:

\textsuperscript{13} Neels, R.J., “The Horizontal Perspective: A Study of Patients’ Attitudes Towards Hospital Chaplains”, New Zealand Medical Journal, 1977, 85; pp.429-432

1) The availability of chaplains was highly valued by patients and received an even stronger endorsement from physicians and nurses.

2) Age and religious preference of patients were important variables in the assessing value patients placed on chaplaincy.

3) The policy of assigning chaplains to care for all patients on a unit, regardless of religious preference, was supported.

4) The value that chaplains placed on various aspects of their ministry differed substantially from the value system of patients, indicating that role communication needed to be improved.\textsuperscript{15}

This thesis concurs with these findings. Item 2 is only considered important in that the inconsistent participant responses indicate that age has little influence on the complete survey. Age may have influenced some older Greenwich Hospital patients and junior doctors to answer certain questions differently, but this was not a consistent factor. Both surveys indicated that the majority of participants were prepared to accept visits from denominational chaplains other than their own if necessary, making this an important variable in the assessment of chaplaincy value.

Results of the 1981 survey were assigned into five major chaplaincy roles and ranked as under:

**Table 1: Lutheran General Hospital - 5 Major Roles of Chaplains.**

<table>
<thead>
<tr>
<th>Chaplains Role</th>
<th>Patients</th>
<th>Nurses</th>
<th>Physicians</th>
<th>Chaplains</th>
<th>Overall Role Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comforter</td>
<td>2.60 (1)</td>
<td>2.80 (1)</td>
<td>2.80 (1)</td>
<td>2.90 (1)</td>
<td>2.78</td>
</tr>
<tr>
<td>Liturgist</td>
<td>2.42 (2)</td>
<td>2.70 (2)</td>
<td>2.78 (2)</td>
<td>2.47 (3)</td>
<td>2.59</td>
</tr>
<tr>
<td>Witness</td>
<td>2.29 (3)</td>
<td>2.60 (3)</td>
<td>2.42 (4)</td>
<td>2.70 (2)</td>
<td>2.50</td>
</tr>
<tr>
<td>Resource</td>
<td>1.83 (4)</td>
<td>2.36 (4)</td>
<td>2.45 (3)</td>
<td>2.47 (3)</td>
<td>2.28</td>
</tr>
<tr>
<td>Counsellor</td>
<td>1.80 (5)</td>
<td>2.00 (5)</td>
<td>1.90 (5)</td>
<td>2.14 (5)</td>
<td>1.96</td>
</tr>
</tbody>
</table>

Overall Group Mean 2.19 2.49 2.47 2.50

Note: These means have been standardized to achieve equivalent ranges for all ratings. Lowest value possible equals 1.00, highest possible, 3.00. Rank order in parentheses.

The major difference between the Lutheran table and the thesis survey is the position of the ‘liturgist’ group. With the exception of a Sydney survey conducted in

\textsuperscript{15} Ibid., p.28.
1993,\textsuperscript{16} which also placed the ‘liturgist’ group above ‘witness’, all other surveys sighted by this researcher have placed the ‘witness’ group in the higher position. It should be noted, however, that in the Lutheran survey the chaplains have placed ‘witness’ above ‘liturgist’ and that they are the only group to have done this.

The 1981 survey focussed strongly upon the question of the importance of having a chaplain of the same faith (denomination) available to the patients at all times, by contrast with the question of the importance of having a chaplain of some faith available. The responses were very similar to those in 1971. Firstly, only about a third of each group felt it was of great importance to have a chaplain of the same faith as the patient available at all times. Secondly, a higher percentage of nurses and physicians than patients endorsed the importance of having a chaplain of some faith available. However, whilst the percentage of patients responding ‘of great importance’ to some faith increased from 40\% in 1971 to 56\% in 1981, the percentage of physicians so responding decreased from 76\% to 83\%. As in the thesis survey, the indications are that the presence of a chaplain of another denomination to that of the recipient is acceptable when one of their own denomination is not available.

Other results from the 1981 survey indicated that patients did not view the role of the chaplain to be as extensive as the medical staff and chaplains themselves. This was evident in the patients’ replies concerning the chaplain as a resource person to the medical staff on matters of ethics and also with regard to chaplains helping the staff with their personal or work problems. The thesis survey also showed the patients recording the lowest percentage of ‘yes’ replies for the expectation of chaplains consulting the medical staff on ethical issues. It would appear, therefore, that the passage of time has not altered patient indecisiveness as to the chaplains’ role in this regard. However, as to the chaplains’ role concerning both work and personal staff problems, the thesis survey reaches different conclusions, the patients recording a higher ‘yes’ percentage than the medical staff. This difference could be, either a change across time in patient views or an American/Australian variation. As more American chaplains are employed directly by hospitals than Australian chaplains, giving them similar professional recognition to that of the medical and other staff members, it is reasonable to suppose that American hospital staff would relate more freely to chaplains with regard to both work and personal problems than would Australian hospital staff to their chaplains. It is probable, therefore, that the American/Australian variation is the reason for the above differences. The chaplains were the only group to record a higher percentage than the patients. As the thesis

\textsuperscript{16} R. Davoren, ‘Quality Assurance Survey of the Medical & Nursing Staff Perceptions on the Role of Hospital Chaplains’, Conducted at Concord Hospital, Sydney, 1993.
survey was based on role expectations only, the actuality of chaplaincy involvement with staff problems will be addressed in Chapter 5.

A final point of note is a quote from the 1981 survey under the title *Need for Initiating Patient Contact*, which is in complete accord with the findings of the thesis survey:

Chaplains must deal with the reality of low expectations and high satisfaction. That is, about one-third of patient respondents placed value on a chaplain’s visit during their hospitalization, yet 81% expressed satisfaction with ministry when the chaplain did visit. This suggests that chaplains must take the initiative since patients are not likely to request visits. Most chaplains would agree that taking initiative is very difficult. Chaplains prefer responding to patient or staff initiative.\(^\text{17}\)

### c. Further Studies Concerning the Role of Faith in Healing

It is hoped to show in the present research that religious faiths, and particularly prayers, have a positive effect on patients, either through a form of Divine intervention or indirectly through the power of positive thinking. Holistic research conducted in the United States of America involving hospital chaplains, has been used to compare with the present research in its anticipation that the special attention patients receive through holistic treatment is, in most instances, beneficial not merely to the patients themselves, but to specific medical units and to the hospital as a whole, and that the chaplain is directly or indirectly contributory to such benefits as an integral part of the team. In assessing the value of the following American studies, the question arises as to whether these studies would have achieved the same or similar results if conducted in Australia; were these study results influenced because Americans are simply more religious than Australians, or were any other unknown factors involved? While admitting that a number of Americans are indeed more demonstratively religious than some Australians, the precise impact of that cannot be determined. Nevertheless, care in the exercise of pastoral duties is clearly demanded, as some of the American research indicates.

Rev. Joseph Fichter, after conducting a sociological survey of American Catholic hospital personnel to assess whether Christians turn confidently to God when they are sick, wrote the following:

We have seen that hospital personnel believe that when sick people are anxious and fearful they are strengthened by the consolations of religion. Sometimes, however, the opposite occurs. The immediate effect of intense pain seems to preoccupy patients with themselves and their own troubles in an unhappy situation.

\(^{17}\) Carey, *op.cit.* p.35.
The greater the pain, the less likely are such patients to be fresh and alert, able to carry on a conversation with a chaplain, ready to pray and meditate.  

As a hospital chaplain herself, the researcher agrees with Fichter’s comments, adding that a correctly trained chaplain would not intrude upon a patient under such circumstances. By showing consideration to the patient’s feelings at that time, the chaplain may be welcomed by the patient at a different time and under different circumstances. The studied American research is listed below:

i. Crisis Intervention in Orthopaedic Surgery Conducted at Evanston Hospital, Illinois

In 1971, a survey on crisis intervention in orthopaedic surgery was carried out at Evanston Hospital, Illinois. The subjects were 150 elective orthopaedic patients. These were divided into a control group of 50, a support treatment group of 30, and an information-support treatment group of 30. All groups were found to be relatively equivalent in age, sex, make-up, types of surgery, number of hospitalizations, basic anxiety reactions, the physicians who treated them, and physiological responses. The control group received basic hospital attention, whilst the support treatment group were supplied with a person to use as an external reference point who would support the expression of their feelings. The essential elements of the supportive treatment were:

‘to establish a relationship with the patient and let the patient know of their availability’;
‘to listen sympathetically to the patient’;
‘to try to communicate understanding and belief in the rehabilitation process’;
‘to communicate confidence in the hospital and staff. Each treater was instructed to try and let the patient lead the conversation and to support the patient’s views of surgery and recovery when realistic’.

Support-information treatment was also designed to help patients cope with their surgery and recovery. The support person was to explain clearly the role expected of the patient during hospitalisation, the hospital routine and the psychological

---

19 Florell, John Loren, Crisis Intervention in Orthopaedic Surgery. A dissertation submitted to the Graduate School of Northwestern University in partial fulfilment of the requirements for the degree Doctor of Philosophy, June, 1971, p.78.
20 Ibid., pp.64/5.
preparation needed for surgery. This treatment was devised to complement the supportive treatment.

The survey concluded that the support and support-information treatments significantly reduced the time that patients stayed in the hospital after their operation by one to two days, with the control group staying an average of 6.1 days, the support group 4.9 days and the support-information group 4.3 days. There were also corresponding reductions in the quantity of pain medication used after surgery and the required nursing attention. The assessed conclusions of this study were that elective surgery appeared to cause emotional and physical reactions that interfered with the healing process of the patient, as indicated by the control group. The treatment groups appeared less emotionally and physically disturbed, as indicated by the physiological and psychological measures. The control group used a higher quantity of pain medication, had higher postsurgical anxiety state scores, made more calls for assistance, had elevated physiological responses, were more incongruent in their assessment of pain and stress with their physicians, rated their treatment as less satisfying and had more written about them in nursing notes than the treatment groups. It was concluded that supportive treatment could help the patient feel that someone was concerned about them and allowed the patient to have faith in the treater. This concern would in turn facilitate healing by decreasing emotional and physical distress.21

John Florell, the instigator of this survey, was the Minister-in-residence and researcher at Evanston Hospital. He considered that the study attempted to combine the insights of theology, education, sociology, medicine, psychology, psychotherapy and nursing to develop the rubrics of treatment. Theology, states Florell, contributed the concept of faith, and allowed concern for the whole patient. He goes on to say that many ministers/chaplains know the value of just sitting and listening to patients during a hospital visit, but even this indirect method of helping a patient could be strengthened if the chaplain understood what was happening to and around the patient. By becoming more informed about the way the hospital is run, the chaplain could directly influence the ability of the patient to organise the hospitalization experience and aid the healing process.22

The results of this early study reinforce the present research findings that when a patient receives special attention for their spiritual/emotional needs, whether this is from a chaplain or other support person, their rate of recovery is increased, less medication is needed and required nursing time is reduced.

21 Ibid., p.114.
ii. University of Virginia Medical Center Research

During research at the University of Virginia Medical Centre, 44 randomly matched orthopaedic patients were divided into two groups, one group receiving daily chaplaincy visits and the other receiving no visits at all from the chaplains. The patients who had received daily visits by the chaplains required two days’ less hospitalisation than those who had not been visited. Additionally, the visited patients required 66 percent less pain medications and nursing attention. These results were similar to those recorded in the above research by John Florell.23

iii. Rochester Methodist Hospital Cardiac Rehabilitation Unit Research

In 1980, the chaplain at Rochester Methodist Hospital recorded the results of a simple questionnaire he had conducted in the Rochester Cardiac Rehabilitation Unit to determine how the personal faith of a patient contributed to his/her rehabilitation. A religious profile was written for thirty patients, out of which twenty-eight felt that somehow God was involved in their situation, not as the one who had caused the incident, but as one who provided, protected and saved during the incident. The enthusiasm of the Unit spurred the chaplain on, with one member reflecting that it had never dawned on him that religion might be an important area to investigate, and yet after the survey it seemed obvious to him. The profiles showed clearly that along with the physical and emotional dimensions, which are often discernible in the heart attack patient, there is a spiritual dimension of each patient which needs attention. According to the article, the team of the Unit now see the patients in a more holistic context, resulting in better patient care.

Richard Kohler, the physical therapist on the cardiac rehabilitation team, depended on reading the religious profiles before working with a patient. Kohler used the data to focus on stress and religious involvement as it relates to the religious profile of the patient. In part, his findings revealed that the high stress group appeared to have a lower level of activity in the Church.

One may deduce from the statistical analysis that there is a connection between the way patients handled their heart attack and their church involvement, the deduction being that high stress signified a low church involvement. Conversely, the deduction is that a high involvement of church activity resulted in lower stress levels. Aside from what might be credibly concluded statistically, the survey results indicated to the

team in a tangible way that the chaplain has significant input into overall patient care and an enthusiasm for a team approach was sparked.24

A prominent theme of the above research is an emphasis on wholeness, the relationship between the mind and body and, as Richard Young points out:

In the threefold ministry of preaching, teaching and healing, Jesus recognised the essential unity of man’s nature. He did not treat the individual primarily as a body or as a soul, but ministered to the whole person, placing emphasis upon totality of body, mind and spirit. The text of his first sermon indicates that the relief of human suffering was a primary purpose of his mission. (Luke 4:18).25

The research indicated that the mind can, in many cases, influence the body by raising a person’s morale, decreasing levels of stress, adopting a positive attitude, and having faith and trust in the medical team, especially the chaplain.

In 1984 Harvard cardiologist Herbert Benson introduced what he described as the ‘faith factor’, based on many years of research. Benson believes that the benefits of religious faith in the healing process are greater than those of faith in medical treatments. He summarises his conclusions by saying: ‘My study in this field has convinced me that, for whatever reason, faith does make a difference in enhancing the power of the mind over health and disease’.26

A number of surveys have been conducted in the United States, appear to support Benson’s conclusion. In 1986 research was commenced at the Duke University Medical Center in North Carolina as part of the National Institutes of Health sponsored Establishment of Populations for Epidemiologic Studies of the Elderly project, to examine the relationship between religious activities and blood pressure in patients over 65 years of age. This study was conducted in three stages, ending in 1994, with more than 2500 patients taking part in personal interviews, during which information concerning demographic characteristics, religious activity and denomination, physical functioning, cigarette smoking, body mass index, and blood pressure was gathered. The data collected on religious activity included such factors as: frequency of attendance at religious meetings or church services; frequency of prayer, meditation or Bible study; and frequency of watching religious television programs or listening to religious radio programs. Whilst the majority of participants who attended religious services, prayed frequently or read the Bible, recorded low blood pressures, those who frequently watched religious television or listened to

religious radio programs actually had higher blood pressure than those who were less active. This can be explained by the following: the largest number of participants who watched television and listened to the radio were the older Black Americans; Black Americans were over-sampled in this survey; age increases the level of blood pressure; and more than 40 percent of Black Americans are taking medication for high blood pressure. However, when the statistics are applied to White Americans only, the results are insignificant.\textsuperscript{27} Harold Koenig and his co-researchers are of the opinion that: “given the link between stress and blood pressure, one might hypothesize that greater religious activity which reduces stress and enhances coping, might be associated with lower blood pressure”.\textsuperscript{28} The indications of this study are that older adults tend to have lower blood pressure levels when they are religiously active than those who are less active.

Between November 1989 and December 1992, an experiment was conducted to examine the relationship of social support and religion to mortality following elective open heart surgery. This experiment was carried out by four staff cardiothoracic surgeons of the Dartmouth-Hitchcock Medical Center in Lebanon, USA, on 232 patients aged 55 years or older. Of the participating patients, 21 died within six months of surgery; four during the actual operation; five within twentyfour hours after surgery; six within three weeks; five within three months; one from lung cancer within five months. Variables which may have contributed to the death of these patients were examined, including: age; presurgery impairment; previous history of cardiac surgery; basic activities of daily living; amount of participation in organized groups; strength and comfort levels obtained from religious sources. The research showed that biomedical characteristics of age, presurgery impairment and previous history of cardiac surgery were clearly significant in the deaths. No significant psychological variables were involved; however, the risk of death following surgery was three times greater for patients who had not participated in organized social or activity groups than those who had actively participated. Religious variables showed a similar result, with patients receiving no strength and comfort from religion having almost three times the risk of dying than those with some measure of strength and comfort. There were also indications that infrequent church attendance and lack of deep religious faith contributed towards an increased risk of death. The researchers of this study found that patients without religious strength and comfort were invariably unmarried and had few close network members with whom to share their emotions. They considered the variable relating to religious strength and comfort to be the best

\textsuperscript{28} \textit{Ibid.}, p.191.
predictor for decreasing death from cardiac surgery amongst the elderly, indicating that
religion is not simply a social contact involvement, but holds a deeper significance for
patients.\textsuperscript{29}

In contrast to the above claims regarding the relation between religion, prayer
and healing, the February 1999 edition of \textit{The Lancet} published an article which
advocated that there is no medical evidence to support a belief in the healing power of
religious faith. The article was written by researchers at the Columbia-Presbyterian
Medical Center in the United States, in an endeavour to ascertain whether patients
would benefit from the promotion of religion by physicians. The conclusions of these
researchers were not reached by conducting their own survey, but by examining
results obtained from studies by others. It was considered by the researchers that there
is only weak and inconsistent evidence that religion, spirituality and health are
associated, and that former studies, even if sufficiently well conducted, have not
allowed for variables such as age and lifestyle. For this reason their opinion is that
more research is required before faith and religion can be promoted as adjunctive
medical treatments. The researchers do not reject the idea that religion and faith are
comforting to some people during illness, but they do not consider that physicians
should actually promote religion actively: They were concerned about ethical
repercussions of such action. A further concern expressed by these researchers was
that, if religious activity was linked to health, problems could arise if a patient related
their illness to insufficient faith on their part.\textsuperscript{30}

Most of the above researchers would claim that variables had been considered
when assessing their results. For example, in the Duke University Medical Centre
study recorded above, not only were variables such as age, race, gender, education,
physical functioning, and body mass index allowed for generally, but response
options for each variable were dichotomized for analysis purposes: Age 65 to 74 years
$= 0$, 75 years or over $= 1$; religious attendance less than once/week $= 0$, once/week or
more $= 1$, and so on. In this way any variables which may have influenced patients’
blood pressure readings were controlled. In a 20 year blood pressure study of 144
nuns and 138 lay women, the researchers adjusted their results by allowing for
education, race, weight, body mass index, smoking, family history of hypertension,
serum cholesterol and triglycerides, and twenty-four-hour urinary sodium excretion.
These examples undermine the claims of the authors of the Columbia-Presbyterian

\begin{flushright} \textsuperscript{29} Oxman, Thomas E., Freeman, Daniel H., Manheimer, ‘Lack of Social Participation or
Religious Strength and Comfort as Risk Factors for Death After Cardiac Surgery in the
\end{flushright}

\begin{flushright} \textsuperscript{30} Sloan, R.P., Bagiella, E., Powell T, ‘Religion, Spirituality, and Medicine’ in \textit{The Lancet},
\end{flushright}
Medical Center study that variables have not been sufficiently considered by researchers.

There is even evidence that religious practises can affect a patient’s health, even where the patient is not him/herself party to or aware of such practises. A 1988 survey carried out by cardiologist Randolph Byrd is instructive. Using a sample of 393 coronary care unit patients at San Francisco General Hospital, Byrd explored the effects of prayers of intercessors on the recovery of the patients. The patients themselves were not aware that they were being prayed for. Byrd’s intent in conducting the study was designed to answer a basic question: ‘Does intercessory prayer to the Judeo-Christian God have any effect on the patient’s medical condition and recovery while in hospital?’ The answer appears to be ‘yes’. Byrd himself reports:

Analysis of events after entry into the study showed the prayer group had less congestive heart failure, required less diuretic and antibiotic therapy, had fewer episodes of pneumonia, had fewer cardiac arrests, and were less frequently incubated and ventilated’.

Margaret Poloma and George Gallup consider that Byrd’s findings suggest that intercessory prayer, even when such prayer is not known to the person who is the object of the intercession, appears to be therapeutically beneficial. Claudia Wallace has also discussed the above-mentioned Randolph Byrd experiment, noting that those patients who had been prayed for were five times less likely to need antibiotics and three times less likely to develop complications. Wallace noted that ‘this study has never been replicated and has come under some criticism for design flaws’. She does not describe these flaws and her comment is contrary to the view held by Paloma and Gallup that ‘Byrd’s study is well designed’. This is supported by an acceptable sized sample being used (393 patients) and the intent of the survey appearing to have been clearly stated.

In November, 1999, a further article on the subject of health and healing was published in the Archives of Internal Medicine, stating that an experiment by cardiologists at St. Luke’s Hospital in Kansas City appears to show that having people pray for another without knowing anything other than a first name, reduces complications and lengths of stay of hospital patients. This survey was conducted in an attempt to replicate Byrd’s 1988 findings, as no other known trial of this nature

relating to cardiac patients has been published. In the latest research, 990 patients admitted to St. Luke’s Hospital Coronary Care Unit were randomly assigned to either usual care or to a special prayer group. The patients were assigned to each group on an alternative computerised number basis which alleviated any opportunity for bias. Once a patient was assigned to the prayer group, an intercessory prayer team leader was given the patient’s Christian name only: no other patient information such as diagnosis, prognosis, age, race, socio-economic status, or family situation was given. The chaplain’s secretary was the only person with access to the assignment code, and she had no contact with the patients, Coronary Care Unit staff, the data collectors or the statistician. The prayer team leader contacted four of the intercessor team, giving the patient’s Christian name, after which the intercessors prayed for ‘a speedy recovery with no complications’ for the patient for 28 consecutive days. Patients who requested the services of the chaplain during their hospitalization were accommodated regardless of the group to which they were attached. The results showed lower overall adverse outcomes for the prayer group patients compared, with those of the usual care group; lengths of stay in hospital were not affected. These findings are consistent with those of Byrd’s survey. Neither the present or Byrd’s study provided any mechanistic explanation for possible intercessory prayer benefits; the research was not intended to explore a mechanism but to identify a phenomenon. The authors’ own words clearly explain the results they believe were achieved by conducting this survey:

Although we cannot know why we obtained the results we did, we can comment on what our data do not show. For example, we have not proven that God answers prayer or that God even exists. It was intercessory prayer, not the existence of God, that was tested here. All we have observed is that when individuals outside of the hospital speak (or think) the first names of hospitalized patients with an attitude of prayer, the latter appeared to have a ‘better’ CCU experience. Although our findings would be expected to occur by chance alone only 1 out of 25 times that such an experiment was conducted, chance still remains a possible explanation of our results.\(^3\,5\)

Mark Ragg, writing in the Sydney Morning Herald on 22 November, 1999, referred to both Byrd’s earlier study and the one described above. His comment on the results was that ‘in science, once is a fluke, an idea, a suggestion. Twice is proof, or pretty close to it. This is twice’.\(^3\,6\)

It is considered that the present research is necessary to assess whether Australian beliefs concur with the American findings and to analyse any differences;


\(^3\,6\) Ragg, Mark, ‘Healing power of strangers’ prayer’, Sydney Morning Herald, Fairfax Limited, 22.11.99, p.3.
this with a view to recommending to the medical and religious professions, any relevant changes which may improve hospital chaplaincy.

The conclusions of the research with regard to the benefits of holistic treatment and the power of prayer will be discussed in Chapter 6.

d. Hypotheses

This research will be an exploratory study into an area not recently surveyed in New South Wales. Comparison of data with previous studies will therefore be limited. It is hypothesized that responses from patients are likely to indicate expectations for the role of chaplains which concentrates on relieving their fears and anxieties, whilst the responses of staff will be more orientated to institutional questions, i.e. making the work place better. Differences between patients and doctors can also be expected; the use of statistics would establish whether differences discovered are significant or not. It can also be anticipated that both patients and staff will differ from the chaplains in that the former are more likely to emphasise the intrinsic value of chaplaincy, i.e. patients will be helped to feel better, staff contribute to the better running of the hospital, and chaplains represent and create good in itself. The null hypothesis for this study is, that there will be no differences between the various groups of respondents in respect of their answers to the questions regarding expectations of the role of hospital chaplains. As the null hypothesis suggests no differences, any significant differences must be accounted for.

e. Backgrounds to Hospitals Participating in the Surveys

Initially, three Sydney hospitals were surveyed in an endeavour to assess the expectations of the role of hospital chaplains by patients, junior and senior doctors, nurses and chaplains themselves. These three hospitals were carefully selected for their different religious backgrounds, size, age and the types of services available at each one. One, a general hospital, is located at Mount Druitt, a working-class area on the outskirts of Western Sydney, whilst another general hospital is located in the more affluent lower North Shore area and accommodates a more extensive range of patients, including some from interstate and overseas. The third is in the same area as the latter, but is basically a rehabilitation, long care and palliative care hospital. The intention was to assess whether the medical and social differences influenced the statistical data when participants’ replies were compared. All three hospitals are in close proximity to the researcher’s residence allowing for easy personal contact and distribution of questionnaires; his proved to be considerably cost-saving, as minimal postage charges were involved. These hospitals are individually discussed below.
i. The Royal North Shore Hospital (RNSH), St. Leonards, NSW

This is the largest and oldest of the three hospitals surveyed and, as its name suggests, it is situated north of the City of Sydney on the Lower North Shore. The foundation stone of the original hospital was laid by Sir Henry Parkes in June 1887 half a mile away from the site of the present hospital. The North Shore Cottage Hospital, as it was then called, opened in June 1888 with 14 beds and five nurses. In June 1903 the new hospital opened its doors with 48 beds and was named Royal North Shore Hospital of Sydney. Additional land was regularly acquired for expansion of the hospital which now totals around 35 acres. Thus, the 14 bed Cottage Hospital founded more than 100 years ago to service the North Shore population of 20,000, now caters for approximately 50,000 patients a year and is currently an 843 bed acute general teaching hospital.

Affiliated with the University of Sydney and the University of Technology, Sydney, RNSH is a significant part of a cooperative network of public and private hospitals and community health services in the Northern Sydney Area Health Service. It provides health care for patients referred from hospitals throughout New South Wales as well as other States and the South Pacific. It offers general, as well as specialised units, including cancer, psychiatric, paediatric, geriatric assessment, spinal injuries, emergency medicine, intensive therapy unit, renal dialysis and transplants, maternity and new born intensive care, together with a drug and alcohol unit.

The RNSH established a Chaplains' Department in 1963, the first of its kind in Sydney and in 1968 the inter-denominational hospital chapel was built. The Head of the Chaplains' Department position has been a hospital appointment since 1972, with further hospital appointments being introduced in 1979 (pastoral educator), 1987 (full-time pastoral counsellor in the Intensive Care Unit), 1988 (partial funding for assistant pastoral educator), 1989 (fulltime secretary for the Chaplains' Department). All additional appointments of hospital chaplains at RNSH are made by individual religious denominations with no hospital or governmental funding involved.

ii. Mount Druitt Hospital (MDH), Mount Druitt, NSW

Mount Druitt Hospital's background is different from that of RNSH. Located west of Sydney and opened as late as 1982 by Queen Elizabeth II it is only a quarter the size of RNSH, with around 200 beds. MDH was established as an acute care hospital.

---


public hospital in the care of the Catholic Church, an unusual arrangement in health care in New South Wales. The hospital is funded from the public purse, as are public hospitals, but managed by a Board appointed by the Catholic Church. In 1986, MDH became a unit within the Prospect Area Health Service and three years later went on to form part of the Western Sydney Area Health Service. The Board reformed to become the Mount Druitt Hospital Council, with the Catholic Bishop of Parramatta holding the senior position of Chairman.

In addition to general wards, MDH boasts facilities to cater for intensive care patients, accidents and emergencies, paediatrics, urology, orthopaedic surgery, pathology, radiology, physiotherapy, and a Diabetes Education Centre. Numerous clinics are held for oncology, ante-natal care, neurology, ophthalmology and natural family planning, and speech pathology. The MDH and Community Health Services have also established the largest Aboriginal Health Worker Programme in Western Sydney, and have an effective Western Area Adolescent Team. The latter adopts a developmental approach to the problems experienced by youth in one of the largest and quickest growing urban developments in Sydney.

The staff of MDH have always been expected to understand, accept and observe the principles and ideals of the Catholic health care ethics and this has been an integral part of the staff orientation programme from its commissioning days until the present time. The hospital has an internal chapel, a religious affairs co-ordinator and a clerical pastoral assistant was appointed in 1989 by the Hospital Council. Priests from surrounding parishes also proffer their services when necessary and additional spiritual services are provided by other denominational clergy and chaplains, with an ecumenical service being held every Sunday in the chapel. These other denominational chaplains are appointed by their individual churches and dioceses.

iii. Greenwich Hospital (GH), Greenwich, NSW

At the time of research writing, Greenwich is one of the Home of Peace Hospitals which is directed by a Board appointed by the Anglican Deaconess Institution, Sydney. The Governing Board is chaired by the Anglican Archbishop of Sydney. It is anticipated that GH will become a member of the privately owned Hope Healthcare Group at a future date, nevertheless remaining as a ministry of the Anglican Deaconess Institution, Sydney.

Established in 1966, GH is a Third Schedule institution under the Public Hospital Act 1929 and is funded by the NSW Department of Health. The smallest of the three hospitals utilised in the initial survey, GH has a mere 100 beds and caters for

---

palliative care and rehabilitation patients only. The rehabilitation clinical caseload is predominantly orthopaedic, hip fractures, joint replacements, neurological and vascular amputations, whilst the palliative care unit provides a comprehensive service for those diagnosed with life threatening illness where relief from symptoms and pain may be required. Outreach services are also practiced at GH, including consultant support to general practitioners caring for those with a life threatening illness within the community and an after hours nursing telephone service.

As part of the Northern Sydney Area Health Service, admissions to GH are facilitated through the Rehabilitation and Geriatric Services of RNSH and its comprehensive rehabilitation programme is offered to both inpatients and post-discharge outpatients. Day respite care is also available within the hospital grounds which provides a social and therapeutic programme on a day-only basis to the chronically disabled residing in the community.

There is a chapel at GH in which an ecumenical service is held every Sunday; a Catholic Mass is also celebrated on the second Saturday of each month. Only one full-time chaplain services GH, in conjunction with Graythwaite Nursing Home (also belonging to the Home of Peace Group), whilst a Catholic Priest and Sister regularly visit members of their own denomination. Other clergy visit their own parishioners when needed.

A further survey was conducted in an endeavour to assess staff views as to the actual duties being performed by chaplains. Personal in-depth interviews, as well as a written questionnaire, were involved and the researcher anticipated that it would be statistically simpler to restrict the samples to small units rather than the extensiveness of the previous survey. As two-thirds of the survey was conducted interstate, time and finance were added considerations. It was anticipated that small, compact groups performing similar duties would be most suitable and, having been well-established for many years, it was considered that Liver Transplant Units would fulfil the desired requirements. As only one Liver Transplant Unit operates in each Australian State, this necessitated the interstate research. Being the closest in proximity, Units at The Austin Hospital in Victoria, The Royal Prince Alfred Hospital (RPA) in New South Wales, and The Princess Alexandra Hospital (PAH) in Queensland, were selected. Their individual backgrounds are shown hereunder:
iv. The Austin Hospital, Heidelberg, Victoria

The Austin Hospital was founded on 24 January, 1882 through the initiative of Mrs Elizabeth Austin who offered 6000 pounds to start a hospital for the incurably ill. In 1935 The Austin was the largest cancer hospital in Australia. By 1956, comprehensive spinal injury treatment and rehabilitation services were fully operational; the Austin became a general hospital when the outpatients and casualty was opened in 1960. In 1965, the Hospital became affiliated with the University of Melbourne when the Clinical School was established for teaching undergraduate medical students, with the first professors being appointed in 1966. On 7 April 1988, The Austin and The Royal Talbot General Rehabilitation Hospitals were amalgamated.

Today The Austin services a catchment population of more than 500 000 people and, as a major public teaching hospital of 568 registered beds, is accountable to the government for the efficient use of the resources provided. It has an obligation to work with and through government to satisfy community needs as designated under the Health Services Act, 1988. The Hospital provides general medicare and surgery, cardiac, hepatobiliary, neurosurgical, spinal, renal, oncology, orthopaedic, rehabilitation and other specialised services for Victoria and other parts of Australia. The Liver Transplant Unit, which was formed in 1989, is a significant addition to the many services offered by The Austin Hospital and in 1993 it performed its 100th operation by transplanting a ‘cut down’ adult liver into a four year old boy.

The philosophy of this Hospital, as stated in the 1992/3 Annual Report, is that it not only believes every patient is entitled to receive high quality health care with dignity, integrity and rights, but it also recognises the importance of members of staff as the primary strength in the achievement of Hospital goals. To this end The Austin Hospital acknowledges the need for team-work and the development of a working environment which enables each individual to reach full potential. The following research results show that this philosophy applies equally to the Department of Pastoral Care and Education, where Unit Chaplains are invited and encouraged to become an integral part of the team for the holistic benefit of the patients and other staff members. It is the general practice at The Austin for the chaplains to work ecumenically, unless a patient specifically requests to see a chaplain or visiting clergy of their own denomination.

The involvement afforded to the Liver Transplant Unit chaplain is extensive. Soon after its commencement, the director of the Unit made the decision to support financially a paid part-time position for a chaplain. This was a ground-breaking decision within the Hospital and involved the drafting of a role description, negotiating

---

40 Background to The Austin Hospital, Heidelberg was compiled from information contained in The Austin Hospital Annual Report, 1992/3.
accountability between the heads of the LTU and the Pastoral Care Department and placing the chaplain within the administrative system of the Hospital.\textsuperscript{41} This Hospital has always been open to new pastoral ideas, and was among the first hospitals to implement clinical pastoral education (CPE) courses in Australia. The LTU chaplain attends weekly meetings with other unit members and is encouraged to have input in the assessment of patients for transplant by providing a pastoral diagnosis. In addition to the weekly full staff meetings, the chaplain meets regularly with the social workers and the LTU clinic nurse to discuss patients’ needs and to express their feelings as to which would be the best way to help them. The following survey results will show how the LTU chaplain’s involvement assessed by other staff members.

The Hospital Chapel, located on the ground floor, is always open for use by patients, relatives and staff. In addition, an Ecumenical Service is held each Sunday in the larger Outpatients Clinic, so as to accommodate more people. Patients are escorted to and from the Service either in a bed, wheelchair or on foot. Church lists are distributed each Friday and patients are encouraged to speak to a nurse if they wish to attend the Sunday Service.

v. The Royal Prince Alfred Hospital, Camperdown, New South Wales\textsuperscript{42}

The Royal Prince Alfred Hospital was named after Queen Victoria’s second son who, during a visit to Australia in 1868, was the victim of an assassination attempt while on a picnic in the northern Sydney suburb of Clontarf. Australians opened a public subscription fund to build a hospital as a memorial to his safe recovery. The Prince authorised his coat of arms to be used as the new hospital’s crest. King Edward VII granted the hospital its Royal prefix in 1902.

Royal Prince Alfred Hospital opened as a 146 bed hospital in 1882 and now facilitates more than 50,000 inpatients and 500,000 outpatients each year. The RPA has always been a progressive hospital and involved in many branches of research. This is evidenced by the following impressive list which contains a number of ‘firsts’:

- First aortic valve replacement in Australia
- First Gynaecological Oncology Unit in Australia
- First open heart surgery in New South Wales to establish a Liver Transplant Unit
- First Sleep Disorders Centre in Australia
- First Coronary angiography in New South Wales


\textsuperscript{42} Background to Royal Prince Alfred Hospital, Sydney, was compiled from information contained in the Royal Prince Alfred Hospital Brochure, Central Sydney Area Health Service.
First National Medical Cyclotron/Positron Emission Tomography Camera
Australia’s first Perinatal Medicine Unit and first Fetal Heart Monitor
First Nuclear Medicine Department in Australia
First Triage Nurses in Australia
First Audiology Unit in an Australian teaching hospital
Only academic Dermatology Service in Australia
Pioneered hospital involvement in Community Health Services and Psychiatric Units in general hospitals.

This Hospital provides a great number of other facilities, including the largest Melanoma Unit in the world, a large In-vitro Fertilisation Unit, a Haemophilia Centre and units for most other major disorders. As a principal teaching hospital of the University of Sydney, RPA has the biggest student intake and one of the largest staffs of resident medical officers in New South Wales.

The Hospital Chapel is a considerable distance from the Pastoral Care Department and is a separate free-standing building away from the Hospital itself. The location of the Chapel may, at times, prevent patients from attending the regular Wednesday or Sunday Services. The chaplains and other pastoral workers of all denomination/religions share a large room close to the main hospital entrance, but minister primarily to their own faith. The Liver Transplant Unit is serviced by the Uniting Church chaplain, unless a patient specifically requests a to see a chaplain of their own denomination/religion. This chaplain is not delegated to the LTU only; his ministry also incorporates a number of other wards, thus minimising available time in the LTU. He is, however, invited to attend weekly LTU staff meetings conducted by the head of the transplant surgery team with surgeons, the medical team, theatre staff and other senior nurses, and the allied health team attached to the unit.

vi. Princess Alexandra Hospital, Woollongabba, Queensland

Princess Alexandra Hospital was opened in 1956 and is an 881 bed public hospital for adults, with more than 200 speciality outpatient clinics and special units. It is a major transplantation centre for livers, kidneys, bone cartilage and corneas. In addition, the centre houses the services of the Queensland Liver Transplant Service, Queensland Eye Bank and the Queensland Bone Bank. The Princess Alexandra Hospital has achieved both national and international acclaim and recognition as a teaching, research and tertiary referral hospital; its high standard has enabled accreditation by the Australian Council on Healthcare Standards.

---

43 Brisbane South Regional Health Authority Annual Report 1994/5.
Princess Alexandra Hospital.
44 Ibid., p.13
The existing Princess Alexandra Hospital situated in South Brisbane was originally the site of the Diamantina Hospital for Chronic Diseases. Following the opening of PAH in 1956, a major step in postgraduate education in Queensland was taken in 1960 when approval was given for the establishment of a branch of the College of Nursing (Australia) at PAH, with 90% of the funds coming from the Government. During 1994/5, PAH commenced integration with the small Queen Elizabeth II Hospital in order to maximise resources already in existence in the Brisbane South. The 93 bed Queen Elizabeth II campus became more of an elective and rehabilitation hospital with a view to reduced elective surgery waiting lists in other areas. A specialised neurological rehabilitation unit for the aged and an Acute Primary Care Centre were also developed.

There is no specific transplant chaplain at PAH, with each chaplain visiting patients of their own denomination/religion and spreading their time between various wards, including the LTU. One chaplain, in particular, liaises frequently with the LTU coordinator and has a special connection with patients who travel from New Zealand for transplants. This chaplain meets the patients at the airport and follows their progress through the whole procedure. A non-theologically or pastorally trained coordinator of this particular unit is highly involved in ways other than spiritual and draws on her own experience as a recipient. During the time of this research, the Princess Alexandra Hospital Chapel was undergoing extensive renovations and was temporarily out of use.

f. Participation Selection Method

In an endeavour to obtain an unbiased cross-section, randomly selected patients, senior and junior doctors, nurses and chaplains were invited to participate in the first survey which was commenced in mid-1993 and was completed by December, 1993. At Royal North Shore Hospital, one-tenth of the nurses and patients were surveyed, i.e. 120 nurses and 80 patients, together with 50 senior doctors, 50 combined registrars, residents and interns, and all the chaplains. Due to their small sizes, it was necessary to survey a larger 25 percent of the medical staff at Mount Druitt Hospital and 50 percent at Greenwich Hospital, together with all chaplains and church visitors. A number of chaplains from Westmead, Hornsby and St Vincent’s Hospitals were also included in the survey, as this group was decidedly smaller than any of the others. Any percentages less than this would not have produced samples sufficiently large to be of any value.

Patients who were able to complete the questionnaire by themselves were asked to do so and their forms were collected the same or following day. Others were

47 Brisbane South Regional Health Authority, *op.cit.* p.13.
assisted by the researcher. As little guidance as possible was given to patients who needed assistance, in order to render their answers equivalent to those of the other recipients for statistical analysis. In some cases the patients could read the questions themselves, but needed help to write their answers, whilst others needed the researcher to read the questions to them and also record their replies. No names were included on the forms, thus protecting patient confidentiality. As this researcher has been a hospital chaplain for a number of years, it was considered by the medical staff that she was sufficiently experienced to assess whether any patient experienced stress during the interview and to terminate the visit immediately if necessary. Nurses were selected at random from computer print outs under Nursing Administration supervision. The questionnaires were then distributed by the internal mail system and returned to a given point. The junior doctors were approached in the same manner, whilst questionnaires for most of the senior doctors were hand delivered to them or their secretaries and hand collected by the researcher.

In addition, Directors of Chaplains from each religion or denomination which was surveyed were interviewed in depth for their interpretations of the chaplains’ role. The replies given by these members of the hierarchy are discussed separately in Chapter 4, but have been included in the tallies for Chapter 3 for comparative purposes. All results will be made available to the Australian College of Chaplains, The Civil Chaplaincies Advisory Committee and the New South Wales Council for Clinical Pastoral Education Course Organisers, to help in effecting necessary role changes or clarifications resulting from this research.

For the second survey, only medical staff and chaplains were involved in an endeavour to assess the actual tasks performed by chaplains as perceived by the staff, again participants were randomly selected. This was deemed necessary by the researcher when consistent expectations of the role of hospital chaplains could not be achieved from the first survey. With their Hospital Ethics Committees’ approval, the LTU staffs from The Austin Hospital in Victoria, Royal Prince Alfred Hospital in New South and Princess Alexandra Hospital in Queensland, took part in this survey, which comprised a short written questionnaire and one-to-one unstructured interviews.

The written survey consisted of two main open-ended questions divided into sub-sections (Appendix XIII). Of the 60 questionnaires distributed, 20 to each unit, 37 (61%) were returned. The highest return was from RPA (80%), followed by PAH (60%) and then The Austin (45%). The lower figure for The Austin was due to the smaller staff numbers in the Unit compared to the other LTUs and the delegated distributor’s inability to enlist more participants. The participants in the three LTUs consisted of: 20 nurses, including some who were generally trained, clinical nursing
coordinators, theatre nurses and transplant coordinators; 14 doctors which included medical, surgical, anaesthetist, pathologist and heptologist participants; one occupational therapist; one physiotherapist and one LTU administration clerk. No completed surveys were received from social workers; it is unclear whether they were not approached by the delegated distributors or whether they declined to participate. However, the personal interview with a Royal Prince Alfred social worker is discussed later in Chapter 5. The only personal information requested on the questionnaire was the name of the hospital at which the participant worked and their occupation. Where necessary, the complete answers given anonymously by the participants to the open-ended questions are tabled in Appendix XIV, with general summaries and comments on each question recorded in Chapter 5.

**g. Statistical Methods**

The data received for this study is not suitable for sophisticated statistical analysis of a scientific nature. However, the analysis includes appropriate frequency distributions, cross tabulations and correlations as used in the multivariate method of statistics to assess a number of variables simultaneously, for instance, how a 33 year old Catholic patient answered in comparison to a 50 year old Anglican doctor. Only aggregated data has been used, apart from comments which have been made on open-ended questions. The rate of refusal to participate is also recorded.

**h. Questionnaire Format**

Following de Vaus’ view that ‘the questionnaire technique of providing highly structured data is an efficient method of creating a variable case matrix for large samples’48 this method was adopted for the first survey. The questions were considered relevant to the concept being measured and were chosen because it was anticipated that they would provide the required data from which easy statistical results could be obtained for analysis. Participants’ names were not requested as it was considered that anonymity would result in more valid replies. However, optional personal questions such as age, sex, religion and occupation were included to help ascertain whether participants’ views and patterns differed amongst various subgroups. These personal questions varied slightly between senior doctors, junior doctors, nurses, patients and chaplains, as appropriate to their specific roles. These differences were:

---

Doctors - medical speciality
Registrars, residents and interns - year commenced medical training
Nurses - position held and years of experience
Patients - length of stay and reason for hospitalization
Chaplains - position held
- ordained or lay
- member of a religious order
- type of remuneration received and from whom
- formally authorised by a church authority
- a member of a local parish acting in a lay capacity
- Clinical pastoral education details, where completed,
  duration of course
- length of time attached to their present hospital.

(Refer Indexes 6,7,8,9,10)

As shown in chapter 3, with the exception of the ‘comforter’ and ‘witness’ questions, the results indicated that the differing responses to questions correlated closely with their membership of these various groups.

The forced-choice question form for this survey requiring mainly ‘yes’, ‘no’ or ‘don’t know’ replies was selected due to the length of the survey and the anticipation that some of the patients surveyed may not be well enough to provide answers to long open-ended questions. Forced-choice questions are also easier to code for statistical purposes; when assessing open-ended questions, interpretation becomes a factor. As de Vaus notes: ‘Researchers can misinterpret the answers and thus misclassify responses. Forced-choice questions allow respondents to classify themselves, thus avoiding coders misclassifying what people meant’.49

Similar types of questions were grouped together, with the first group of personal questions being considered relevant to the purpose of the study. The questions then continued from easy to more complex, with two open-ended ones towards at the end. These were included in an effort obtain a wider general feeling as to participants’ views regarding the most important tasks performed by chaplains and additional duty recommendations. All the medical staff, chaplains and the hierarchy were asked to complete 55 questions in the main body of the survey, (Refer Appendix XI) with patients being asked the additional question ‘Have you been visited by a hospital chaplain during this stay in hospital?’. This question was not, of course, applicable to the other participants.

The questionnaire format basically followed the one adopted by Raymond G. Carey when he conducted surveys in 1971 and 1981 at the Lutheran General Hospital in Illinois into the ‘Perceived Need, Value and Role of Hospital Chaplains’. 50
purpose of using this format was to provide easy research comparisons with these previous American surveys. With fewer questions (19 only), Carey divided his research into five major groups: ‘Comforter’; ‘Liturgist’; ‘Witness’; ‘Resource Person’; ‘Counsellor’. A more complex structure, eleven groups of questions, have been used for the purposes of this survey. With almost 60 questions involved, some of these were not applicable to Carey’s groups, and additional groups were considered necessary to categorise and assess the relevant survey data correctly. The groups of questions are categorised as follows:

a) General Role Expectations  
b) Miscellaneous  
c) Witness  
d) Ethical  
e) Comforter  
f) Counsellor  
g) Resource  
h) Liturgist  
i) Overall Assessment  
j) Record of Religious Practice  
k) Chaplaincy Visits

Questions pertaining to each group are discussed in detail under Section 4 of Chapter 3. The following points should be noted: first, whilst the overall percentages of survey participants recording ‘no answer’ to the following questions have been included, it was not deemed relevant to include all of these in the ‘break-up’ calculations. The latter will therefore account for a slightly less than 100% total in some cases. Second, where the Christian denominational figures are recorded, the Presbyterian participants have been coupled with the Uniting, as a number of participants advised verbally that they were ‘the old Presbyterians who have now been amalgamated with the Uniting Church’. The Salvation Army, Seventh Day Adventists, Baptists and Methodist have been grouped together under the heading ‘other’ due to the small numbers involved; when compared to the larger denominational figures, these would not have allowed a reliable comparison. An even smaller group, including Brethren, Quaker, Lutheran, Church of Christ, Greek Orthodox and Mormon, have been listed as ‘miscellaneous’. The number of participants who stated a religion other than Christian was also too small to be significant. The denominations of the chaplains have been recorded individually.

A small number of questions proved to be ambiguously worded causing contradictory results amongst participants; these have been discussed in the results chapter.

In addition to the patients, medical staff and chaplains who participated in the ‘Expectations of the Role of Hospital Chaplains’ survey, it was extended to a number
of high ranking clerics or administrators responsible for the chaplaincy procedures in eight of the major religious denominations. The purpose of approaching those responsible for chaplaincy procedures was adopted to form a basis on which to assess whether hospital chaplains are ministering in the manner expected by their own religious bodies. It was also intended to ascertain how the religious hierarchy view chaplaincy generally, the role they expect chaplains to be playing in the hospital scene, and whether chaplaincy procedures as seen by the hierarchy differ from those of the chaplains themselves. The hierarchy, as they will be referred to, were asked to complete the same written survey as the hospital patients, medical staff and chaplains, after which the answers of each denomination were compared to each other. After the written surveys were returned, all of these participants subsequently consented to discuss their answers verbally. These interviews were unstructured in as much as no list of specified questions was used, although the same or similar questions were asked during each discussion. This method of interviewing was chosen, and also for subsequent interviews with medical staff attached to the Liver Transplant Units, (refer Chapter 5) in an attempt to encourage participants voluntarily to expand upon their views on hospital chaplaincy, rather than simply proffer yes or no answers. The identities and denominations of the relevant hierarchy are listed in Appendix V.

The object of the second survey is to assess whether chaplains, when fully integrated into the hospital system, are a significant factor in the overall care and recovery of patients. It is expected that, as a non-medical member of the hospital team, the chaplain is seen as someone to whom the patients, regardless of their religious orientation, can discuss their fears and problems. It is also expected that, by allowing patients to do this, the chaplain is often instrumental in reducing stress levels by listening to them, saying a quiet prayer, or simply by being there. The expectation is that some staff members and relatives of patients refer their spiritual or emotional needs to the chaplain and, by dealing with their own problems, the staff and relatives are ultimately in a better position to help and support the patients. When the chaplain is an integral part of the team, it is anticipated that he/she is in a position to liaise with the medical and allied health staff concerning matters of patient welfare, questions of ethics, and resource matters, and that professional unity of this nature further contributes to the overall care and recovery of the patients.

To this end, research was conducted into the relationship between staff and chaplains in the Liver Transplant Units of three hospitals in three different Australian States. A survey and personal interviews were conducted in an attempt to ascertain from the medical staff their opinions of the actual tasks being performed by the chaplain in their Unit and then to assess whether the different ways of running each Unit affected chaplaincy input. The survey took the form of a written questionnaire
(Appendix XIII) requiring open-ended response replies, together with 'unstructured' personal interviews. Being considerably shorter than the first questionnaire, it was anticipated that any replies open to misinterpretation by use of the open-ended questionnaire could be eliminated during the personal interviews. According to Henerson, et. al, in their How to Measure Attitudes, open-response formats have certain advantages in that:

1. They permit the ventilation of feelings. People can express their exact opinion in an open-ended response whereas if asked to simply check items they may feel that they have been forced into responses that do not exactly match their attitudes.

2. Open-ended questions may produce responses which draw the evaluator's attention to a situation or outcome that was unanticipated when constructing the questionnaire.

3. Open-ended questions do not limit the range of possible answers as do closed-response questions. For example, if you want to know about people's most salient impression of a program, an open question asking for impressions is better than a forced choice response.51

For these reasons the unstructured personal interviews comprise an important part of the research. Both the open-ended survey and unstructured interviews conducted by the researcher evidenced these advantages, as shown by the following deductions. On the question of staff stress and trauma, it became obvious that the death of a patient creates extreme stress for the medical staff. They deal with this stress in different ways: by talking to the chaplain; by coping alone; by talking to their peers; by talking to family members or friends; or by visiting the staff counsellor. Reasons given by some staff members for not talking to their chaplain at these times were mainly that they did not know him/her well enough, or they did not realise it came within within the chaplain's role, believing that the chaplain was there for the patients only. This indicated that some chaplains are frequently not extending their ministry to the staff. It also highlighted the possibility that counsellors and other allied health care staff are performing duties which were once considered the domain of the chaplain.

This same question produced answers pertaining to the ethics of giving transplants to alcoholics or other recipients who were likely to self-destruct after the operation. This in turn raised the question of whether a chaplain should be involved with the medical staff in selecting recipients. Other participants found their working conditions stressful and traumatic; poor staff mix sometimes created dissension on the wards, causing problems amongst co-workers. The research gave a clear indication that the medical staff often experience difficult and stressful situations, but that, in

many cases, chaplains are not being utilised to assist in coping with such situations. Subsequent research indicated that greater ward harmony existed in hospitals where the chaplain frequently visited the wards and integrated with the staff.

From the information supplied by the open-ended and unstructured questioning, it could be interpreted that the three Liver Transplant Units involved in the research were operating differently, their attitudes towards their chaplains differing greatly. Many recipients claimed the chaplain was part of their team; however, the extent to which this claim was practised varied in each Unit. This prompted the researcher to assess whether any one method of chaplaincy involvement was preferable to another, by calculating the length of time that patients were hospitalised over a five year period. The results show that the hospital which had received the most chaplaincy input had a quicker discharge rate than did the other two. This is discussed fully in Chapter 5.
CHAPTER 3

RESULTS OF SURVEY CONDUCTED AT THREE SYDNEY HOSPITALS AS TO THE EXPECTED ROLE OF CHAPLAINS

Ask and it will be given to you;  
Seek and you will find;  
Knock and the door will be opened to you.

Matthew 7:7

INTRODUCTION

This chapter discusses the results of a survey conducted at Royal North Shore Hospital, Mount Druitt Hospital, and Greenwich Hospital, regarding the expectations of the role of hospital chaplains. (See Appendix XI). These results are recorded in cross-tabulated table form to show the complete and break-up statistical data of responses from doctors, nurses, chaplains and patients. Comparisons between the present survey groups and previous surveys of a similar nature will be made and the conclusions discussed in Chapter 6.

The survey questions have been categorised into the following sub-headings to provide simpler correlation for statistical purposes, and also to provide easy comparisons to surveys conducted by Raymond G. Carey1 in America which utilised similar methodology:

a) General Role Expectations  
b) Miscellaneous  
c) Witness  
d) Ethical  
e) Comforter  
f) Counsellor  
g) Resource  
h) Liturgical  
i) Overall Assessment  
j) Record of Religious Practice  
k) Chaplaincy Visits

The questions pertaining to each group are discussed in detail under Section 3 of this chapter.

1. **STATISTICAL RESULTS OF PERSONAL DETAILS**

The following tables show the general break-up, by group, sex, religion, denomination and age, of all participants in the survey. The same statistical method will be used to assess the survey question results, in order to ascertain any variance in replies which could be attributed to different lifestyles or lifestages.

**Table 2:** Completed surveys returned at Royal North Shore (RNSH), Mount Druitt (MDH) and Greenwich (GH) Hospitals combined by groups.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Actual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>158</td>
<td>34.3</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>56</td>
<td>12.1</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>33</td>
<td>7.2</td>
</tr>
<tr>
<td>Nurses</td>
<td>157</td>
<td>34.1</td>
</tr>
<tr>
<td>Chaplains</td>
<td>48</td>
<td>10.4</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>9</td>
<td>2.0</td>
</tr>
<tr>
<td>Number of completed surveys returned out of 601 distributed.</td>
<td>461</td>
<td>76.8</td>
</tr>
</tbody>
</table>

**Table 3:** Completed surveys returned at RNSH, MDH and GH combined by sex.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Actual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>183</td>
<td>39.7</td>
</tr>
<tr>
<td>Female</td>
<td>277</td>
<td>60.1</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

The high percentage of females is caused by the nurses group where females greatly outnumber the male nurses.
Table 4: Completed surveys returned at RNSH, MDH and GH combined by religion.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Actual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>385</td>
<td>83.5</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Moslem</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Jewish</td>
<td>10</td>
<td>2.2</td>
</tr>
<tr>
<td>Other (Agnostic, Spiritual, Koori, Sikh)</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>No religion</td>
<td>47</td>
<td>10.2</td>
</tr>
<tr>
<td>No answer</td>
<td>10</td>
<td>2.2</td>
</tr>
</tbody>
</table>

According to the Australian Bureau of Statistics, there has been a steady increase of residents with ‘no religion’ since the 1947 national census. In 1947 the number was 26 328 (0.3%); 1966: 96 140 (0.8%); 1971: 855 676 (6.7%); 1976: 1 130 300 (8.3%); 1981: 1 576 718 (10.8%); 1986: 1 977 465 (12.7%); 1991: 2 177 000 (12.9%). The trend of increased numbers of ‘no religion’ residents was still evident in the 1996 Census when the number of ‘no religion’ residents rose to 2 948 348 (16.5%), whilst 1 550 370 (8.7%) people declined to state any religion. As religious persuasion was not a compulsory question in the Census, it may not have been answered by some people and, consequently, the figure of almost three million could possibly be much higher. The above survey was completed in 1993/4 and, when allowances are made for the small sample total compared to the Census millions and the participants who declined to answer the question concerning their religious affiliation, the figure of 10.2% corresponds fairly accurately to the anticipated result.

It is impossible to assess accurately what participants in the Census or the above survey mean by ‘no religion’. This could mean they have no near faith whatsoever in anything beyond this world, or it could simply mean they do not attend any type of church or align themselves to any particular religious persuasion. Some may have their own personal relationship with a ‘God’ of their choosing, but still consider they have no religion because this is not exhibited publicly. Another possibility for the Census increase of ‘no religion’ cannot be ignored: this is the changing attitude in Australia to honesty. Whereas in the past the trend was to conform quietly to received opinion, it is now more acceptable to express divergent opinions openly. Gary Bouma points out that ‘some of the “decline” in religious identification in Australian society may be due to an increase in honesty rather than an increase in secularism.’

---


Table 5: Completed surveys returned at RNSH, MDH and GH combined by denomination of Christians.

<table>
<thead>
<tr>
<th>Denomination of Christians</th>
<th>Actual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglican</td>
<td>114</td>
<td>24.7</td>
</tr>
<tr>
<td>Catholic</td>
<td>122</td>
<td>26.5</td>
</tr>
<tr>
<td>Uniting</td>
<td>24</td>
<td>5.2</td>
</tr>
<tr>
<td>Baptist</td>
<td>14</td>
<td>3.0</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>19</td>
<td>4.1</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>Methodist</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Miscellaneous (Brethren, Quaker, Lutheran, Church of Christ, Greek Orthodox, Mormon)</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>Christian - No denomination</td>
<td>66</td>
<td>14.3</td>
</tr>
<tr>
<td>Other or No religion or no answer</td>
<td>76</td>
<td>16.5</td>
</tr>
</tbody>
</table>

Due to the anonymity of the participants, it was not possible to question further the 14.3% who stated they were Christians, but did not align themselves with a specific denomination. It can be ventured, however, that many of this 14.3% would consider that, because they live their lives in what they feel to be a Christian manner, they are therefore Christians, but for various reasons have no desire to be associated with ‘the Church’ as an institution. Others may call themselves Christians by virtue of their birth to Christian parents, irrespective of their way of life.

The percentages of specified religious denominations of the randomly selected participants in this survey reflect those of the Australian national figures, which show the Catholics, Anglicans and Uniting Church as the most prominent, in that order.

Table 6: Comparison of National Census and the present Survey figures relating to denominations.

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Census 1986</th>
<th>Census 1996</th>
<th>Present Survey 1993/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>26.1</td>
<td>26.8</td>
<td>26.5</td>
</tr>
<tr>
<td>Anglican</td>
<td>23.9</td>
<td>21.8</td>
<td>24.7</td>
</tr>
<tr>
<td>Uniting/Presbyterian/Methodist</td>
<td>11.2</td>
<td>11.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Baptist</td>
<td>1.3</td>
<td>1.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Seventh Day Advent.</td>
<td>0.3</td>
<td>0.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>0.5</td>
<td>0.4</td>
<td>0.9</td>
</tr>
<tr>
<td>No Religion</td>
<td>12.7</td>
<td>16.5</td>
<td>16.5</td>
</tr>
</tbody>
</table>
**Table 7:** Completed surveys returned at RNSH, MDH and GH combined by age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Actual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20 years</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>20-29</td>
<td>89</td>
<td>19.3</td>
</tr>
<tr>
<td>30-39</td>
<td>86</td>
<td>18.7</td>
</tr>
<tr>
<td>40-49</td>
<td>92</td>
<td>20.0</td>
</tr>
<tr>
<td>50-59</td>
<td>68</td>
<td>14.8</td>
</tr>
<tr>
<td>60-69</td>
<td>49</td>
<td>10.6</td>
</tr>
<tr>
<td>70-79</td>
<td>42</td>
<td>9.1</td>
</tr>
<tr>
<td>Over 80</td>
<td>18</td>
<td>3.9</td>
</tr>
<tr>
<td>No answer</td>
<td>11</td>
<td>2.4</td>
</tr>
</tbody>
</table>

**Table 8:** Returned surveys per hospital. (Percentages bracketed).

<table>
<thead>
<tr>
<th></th>
<th>Distributed</th>
<th>Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal North Shore</td>
<td>324</td>
<td>232 (50.3%)</td>
</tr>
<tr>
<td>Mount Druitt</td>
<td>150</td>
<td>120 (26.0%)</td>
</tr>
<tr>
<td>Greenwich</td>
<td>100</td>
<td>82 (17.8%)</td>
</tr>
<tr>
<td>Hierarchy + Extra Chaplains</td>
<td>27</td>
<td>27 (5.9%)</td>
</tr>
</tbody>
</table>

**Table 9:** Returned surveys per hospital by groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>RNSH</th>
<th>Mt.Druitt</th>
<th>Greenwich</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>78 (49.4)</td>
<td>40 (25.3)</td>
<td>40 (25.3)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>46 (82.1)</td>
<td>6 (10.7)</td>
<td>4 (7.1)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>15 (45.5)</td>
<td>17 (51.5)</td>
<td>1 (3.0)</td>
</tr>
<tr>
<td>Nurses</td>
<td>75 (47.8)</td>
<td>47 (29.9)</td>
<td>35 (22.3)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>18 (60.0)</td>
<td>10 (33.3)</td>
<td>2 (6.7)</td>
</tr>
<tr>
<td>Extra Chaplains</td>
<td>Westmead</td>
<td>St.Vincent's</td>
<td>Hornsby</td>
</tr>
<tr>
<td></td>
<td>10 (55.6)</td>
<td>6 (33.3)</td>
<td>2 (11.1)</td>
</tr>
</tbody>
</table>
**Table 10:** Returned surveys per hospital by sex.

<table>
<thead>
<tr>
<th>Sex</th>
<th>RNSH.</th>
<th>Mt.Druitt</th>
<th>Greenwich</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>96 (57.5)</td>
<td>42 (25.1)</td>
<td>29 (17.4)</td>
</tr>
<tr>
<td>Female</td>
<td>136 (51.1)</td>
<td>78 (29.3)</td>
<td>52 (19.6)</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Hierarchy</th>
<th>Extra Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

**Table 11:** Groups' break-up of all participants by sex.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>73 (46.2)</td>
<td>85 (53.8)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>49 (87.5)</td>
<td>7 (12.5)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>19 (57.6)</td>
<td>14 (42.4)</td>
</tr>
<tr>
<td>Nurses</td>
<td>14 (9.0)</td>
<td>142 (90.4)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>20 (41.7)</td>
<td>28 (58.3)</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>8 (88.9)</td>
<td>1 (11.1)</td>
</tr>
</tbody>
</table>

Some gender anomalies appear in this table, most glaringly, the predominance of male senior (or consultant) doctors over the female senior doctors. The margin between male and female junior doctors is much narrower. The junior figures would appear to support the present trend of ‘equal opportunity’ for males and females, whereas the opportunities for females were more limited during the period that many senior doctors were trained. The large margin between the male and female nurses has been mentioned previously (refer Table 2); it will be noted that nursing still appears to remain predominantly a female occupation.

**Table 12:** Groups' break-up of all participants by age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Patients</th>
<th>Senior Doctors</th>
<th>Junior Doctors</th>
<th>Nurses</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.20 yrs.</td>
<td>5 (3.2)</td>
<td>-</td>
<td>-</td>
<td>1 (0.6)</td>
<td>-</td>
</tr>
<tr>
<td>20-29</td>
<td>11 (7.1)</td>
<td>24 (75.0)</td>
<td>7 (21.9)</td>
<td>52 (33.1)</td>
<td>2 (4.3)</td>
</tr>
<tr>
<td>30-39</td>
<td>15 (9.5)</td>
<td>10 (18.5)</td>
<td>1 (3.1)</td>
<td>53 (33.8)</td>
<td>1 (2.1)</td>
</tr>
<tr>
<td>40-49</td>
<td>20 (12.7)</td>
<td>28 (51.9)</td>
<td>14 (8.9)</td>
<td>34 (21.7)</td>
<td>8 (17.0)</td>
</tr>
<tr>
<td>50-59</td>
<td>16 (10.2)</td>
<td>12 (22.2)</td>
<td>11 (23.4)</td>
<td>1 (0.6)</td>
<td>11 (23.4)</td>
</tr>
<tr>
<td>60-69</td>
<td>33 (21.0)</td>
<td>4 (7.4)</td>
<td>16 (26.3)</td>
<td>3 (6.4)</td>
<td>-</td>
</tr>
<tr>
<td>70-79</td>
<td>39 (24.8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>80 over</td>
<td>18 (11.5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The most significant thing to note about this table is that 70.2% of the chaplains are aged between 50 and 70 years. In a cross reference of chaplains by age and denomination shown in Table 23 below, only two came in the 20-29 year range, one being a Catholic and the other Seventh Day Adventist, whilst one Catholic only was in the 30-39 year range. The majority of Anglican chaplains were in the 50-59 year group and the Catholics’ highest majorities were in the 50-59 and 60-69 year range, with two between 70 and 79 years. All the Uniting chaplains were in the 50 to 79 year range. Whilst the Catholic member of the hierarchy commented that particular emphasis is being placed upon recruiting younger chaplains, the survey figures above do not confirm any success in this regard, with the majority being over the age of 50 years. However, when comparing these figures with the other denominations, it should be noted that the sample of Catholic chaplain participants was higher than the other denominations. One of the chaplains did not think it relevant to supply an age.

**Table 13:** Groups break-up of all participants by religion.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Patients</th>
<th>Senior Doctors</th>
<th>Junior Doctors</th>
<th>Nurses</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>135 (88.2)</td>
<td>40 (74.1)</td>
<td>24 (75.0)</td>
<td>131 (85.1)</td>
<td>47 (98.0)</td>
</tr>
<tr>
<td>Moslem</td>
<td>1 (0.7)</td>
<td>-</td>
<td>1 (3.1)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jewish</td>
<td>2 (1.3)</td>
<td>4 (7.4)</td>
<td>-</td>
<td>2 (1.3)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (2.0)</td>
<td>-</td>
<td>-</td>
<td>3 (1.9)</td>
<td>-</td>
</tr>
<tr>
<td>No religion</td>
<td>12 (7.8)</td>
<td>10 (18.5)</td>
<td>7 (21.9)</td>
<td>18 (11.7)</td>
<td>-</td>
</tr>
</tbody>
</table>

**Table 14:** Groups break-up of Christian denominations.

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Patients</th>
<th>Senior Doctors</th>
<th>Junior Doctors</th>
<th>Nurses</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglican</td>
<td>51 (47.2)</td>
<td>18 (58.0)</td>
<td>2 (9.5)</td>
<td>32 (30.0)</td>
<td>10 (22.7)</td>
</tr>
<tr>
<td>Catholic</td>
<td>32 (29.6)</td>
<td>10 (32.3)</td>
<td>12 (57.2)</td>
<td>47 (44.0)</td>
<td>19 (43.3)</td>
</tr>
<tr>
<td>Uniting</td>
<td>6 (5.6)</td>
<td>-</td>
<td>1 (4.8)</td>
<td>10 (9.3)</td>
<td>6 (13.6)</td>
</tr>
<tr>
<td>Baptist</td>
<td>3 (2.8)</td>
<td>-</td>
<td>-</td>
<td>7 (6.5)</td>
<td>3 (6.8)</td>
</tr>
<tr>
<td>Presb.</td>
<td>7 (6.5)</td>
<td>2 (6.5)</td>
<td>4 (19.0)</td>
<td>4 (3.7)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>Sal.Amy</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1 (0.9)</td>
<td>2 (4.5)</td>
</tr>
<tr>
<td>SDA</td>
<td>1 (0.9)</td>
<td>-</td>
<td>-</td>
<td>2 (1.9)</td>
<td>2 (4.5)</td>
</tr>
<tr>
<td>Methodist</td>
<td>3 (2.8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Others</td>
<td>5 (4.6)</td>
<td>1 (3.2)</td>
<td>2 (9.5)</td>
<td>4 (3.7)</td>
<td>1 (2.3)</td>
</tr>
</tbody>
</table>
Table 15: Cross reference of combined hospitals by Christian denominations and age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Christian with NO denomination</th>
<th>Catholic</th>
<th>Anglican</th>
<th>Uniting</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>3 (4.5)</td>
<td>13 (11.9)</td>
<td>1 (0.9)</td>
<td>-</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>20-29</td>
<td>16 (24.2)</td>
<td>16 (14.7)</td>
<td>27 (24.3)</td>
<td>9 (21.4)</td>
<td>6 (23.1)</td>
</tr>
<tr>
<td>30-39</td>
<td>13 (19.7)</td>
<td>22 (20.2)</td>
<td>25 (22.5)</td>
<td>8 (19.0)</td>
<td>6 (23.1)</td>
</tr>
<tr>
<td>40-49</td>
<td>13 (19.7)</td>
<td>20 (18.3)</td>
<td>24 (21.6)</td>
<td>7 (16.7)</td>
<td>4 (15.4)</td>
</tr>
<tr>
<td>50-59</td>
<td>6 (9.1)</td>
<td>13 (11.9)</td>
<td>9 (8.1)</td>
<td>4 (9.5)</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>60-69</td>
<td>9 (13.6)</td>
<td>15 (13.8)</td>
<td>13 (11.7)</td>
<td>4 (9.5)</td>
<td>4 (15.4)</td>
</tr>
<tr>
<td>70-79</td>
<td>4 (6.1)</td>
<td>8 (7.3)</td>
<td>9 (8.1)</td>
<td>7 (16.7)</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>80 over</td>
<td>2 (3.0)</td>
<td>-</td>
<td>3 (2.7)</td>
<td>3 (7.1)</td>
<td>1 (3.8)</td>
</tr>
</tbody>
</table>

The highest percentage of Christians who did not align themselves to a specific denomination fell within the 20 to 50 age groups. This may reflect a swing away from organised religion by younger people, with possible causes for this being: disillusionment with ‘the Church’ as an institution; increased independence from the views and traditions of parents; belief that the Christian faith should be universal or ecumenical and not grouped into denominations; or belief that specific denominations do not understand the spiritual and emotional needs of younger people. It might be also noted that the above figures are based on the stated denomination of the participants only and do not correspond to church attendance figures, which are discussed under questions 53 and 54 later in this chapter.

Table 16: Cross reference of Christians by denomination and individual hospitals.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Christian with NO denomination</th>
<th>Catholic</th>
<th>Anglican</th>
<th>Uniting</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNSH</td>
<td>36 (54.5)</td>
<td>68 (62.4)</td>
<td>49 (44.2)</td>
<td>20 (47.6)</td>
<td>16 (61.6)</td>
</tr>
<tr>
<td>MDH</td>
<td>17 (25.8)</td>
<td>17 (15.6)</td>
<td>46 (41.4)</td>
<td>10 (23.8)</td>
<td>5 (19.2)</td>
</tr>
<tr>
<td>GH</td>
<td>13 (19.7)</td>
<td>24 (22.0)</td>
<td>16 (14.4)</td>
<td>12 (28.6)</td>
<td>5 (19.2)</td>
</tr>
</tbody>
</table>

The lower ‘Christian with no denomination’ percentage can be attributed largely to the patient component at Greenwich Hospital. With a high percentage of these patients being admitted to the palliative care wards, again age would appear to be a significant factor, with many such patients being outside the 20-50 year age bracket of participants who stated they had no religion or no denomination.
**Table 17:** Cross reference of Christian denominations /no religion and patients/combined doctors/nurses.

<table>
<thead>
<tr>
<th>Group</th>
<th>NO religion</th>
<th>Christian with NO denomination</th>
<th>Catholic</th>
<th>Anglican</th>
<th>Uniting</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>12 (8.2)</td>
<td>27 (18.5)</td>
<td>51 (34.9)</td>
<td>32 (21.9)</td>
<td>16 (11.0)</td>
<td>8 (5.5)</td>
</tr>
<tr>
<td>Doctors</td>
<td>17 (21.0)</td>
<td>12 (14.8)</td>
<td>20 (24.7)</td>
<td>22 (27.2)</td>
<td>7 (8.6)</td>
<td>3 (3.7)</td>
</tr>
<tr>
<td>Nurses</td>
<td>18 (12.2)</td>
<td>24 (16.3)</td>
<td>32 (21.8)</td>
<td>47 (32.0)</td>
<td>14 (9.5)</td>
<td>12 (8.2)</td>
</tr>
</tbody>
</table>

**Table 18:** Cross reference of Patients/Doctors/Nurses by age and no religion/religion.

<table>
<thead>
<tr>
<th>Age</th>
<th>NO Religion</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>-</td>
<td>5 (1.5)</td>
</tr>
<tr>
<td>20-29</td>
<td>11 (23.5)</td>
<td>70 (21.5)</td>
</tr>
<tr>
<td>30-39</td>
<td>12 (25.5)</td>
<td>68 (20.9)</td>
</tr>
<tr>
<td>40-49</td>
<td>12 (25.5)</td>
<td>66 (20.3)</td>
</tr>
<tr>
<td>50-59</td>
<td>5 (10.6)</td>
<td>32 (9.8)</td>
</tr>
<tr>
<td>60-69</td>
<td>3 (6.4)</td>
<td>33 (10.2)</td>
</tr>
<tr>
<td>70-79</td>
<td>4 (8.5)</td>
<td>34 (10.6)</td>
</tr>
<tr>
<td>Over 80</td>
<td>-</td>
<td>17 (5.2)</td>
</tr>
</tbody>
</table>

**Table 19:** Cross reference of Patients/Doctors/Nurses by hospital and no religion/religion.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>NO Religion</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNSH</td>
<td>26 (55.3)</td>
<td>174 (53.2)</td>
</tr>
<tr>
<td>MDH</td>
<td>14 (29.8)</td>
<td>85 (26.0)</td>
</tr>
<tr>
<td>GH</td>
<td>7 (14.9)</td>
<td>68 (20.8)</td>
</tr>
</tbody>
</table>

**Table 20:** Break-up of Chaplains by sex.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaplains</td>
<td>20 (41.7)</td>
<td>28 (58.3)</td>
</tr>
</tbody>
</table>
The higher percentages of female chaplains indicates the number of lay chaplains involved in the survey as opposed to ordained clergy. Women priests are not permissible in the Roman Catholic faith nor in the Sydney Anglican Diocese. The expectancy of females as chaplains is discussed further in this chapter under Question 2 of Item 3 a.

**Table 21:** Break-up of Chaplains and Extra Chaplains by hospital.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Chaplains</th>
<th>Extra Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNSH</td>
<td>18 (60.0)</td>
<td>-</td>
</tr>
<tr>
<td>MDH</td>
<td>10 (33.3)</td>
<td>-</td>
</tr>
<tr>
<td>GH</td>
<td>2 (6.7)</td>
<td>-</td>
</tr>
<tr>
<td>Westmead</td>
<td>-</td>
<td>10 (55.6)</td>
</tr>
<tr>
<td>St.Vincent's</td>
<td>-</td>
<td>6 (33.3)</td>
</tr>
<tr>
<td>Hornsby</td>
<td>-</td>
<td>2 (11.1)</td>
</tr>
</tbody>
</table>

**Table 22:** Cross reference of Chaplains by hospital and denomination.

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Extra</th>
<th>RNSH</th>
<th>MDH</th>
<th>GH</th>
</tr>
</thead>
<tbody>
<tr>
<td>No denom. indicated (Incl. Jewish)</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Anglican</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Catholic</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Uniting</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Baptist</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Church of Christ</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Table 23: Cross reference of Extra Chaplains by hospital and denomination.*

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Westmead</th>
<th>St.Vincent's</th>
<th>Hornsby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglican</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Catholic</td>
<td>4</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Uniting</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Baptist</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Chaplains from hospitals other than the three major surveyed hospitals. An additional chaplains’ survey was necessary to provide an adequate sample for statistical purposes. (Refer P.58).

### Table 24: Cross reference of Chaplains by denomination and sex.

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO denom. indicated</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Anglican</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Catholic</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Uniting</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Baptist</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Church of Christ</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

### Table 25: Cross reference of Chaplains by age and denomination.

<table>
<thead>
<tr>
<th>Denomination</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO denom. indicated</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Anglican</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Catholic</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Uniting</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Baptist</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Church of Christ</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Refer to comments under Table 10.
Table 26: Break-up of Chaplains and Clinical Pastoral Education Students by sex.
(These CPE students have hitherto been included in the chaplains' statistics).

<table>
<thead>
<tr>
<th>Sex</th>
<th>Chaplains</th>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>6</td>
</tr>
</tbody>
</table>

It is significant that six of the seven Clinical Pastoral Education students are female. This could be attributed to a number of causes, including the drop in male ordinations and increased female ordinations in some denominations; the greater number of females entering the work force generally; or it may be that more females are enrolling in all educational courses in an endeavour to equal male qualifications and opportunities. It should be noted, however, that there are a number of sacramental duties which women are not permitted to perform under the ecclesiastical laws of their particular denomination or diocese. The female CPE prevalence may also be created by a reluctance of males to participate in courses which may have no, or little, financial gain for them; enrolment in a CPE course by no means guarantees any form of employment.

Table 27: Break-up of Chaplains and CPE Students by religion.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Chaplains</th>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>40</td>
<td>7</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 28: Break-up of Chaplains and CPE Students by denominations.

<table>
<thead>
<tr>
<th>Denominations</th>
<th>Chaplains</th>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO denom. indicated (Incl, Jewish)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Anglican</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>Catholic</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Uniting</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Baptist</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Church of Christ</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 29: Break-up of Chaplains and CPE students by age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Chaplains</th>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>30-39</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>40-49</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>60-69</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>70-79</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 30: Break-up of Chaplains and CPE Students by hospital.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Chaplains</th>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal North Shore</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Mount Druitt</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>Greenwich</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Westmead</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>St. Vincent's</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Hornsby</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

2. GENERAL SURVEY RESULTS

There were clear indications from the majority of the survey participants that chaplains have an overall value and are expected to be part of the hospital team. To what extent those roles are actually being exhibited will be researched in Chapter 4. The survey indicated that patients welcomed chaplaincy visits, with three-quarters of them expressing a positive attitude towards the chaplains. This applied regardless of whether or not the patients had received a visit from a chaplain, and irrespective of their religion/denomination or non-religion/denomination.

There is no doubt that the majority of survey participants, including the chaplains, expected the ‘comforter’ tasks to constitute the major role of chaplains, with the ‘witness’ tasks a close second. Although the ‘liturgist’ tasks were certainly expected to be included as part of the chaplains’ role, they did not rate highly in order of importance; much lower percentages were recorded for the ‘liturgist’ tasks than the ‘comforter’ or ‘witness’ tasks. The considerable drop in church attendances, indicated by the survey across all denominations, does not appear to have had an influence on the importance of the ‘liturgist’ tasks, as a high percentage of participants considered
such tasks to be part of the chaplains’ role, although not as important as some others. The ‘resource’, ‘ethical’ and ‘counsellor’ categories are also expected by many to be part of the chaplains’ role but, again, they are not considered as important as the ‘comforter’ and ‘witness’ tasks.

According to other surveys, chaplaincy role expectations do not, on the surface, appear to have changed greatly during the past twenty-five years. Two surveys conducted at the Lutheran General Hospital, Illinois in 1971 and 1981 substantiate this. These surveys are discussed under Item 5f of this Chapter. The most significant aspect is the change in importance of the ‘Liturgist’ role which, in the earlier surveys, was placed in second position, above the ‘Witness’ role and below ‘Comforter’; participant in the present thesis survey placed the ‘Liturgist’ role third in order of importance after ‘Comforter’ and ‘Witness’, with 46.6% stating ‘Comforter’, 33% ‘Witness’ and 2% ‘Liturgist’.

Despite the agreement over the primary roles of comforting and witnessing, there was obvious confusion by all groups as to what they expected the term ‘chaplain’s role’ to involve. Participants’ replies in the various groups were divided amongst themselves and, in a great many cases, differed from other groups. The chaplains’ responses were often influenced by variances in employment and duty guidelines operating in the individual hospital to which they were attached. The ‘ethical’ questions, in particular, produced significant inconsistency, with some of the medical staff and chaplains disagreeing with the patients, and the chaplains often registering divided views. The only ‘ethical’ aspects on which the majority of participants agreed were those of trustworthiness and confidentiality which they expected chaplains to exhibit. From the ‘ethical’ question replies, there were indications that many participants from all groups responded to the way the various chaplaincy tasks would affect them personally and not as what could be expected from the role in general. This applied also to the ‘counsellor’ questions, with considerable uncertainty amongst all participants. The senior doctors, who had generally recorded a low percentage of uncertainty for most questions, were most unsure as to their expectations regarding the chaplains’ participation in both staff ‘personal’ and ‘work’ problems.

With the ‘witness’ questions, gender, age and hospital had no great significance on the overall results, with religion/denomination playing a very small part in variances. However, other sections of the survey, whilst age and hospital appeared to have some influence on the way participants replied, religion/denomination and gender showed only isolated significance. The junior doctors answered the ‘witness’ questions more positively than they did some of the other sections of the survey. There was little difference between the medical staff and patients of chaplaincy
expectations regarding the ‘witness’ role, with the chaplains recording a slightly higher percentage, as could be reasonably expected. There was more uncertainty amongst the junior doctors and patients regarding the ‘resource’ tasks of chaplaincy, but in general it was agreed that this was part of the expectations of the chaplain’s role. The medical staff expected liaison and a high percentage also expected pastorally related lectures. The chaplains agreed with these expectations.

With such inconsistency in the individual expectations of the chaplaincy role by all groups, it is difficult to assess conclusively how the medical staff and patients view the chaplains by comparison with to the way in which the chaplains see themselves. However, a calculation of questions which recorded the greatest number of ‘yes’ or ‘no’ replies of one group compared to another group showed that the patients and chaplains disagreed the most, with the female patients in particular disagreeing with the male chaplains. The number of individual ‘yes’ and ‘no’ replies was very close in some instances, which meant that a group ‘yes’ result could occur with only a slightly higher ratio to the ‘no’ results. This means that although the group calculation shows one thing, there could be an inconsistency of replies amongst the individual participants. The junior doctors followed the patients, with the senior doctors and nurses showing the least overall disagreement with the chaplains. For most questions, the senior and junior doctors were more in agreement with each other than disagreement, however, the majority of the combined doctors and nursing groups disagreed with the patients on more questions than which they agreed.

The survey shows that a number of points indicate reasons for concern. Firstly, by the number of patients who are not being visited, there appears to be a need for many more chaplains. A high percentage of patients who had been visited, together with those who had not, indicated that they would welcome a routine visit. Secondly, there appears to be a lack of information available regarding very basic aspects of chaplaincy, such as the gender and status of chaplains. A number of participants from all groups, including the chaplains themselves, did not completely seem to understand the chaplain’s role or what tasks were expected to be performed. The result in this regard appears to indicate a high state of confusion generally, whilst the responses of some chaplains would seem to be cause for concern. It is highly unsatisfactory on the chaplains’ part. Gary D.Bouma discussed the importance of marginality in this context:

Marginality - occurs when someone is not central to the key group [...] marginals often get the feeling they do not belong.

Marginality - occurs when someone is caught between two loyalties, two memberships, two identities, neither one or the other.
Hospital chaplaincy is a marginal profession, it is neither medical or administrative, chaplains wear neither a white coat or a three piece suit - what is their uniform?

The chaplain’s approach to the patient is neither medical nor financial, not sanctioned by physicians. The role is not clearly defined, generally undervalued, misunderstood.

Marginality - in the church - chaplains are not real, not in parishes, not in administration (bishop or archdeacon), but in ‘sector’ ministries.\(^4\)

Bouma does admit however that there is another, more positive side to marginality:

Marginality is associated with creativity/innovation - freedom - prophetic vision. Marginals are not tied to a parish or the hospital - they are free to transcend the demands of others - able to see things from a different perspective, not blinkered to the medical model.\(^5\)

It would seem, therefore, that the positive parts of marginality need to be accentuated and the negatives addressed. Whilst it is conceded that there will always be a number of specific tasks relevant to a particular hospital, the chaplain’s role in general needs to be clearly clarified and recognised by both the medical and clerical professions in order for it to be fully integrated in the operation of the hospital. The image of chaplaincy also needs to be clarified and upgraded to a profession in its own right, rather than ‘hanging in limbo’ between the hospital and the church. It is also important to improve its status within the Church, so that it is not accorded a ‘Cinderella’ status, by which is meant a status of a poor and unappreciated adjunct to the ‘real’ and important functions of the clerical members of the Church.

3. RESPONSES TO SPECIFIC QUESTIONS

Responses to questions which do not directly affect the argument have been included in appendix XII.

a. General Role Expectations

These general role expectation questions indicate a great deal of confusion and lack of information as to gender and status of hospital chaplains. There is very little

---

\(^5\) Ibid. p.9.
consistency in the replies, with the various groups being divided amongst themselves and with other groups. These variances applied to the chaplain and hierarchy groups as well as to the patients and medical staff. Whilst age appears to have played some part in the replies, only isolated areas appear to have been influenced by denomination/religion/no religion or individual hospitals (apart from the age factors) and gender was also insignificant. Question 8, however, gave a clear indication from the patients that they welcomed chaplaincy visits. This positive attitude towards the chaplains was expressed by three-quarters of the patients, whether or not they had already received a visit, including many who classified themselves as having ‘no religion’. The medical groups’ evaluation of the chaplains’ worth was ascertained by Question 50, when five ‘no’ and seven ‘don’t know’ responses only were given to the question ‘is the chaplain’s role advantageous for a patient’s well-being?’ This positive attitude by the medical staff towards the chaplains’ worth is relevant to Chapter 4 where staff/chaplaincy relationships are further discussed.

The most relevant result to emerge from these first nine questions, is that much more promotion of basic knowledge is needed to explain ‘who’ the chaplain is, not only ‘what’ he/she does.

Question 1: Do you know that there are hospital Chaplains? Of the total number of participants surveyed, only 2.6% (12) answered negatively and 0.9 (4) gave no answer to this question. These 16 participants were all patients spread evenly across the three hospitals taking part, with a 100% ‘yes’ reply from the medical staff and chaplains. This appears to indicate that hospitals are, in one way or another, promoting the existence of their chaplains.

Question 2: Do you expect a Chaplain will be male/female/either/don’t know? This question produced a few surprising replies. Overall 17.1% (79) answered ‘male’; 1.1% (5) ‘female’; 79.0% (364) ‘either’; with 2.2% (10) ‘don’t know’ and 0.7% (3) ‘no answers’. Whilst the minority result for ‘female’ chaplain expectancy was anticipated, also the high replies for ‘either’, the number of participants who answered ‘male’ was higher than expected. Of the 17.1% (79) overall participants who answered ‘male’ to this question, 37 were patients, seven senior doctors, three junior doctors, 26 were nurses and six chaplains. Whilst age and gender had little influence on the replies, the following table shows a variation in the hospitals, with Mount Druitt registering the highest ‘male’ percentage and lowest ‘either’ percentage amongst the patients, doctors and nurses.
Table 31: Question 2 - Combined patients, doctors and nurses by Hospitals.

<table>
<thead>
<tr>
<th></th>
<th>RNSH</th>
<th>Mount Druitt</th>
<th>Greenwich</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13.7%</td>
<td>29.6%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Females</td>
<td>1.5%</td>
<td>2.0%</td>
<td>-</td>
</tr>
<tr>
<td>Either</td>
<td>84.8%</td>
<td>68.4%</td>
<td>80.3%</td>
</tr>
</tbody>
</table>

The Mount Druitt variation may be attributed to the fact that this hospital has a Catholic heritage and that patients, in particular, were influenced by the knowledge that all Catholic priests are male. This is seemingly contradicted, however, in the next table which shows the Anglican participants with an almost double percentage figure stating ‘male’ to that of the Catholics. It is possible, therefore, that patients who had not received a visit from a female chaplain could assume the male clergyman rules followed through to chaplaincy. Junior nurses and doctors may also not have encountered the female chaplains. It would seem highly probable that participants who answered ‘female’ had been visited by, or had contact with, women chaplains only, creating an incorrect expectation that all chaplains are female. The foregoing implies two things: firstly that knowledge of chaplains is very poor and, secondly, that it may be more difficult for women where certain expectations pertaining to their religion/denomination lead people to assume that they should not be there.

A view that all mainstream religious traditions are inherently patriarchal is a legacy from the past. Sacred texts and many passages in the Old and New Testaments convey that the Christian tradition is sexist and misogynistic. The First Letter to Timothy is an example of this when the writer instructs the community thus:

A woman should learn in quietness and full submission. I do not permit a woman to teach or to have authority over a man; she must be silent. For Adam was formed first, then Eve. And Adam was not the one deceived; it was the woman who was deceived and became a sinner. But woman will be saved through childbearing - if they continue in faith, love and holiness with propriety. (1 Tim. 2:11-15).

Patristic, medieval, and later theologians such as Jerome, Augustine and Thomas Aquinas can be similarly criticised for misogyny, whilst Leona Stucky-Abbott notes that ‘from Ruether to Daly, from Fiorenza to Lerner, both Christian and post-Christian feminists are in agreement that exclusive male God images and patriarchal religious beliefs hamper the esteem and well-being of women’. Many patriarchal practices

---

stem from the belief that God is male, and the fact that Christianity evolved from the male Christ’s human ministry on earth. As Linda Tischhart Sanford and Mary Ellen Donovan observe, the damage done to women’s self-esteem by the belief that only man is created in God’s image is incalculable and it is this belief that may have influenced some survey participants’ replies regarding female chaplains. The view by Piaget and Freud that women’s moral reasoning was underdeveloped and illogical was disputed in a 1982 study conducted by Carol Gilligan, where she demonstrated that such notions ‘had been based on what were assumed to be absolute standards derived exclusively from the empirical study of male ways of being’. Women, however, operate on a different paradigm than men and in reality women use ‘different values than those commonly taken for granted by men, values that had been either ignored or simply missed because it had not been possible for the female perspective to be heard in a world dominated and defined by patriarchal values’. Modernity eventually gave many women the chance to share the same opportunities and privileges as men providing they adopted male ways of doing things. With the emergence of post-modern culture, however, women are beginning to be accepted for their own abilities.

Table 32: Question 2 - Combined patients, doctors and nurses by Christian denomination.

<table>
<thead>
<tr>
<th>No denom.</th>
<th>Cath.</th>
<th>Ang.</th>
<th>United</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22.7</td>
<td>16.5</td>
<td>29.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Female</td>
<td>3.0</td>
<td>1.8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Either</td>
<td>72.7</td>
<td>77.1</td>
<td>68.5</td>
<td>88.1</td>
</tr>
<tr>
<td>D.K.</td>
<td>1.5</td>
<td>3.7</td>
<td>1.8</td>
<td>-</td>
</tr>
</tbody>
</table>


Ibid., p.173.

Ibid., p.174.
The puzzling result from this question relates to the chaplains themselves. Six chaplains stated that they expected the chaplain would be ‘male’, not ‘female’ or ‘either’. Three of these chaplains were Catholic, one Anglican and two did not state any denomination. One was a student chaplain taking part in a Clinical Pastoral Education Course, whilst the other five were, as far as can be ascertained from the questionnaire, experienced chaplains. It is difficult to comprehend that, in the often ecumenical atmosphere of hospital chaplaincy, six out of 48 chaplains are not aware that a great many of their fellow chaplains are, in fact, female. One chaplain chose not to express an opinion and ticked the ‘don’t know’ box. Perhaps a clue to these unexpected replies lies in the word ‘expect’. It may be that participants do actually ‘know’ that both male and female chaplains exist, but they may still ‘expect’ differently.

Question 3: Do you expect a Chaplain will be a Minister of the Church/a lay person/either/don’t know? The combined replies to this question were fairly evenly divided between the two options of ‘Minister of the Church’ 46.9% (216) and ‘either’ 44.3% (204), with 2.6% (12) ‘lay’ and 5.4% (25) ‘don’t know’. The following table shows a break-up by groups.

**Table 33:** Question 3 - Group percentages.

<table>
<thead>
<tr>
<th>Group</th>
<th>Minister</th>
<th>Lay</th>
<th>Either</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>44.3</td>
<td>4.4</td>
<td>38.0</td>
<td>12.7</td>
</tr>
<tr>
<td>Sen. Doctors</td>
<td>57.1</td>
<td>1.8</td>
<td>39.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Jun. Doctors</td>
<td>66.7</td>
<td>-</td>
<td>27.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Nurses</td>
<td>49.7</td>
<td>2.5</td>
<td>45.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Chaplains</td>
<td>26.5</td>
<td>-</td>
<td>72.2</td>
<td>-</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>11.1</td>
<td>-</td>
<td>88.9</td>
<td>-</td>
</tr>
</tbody>
</table>

The majority of the ‘don’t know’ replies were from patients (20) but the number is too small to be of much consequence and the differences came between the ‘minister’ and ‘either’ replies. As can be seen, all the patient and medical groups had higher percentages, expecting the chaplain to be a minister of the church, the highest percentage coming from the junior doctors (66.7). The chaplains placed ‘either’ higher than ‘minister’. However, 13 chaplains (only two of which were CPE students) again, stated somewhat surprisingly, that they would expect a chaplain to be a minister of the church. Denominations, religion/no religion, gender, age and individual hospitals had no particular significance in this result, other than the fact that
almost half of all participants were unaware that chaplains are not always ministers of the church, but are often appointed from the laity. This is evidenced by the fact that the replies were almost evenly divided between ‘minister’ and ‘either’. There is a possibility, however, that some people did not know the difference between an ordained minister of the church and a lay person, but did not admit this. Whilst slightly more of the overall Anglican than Catholic participants expected that a chaplain would be a minister of the church, more Catholic chaplains themselves thought this than the Anglican chaplains.

Question 4: Do you expect a Chaplain will be trained in Chaplaincy/not trained in Chaplaincy/either/don’t know? This question, as anticipated, produced an overall result of almost 80% (364) expectancy that chaplains ‘will be trained’, with the combined senior and junior doctors showing 96.2% (76). This high doctor expectation may result from the extensive training they themselves had to undergo before they could ‘practice’. Only 0.9% (4) of the overall participants thought that chaplains would be ‘untrained’, with 10.4% (48) recording ‘either’ and 8.5% (39) stating ‘don’t know’. This 20% was spread across all groups including the chaplains. It is possible that the word ‘trained’ may have been interpreted by some to mean degree training rather than some lesser, but adequate, formal training. The reasonably high 8.5% of participants who replied ‘don’t know’ and 1.3% who did not answer at all indicates some confusion over the question.

Question 5: Do you expect that all Chaplains will be of the Christian faith? With this question there was a high percentage of variance in the overall replies, with 57.3% (264) participants answering ‘yes’; 34.9% (161) ‘no’; 6.9% (32) ‘don’t know’ and 0.9% (4) ‘no answer’. The break-up by groups for this question is shown in the following table:

Table 34: Question 5 - Group percentages.

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>Don’t Know</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>68.4</td>
<td>20.3</td>
<td>10.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>39.3</td>
<td>55.4</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>51.5</td>
<td>39.4</td>
<td>9.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>56.1</td>
<td>37.6</td>
<td>5.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains</td>
<td>51.2</td>
<td>45.5</td>
<td>3.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hierarchy</td>
<td>55.6</td>
<td>44.4</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As can be seen, although the patients had the highest percentage of ‘don’t know’ responses, they also easily recorded the highest percentage of ‘yes’ replies, with only 20.3% stipulating ‘no’. These figures were influenced by the patient component of the patients/doctors/nurses combined figures for Greenwich Hospital (80.3% ‘yes’ and 19.7% ‘no’), which can be understood when the religion/no religion component for patients/doctors/nurses is also examined as follows: the figures for the combined patients/doctors/nurses from all hospitals shows 38.6% of those who classified themselves as having no religion would expect all chaplains to be of the Christian faith whilst 61.4% stated that they would not expect this. Of those classifying themselves as following a specific religion, 68.3% answered ‘yes’ to the question and 31.7% ‘no’. As the majority of overall survey participants who specified no religion were in the younger age groups, and as many Greenwich Hospital patients were in an older age group than the Royal North Shore and Mount Druitt Hospital patients, it follows that the Greenwich patients would be more likely to answer ‘yes’ to this question, thus contributing largely to the stated variance between 68.4% ‘yes’ and 20.3% ‘no’ for the combined patients.

An explanation for the younger, ‘no religion’ participants expecting that all chaplains will not be of a Christian faith may be that many non-Christian faiths have developed or increased in numbers in recent years, receiving more media coverage and publicity than in the past. It is reasonable to expect that the younger participants would be more aware of and knowledgeable about the so-called New Age Religions, Buddhism, Hinduism and Judaism, than older participants, and that this may have accounted for the way in which participants answered this question. As the senior doctors’ figures for this question were in contrast to those of the junior doctors and nurses, with the junior doctors recording a higher ‘yes’ percentage than ‘no’, this suggests that age is indeed a factor. As the largest number of junior doctors participating were from Mount Druitt Hospital (51.5%) and only 3.0% from Greenwich Hospital (refer Table 9), the high combined ‘yes’ figure for Mount Druitt, as shown in the following table, further supports the argument that the younger doctors influenced the result.

**Table 35: Question 5 - Patient/Doctor/Nurses percentages by hospital.**

<table>
<thead>
<tr>
<th></th>
<th>RNSH</th>
<th>MDH</th>
<th>GH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>57.3</td>
<td>67.0</td>
<td>80.3</td>
</tr>
<tr>
<td>No</td>
<td>42.7</td>
<td>33.0</td>
<td>19.7</td>
</tr>
</tbody>
</table>
As shown in Table 11, 66.9% of the nurses are aged between 20 and 39 years, whilst 71.4% of the senior doctors are aged between 40 and 59 years. This could, again, have contributed towards their varying expectations as to whether or not all chaplains would be of the Christian faith.

It can be seen from Table 34 above, that the chaplains were once again completely divided in their views. Whilst the majority of hospital chaplains will indeed be Christian, other religions make their ‘ministers’ available when needed and no explanation can be ascertained from the survey as to why so many of the chaplains considered that all chaplains would be of the Christian faith. The only explanation that can be drawn is that they took the word ‘chaplain’ literally and did not allow for appointed pastoral workers from other religions who may adopt a different title. As stated by Rabbi Apple in Chapter 4 chaplaincy afforded to Jewish patients is conducted differently from that of many Christian faiths and this applies also to other non-Christian faiths. Whilst the non-Christian chaplains (or by whatever name they may wish to minister under) would, in most cases, minister only to their own followers, they are usually available and contractible by individual hospitals at all times.

Question 6: If a patient is non-Christian would you expect the Chaplain to represent all faiths? Almost 60% (276) of the overall participants answered ‘yes’ to this question, with 30.8% (142) ‘no’; 8% (37) ‘don’t know’ and 1.3% ‘no answer’. The senior doctors recorded a 53.68% ‘no’ reply, whilst the chaplains gave a higher ‘yes’ response (60.0%). This was in line with the patients (68.4%) and nurses (63.7%).

The overall gender, denominational and religion/no religion replies were consistent with each other, thus having no particular bearing on the results. However, the chaplains’ denominational figures show significant variation, particularly between the Catholics and Anglicans. (Catholics 73.7% ‘yes’ and 26.3% ‘no’ : Anglicans 22.2% ‘yes’ and 77.8% ‘no’). The high Catholic chaplains response may have been enhanced by the chaplains from St. Vincent’s Hospital, Darlinghurst, where the large Catholic pastoral team visit entire wards of patients on a regular basis, regardless of denomination or religion, whilst the denominational chaplains at St. Vincent’s usually restrict their visits to patients of the same denomination or religion. At the smaller Hornsby Hospital, the Anglican chaplain visits all patients on all wards, but at the larger Westmead Hospital the chaplains visit mainly their own denominational patients. This is apart from minimal entire ward visits and their rostered trauma and night-duty calls; even then, patients are referred to chaplains of their own faith or denomination if required. This is a possible explanation for the high Anglican ‘no’ response.
When interviewing the hierarchy verbally, it became evident that some were apprehensive about the word ‘represent’, considering that chaplains visiting patients of another faith must stay within the bounds of their own denomination/religion. Nevertheless, they advocated at the same time that they did not object to their chaplains visiting other denominations/faiths when required. It is conceded that the wording of this question may have created a difficulty for some participants. The word ‘represent’ was not meant to imply that an Anglican chaplain, for instance, should literally take the place of a Rabbi, but to ‘be there’ when needed in an ecumenical capacity regardless of a patient’s faith.

Question 7: Do you expect that a Chaplain will routinely visit all patients?

The overall replies were fairly evenly divided with 45.3% (209) ‘yes’; 48.4% (223) ‘no’; 5.4% ‘don’t know’ and 0.9 (4) ‘no answer’, but as will be seen by the following table, the ‘yes’ and ‘no’ replies were not consistent.

**Table 36:** Question 7 - Overall groups.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Yes %</th>
<th>No %</th>
<th>Don’t know %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>59.5</td>
<td>27.2</td>
<td>12.7</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>16.1</td>
<td>78.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>15.2</td>
<td>84.8</td>
<td>-</td>
</tr>
<tr>
<td>Nurses</td>
<td>47.8</td>
<td>50.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Chaplains</td>
<td>43.3</td>
<td>52.2</td>
<td>-</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>44.4</td>
<td>55.6</td>
<td>-</td>
</tr>
</tbody>
</table>

When attempting to ascertain an explanation for the extreme variances in replies to this question, it was noted that the patients/doctors/nurses at the different hospitals replied with substantial differences, as shown in Table 37 below.

**Table 37:** Question 7 - Patients/Doctors/Nurses by Hospitals.

<table>
<thead>
<tr>
<th></th>
<th>RNSH %</th>
<th>MDH %</th>
<th>GH %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>34.1</td>
<td>61.5</td>
<td>70.8</td>
</tr>
<tr>
<td>No</td>
<td>65.9</td>
<td>38.5</td>
<td>29.2</td>
</tr>
</tbody>
</table>

The size of Royal North Shore Hospital may have had some bearing on the results, with participants considering that such a large number of patients could not be visited
by the limited number of available chaplains. Being a public hospital with no former religious affiliation, as has Mount Druitt Hospital, and by accommodating patients of all ages for varying periods rather than terminal or long-term rehabilitation patients, as does Greenwich Hospital, could explain why participants at Royal North Shore did not expect routine chaplaincy visit to all patients to the same extent as did Mount Druitt and Greenwich Hospitals.

When looking at the patients/doctors/nurses denominational results, it can be seen that the two largest denominations, Catholic and Anglican, are at variance with the combined chaplains’ figures. Whilst the Catholic patients/medical groups recorded 43.1% (47) ‘yes’; 47.7% (52) ‘no’ and 9.2% (10) ‘don’t know’, with the Catholic chaplains stating 66.5% ‘yes’ and 33.5% ‘no’, the overall Anglican chaplains, in particular, replied very differently. The corresponding Anglican figures were: patients/medical groups 57.7% (64) ‘yes’; 38.7% (43) ‘no’; and 2.7% (3) ‘don’t know’, with the combined Anglican chaplains recording 10.0% ‘yes’ and 90.0% ‘no’. The United Church patients/medical groups were, on average, similar to the Anglicans, but the combined United chaplains recorded 83.4% ‘yes’ and 16.6 ‘no’. Whilst not conclusive, one possible explanation for the variances between the Catholic, Anglican and United combined chaplains’ expectations of routine visits to all patients, may be associated with the availability of chaplains in relation to patient numbers. Denominations with fewer appointed chaplains would obviously not be in a position to visit as many patients as some other denominations. As the results shown in Question 8 substantiate, an increase in the availability of chaplains generally would appear to be warranted.

Question 8: Would you welcome such a visit? A significant percentage of the overall participants answered affirmatively to this question with 72.5 (334) ‘yes’; 14.5% (67) ‘no’; 10.8% (50) ‘don’t know’ and 2.2% (10) ‘no answer’. A relevant outcome of this question was the 78.8% (50) ‘yes’ replies from patients/medical staff who had indicated no denomination and 44.4% (16) ‘yes’ from those who stated no religion at all. Patients who had been visited by a chaplain replied with 88.5% (92) ‘yes’ replies and only 11.5% (12) ‘no’ replies. Of those not visited 78.4% (29) recorded ‘yes’ and 21.6 (8) ‘no’. These results clearly indicate that the patients involved in this particular survey welcomed or would welcome chaplaincy visits for comforter purposes regardless of any religious affiliation. Gender, denomination, age, sex or hospital had no particular significance in the responses to this question.

The highest percentage of the ‘don’t know’ replies were from the nurses and combined doctors, as opposed to the patients, to whom the question would have been more relevant at the time of reply. One possible factor here is that some doctors and
nurses see the chaplains as hospital staff and as such are there primarily for the patients and not other staff members. This aspect will be dealt with further in Chapter 5. The possibility also exists that some of the medical staff may have interpreted the question as applying to visits to their patients and not to themselves if hospitalised. However, from the positive responses received from the staff to the questions regarding the acceptance and need of chaplains on the wards, it seems more likely that the staff related this question to themselves. In the event of a staff member becoming a patient, it is reasonable to expect that their spiritual needs would be comparable to any other patient. It is sometimes difficult for a person to assess their anticipated reactions to a given situation until it eventuates and at times patients, staff included, who have initially rejected a chaplain’s visit, may ultimately welcome such a visit (or vice versa!). This change does indeed often occur when a patient’s health deteriorates, when recovery takes longer than expected, when their independence is threatened or, most glaringly when they are told nothing more can be done for them medically. The spiritual needs of staff in their work will also be discussed fully in Chapter 5 when the interaction between the chaplain and staff in the Liver Transplant Unit at the Austin Hospital is discussed at length.

The chaplains, as expected, were almost a hundred percent in agreement that they would welcome a visit from another chaplain. The only exception being from a religion other than Christian who answered ‘no’.

Question 9: Will you specifically request to see a Chaplain during your present hospitalization? (Patients only). This question was applicable to the patients only, to ascertain how many would specifically request to see a chaplain rather than merely welcoming a routine visit. The comparative patient figures for Questions 8 and 9 are shown below.

**TABLE 38:** Comparative figures for Question 8 and Question 9.

<table>
<thead>
<tr>
<th>Patients only:</th>
<th>Question 8</th>
<th>Question 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76.5% (121)</td>
<td>29.7% (47)</td>
</tr>
<tr>
<td>No</td>
<td>12.7% (20)</td>
<td>54.5% (86)</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>9.5% (15)</td>
<td>12.0% (19)</td>
</tr>
<tr>
<td>No answer</td>
<td>1.3% (2)</td>
<td>3.8% (6)</td>
</tr>
</tbody>
</table>

The above figures clearly indicate an active role is expected of chaplains, as against the passive role of most patients. Greenwich Hospital was the only hospital with more patients stating they would ask to see a chaplain. The age of patients and the
predominance of palliative care facilities at this hospital may be the attributing factor in the recorded replies. With regard to the high ‘no’ response from the other hospitals, it is not difficult to understand that a person might welcome someone visiting them, but still not ask to see them. The first is classified as a passive state and makes no assumption of knowledge of chaplaincy, whilst the second is active and assumes intention. The fact that the ‘comforter’ role, the one considered to be the most important aspect of chaplaincy by the majority of participants, is a passive role reinforces the explanation of patients’ reluctance to ask to see a chaplain.

As the status of many hospital patients is, in effect, passive, it is important for hospital chaplains to know that they will probably not ask for a chaplain. Whilst some patients may devise other methods of expressing their spiritual need for a chaplain, such as wearing a cross, leaving an open Bible at their bedside, or visiting the chapel, the findings suggest that the chaplains themselves must take the active role and approach the patients. When a chaplain presents him/herself routinely, there is no prior commitment made by the patient and they have the right of choice to welcome the chaplain or request that they leave.

Whilst neither gender nor denomination played any significant part in Question 9, two patients who classified themselves as having no religion nevertheless answered affirmatively. No conclusive reason can be given for this, only the suggestions that loneliness, a need to speak to someone regarding a specific worry, or lack of knowledge of a chaplain’s role may have prompted these affirmative replies.

b. Miscellaneous Questions

Results of the miscellaneous questions, discussed below, give a clear indication that chaplains are considered by all groups to be advantageous to a patient’s well-being, and that they are expected to have access to the wards at most times. Nevertheless, there are variances shown in employment and duty guide-line expectations due to different methods being utilised in individual hospitals.

When participants were asked ‘if they would expect the chaplain to have access to patients, relatives and staff at most times’ as in Question 10, the overall percentages produced a high positive result, with 81.3% (375) ‘yes’; 11.7% (54) ‘no’; 5.4% (25) ‘don’t know’ and 1.5% (7) ‘no answer’. The highest ‘no’ and ‘don’t know’ percentages came from the patients, and the number of male patients recording ‘no’ replies was more than double that of the females. As gender was not a significant factor when patients were asked if they would welcome a chaplain’s visit, it is unlikely that the male opaque replies concerning access to patients, relatives and staff reflect a negativity towards chaplains generally, but the fact that discretion needs to be used as to the timing of visits. This suggests that chaplains must be careful not to become an
intrusion in order to remain ‘welcome’. Only 6.4% (10) of the nursing staff said ‘no’ to Question 10, indicating that most do not find the presence of the chaplain an interference to the ward routine. All the chaplains, with the exception of one Catholic Clinical Pastoral Education student, answered affirmatively to this question and it may be that where the question of access is concerned, the chaplains are thinking of themselves as staff or at least being entitled to staff access privileges.

In reply to Question 50 (Do you consider the chaplain’s role to be advantageous for a patient’s well-being during hospitalisation?), the vast majority of participants thought it was, with 87.9% (405) ‘yes’; 2.2% (10) ‘no’; 6.5% (30) ‘don’t know’; and 3.5% (16) ‘no answer’. Only five patients recorded a negative reply. These results indicate that, regardless of the varying interpretations of the chaplain’s role by participants, the majority conclusion is that this role is advantageous to patients’ well-being generally. As could be reasonably expected, the chaplains themselves recorded a unanimous ‘yes’ reply to this question.

Question 48 asked: ‘Do you expect chaplains to be employed by: the Hospital, Religious Body, Government, Other Body?’. Most of the overall replies stipulated either ‘Hospital’ 35.1% (162) or ‘Religious Body’ 40.8% (188). Only 5.0% (23) expected the ‘Government’ to be the employer. The majority of patients placed the ‘Religious Body’ before the ‘Hospital’ (51.5% to 28.0%), whilst the nurses placed the ‘Hospital’ first (47.9% to 36.6%). The combined doctors were evenly divided. There was much variation amongst the Chaplains, reflecting the inconsistency of chaplaincy employment methods. It is assumed that each chaplain indicated their own specific situation, without a great deal of knowledge as to the situation of their peers. A similar situation applied to Question 49 (Do you think the guide-lines for the chaplain’s role would be formulated by the Hospital, Religious Body, Government, Other?), where again the overall figures were similarly divided between the ‘Hospital’ and ‘Religious Body’, but with a higher combined ‘Hospital/Religious Body’ percentage. The highest majority for ‘Religious Body’ alone came once more from the patients, with the medical groups favouring the ‘Hospital’ and ‘Hospital/Religious Body’ combined categories. Most of the combined chaplains and the hierarchy stipulated ‘Religious Body’ and combined ‘Hospital/Religious Body’.

c. Witness Questions - (See also Appendix XII)

Gender, age or hospital had no great influence on the overall results of the witness questions relating to the expectations of the chaplain as a witness of God’s
love and concern and a prayer intercessor. The patients’ figures were slightly higher in the ‘no’ and ‘don’t know’ areas of the prayer related questions, whilst the junior doctors were more positive in their responses regarding their expectations of faith matters being discussed by the chaplain. Denominations played a small part in the prayer questions variances, particularly between the Catholics and Anglicans, with more Catholic participants saying that they did not expect the chaplain to pray with, or for them. A possible explanation for this could be that more Catholics expected to receive the sacraments rather than just prayers. These variations were not large enough to be of great significance.

The ambiguity of question 27 (Would you expect the chaplain to defend when a patient is angry or disillusioned with God?) created a high overall percentage variance and produced the only marked differences between the patients and medical staff expectations of the chaplains’ role and those of the chaplains themselves. The remaining witness questions showed slightly higher percentages recorded by the chaplains than the other groups (with a few dissenting chaplains) and, overall, there is little difference between the expectations of the role of chaplains by patients, medical staff and the chaplains in this group of questions. This expectancy shows clearly that the ‘witness’ component is quite clearly considered to constitute a major part of the chaplain’s role, as the following results indicate.

Question 11 (Would you expect the chaplain to push a religious approach?), showed clearly that this was not expected with 87.6% (404) stating ‘no’; 7.6% (35) ‘yes’; 3.5% (16) who ‘don’t know’; and 1.3% (6) who gave ‘no answer’. The small number of ‘no’, ‘don’t know’ and ‘no answer’ replies were spread fairly evenly between each group, hospital, denomination/religion, gender and age, with the exception of the combined chaplains who answered 100% affirmatively: thus no great significance can be attributed to the negative replies. Participants who did reply negatively may, through lack of chaplaincy knowledge, have assumed that evangelizing is the chaplain’s sole objective or they may have experienced an unfortunate situation when they felt the chaplain had persisted in promoting some form of religious activity not required by the patient.

The expectation of prayer in various forms rated highly, although it was not expected that chaplains would pray or read scriptures during every visit. Question 12 (Would you expect the chaplain to pray with patients individually?) recorded a high overall ‘yes’ percentage of 79.8% (368), with ‘no’ 9.8% (45); ‘don’t know’ 7.8% (36) and ‘no answer’ 2.6% (12). Whilst one Anglican chaplain and one Catholic CPE
student answered 'no', it was the patients who produced the bulk of the 'no' replies with 27 of the total 45 and 17 of the 36 'don't know' replies. These came from various denominations, hospitals, gender and age categories, as did the remaining negative replies from other groups. It could be that the participants who answered negatively were reflecting the feeling that they personally would not want the chaplain to pray with them.

The same explanation could apply to Question 13 (would you expect the chaplain to help patients to formulate their own prayers?) where the overall results were 'Yes' 76.4% (352); 'no' 10.8% (50); 'don't know' 10.0% (46) and 'no answer' 2.8% (13). The patients were again the majority group who answered 'no' and 'don't know' to this question. The highest percentage of these came from the Catholic denomination, of whom 15.6% replied 'no' and 13.8% replied 'don't know'. However, six of the chaplains answered 'no' or 'don't know', none of whom were Catholic. Three were Anglican, one Baptist and two stipulated no denomination. Why these chaplains would not expect to help patients to formulate their own prayers, with one exception, is unknown. One reason may be that they themselves do not feel comfortable doing this. The one exception was a Rabbi who, as will be discussed in Chapter 4, approaches his chaplaincy duties in a different manner. The Jewish hospital chaplaincy tradition is to visit patients in a friendly rather than in a religious capacity. The Rabbi stated that Jewish patients would be expected, by reason of the traditional religious teachings of the Jewish faith, to know how to formulate their own prayers. If formal prayers are requested by a Jewish patient, these are administered by a Rabbi or other Jewish person, if present: Prayers offered by non-Jewish chaplains are permissible, in the absence of a member of the Jewish faith, at the request of the patient. No other factors were significant for this question.

As for the chaplain praying privately for individual patients, (Question 14), the overall figures showed 70.5% (325) 'yes'; 14.1% (65) 'no'; 13.0% (60) 'don't know' and 2.4% (11) 'no answer'. There were few variations between groups, ages, genders, hospitals and denominations/religions. However, the overall Catholic replies were 21.1% 'no' and 15.6% 'don't know', which were higher than other denominations. As previously stated, this may be accounted for by a Catholic expectation that the chaplain would offer the Blessed Sacrament or perform any other rituals required by a Catholic patient during the visit rather than merely praying for them privately. Most of the chaplains recorded a 'yes' for this question, with only one chaplain stating 'no' and one 'don't know'.
The majority of participants did not expect the chaplain to pray or read scriptures during every visit (Question 15), and the break-up percentages for all categories of this question were fairly evenly divided, with the overall figures showing 16.9% (78) ‘yes’; 72.7% (335) ‘no’; 8.0% (37) ‘don’t know’ and 2.4% (11) ‘no answer’. Although 41 chaplains were in accord that chaplains would not be expected to pray or read scriptures during every visit to patients, seven chaplains disagreed. This may indicate that some denominations are not providing firm enough guidelines or supervision for their chaplains. Although certain allowances must be made for the individuality of chaplains, a question like this could reasonably have been expected to produce a 100% ‘no’ response. This is on the assumption that chaplains would be aware that, whilst a minimal number of patients may desire prayers or scripture readings during every visit, many others may not. Indeed, patients may quite frequently indicate that they prefer not to receive any type of prayer or reading at all, whilst still making the chaplain welcome at their bedside.

Question 19 (Would you expect the chaplain to be a witness of God’s love and concern?); Question 21 (Would you expect the chaplain to discuss matters of faith?); and Question 22 (Would you expect the chaplain to give spiritual comfort?), all recorded highly affirmative results. Questions 19 and 22 showed no significant variances regarding denomination/religion/no religion; gender; age; or hospital. However, Question 21 showed that the younger doctors had more definite expectations regarding chaplains discussing matters of faith than they had recorded for many other questions, with 93.9% stating ‘yes’. This could indicate that these junior doctors related more closely to the spiritual concept of faith generally than to its outward manifestation such as prayer.

Question 26 (Would you expect the chaplain to promote reconciliation between a patient and God?) produced a number of variances. There was a high ‘don’t know’ percentage of 16.1% (74), with 66.6% (307) ‘yes’; 16.3% (75) ‘no’ and 1.1% (5) ‘no answer’. The following tables show the group and Christian denominational break-ups.
Table 39: Question 26 - Groups.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>D/K.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>58.2 (92)</td>
<td>17.1 (27)</td>
<td>23.4 (37)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>66.1 (37)</td>
<td>14.3 (8)</td>
<td>16.1 (9)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>75.8 (25)</td>
<td>12.1 (4)</td>
<td>12.1 (4)</td>
</tr>
<tr>
<td>Nurses</td>
<td>64.3 (101)</td>
<td>21.0 (33)</td>
<td>14.0 (22)</td>
</tr>
<tr>
<td>Chaplain</td>
<td>93.4 (44)</td>
<td>5.0 (3)</td>
<td>1.6 (1)</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>88.9 (8)</td>
<td>-</td>
<td>11.1 (1)</td>
</tr>
</tbody>
</table>

Table 40: Question 26 - Christian Denominations.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>D.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Denominations</td>
<td>59.1 (39)</td>
<td>19.7 (13)</td>
<td>18.2 (12)</td>
</tr>
<tr>
<td>Catholic</td>
<td>57.8 (63)</td>
<td>18.3 (20)</td>
<td>23.9 (26)</td>
</tr>
<tr>
<td>Anglican</td>
<td>80.2 (89)</td>
<td>15.3 (17)</td>
<td>4.5 (5)</td>
</tr>
<tr>
<td>Uniting</td>
<td>69.0 (29)</td>
<td>14.3 (6)</td>
<td>16.7 (7)</td>
</tr>
<tr>
<td>Other</td>
<td>69.2 (18)</td>
<td>11.5 (3)</td>
<td>15.4 (4)</td>
</tr>
</tbody>
</table>

Again the junior doctors were more positive in their replies than the other medical groups and the Anglicans more positive than the other denominations, particularly the Catholics. The chaplains’ responses included five ‘no’ or ‘don’t know’ replies, two of which were Clinical Pastoral Education students. The possibility arises that many participants did not understand the meaning of ‘reconciliation’ in this context, thus a correct result may not have been statistically achieved.

This problem was also evident with Question 27 (Would you expect the chaplain to defend when a patient is angry or disillusioned with God?). This question created a certain amount of confusion as to who was being ‘defended’; God or the patient. The total overall figures of 38.8% (179) ‘yes’; 39.9% (184) ‘no’; 18.4% (85) ‘don’t know’ and 2.8% (13) ‘no answer’ indicates the ambiguity of the question. This ambiguity would appear to have caused variance between the groups, regardless of their religion/denomination, age, gender or the hospital involved, with the exception of the chaplains, the majority of whom replied negatively. It was hoped to ascertain expectations as to whether the chaplain would censure a patient for being angry or disillusioned with God as a result of their illness. The chaplains presumably
interpreted the question this way, hence so many ‘no’ responses. This suggests that the chaplains would try to understand the patients’ feelings and help them to work through such emotions with love and caring, rather than by condemnation.

d. Ethical Questions

Whilst, as anticipated, it is generally expected that a chaplain will be trustworthy and will treat as confidential their interaction with medical staff and patients, there is little consistency as to the expectations of the role of chaplains where other ethical issues are concerned. In the case of the chaplains answering patients medical questions, the medical staff and chaplains agreed that this is not the chaplains’ role, but quite a number of the patients expected that it would be. With the additional differences between the answers of participants of ‘no denomination’ and those of ‘no religion’, plus hospital variations, it would appear that each participant answered in the way that the question would affect them personally and not as they expected it may affect chaplaincy generally. The medical staff and chaplains would have realised that the chaplains, in most cases, would not be professionally qualified to answer medical questions, whereas a number of the patients may have felt a personal need for reassurance or confirmation pertaining to their condition from someone outside the medical profession or their family.

With regard to the chaplain’s access to patients records, more medical staff and chaplains expected this to be part of the chaplains’ role. Whilst the chaplain may not need to be aware of the patient’s condition for the purpose of answering questions pertaining to such condition, it is often an advantage for the chaplain to read the medical report in order to minister correctly to the patient or relatives. It is helpful for the chaplain to be aware if the patient is close to death, suffering from a prolonged terminal, incurable illness, about to lose a limb or their eyesight, require surgery or tests, or if, by contrast, a more minor procedure is involved. The type of ministry needed and the attitude of the chaplain varies considerably according to the patient’s need, and it is often necessary to know some initial background. This does not mean that every chaplain should automatically peruse every patient’s records, but that they should be given access to such records as necessary to perform their tasks.

Despite the large percentage or surveyed participants who stated that they would not expect the chaplain to have access to their records, the researcher has found during her own experience that the majority of patients assume that he/she is already aware of their condition when he/she visits them. Whilst the majority of chaplains are not considered to be hospital employees with access to detailed hospital records, nevertheless it is expected that they will be privy to the general prognosis of the patient.
The chaplains were often divided in their views concerning the ethical questions. In responding to Question 34 (Would you expect the chaplain to answer questions from patients pertaining to their medical condition?) the chaplains were in accord that this should not be expected. Question 43 (Would you expect the chaplain to consult with medical staff on ethical issues?) produced a high ‘yes’ response from the chaplains. However they did not agree over Question 35 (Would you expect the chaplain to have access to patients’ medical records?), with the chaplains from St. Vincent’s, Westmead and Hornsby Hospitals recording a much higher ‘yes’ percentage than the Royal North Shore, Mount Druitt and Greenwich Hospitals. Furthermore, the chaplains from Royal North Shore, Greenwich and Mount Druitt Hospitals did not appear to be happy with the suggestion of Question 44 (Would you expect the chaplain to counsel patients on ethical issues?), whilst those from St. Vincent’s, Westmead and Hornsby Hospitals were much more accepting of this as an expectation. In this regard, the hospital at which the chaplains were involved again appeared to influence their replies. This fuels the argument that, at present, there are no specific directives being followed which can be classified as a true chaplains’ role.

The high response by senior doctors to Question 43 (Would you expect the chaplain to consult with medical staff on ethical issues?), may indicate that doctors are not always completely confident or comfortable when ethical decisions need to be made and a chaplain’s input may be sought to help the doctor make a conscientious decision.

There was no doubt that chaplains are expected to be trustworthy with confidentiality, (Question 16), with 97.2% (448) of the overall participants answering ‘yes’. Only 0.4% (2) said ‘no’; 0.9% (4) ‘didn’t know’; and 1.5% (7) gave ‘no answer’. Question 34 (Would you expect the chaplain to answer questions from patients pertaining to their medical condition?) showed a difference between the patients and medical staff. The overall figures were 12.6% (58) ‘yes’; 79.6% (367) ‘no’; 5.4% (25) ‘don’t know’ and 2.4% (11) ‘no answer’ with the following table showing that the majority of ‘yes’ and ‘don’t know’ replies coming from the patients.

The following table shows the group break-up.
The participants who stated they had ‘no denomination’ recorded a high ‘yes’ reply to this question, whilst those who regarded themselves as having ‘no religion’ at all recorded a very low ‘yes’ reply (one participant out of 46). Whilst it could be argued that the ‘no denomination’ participants may not be fully aware of a chaplain’s role, thus expecting their questions pertaining to their medical condition to be answered by the chaplain, this argument would be countered by the replies recorded by the ‘no religion’ participants. It could reasonably be assumed that the participants with ‘no religion’ would be less aware of the chaplain’s role than those who identify with some form of faith, but simply do not align themselves to a particular denomination. A reason for the low ‘yes’ response by the ‘no religion’ participants, may be that they prefer any conversation with the chaplain to be on a strictly general, non-personal level.

In addition, Royal North Shore Hospital recorded 6.5% ‘yes’ responses whilst at both Mount Druitt (21.3%) and Greenwich (26.8%) Hospitals, the ‘yes’ responses were much higher. The Greenwich figures may be explained by the fact that many of the patients are elderly and in a palliative care situation, whilst others are undergoing long term rehabilitation programs; such patients often form close relationships with the chaplain and may expect the chaplain to answer questions on many subjects. The size of Royal North Shore Hospital and high staff numbers compared with Mount Druitt Hospital, may account for the lesser need by RNSH participants to question the chaplains concerning their medical conditions. It is reasonable to assume that adequate medical staff would be available for this purpose.

What does emerge from this question, however, is that in general the medical staff and the chaplains themselves do not consider it to be part of the chaplains’ role to answer patients questions concerning their medical conditions, whereas only just over half of the patients stated an outright ‘no’, with the rest answering ‘yes’ or ‘don’t know’. This raises questions as to why so many more patients than other groups answered affirmatively or were not sure. If patients feel a need to discuss medical
matters with the chaplain, does this imply that the hospital staff responsible for keeping patients informed about their condition are not fulfilling this duty sufficiently? Are they neglecting to spend enough time explaining the situation or not encouraging patients to ask questions about their condition or any worries and fears they may have concerning medical procedures? If so, it is a flaw in our hospital system which needs to be rectified. Staff shortages and insufficient visits by consultant doctors may be one area needing attention in this regard.

The combined results of this question showed 23.2% (107) 'yes'; 65.3% (301) 'no'; 9.3% (43) ‘don’t know’ and 2.2% (10) ‘no answer’. However, as the following table shows, there are interesting group comparisons between Questions 34 relating to patients’ questions pertaining to their medical condition and Question 35 concerning access to patients’ medical records.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>D.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Patients</td>
<td>12.7 (20)</td>
<td>72.8 (115)</td>
<td>11.4 (18)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>26.8 (15)</td>
<td>58.9 (38)</td>
<td>12.5 (7)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>24.2 (8)</td>
<td>66.7 (22)</td>
<td>9.1 (3)</td>
</tr>
<tr>
<td>Nurses</td>
<td>24.2 (38)</td>
<td>66.2 (104)</td>
<td>8.3 (13)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>58.3 (25)</td>
<td>36.7 (20)</td>
<td>2.2 (1)</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>11.1 (1)</td>
<td>77.8 (7)</td>
<td>11.1 (1)</td>
</tr>
</tbody>
</table>

This table shows that all groups other than the patients have increased the ‘yes’ percentage compared to Question 34. A greater number of the medical staff expected the chaplain to have access to patients’ medical records than to answer medical questions, although a large number still replied negatively. The chaplains followed this trend, answering as for Question 34. Some medical staff evidently understood that the chaplain would, as stated above, be in a better position to assess the type of ministry needed if he/she were aware of the patient’s condition.

However, a greater number of patients expected that the chaplain would answer questions pertaining to their medical condition than to have access to their medical records. This appears to be a contradiction, as neither a chaplain nor anyone else would be in a position to answer questions without knowing the relevant details. Some patients may have thought that they had an option in Question 34, whilst considering that their records may be accessed without their permission in Question
35. The patients’ individual views as to whether or not the chaplain is considered a member of the hospital staff may also have influenced their replies.

The expectations of the chaplain consulting with medical staff on ethical issues such as abortion, IVF, life support systems, and so on (Question 43) were divided, the overall results being 53.4% (246) ‘yes’; 29.1% (134) ‘no’; 15.8% (73) ‘don’t know’; 1.7% (8) ‘no answer’. As anticipated, the chaplains (81.1%); recorded the highest percentage of ‘yes’ replies, with the senior doctors also recording a high 78.6% ‘yes’. The nurses (50.3%) and junior doctors (48.5%) were evenly divided, whilst the patients recorded a lower 38.6%. There was also quite a degree of indecision amongst the patients (22.2% ‘don’t know’) and the nurses (19.1% ‘don’t know’). Denominational and hospital differences were of no great significance, with all recording more ‘yes’ than ‘no’ replies. The Anglicans and Uniting participants showed a slightly higher percentage of ‘no’ replies than the other denominations, yet not enough to be of consequence. The ‘don’t know’ replies were spread very evenly across all denominations. The most significant outcome of this question is that the senior doctors, usually the persons most involved in medical ethical issues, have largely answered in the affirmative, expecting the chaplain to consult with them on such matters. This appears to indicate that these doctors are prepared to listen to and value the opinions of the chaplains. Another point of significance is the possibility that participants’ replies, particularly those of the patients, were influenced by their individual feelings towards the above ethical issues rather than their general expectations of the chaplain consulting with medical staff on such issues.

The same explanation may have been relevant to Question 44 (Would you expect the chaplain to counsel patients on ethical issues?). The overall replies were similar to Question 43 above: 53.6% (247) ‘yes’; 27.5% (127) ‘no’; 15.8% (73) ‘don’t know’; 3.0 (14) ‘no answer’. Whilst a few more patients and junior doctors answered ‘yes’, a few more senior doctors answered ‘no’. The chaplains themselves reduced their ‘yes’ replies for this question by 30% from the previous question. It may be that the chaplains do not consider it their role to counsel patients on ethical issues. Although the term ‘pastoral counselling’ is often used in chaplaincy, some chaplains may feel that such counselling on ethical issues is beyond their capability or, alternatively, they may not wish to influence a patient’s medical decision. Consulting with medical staff could be seen as an advisory role whilst, by counselling the patient directly, the chaplain may feel threatened by having to address their own feelings on the subject which may, in some cases, be contrary to the teaching of their religious body.
e. Comforter Questions - (See also Appendix XII)

This is the first group of questions where, not only have the chaplains agreed regarding their role expectation, but the other survey participants have also concurred. The ‘comforter’ area has always been seen as the chaplain’s domain and a major proportion of all groups taking part in this survey obviously consider that it is still a principle and expected facet of the chaplain’s role.

There is nothing in the ‘comforter’ question replies to indicate that the chaplains view their role differently from the way in which the patients and medical staff view it. When asked if they expected the chaplain to listen to patients, show care, compassion and kindness, and to discuss patients’ fears and anxieties, the percentages of ‘yes’ replies from all groups was in the high 90s. This indicates that chaplains are expected to be caring, trustworthy people, someone to whom they can, if the need arises, express feelings which they may otherwise suppress. The expectation seems to be that the chaplain’s visit will be less hurried than those of the medical staff and that the chaplain will also exhibit the caring qualities associated with their profession. It was also expected, however, that the chaplain would discuss sport, entertainment or any other topic with a patient if this is what a patient desired. This shows that most participants also saw the chaplain as a person to whom they could relate on an everyday level if need be and not only on a ‘religious’ level.

Other ‘comforter’ questions, relating to expectations of the chaplain’s assistance to patients and relatives during a crisis and helping them to face death when necessary, produced almost a 100% affirmative response, indicating that this area is considered by most as a very definite part of the chaplain’s role. During times of deep crisis and death many, including those who are not normally considered ‘religious’, look for some supernatural comfort and help and they see the chaplain as a connecting link or bridge to God, or whatever they are seeking. Death is, in general, related to religion in this society and the writer’s personal experience has shown that very few funerals are conducted without some form of prayer or worship being offered. If this is universally correct it would, no doubt, help to account for the way in which these crisis and death survey questions were answered.

The only question which was not answered as overwhelmingly in the affirmative as the other questions was in respect to the chaplain visiting a patient before an operation. Here, however, simple ‘no’ replies were lower than the combined ‘don’t know’ and ‘no answer’ ones. The ‘no’ and ‘don’t know’ replies were spread across all groups and categories, showing no specific significance. Two chaplains answered ‘no’, with one being undecided. A number of reasons could account for these replies. Some participants may think the patient would be too drowsy from medication or that anyone other than medical staff could be in the way. It is unlikely,
however, that a chaplain would visit close to a patient’s operation time unless specifically requested. The most significant aspect is that the ‘comforter’ role is seen by most participants from all groups, to be the one most expected to be associated with hospital chaplains.

f. Counsellor Questions - (See also Appendix XII)

There was considerable uncertainty amongst all participants as to the type of counselling they would expect to be classified as part of the chaplains’ role. Participants’ own personal preferences with regard to counselling would appear to have played a significant part in their replies, whilst the senior doctors, who had very low percentages of uncertainty when replying to most other questions, recorded a high 14.3% uncertainty regarding their expectation of the chaplains’ participation in the staff’s personal and work problems.

The chaplains themselves had varied views as to what they considered would be expected from them with regard to the ‘Counsellor’ questions and their replies appear to have been influenced by the individual hospital at which they minister. Their individual interaction with staff and varying administrative procedures at each hospital would have had a bearing on the chaplain’s own expectations. This highlights the need for added interaction between various medical institutions and religious bodies, in an endeavour to increase the profile of their chaplains by formulating a role for them which would be more easily identified by staff, patients and the chaplains themselves. There was considerable disagreement amongst the overall participants regarding expectations of the chaplain’s help in examining a patient’s lifestyle (i.e. smoking, drinking alcohol, worrying, over-exertion) in order to improve their health.

With the overall figures showing 44.3% (204) ‘yes’; 41.4% (191) ‘no’; 12.6% (58) ‘don’t know’ and 1.7% (8) ‘no answer’, the following table is needed to show the way in which the various groups replied.

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No</th>
<th>D.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Patients</td>
<td>56.3 (89)</td>
<td>25.3 (40)</td>
<td>16.5 (26)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>41.1 (23)</td>
<td>53.6 (30)</td>
<td>1.8 (1)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>39.4 (15)</td>
<td>45.5 (15)</td>
<td>15.2 (5)</td>
</tr>
<tr>
<td>Nurses</td>
<td>33.1 (52)</td>
<td>53.5 (84)</td>
<td>12.1 (19)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>46.6 (22)</td>
<td>35.5 (18)</td>
<td>16.1 (7)</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>55.6 (5)</td>
<td>44.4 (4)</td>
<td>-</td>
</tr>
</tbody>
</table>
Only a quarter of the patients recorded a straight out ‘no’ for this question, whilst the medical staff recorded much higher ‘no’ percentages. It is possible that the patients related the question to their own individual lifestyle and, in their state of ill-health, felt that some changes were needed. The medical staff, on the other hand, probably approached the question less subjectively. The chaplains were divided in their views, which could mean either, that they simply did not consider examining patients’ lifestyles was part of their role or, that some chaplains did not feel confident or experienced enough to deal with this type of counselling ministry. Assessing the significance of denomination, age, hospital, and so on, it appears that these factors had no specific bearing on participants’ expectations, and personal preferences seem to have been the main motivation for the way in which this question was answered.

The responses as to expectations of chaplains helping patients to clarify and understand their own feelings and emotions, and to use their hospital experiences positively, were much more in tune with one another, with the majority of participants saying ‘yes’. This again indicated that chaplains are expected to guide and offer pastoral counselling. Pastoral counselling training is one of the recommendations to be included in a suggested postgraduate chaplaincy degree outlined in Chapter 6. The researcher considers that pastoral counselling should complement other forms of counselling which a patient may be receiving; this is achievable when chaplains and other allied health professionals consult with each other, so the better to understand each other’s disciplines. Such pastoral counselling, must however, be complementary to and not intrusive upon any other form of counselling a patient may be receiving from other counselling disciplines.

**Question 41** (Would you expect the chaplain to help hospital staff with *personal* problems?) was answered very differently from **Question 42** (Would you expect the chaplain to help hospital staff with *work* problems?) by all groups. The following tables indicate these different opinions.

**Personal problems**: Overall figures: 68.8% (317) ‘yes’; 16.5% (76) ‘no’; 12.8% (59) ‘don’t know’; 2.0% (9) ‘no answer’.

**Table 44: Question 41 - Groups.**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>D.K. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>67.7 (107)</td>
<td>10.8 (17)</td>
<td>17.7 (28)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>64.3 (36)</td>
<td>17.9 (10)</td>
<td>14.3 (8)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>66.7 (22)</td>
<td>27.3 (9)</td>
<td>6.1 (2)</td>
</tr>
<tr>
<td>Nurses</td>
<td>65.6 (103)</td>
<td>21.0 (33)</td>
<td>12.7 (20)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>83.3 (40)</td>
<td>14.6 (7)</td>
<td>2.1 (1)</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>100.0 (9)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Work Problems: Overall figures: 36.7% (16.9) 'yes'; 48.8% (225) 'no'; 12.6% (55) 'don't know'; 2.0% (9) 'no answer'.

**Table 45: Question 42 - Groups.**

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No</th>
<th>D.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Patients</td>
<td>42.4 (67)</td>
<td>36.7 (58)</td>
<td>17.7 (28)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>26.8 (15)</td>
<td>55.4 (31)</td>
<td>14.3 (8)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>27.3 (9)</td>
<td>57.6 (19)</td>
<td>15.2 (5)</td>
</tr>
<tr>
<td>Nurses</td>
<td>31.8 (50)</td>
<td>56.7 (89)</td>
<td>10.8 (17)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>52.7 (23)</td>
<td>44.4 (24)</td>
<td>-</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>55.6 (5)</td>
<td>44.4 (4)</td>
<td>-</td>
</tr>
</tbody>
</table>

The patients and medical staff at the Royal North Shore Hospital recorded a higher ratio between 'yes' and 'no' replies than either Mount Druitt or Greenwich Hospitals. Whilst 67.7% of the patients expected chaplains to help staff with personal problems, only 42.4% expected them to help with work problems. The reason could be that patients do not see the chaplains as being connected with the hospital on a medical profession level. Similarly, the majority of medical staff clearly expected the chaplain to assist them with personal problems, but this expectation dropped significantly where work problems were concerned, with the senior doctors recording a higher percentage of uncertainty for both questions than they did for most other questions. This again indicates the general confusion as to how the role of the chaplain is actually constituted. It is possible that the medical staff expected that other allied health staff or the administrative staff would be better qualified to deal with work problems than chaplains. As Table 46 shows, the Royal North Shore Hospital, which is larger than Mount Druitt or Greenwich Hospitals and could be expected to employ a larger number of allied health staff, recorded the highest 'no' replies regarding the expectancy of chaplains helping staff in relation to work problems.

**Table 46: Question 42 - Hospitals.**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Royal North Shore</td>
<td>35.8</td>
<td>64.2</td>
</tr>
<tr>
<td>Mount Druitt</td>
<td>44.9</td>
<td>55.1</td>
</tr>
<tr>
<td>Greenwich</td>
<td>50.0</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Most of the chaplains themselves expected to help with personal problems, with only seven replying negatively and one uncertain. However, three of these were
Clinical Pastoral Education students who might not have realised that chaplains may also be available for staff ministry. With regard to work problems, the chaplains were not in accord with one another. This becomes significant when comparing the denominations of the chaplains. Whilst double the number of Anglican and United chaplains said ‘yes’ rather than ‘no’, the opposite was the case for the Catholics. This again indicates that the hospital at which the chaplains were employed influenced their expectations more than their denomination or other factors.

The ‘no denomination’ participants, together with the major denominations, recorded a ‘no’ majority, whilst 50% of the combined minor denominations, including Baptist, Salvation Army, Methodist and Seventh Day Adventist, expected that the chaplain would help staff with work problems. The reason for this could be that participants from the minor denominations expect the role of the ‘Church’ generally to be wider than those of the major denominations (Catholic, Anglican and United).

g. Resource Person Questions - (See also Appendix XII)

In all the resource person questions, the junior doctors and patients recorded the highest percentages of ‘no’ and ‘don’t know’ answers. However, the majority still expected that the chaplain would be a resource person. (Refer Appendix XII). The senior doctors and nurses highly expected that the chaplain would act as a liaison between patients and hospital staff when necessary and a high percentage also expected the chaplain would conduct pastorally related lectures. It is possible that the number of patients and junior medical staff who answered ‘no’ or who were undecided as to their expectation of chaplains as a resource person, may have been under the impression that the chaplain is an independent visitor and not officially part of the hospital network. The junior doctors, being at the start of their professional careers, may not have encountered much personal interaction with the chaplain. There is no doubt, however, that the majority of the chaplains considered that they would be expected to incorporate the above ‘resource’ topics into their role as chaplains, with their question responses being in accord with one another and most of the medical staff.

The expectation that the chaplain would listen to patients’ complaints concerning hospital administration or staff, and to report such complaints to the person concerned, produced a higher ‘yes’ than ‘no’ result, with the senior doctors recording an affirmative 66.1%; 23.2% ‘no’; 8.9% ‘don’t know’ and 1.0% ‘no answer’. It is obvious, therefore, that the chaplain is considered as someone to whom patients can express their feelings and that the chaplain is in a position to pass on patient concerns and complaints if these are considered reasonable and if it is considered that a response would be beneficial to the patient’s well-being.
Whether chaplains are expected to conduct lectures for medical staff on pastoral concerns produced an exceedingly high percentage of uncertainty. However, the majority of senior doctors and nurses expected such lectures to be given and this could also indicate that they accepted them. The fact that most chaplains also stated ‘yes’ to this question would seem to imply that they, in turn, would be prepared to conduct lectures. Whilst this is done in some hospitals, the feeling is that this service could be increased or instigated. The patients and junior doctors recorded the highest percentage of ‘no’ and ‘don’t know’ for this question. This may be because the patients themselves would not be involved and were thus reluctant to comment on the subject, and the junior doctors may have felt that during this early stage of their career they were already attending all the lectures they could cope with.

With regard to the chaplain being part of a team with doctors and nurses for the overall care of the patients (Question 45), and being an integral part of the whole hospital system (Question 46), the general opinion was a definite ‘yes’. Those answering negatively came mainly from the junior doctors and patient groups. This could again stem from confusion as to the chaplains’ role in the hospital and their status in each individual hospital.

The junior doctors and patients again recorded the highest ‘no’ and ‘don’t know’ replies when asked about their expectation regarding chaplains’ liaising with parish clergy, although overall 336 participants expected some form of liaison. It may be that some patients could say things to a chaplain which they would not want repeated to anyone else, including their parish clergy; this may account for the negative replies by some. It would, however, be unethical for a chaplain to repeat any part of a patient’s conversation without permission and a chaplain should not attempt to make any contact with parish clergy without such permission being sought. If the chaplain deems it necessary to make contact with a patient’s church after that patient’s death, permission to do this should be obtained from a close relative if available.

h. Liturgist Questions - (See also Appendix XII)

The majority of participants were in agreement with regard to their expectations of the chaplain in the liturgist questions. (Refer Appendix XII. However, as seen by the Question 51 results, the ‘liturgist’ role was ranked considerably lower than the ‘comforter’ and ‘witness’ roles. The administration of Holy Communion and performance of Baptism in hospital were generally expected if requested, but this does not appear to be considered part of the chaplain’s role as a matter of course. This could be expected from participants of denominations or religions in which the Sacrament of Holy Communion is not practiced or not treated as importantly as it is in
some other Christian denominations. The majority of participants expected the chaplain to hold services of worship in the hospital. The only group which recorded any significant replies was that of the patients, with 69.0% (109) stating ‘yes’; 14.6% (23) ‘no’ and 12.0% (19) ‘don’t know’. For some inexplicable reason 16 of the 23 ‘no’ responses were recorded by males, whereas gender held little relevance in the survey as a whole. No other figures appear to be relevant for this question. The expectations of the chaplains themselves regarding the ‘liturgist’ role agreed with each other and with participants of other groups. The only dissenting chaplain, understandably, was of the Jewish faith.

i. Overall Assessment Questions

The majority of participants considered the chaplains’ most important task would fall into the categories of ‘comforter’ or ‘witness’, the ‘witness’ category being boosted by the junior doctors. A number of the ‘comforter’ and ‘witness’ tasks are, of course, closely related. What became obvious through this survey was that the offering of the Blessed Sacrament, which is considered the most important function in many churches, is regarded with much less importance in the hospital setting. The implications of this for the chaplains’ role will be discussed in Chapter 6.

Question 51: What do you think is the most important task of a chaplain?

This was one of only two open-ended questions in the survey. The most common overall answers given by participants are shown below and have been placed under relevant group headings.

**Comforter - 46.6% (215)**
- Being there
- Listening (to patients and/or relatives)
- Support patients/relatives suffering fear or anxiety
- Grief support/counselling
- Being non-judgemental
- Being accepting
- No religious discrimination

**Witness - 33.0% (152)**
- Spiritual care of all
- Witness as to God’s love and concern during crises and at all times
- Reconciliation
- Prayer (privately or with others - or helping others with their own efforts when they experience difficulty praying).
- Provide a Christian influence in an often secular environment.
Liturgist - 2.0% (9).
- Administer Sacraments upon request
- Provide Services of Worship in hospital

Resource Person - 1.5% (7).
- Team member for total care of patient
- Liaise between parish clergy and patient

Miscellaneous - 0.9% (4)
- Flexibility
- Honesty
- Confidentiality
- Know when not wanted
- Do not push religion

No answer - 16.1% (74)

Whilst the chaplains’ tasks considered to be the most important by the greatest number of participants were ‘being there’ and ‘listening’, the following table shows that the group replies were not consistent with each other, with some high percentages of participants electing not to specify any particular task.

**Table 47: Question 51 - Groups**

<table>
<thead>
<tr>
<th>Group</th>
<th>Comforter %</th>
<th>Liturgist %</th>
<th>Witness %</th>
<th>Resource %</th>
<th>Misc. %</th>
<th>No Ans. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>51.3</td>
<td>2.5</td>
<td>19.0</td>
<td>0.6</td>
<td>0.6</td>
<td>25.9</td>
</tr>
<tr>
<td>Sen.Doctors</td>
<td>42.9</td>
<td>1.8</td>
<td>30.4</td>
<td>-</td>
<td>-</td>
<td>25.0</td>
</tr>
<tr>
<td>Jun.Doctors</td>
<td>30.3</td>
<td>3.0</td>
<td>54.5</td>
<td>-</td>
<td>-</td>
<td>12.1</td>
</tr>
<tr>
<td>Nurses</td>
<td>47.8</td>
<td>0.6</td>
<td>38.2</td>
<td>3.8</td>
<td>1.9</td>
<td>7.6</td>
</tr>
<tr>
<td>Chaplains</td>
<td>50.0</td>
<td>3.3</td>
<td>43.4</td>
<td>-</td>
<td>-</td>
<td>3.3</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>11.1</td>
<td>-</td>
<td>77.8</td>
<td>-</td>
<td>-</td>
<td>11.1</td>
</tr>
</tbody>
</table>

The patients, senior doctors and nurses groups considered the ‘comforter’ tasks to be the most important. The junior doctors, however, favoured the ‘witness’ category, with most of them answering the question. Two of the chaplains opted not to reply, with the others being divided primarily between ‘comforter’ and ‘witness’. The hierarchy, however, recorded a high 77.8% for the ‘witness’ category, with only one participant selecting ‘comforter’ and one not answering.

Perhaps the most surprising/significant finding drawn from responses to this question is the small percentage of participants who considered the tasks listed under the ‘liturgist’ heading to be the most important, regardless of denomination. The break-up by denomination shows that the majority of the few who did select ‘liturgist’ were Anglicans. They were not, however, from the combined chaplains or hierarchy groups.
Table 48: Question 51 - Denominations.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>53.2</td>
<td>1.8</td>
<td>22.9</td>
<td>0.9</td>
<td>0.9</td>
<td>20.2</td>
</tr>
<tr>
<td>Anglican</td>
<td>40.5</td>
<td>6.3</td>
<td>37.8</td>
<td>2.7</td>
<td>-</td>
<td>12.6</td>
</tr>
<tr>
<td>Uniting</td>
<td>47.6</td>
<td>-</td>
<td>42.9</td>
<td>2.4</td>
<td>-</td>
<td>7.1</td>
</tr>
<tr>
<td>Other</td>
<td>50.0</td>
<td>-</td>
<td>42.3</td>
<td>-</td>
<td>-</td>
<td>7.7</td>
</tr>
<tr>
<td>No Denom.</td>
<td>54.5</td>
<td>-</td>
<td>28.8</td>
<td>-</td>
<td>1.5</td>
<td>15.2</td>
</tr>
</tbody>
</table>

The overall hospital figures were fairly constant and did not appear to have any relevance. Age may have contributed to a small extent when taking into account the junior doctors' preference for 'witness' rather than 'comforter' tasks. Indications were that males and females of other ages considered 'Comforter' tasks to be the most important. The combined chaplains figures for 'comforter', 'liturgist' and 'witness' are shown below:

Table 49: Question 51 - Combined Chaplains figures.

<table>
<thead>
<tr>
<th>Group</th>
<th>Comforter</th>
<th>Liturgist</th>
<th>Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>55.6 (10)</td>
<td>11.1 (2)</td>
<td>33.3 (6)</td>
</tr>
<tr>
<td>Anglican</td>
<td>40.0 (4)</td>
<td>-</td>
<td>60.0 (6)</td>
</tr>
<tr>
<td>Uniting</td>
<td>44.4 (4)</td>
<td>-</td>
<td>55.6 (5)</td>
</tr>
<tr>
<td>Other</td>
<td>66.7 (6)</td>
<td>-</td>
<td>33.3 (3)</td>
</tr>
</tbody>
</table>

Two Catholic chaplains considered 'liturgist' to be their most important task, with the highest majority opting for the 'comforter' role. The Anglicans and Uniting considered 'witness' more important, whilst the remaining denominations stated a definite 'comforter' preference. All of the Clinical Pastoral Education students specified the 'comforter' tasks.

Question 52: Is there any other task that you think a chaplain should perform? Again this was an open-ended question, giving participants an opportunity to suggest tasks which may not be generally thought of as part of the chaplains' role. The majority of participants declined to answer (52.3%) and 22.6% replied negatively. A further 20.4% had nothing further to add beyond the survey questions already completed. However, the following suggestions were made by the remaining participants:
- After Care of patients - 2.2% (1 patient; 1 senior doctor; 4 nurses; 1 chaplain; 3 extra chaplains).
- Participation on Ethics Committee - 0.2% (1 nurse).
- Liaison Person - 2.2% (1 patient; 2 senior doctors; 1 junior doctor; 2 nurses; 2 chaplains; 1 extra chaplain; 1 hierarchy).
- Conversion - 0.2 (1 nurse).

Although these suggestions came from such a small minority of participants, it is considered that they may be of merit and further comments will be made in Chapter 6.

j. Record of Religious Practices

This survey certainly indicates a drop in ‘regular’ church attendances by all denominations generally. This is substantiated by research conducted in 1991 and 1996, by the Board of Mission of the Uniting Church (NSW) and Anglicare (NSW), who combined to conduct two National Life Surveys. The results of this research are published in the book Build my Church, and show that between 1950 and 1980 the number of Australians who claimed to attend church at least monthly dropped from 44% to less than 25%. The Catholic decline, however, was less than other denominations, possibly due to the large intake of Catholic migrants from Europe during that period. Whilst research based on the 1991 survey indicated that church attendances in Anglican and Protestant denominations had stabilised before 1991, a comparison of 1991 and 1996 results indicated that mainstream denominational attendances had declined between the two surveys. The declines were recorded as Anglican 5%, Lutheran 11%, Uniting 12% and Catholic 10%. The National Church Life Survey researchers listed factors which discourage attendance at church obtained from a 1998 Australian Community Survey, as follows:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boring church services</td>
<td>42%</td>
</tr>
<tr>
<td>Beliefs of the churches</td>
<td>35%</td>
</tr>
<tr>
<td>Churches' moral views</td>
<td>35%</td>
</tr>
<tr>
<td>No need to go to church</td>
<td>34%</td>
</tr>
<tr>
<td>Prefer to do other things</td>
<td>31%</td>
</tr>
<tr>
<td>My beliefs are too weak</td>
<td>27%</td>
</tr>
<tr>
<td>The way churches are organised</td>
<td>24%</td>
</tr>
<tr>
<td>Too many commitments</td>
<td>21%</td>
</tr>
<tr>
<td>Bad experiences of church people</td>
<td>16%</td>
</tr>
<tr>
<td>Not enough time because of work</td>
<td>15%</td>
</tr>
<tr>
<td>Uncomfortable with church people</td>
<td>14%</td>
</tr>
</tbody>
</table>

13 Ibid., p.21.
14 Ibid., p.23.
No previous involvement with churches 8%
Family or friends don’t like church 6%
No churches of my denomination near by 4%
No good churches near by 4%
Poor health/disability 3%
No transport to get to church 2%

Although participants in the present survey were not asked to provide reasons for not attending church, it could be reasonably assumed that if they had been asked, the results would have been similar to those listed above. This drop in church attendance figures by no means gauges the faith or beliefs of participants. Disillusionment with the ‘Church’ as an institution, or individual members of the clergy, may influence participation in public worship, but a participant’s personal relationship with God may be as strong and important to them as when they attended church. It is difficult for one person to fully understand the religious beliefs and motivations of another; the former person’s interpretation of what the latter believes may be very different from that which he or she really believes. The distinction between ‘appearance’ and ‘reality’ regarding Church-going practices, must be kept in mind in the consideration of this section of the survey.

Question 53: Do you attend Church? Question 54: Did you ever attend Church? (i.e. as a child or before illness). These two questions have been bracketed together in order to simplify comparisons.

**Table 50: Questions 53/54 - Do you/did you ever attend church.**

<table>
<thead>
<tr>
<th></th>
<th>Do you attend church?</th>
<th>Did you ever attend church?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>30.8% (142)</td>
<td>67.7% (312)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>33.0% (152)</td>
<td>17.4% (80)</td>
</tr>
<tr>
<td>Weddings, Baptisms,</td>
<td>19.7% (91)</td>
<td>6.9% (32)</td>
</tr>
<tr>
<td>funerals, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>12.6% (58)</td>
<td>2.6% (12)</td>
</tr>
<tr>
<td>No answer</td>
<td>3.9% (18)</td>
<td>5.4% (25)</td>
</tr>
</tbody>
</table>

The most significant comparison is, of course, the participants who do now attend church ‘regularly’ and those who did in the past. The number of those not attending ‘regularly’ is more than double those who do attend. The high percentage of participants who stated that they did at one time attend ‘regularly’, but now only

15 Ibid., p.49.
'occasionally' has consequently increased the 'occasional' figure to 33.0% from 17.4%. With 86.6% of the participants stating they once attended church 'regularly' or 'occasionally', compared to 63.8% of the present attenders, this leaves in excess of 20% of 'special occasions' and 'never' participants who were once 'regular' or 'occasional' attenders. What this survey indicates, therefore, is that the number of 'regular' church attenders has dropped considerably. Some have become 'occasional' attenders only, whilst others merely attend on 'special occasions' or 'never' at all. As would of course be expected, the chaplains stated that they were all 'regular' church attenders. There was one dissension amongst the hierarchy, this being the Jewish participant who answered the question literally; he does, of course, attend a Synagogue.

The following tables show the group and denominational break-ups with the present attendance percentages first and the former attendance percentages following in brackets:

**Table 51: Questions 53/54 - Groups.**

<table>
<thead>
<tr>
<th>Group</th>
<th>Regularly %</th>
<th>Occasionally %</th>
<th>Special %</th>
<th>Never %</th>
<th>No Ans. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>15.8 (55.1)</td>
<td>41.1 (26.6)</td>
<td>23.4 (9.5)</td>
<td>15.2 (3.2)</td>
<td>4.4 (5.7)</td>
</tr>
<tr>
<td>Senior Doctors</td>
<td>28.6 (69.6)</td>
<td>37.0 (17.9)</td>
<td>16.1 (1.8)</td>
<td>10.7 -</td>
<td>7.1 (10.7)</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>15.2 (60.6)</td>
<td>39.4 (15.2)</td>
<td>15.2 (9.1)</td>
<td>24.2 (9.1)</td>
<td>6.1 (6.1)</td>
</tr>
<tr>
<td>Nurses</td>
<td>25.5 (70.7)</td>
<td>33.8 (14.6)</td>
<td>25.5 (8.3)</td>
<td>12.7 (2.5)</td>
<td>2.5 (3.8)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>100.0 (96.7)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>100.0 (100.0)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(1 Synagogue)
Table 52: Questions 53/54 - Denominations.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Regularly %</th>
<th>Occasionally %</th>
<th>Special %</th>
<th>Never %</th>
<th>No Ans. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Denom.</td>
<td>19.7 (65.2)</td>
<td>37.9 (18.2)</td>
<td>22.7 (3.0)</td>
<td>9.1 (1.5)</td>
<td>10.6 (12.1)</td>
</tr>
<tr>
<td>Catholic</td>
<td>23.9 (65.1)</td>
<td>40.4 (24.8)</td>
<td>25.7 (6.4)</td>
<td>9.2 (1.8)</td>
<td>0.9 (1.8)</td>
</tr>
<tr>
<td>Anglican</td>
<td>41.4 (80.2)</td>
<td>37.8 (11.7)</td>
<td>9.9 (1.8)</td>
<td>6.3 (2.4)</td>
<td>4.5 (6.3)</td>
</tr>
<tr>
<td>Uniting</td>
<td>33.3 (76.2)</td>
<td>38.1 (14.3)</td>
<td>21.4 (4.8)</td>
<td>4.8 (2.4)</td>
<td>2.4 (2.4)</td>
</tr>
<tr>
<td>Other</td>
<td>42.3 (76.9)</td>
<td>38.5 (11.5)</td>
<td>11.5 (7.7)</td>
<td>7.7 (-)</td>
<td>- (3.8)</td>
</tr>
</tbody>
</table>

The percentage ratio between the individual groups of ‘regular’ present and former church attenders is fairly consistent, indicating that participants’ action across the board has changed. With regard to denominations, similar percentage differences occur between the present and past. However, the individual denominational figures were surprising, with 19.7% of the ‘no denomination’ participants stating that they attend church ‘regularly’ and 37.9% ‘occasionally’. Only 9.1% never attend church, which was less than the Catholic percentage of 9.2%, the highest percentage of any denomination. The Anglican participation in ‘regular’ church attendance was higher than the Uniting and Catholic participation, with the Catholics recording only 23.9%.

In the past, 32.6% of the patients, doctors and nurses who specified ‘no religion’, attended church ‘regularly’ and 23.9% ‘occasionally’, whilst now none of them attend ‘regularly’, but 10.6% do attend ‘occasionally’ and 36.2% on ‘special occasions’. The individual hospitals did not appear to be a relevant factor in these questions. Neither did gender, once the ratios of males and females in each group are taken into account, i.e. there were only 14 male nurses compared to 142 female nurses and 68 combined male doctors to 21 females. Comparing the junior doctors’ church attendance figures with other participants, it also does not appear that age was an issue other than that the death of older church attenders may contribute to a future decline if young attenders are not encouraged to replace them. Responses given to Question 8 (would you welcome a routine visit by a chaplain) indicate that participants who were not church-going nevertheless had clear interests in the presence of a chaplain.
k. Chaplaincy Visits

A total of 375 participants answered Question 55 (If you have ever been a hospital patient were you visited by a chaplain?). Of the total 375 participants who responded to this question, 162 stated that they had been visited by a chaplain and 213 stated that they had not. Whether this was from choice or whether a chaplain was not available is, of course, unknown. The group to which these participants belong is irrelevant, as they were all patients at the time of visitation or otherwise. The surveyed hospitals are also irrelevant, as these may not have been the ones at which the participants did or did not receive such a visit. It does appear, however, that again many patients are not being offered a chaplain’s ministry during their hospitalisation.

This question was reworded for patients only, who were asked if they had received a chaplaincy visit during their present hospitalisation. Of the 158 patients who returned their surveys, 92 had been visited, 57 had not and nine gave no answer. Results by hospital for this question were:

- Royal North Shore: 'Yes' 58.3%, 'No' 39.3%, 'No ans.' 2.4%
- Mount Druitt: 'Yes' 48.8%, 'No' 41.4%, 'No ans.' 9.8%
- Greenwich: 'Yes' 68.3%, 'No' 21.9%, 'No ans.' 9.8%

Although just under half of the RNSH and MDH patients had not been visited, many factors could have contributed to this: some patients may have only been in the hospital a short while when asked to complete the survey; others may have been receiving treatment, having tests or have been in the operating theatre during the chaplain’s rounds; or, of course, the patient may have stated that they did not want to receive a visit. The length of stay of Greenwich Hospital patients is often quite extensive and, because of this, it may be that their chaplain had been able to visit a larger number of patients over a longer period. Whilst the Greenwich figures appear to be considerably more favourable than the other two hospitals, it must be remembered that Greenwich is largely a rehabilitation and palliative care hospital, with patients often remaining for longer periods than at Royal North Shore and Mount Druitt. This allows more time for the Greenwich chaplains to visit a greater number of patients. From these figures, it would appear that not enough chaplains are available to visit a large proportion of patients at the two larger hospitals.

Responses to the majority of the survey questions were not significantly affected by participants having been visited by a chaplain or not. However, a few warrant some comment, as follows:
Question 3: Would you expect the chaplain to be a minister, lay or either? Patients who had not been visited stated 65.8% ‘minister’; 7.9% ‘lay’; 26.3% ‘either’; whilst those who had received a visit stated 45.5% ‘minister’; 4.0% ‘lay’ and 50.5% ‘either’. This may indicate that chaplains other than ministers of the church had, in fact, visited a number of patients, who would then have gained the awareness that chaplains may be either a minister of the church or a lay person. The visited patients who stated ‘minister’ had possibly never been visited by a ‘lay’ chaplain. Those who had not been visited were apparently less sure about who or what a chaplain is or does.

Question 8: Would you welcome a routine visit? It is relevant to note that 88.5% of patients who had been visited stipulated that they would welcome such a visit, which can reasonably be interpreted as a positive response in that they had, in fact, welcomed the chaplaincy visit they had already received. The patients who had not been visited also recorded a high 78.4% ‘yes’ reply. This projects a very positive acceptance of chaplains by the patients.

Question 9: Would you specifically request to see a chaplain during hospitalization. Whilst 83.3% of ‘not visited’ patients and 57.7% ‘visited’ patients stated ‘no’ to this question, a much higher percentage of ‘visited’ patients (42.3%) stated ‘yes’ than the ‘not visited’ ones (16.7%). Again this indicates a more positive acceptance of chaplaincy by patients who had been ‘visited’ than those who had not.

Question 34: Answer questions pertaining to patients’ medical condition? With this question, not as many ‘visited’ patients as ‘not visited’ participants expected that the chaplain would answer such questions.

<table>
<thead>
<tr>
<th></th>
<th>Not Visited</th>
<th>Visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42.9%</td>
<td>30.3%</td>
</tr>
<tr>
<td>No</td>
<td>57.1%</td>
<td>69.7%</td>
</tr>
</tbody>
</table>

These figures show, however, that quite a high percentage of patients do expect the chaplain to answer medical questions. This places an expectation upon the chaplain to fulfil a task for which he or she is probably not qualified.

Question 40: Conduct lectures for medical staff on pastoral concern subjects? This question, surprisingly, showed the highest question percentage difference between ‘not visited’ and ‘visited’ patients.
<table>
<thead>
<tr>
<th></th>
<th>Not Visited</th>
<th>Visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26.1%</td>
<td>62.0%</td>
</tr>
<tr>
<td>No</td>
<td>73.9%</td>
<td>38.0%</td>
</tr>
</tbody>
</table>

No definite reason can be offered as to why the ‘visited’ patients answered in this way. An hypothesis may be offered that, through their association with chaplains, these ‘visited’ patients realised that chaplains would be competent and knowledgeable enough to conduct lectures for the medical staff and that such lectures would be beneficial to the staff.

Question 50: Do you consider the chaplains’ role to be advantageous for a patient’s well-being during hospitalization? The overwhelming affirmative responses from all patients, (99.0% of those ‘visited’ and 87.5% of those ‘not visited’) leaves no doubt whatsoever that patients in this survey do consider the chaplains to be advantageous to their own and/or other patients’ well-being. This is irrespective of religious affiliation, church-going practices or stated denomination.

At the conclusion of this survey, it was clear that the expectations of the role of chaplains is highly ambiguous. It is important, therefore, to conduct research of the actual tasks which are being performed by chaplains, as opposed to what is expected of the role, in an endeavour to ascertain the extent to which the actual and expected interact. To this end, further research into chaplaincy procedures was conducted at three Liver Transplant Units in three separate hospitals, the results of which are recorded in Chapter 5 of this thesis.
CHAPTER 4


I do not want to use paper and ink, instead I hope to visit you and talk with you face to face.
2 John 12.

INTRODUCTION

As noted in the Methodology Chapter 2, a number of high ranking clerics and administrators from eight major religious denominations were also surveyed for the purpose of assessing whether, in their view, hospital chaplains are ministering in the manner expected by their own religious bodies. The hierarchy, as they will be referred to, were asked to complete the same written survey as the hospital patients, doctors, nurses and chaplains, after which they all subsequently consented to discuss their views verbally. The identities and denominations of the relevant hierarchy are listed in Appendix V.

1. GENERAL SURVEY OF RESULTS

a. The Question of the Standards of Chaplaincy in Hospitals

The interviews with the Church hierarchy were conducted over a two week period, with each participant being asked initially to comment on the suggestion that, in the past, chaplains were men who had left the ministry, become too old to be a pastor of a church, couldn't preach well or, for some other reason, were not suitable to be placed elsewhere. They were also asked to comment on the present day attitude of their particular denomination towards chaplaincy and on the participation of lay persons.

Of the fifty-five questions asked in the general questionnaire, the hierarchy answered twenty-four identically. The majority of the questions on which agreement was found fell within the ‘Comforter’ and ‘Witness’ categories. As a comforter, the chaplain is expected to ‘be there’ for patients, relatives and staff. This can be done by love and caring, by ‘listening’, by showing understanding and by comforting during times of grief. As a ‘Witness’ the chaplain is expected to be an advocate of God’s love and concern for all, through prayer, scripture readings and by promoting faith and
reconciliation with God when needed. There were also a number of questions from these categories and others that were answered differently by the various denominational representatives, as will become clear in what follows.

A significant result arising from these preliminary questions is the adamant assurance by participants that the present day standards of chaplaincy within their own denomination is exceedingly high. Phrases such as 'top people'; 'high degree of competency'; 'bit better than average'; 'specialised ministry'; 'skills and training' and 'highly committed' were used to press their point. Four of the largest denominations were not prepared to concede any negative aspects of their chaplaincy and denied that chaplaincy is, or ever was, 'a refuge for misfits' or that it was to be considered a 'Cinderella' ministry. One participant considered that bad assessments in this regard may have been made by people in the past.¹ Some participants spoke of changes for the better when chaplaincy became a specialised ministry, but claimed this to be created by a better understanding of patients' needs and specialised training methods, not because chaplaincy had formerly been an option for ministerial incompetency. This view was inclined to be held by the smaller denominations, particularly the youngest participant.

The only criticism of present day chaplaincy networks which could be drawn from the hierarchy, was from the sole female SA participant. Her concern is not over the standard of hospital chaplaincy by any other denomination, for which she expressed an extremely high respect; her worry concerned the small percentage of available chaplains in proportion to the total number of hospitals and patients in Australia. This aspect will be discussed further in the following account of participants' views, together with the fact that, to varying degrees, there is a general acceptance by all denominations and religions of lay involvement in chaplaincy. From this account, there is no doubt that the majority of the hierarchy participants consider hospital chaplaincy to be an extremely high profile form of ministry. The research of Chapter 3 was intended to reveal whether or not this view is shared by patients, medical staff and chaplains themselves.

The response by the Anglican Church of Australia participant (hereafter abbreviated to Anglican) view was that chaplaincy in Australia has never been a refuge for misfits. It is regarded as a vital, strategic ministry which needs top people and, when a retired or former parish clergyman is granted a chaplaincy position, it is because he has a proven record of high standard pastoral ministry.

¹ Early chaplaincy status is referred to by Mitchell, Kenneth R., in Hospital Chaplain, Westminster Press, Philadelphia, 1972, p.15
A similar view was held by The Catholic Church (Catholic) participant, with particular emphasis on the age of chaplains. He considered that chaplaincy requires a fair degree of health and energy. In addition to full time chaplains, there are certain expectations from local parish priests, but they are not retired into hospital chaplaincy, nor are they placed in hospitals because they have experienced problems in ministry. Some retired priests do visit nursing homes, but hospitals are the domain of younger clergy (usually up to their early fifties) and never a retirement option.

Both the Uniting Church in Australia (Uniting) and The Seventh-Day Adventist (SDA) participants concurred with the Anglican and Catholic assessments, with Uniting stating that the general feeling in the Uniting Church is that hospital chaplains need to be a bit better than average. Their chaplains are appointed for five years, then reviewed; if anyone is not performing to the high standard expected or not considered suitable to the position for any reason, they can be, and indeed are, replaced. It should be pointed out that it is also the practice in other denominations to assess regularly their chaplains' suitability, although this was not specifically discussed during the interviews.

The SDA participant was adamant that chaplaincy is considered a very special ministry in the Church and is certainly not an option for ministerial incompetence. He did not consider that there is conclusive evidence that chaplains were misfits in the past and thinks this may be a bad assessment by a few church historians. This participant added that considerable emphasis is placed on specialised appointments such as chaplaincy in overseas countries, particularly in South America, where much work is being done by the SDAs.

A different view of the past was expressed by The Presbyterian Church in New South Wales (Presbyterian) participant. Whilst not classifying chaplains in the 'misfit' category, it was felt that this type of chaplaincy is now changing. It is becoming a more specialised ministry in the Church and as such requires specialised skills. Although chaplains were well trained theologically in the past, the Presbyterian participant felt that people skills were not included in their training. The focus was on spreading the Gospel, but this alone did not always meet a patient's needs. This situation has been remedied and Presbyterian chaplains today are extensively trained in all aspects of chaplaincy under the jurisdiction of the Presbyterian Social Services Executive Committee.

The Baptist Church of New South Wales (Baptist) participant also felt that there had been advancement in Baptist chaplaincy, similar to that of Presbyterian chaplaincy. He expressed the view that today's Baptist chaplains are not only highly committed, vocational people with very strongly demonstrated gifts discernible from their work, but they are also fundamentally trained. All are expected to take part in
training courses such as the Clinical Pastoral Education Courses (CPE) conducted regularly at a number of major hospitals. This had not always been the case, however, and the Baptist participant considered that a healthy change was made when specialised ministry was added to the Ordination of Ministry of the Word. He believed pastoral work is more than simple ministry and that the growth of specialised ministries certainly lifts chaplaincy out of the ‘realm of misfits’.

The situation with the Jewish Orthodox Church (Jewish) chaplains is rather different from other religions and denominations. They have no full-time chaplains and professionally differ quite considerably from Christian denominations, most of which place high importance on the difference in status between the ordained and the laity. The Rabbis, who are selected by the congregation, have always had to combine teaching and their Synagogue duties with their chaplaincy work, which is backed up by lay helpers. The participant explained that Jewish hospital visiting is different from that of other denominations, in that it is mainly intended to provide companionship and comfort when necessary. The lay helpers visit on behalf of the Rabbi of their local synagogue, usually alternating with the Rabbi. These lay visitors are carefully selected and possess considerable expertise. Formal chaplaincy training is not considered to be a necessary requisite and the visitors do not adopt any particular title. The participant had found that unauthorised visitors have created problems for Jewish patients from time to time and he has distributed a letter of identification to appointed lay helpers. The interviewed Rabbi did not think that the Jewish faith ever used chaplaincy as ‘an outlet for misfits’. His reasoning was logical: the Anglicans and the Catholics could have afforded to do that years ago had they so wished, but the Jewish faith has never had the luxury of so many Rabbis.

b. The Question of the Use of Christian Laity in Hospital Chaplaincy

In order to understand the importance of questions regarding the status of lay ministry in the hospitals, it is necessary to keep in mind the division of clergy and laity within the Christian Church, discussed in the Introduction. The use of lay helpers was discussed with the Christian hierarchy and all confirmed that they utilise their services to varying degrees. The Anglican participant stated that although historically chaplains were theologially trained clergy or deaconesses who possessed certain gifts, he had no problem with lay chaplains of a similar level of training and gifts. Such chaplains must be recognised and authorised by the Anglican Diocese concerned. These lay chaplains are usually referred to as assistant chaplains or pastoral assistants, depending on the custom of the relevant hospital or nursing home. The Anglican Church does not permit the laity to preside over the consecration of the bread and wine, nor to offer officially a reserved sacrament. Confirmation as to whether or not such practices
occur unofficially is not available to this researcher. With regard to the Catholic situation, members of religious orders such as the Christian Brothers and Sisters of Mercy are still regarded as lay persons and cannot consecrate the bread and wine for the Sacrament of Holy Communion. As many hospital chaplains come from these Orders, an ordained priest must also be available to perform the sacramental ministry to the sick and reconciliation anointing. Lay persons in the Catholic Church are, however, permitted to give the reserved sacrament which has been consecrated by a priest. The Catholic participant cannot foresee this situation changing, since the rules governing the administration of the Blessed Eucharist are very strict in the Catholic Church. The same situation applies to other suitably trained lay chaplains: Many become Lay Ministers of the Eucharist, but they come under the same restrictions as the religious orders.

The Uniting Church appoints lay chaplains and supervisors for their suitability to the position, believing that this is the important factor, not whether the person has been ordained. It is admissible for an authorised lay chaplain to preside during a service to bless the bread and wine before Holy Communion, provided that this chaplain has attended a special training course in this regard. The network of the SDAs is made up of ordained pastors/chaplains, Elders (who are elected senior officials in their local church), and hospital visitors. Local parish pastors are fairly active and usually combine their parish duties with a certain amount of chaplaincy work. The Baptist Church is active with ordained ministers and lay visitors with training and special gifts, as also is the Presbyterian Church which utilises ordained chaplains, trained lay pastoral care workers and hospital visitors. The Baptist Church does not consecrate bread and wine, but offers its followers bread and fermented grape juice as a symbol, accompanied by appropriate prayers. Trained lay Baptist chaplains are authorised to offer these when requested, mainly for long term or dying patients, and sometimes for psychiatric and young patients.

Like the Jewish Orthodox, the Salvation Army has no full-time chaplains and the part-time ones are mostly women. This is because the wives of full-time, paid male officers often perform voluntary duties such as chaplaincy. Others, like the SA participant herself, combine chaplaincy work with their additional duties. This does not mean that they are not adequately trained. Some attend the Catholic Training School and also become involved in the CPE courses. The SA participant is of the opinion that there was, and still is, an adverse attitude towards chaplaincy in some denominations, classifying it as the ‘Cinderella’ ministry within those denominations. Her statement was backed by a letter from one of the retired male officers who is now doing voluntary work in hospitals and nursing homes in Queensland. This former
officer performed many duties as an officer but chaplaincy had never been included. His letter expressed great concern for what was, in his opinion, the ‘Cinderella’ status of the profession, as for shortage of chaplains generally.

This researcher agrees with the SA participant that, when the number of paid parish clergy and church administrators is compared to paid chaplains, this would indeed appear to place chaplaincy in the ‘Cinderella’ sphere. This cannot be substantiated by the Bureau of Statistics Census figures as chaplaincy is not a specified occupation. However, as an example, for the year 1996, the Sydney Anglican Year Book listed 444 clergy holding a clerical appointment in the Diocese and 229 holding a General Licence to officiate or with authority to officiate, including women deacons. Fifteen deaconesses were also licensed. Under the heading ‘Appointments not Parochial’ were six full-time male clergy hospital chaplains listed as being employed by the Home Mission Society (now Anglicare), in addition to the Director of Chaplains. Three women deacons and one deaconess in general hospitals were listed, with two hospital chaplaincy positions vacant at the time of printing. A male clergyman was also employed as a part-time hospital chaplain. Four chaplains were assigned to psychiatric hospitals, three to the Anglican Retirement Villages at Castle Hill, with one deaconess assigned to cover the ten Chesalon Nursing Homes as far apart as Malabah and Nowra. (This has now been increased to two.) Four other hospitals and nursing homes are listed as receiving chaplaincy services from local church rectors or clergy.\(^3\)

It would seem therefore that, when these Anglican chaplaincy figures are compared to the number of licensed clergy and authorised lay workers, chaplaincy can indeed be accorded ‘Cinderella’ status by the Church hierarchy. Whilst conceding that many clergy, particularly in rural towns, combine chaplaincy with their parish duties, the amount of time spent in hospitals may be unavoidably minimal. This conclusion may reasonably be drawn from the assessment that parish clergy have a great many other duties to perform which restrict the amount of time available for hospital visiting. In many rural towns clergy are required to service large areas and travel considerable distances, often being responsible for multiple church congregations and, with increasing rural health services, also be available to visit hospitals which are themselves often great distances apart. This becomes necessary if no suitably qualified hospital chaplains are available. Whilst both urban and rural parochial clergy have always been expected to visit their own parishioners when hospitalised, specialised chaplains should be appointed to all hospitals and nursing homes, allowing the parochial clergy to concentrate on other duties. This raises the question of whether or

---

not the role of parochial clergy appropriately or realistically includes hospital chaplaincy. The opinion of this writer is that a century ago it did, but with greater involvement by the clergy in community life, family problems, drug addiction, homelessness, youth clubs and other activities being expected today, the writer considers that hospital chaplaincy should not be included as a general routine part of the parochial clergy role. It is further conceded that some chaplains are employed directly by an individual hospital, some by their own local church, and some minister voluntarily, particularly retirees. However, it would seem that proportionately there are not sufficient officially recognised hospital chaplains. The reasons for this, whether they be financial, priority issues or role inadequacies, will be considered in Chapter 6, together with suggested ideas as to how the situation may be improved.

c. Expectations of the Role of Hospital Chaplains among the Hierarchy

After the preliminary discussion with each of the hierarchy participants, they were asked to comment on a number of questions in the written survey which were considered relevant to the assessment of their various denominational views on the chaplaincy role. The outcome of these questions showed that overall the various denominational hierarchy had little difficulty in answering the straight-forward questions as to the expected role of the chaplain but, when faced with the more controversial subjects such as ethical and staff issues, some participants were reluctant to commit themselves by giving straightforward answers. There were few unanimous answers to the ethical questions, indicating confusion amongst the hierarchy as a whole as to what issues should be classified as the chaplain’s role and what should be considered the medical staff or the social worker’s domain. The risk of overstepping boundaries and intruding into other disciplines was judged to be an important issue by all. The conclusion drawn from this is that a definite fear of overstepping certain boundaries exists within the hierarchy, and that this fear may stem from the lack of clarity as to the chaplain’s role and, in particular, where this role ends. As will be seen in Chapter 3, results from other groups surveyed also emphasised the need for specific role boundaries, thus eliminating confusion as to expectations of the role of chaplains.

Questions referring to the chaplain’s role as one of a ‘comforter’ and ‘witness of God’s love’ were unanimously considered the most relevant and important. All the hierarchy participants were in agreement that the chaplain’s role was first and foremost to ‘be there’ for the patients, relatives and, if necessary the staff in all ways, physically, spiritually and emotionally. This is substantiated by the following replies given to the the question - ‘What do you think is the most important task of a chaplain?’
Anglican: ‘To care for patients pastorally, representing Christ to them by their compassionate care, presence, willingness to listen and to empathise’.

Catholic: ‘It is important to be available in the hospital as a pleasant and believing person’.

United: ‘Pastoral care’.

Salvation Army: ‘Being Christ to the patient, relatives, friends and staff’.

Presbyterian: ‘To present in a loving way the claims of the Gospel of Jesus Christ and bring peace to the patients’.

Seventh-Day Adventist: ‘Be the patient’s spiritual resource, i.e. his/her pastor’.

Baptist: ‘To be supportive of the patient and family where applicable, to relate Christian faith from a non-threatening stance, to cooperate with hospital staff in the healing process’.

Jewish: ‘To support the patient’s morale and person-ness without necessarily imposing religious doctrines or practices’.

Privacy and confidentiality were stressed and the necessity of patients’ approval before any chaplaincy procedure is commenced were repeatedly emphasised. There were, however, some differences amongst them in ideas as to the chaplain’s role when visiting patients. At one end of the spectrum is the belief that the chaplain should support the patient’s morale and personhood without necessarily imposing religious doctrines, whilst at the other is the belief that the chaplain should make praying and scripture reading the goal during every visit. All the hierarchy did agree, however, that the patient’s wishes are paramount and that all approaches by chaplains should be non-threatening.

The interviewed denominational representatives were one in their overall concern for patient welfare, all considering it acceptable for a chaplain from another denomination to visit a patient of their faith in an emergency, providing such chaplain made it known to the patient that he/she was of another faith and also providing the patient approved. It was generally felt that a chaplain could not, in actual fact, represent another faith, but could minister to a patient of a different faith as a member
of his/her own. This indicates that the hierarchy are, when necessary, prepared to adopt some form of ecumenical thinking where the sick are concerned.

Whilst the 'comforter' and 'witness' duties were seen to be the most important aspects of the chaplain's role, to a lesser extent the hierarchy saw chaplains as 'resource' persons, being an integral part of the whole hospital system, and as 'liturgists', with the obvious exception of the Jewish representative. With regard to the 'liturgist' questions pertaining to Holy Communion, Services of Worship and Baptism in hospitals, the hierarchy agreed that all these may be desirable under certain circumstances but, as shown in Chapter 3, 'liturgist' duties are not rated very highly in the scale of importance either by the hierarchy or other participating groups. They are certainly considered to be part of the chaplain's role, but are not rated as highly as could be expected given the prominence afforded to them by some denominations. It must be wondered whether this line of thinking by the hierarchy, rating the 'comforter' and 'witness' duties so highly on the importance scale, does not again reflect a 'Cinderella' ministry, as far as the clergy are concerned. Whilst conceding the extreme importance and definite need for 'comfort' and 'witness' orientated chaplains, it is pointed out that such chaplains could just as easily be trained lay persons as ordained clergy.

In general, the Jewish view differed most commonly from the other interviewed participants, with the Seventh-Day Adventist and Presbyterian closely following. Of the dissenting answers, the Jewish and Seventh-Day Adventist participants were the most in tune with each other, whilst the Catholic and Baptist joint views were just behind. There were no significant differences between the Catholic Bishop's and the replacement participant's questionnaires, but the original Presbyterian participant and his assistant did not agree on the question of whether chaplains should have access to medical records, nor on the question of chaplains consulting with medical staff on ethical issues. There was significant age difference between these two gentlemen, however, which may account for the affirmative replies of the younger participant and his tendency towards involvement. In many cases the older hierarchy appeared apprehensive or sceptical towards ideas of extending the chaplain's role too far beyond their present expectancy. This may be attributable to a fear of change or because attempts at radical changes in the Church often meet with opposition. The other interpretation is, of course, that the hierarchy do not consider any improvements or changes need to be made to the present role of the chaplain. When the Austin Hospital's Liver Transplant Unit is discussed in Chapter 5 it will be

4 Refer Appendix V.
5 Refer Appendix V.
shown that a more extensive form of chaplaincy involvement than is usual or expected is proving to be highly successful.

The following comments ascertained from the hierarchy participants’ interview replies will substantiate the above conclusions.

2. RESPONSES TO SPECIFIC QUESTIONS

The Seventh-Day Adventist and Jewish representatives considered that chaplains could be trained or not trained, whilst all other participants expected them to be trained. The SDA considered that a person’s aptitude for a particular task may sometimes override the need for specific training, whilst the Rabbi stated that a person may have an ability for the job without holding any professional certificate. These participants answered the question as it directly affected their own form of chaplaincy, with ‘trained’ being interpreted as formal training. Some formal training is required in some denominations, others are less stringent. Most denominations, however, require some form of training depending on the level of chaplaincy involvement.

Asked if all chaplains were expected to be of the Christian faith, the SA, Uniting, Presbyterian and SDA, participants initially replied in the affirmative. When asked to comment on their assumption that there are no Jewish chaplains or Muslim equivalents, most then agreed that they probably exist, but in small numbers. The Anglican gave a clear explanation as to why he answered ‘no’ to this question. Whilst stressing that his answer is not meant to imply that it does not matter whether a chaplain is Christian or not, he thinks that in our multicultural society it cannot be expected that only Christians will provide chaplains. Again, when asked if a chaplain should be expected to represent all faiths regardless of whether the patient is Christian or non-Christian, the SDA, together with the SA, disagreed with the other participants by answering ‘yes’. However, they enlarged on this during their interviews by adding ‘only if there was no-one available from their own faith and only if the patient agreed’.

The participants who answered ‘no’ on the questionnaire did not stick rigidly to this response during their interviews. The Uniting participant stated on his questionnaire that arrangements should be made for a visitor from the faith of the patient to be called. However, verbally he added that if this cannot be arranged the patient’s needs are all that matters and he would have no objection to a chaplain from another faith ministering to a Uniting Church patient under these circumstances if the patient so desired.
The Anglican was concerned over the word ‘represent’. However, he had no objection to Anglican chaplains visiting patients irrespective of religion, providing the patients were aware that the chaplain was a Christian and could only minister to them as such. He would not expect an Anglican chaplain to actually represent another faith and, like the Uniting participant, he says that if possible a representative of the patient's own faith should be provided. The Catholic participant agreed that an Anglican could, for instance, visit a Catholic patient as an Anglican, but could not perform any eucharistic ministry specifically observed by the Catholic Church. He did not mention non-Christians at all. Both the Presbyterian and Baptist participants held similar views, with the Baptist stating that non-Christians can be visited under certain circumstances, basically as a Christian representative, but not to press the Baptist faith.

Although the Jewish participant would not expect a Christian chaplain to represent the Jewish faith, he had distributed a set of prayers suitable for use by non-Jewish chaplains in the case of an emergency with a Jewish patient. The patient must be made fully aware that the reader is not Jewish and that no Rabbi or his representative is available.

The hierarchy were then asked why they had answered the question - ‘Do you expect a chaplain will routinely visit all patients?’ - in a particular way on the questionnaire. This was because four answered ‘yes’ and the other four ‘no’. There were no significant reasons for the replies, simply personal opinions. The Anglican would like all patients visited, but acknowledges that this is unrealistic and that visiting all patients does not necessarily equate with effective chaplaincy. The Catholic added that if a chaplain were visiting a certain person in a ward and another patient looks as if they would like a visit, then the chaplain should be polite and speak to him/her, but certainly not try to cover every patient.

When asked if they would welcome such a visit from a chaplain if they themselves were hospitalised, all the participants expressed that they would. The Rabbi, however, indicated that he would only welcome a visit as long as it was not theologically orientated. This was in line with his view that a chaplain's visit basically should be one of friendship.

a. ‘Comforter’ and ‘Witness’ Questions

There is no doubt that the hierarchy of all denominations consider that the chaplain's role is mainly a ‘comforter’ role, with the ‘witness’ role a close second. All questions pertaining to these aspects received almost maximum results in the survey and little more was said during the interviews. The question of whether the chaplain should push a religious approach attracted a ‘no’ response from all denominations with
the exception of one participant, the Uniting Church, who considers that chaplains should be seen as ministers and not as someone to simply discuss football or the time of day. When completing the questionnaire, the Anglican did comment that he assumed that the word ‘push’ was being used in a bad sense, to connote ‘pushy’ or ‘manipulative’, and added that he expected an Anglican chaplain’s faith to control his/her approach at all times.

The group of questions relating to prayer and scripture reading were basically agreed to by all participants providing the patient’s wishes were adhered to. However, the Presbyterian and SDA representatives both responded ‘yes’ for the question relating to praying or reading scriptures during every visit, whilst the others responded in the negative. The Presbyterian view was qualified during the interview by adding ‘if appropriate’ - whilst the SDA view was that an endeavour to pray should always be made and should ideally be the goal.

b. ‘Counsellor’ Questions

The hierarchy produced a number of different ideas regarding the question of whether the chaplain should help patients to examine their lifestyles, such as smoking, drinking or worrying, in an endeavour to improve their health. The Catholic, Baptist, SDA and Jewish participants all answered affirmatively on the questionnaire, whilst the remainder disagreed. Interview comments by those expecting that the chaplain’s role would involve helping in this way, include one from the SDA who felt that although the chaplain may be treading on someone else’s discipline, he/she would be obliged to try to help, providing they had an awareness of the problem.

As the overall statistics of the completed survey show that a large percentage of the female nurses and chaplains answered this question negatively, the hierarchy were asked if they had any theories as to the reason for this. The Jewish and Catholic said they had no idea, whilst the Baptist thought that the females may be a little more sensitive to the thought of a chaplain overstepping his/her boundaries. He further wondered whether females were maybe more sensitive concerning smoking than men. These are only suggestions as to reasons for the predominantly negative answers by females, and this aspect was researched further in an endeavour to ascertain a reasonable explanation. (Refer Chapter 3).

The SA answered ‘no’ to the question concerning the chaplain’s role in helping the patient to improve his/her lifestyle, because she considers the chaplain would not see the patient often enough and help of this kind would probably need to be on-going. The Uniting participant said ‘no’ because he said, it is not the chaplain’s business. This was also the Presbyterian view, with their participant considering that, in general, the chaplain is not in a position to help with health matters, it not really
being their work, and that there is always a danger of treading on the toes of others in the hospital. The Anglican representative also marked ‘no’ on the questionnaire, but qualified this by saying that he thought chaplains may deal with these issues, but that he saw them as an extension of their role rather than an essential part of it. In other words, it should only be a secondary, not a primary, area of the chaplain's role. (This question was further discussed in Chapter 3.)

All the hierarchy expected chaplains to help staff with personal problems, but were divided in their views regarding work problems. The staff themselves favoured a ‘no’ response where work was concerned, with the female nurses voting 81 to 43 against, despite a majority ‘yes’ response for personal problems. When interviewed, the Presbyterian participant felt the staff response may be due to lack of the conception of team work, he also felt that there could be a danger of chaplains intruding into another discipline. The SA participant considered the personal aspect would be more frequent, but believed that the chaplain has a role to play in work related stress, particularly for staff involved in general trauma and accident situations. Whilst indicating a ‘yes’ response, the Anglican considered personal and work problems are connected, so that the chaplain cannot avoid touching on these areas. However, he did not think it is strictly part of the chaplain’s role to help hospital staff with work problems. The SDA on the other hand, stated that at least three chaplains are available in the Sydney Adventist Hospital at Wahroonga to minister to the nursing staff.

c. ‘Resource’ Questions

A number of the hierarchy were not sure how they felt about the chaplain reporting patient’s complaints concerning hospital administration or staff to a relevant person and actually ticked ‘don’t know’ on their questionnaires.

The Catholic Bishop, who was not available to be interviewed but completed the written questions, expressed the clearest thoughts on the subject by a notation on his questionnaire. His opinion was that when a complaint has substance and to report it would be advantageous to the patient and likely to bear results, the complaint should be reported. The Bishop’s fellow Catholic participant, marked ‘don’t know’ on his questionnaire but, during his subsequent interview, he concurred with the Bishop’s comments.

Whilst the hierarchy indicated that they definitely expected chaplains to conduct lectures for medical staff on pastoral concern subjects, it appears little is actually being achieved in this respect. The SDA participant was the only one who actually knew of lectures which were being conducted at the time of the interviews.
As there are indications that medical staff also expect pastoral lectures to be part of the chaplain’s role, this subject was be discussed further in Chapter 3.

One ‘resource’ question on which the hierarchy were in agreement was that referring to the chaplain liaising with parish clergy concerning individual patients. They all answered this question affirmatively, with the Anglican representative stressing that the patient’s right to privacy and confidentiality must not be breached. The Presbyterian assistant expanded upon his response; he felt strongly that more extensive training for pastoral work should be included in all theological training courses before ordination is effected. He felt that, if a greater empathy towards pastoral ministry could be instilled into theological students, it would create closer liaison between parish clergy and chaplains and so give a better insight as to the chaplain’s role. If the Presbyterian assistant’s suggestions were implemented, this would surely increase chaplaincy status, if indeed the results of this research indicate such a need.

d. ‘Ethical’ Questions

Every hierarchy participant replied negatively to the question - ‘is it the chaplain’s role to answer patients’ questions pertaining to their medical condition?’ - They were all in agreement that this may be a very dangerous thing to do unless specifically requested by doctors and family. Conversely, however, quite a large percentage of patients indicated ‘yes’ for this question; possible reasons for this response was researched further in Chapter 3. The question of whether the chaplain’s role includes having access to patients’ medical records also warranted further general research in Chapter 3, as the overall results produced a definite split in opinions by the various groups surveyed. So far as the hierarchy were concerned, the Anglican was the only one to answer ‘yes’ on the questionnaire. However, although the original Presbyterian participant had answered ‘no’, his assistant agreed with the Anglican viewpoint. Both the Anglican and the Presbyterian assistant qualified their answers by adding that only officially appointed senior chaplains should have access to medical records, not assistant chaplains, and both stressed the privacy aspect. The Baptist also qualified his ‘no’ answer by saying this may be acceptable under special circumstances and in alliance with the doctors.

The question - ‘should the chaplain consult with medical staff on ethical issues?’ - was one where the younger and older Presbyterian hierarchy disagreed. The original Presbyterian participant did not consider this to be part of the chaplain’s role; his assistant however felt that, although ultimate decisions were the domain of the patient, doctors and hospital administration, the chaplain should be consulted. The Anglican considered it would be good if the medical staff consulted chaplains on
ethical issues, but felt it could be a rare occurrence. However, the SA advised that their Royal Prince Alfred Hospital chaplain is, in some cases, invited to attend staff meetings as part of the team, whilst the SDA spoke of annual Bio-Ethics Conferences held at the Sydney Adventist Hospital which are widely attended by medical staff, researchers and numerous religious body representatives Australia-wide. The 1996 Conference was attended by the author of this present research.

When it came to the question - ‘should the chaplain counsel patients on ethical issues?’ - the two Presbyterian hierarchy again disagreed. Whilst the original Presbyterian registered a ‘no’ response to the other participant’s ‘yes’, his assistant considered his reply to the previous question applied equally to this one. All groups surveyed said ‘yes’ in varying degrees, but the extreme closeness between the ‘yes’ and ‘no’ or ‘don’t know’ categories was evident amongst the female patients, nurses and chaplains. The hierarchy were asked for their theories on this. The SDA thought that the females desire for privacy was stronger than the males or that female independence was being expressed. The Baptist’s theory was along the same lines, saying that he wondered whether the females were influenced by the spirit of the age of women’s movements. He also theorised that the female nurses, in particular, may see their work more as a profession and less of a calling and consequently consider ethical issues involving patients to be medical ones and not religious. The other participants had little to add to these comments. Further research into the question, together with the previous one, was discussed in Chapter 3.

e. ‘Liturgist’ Questions

The Christian hierarchy all agreed that Holy Communion, Services of Worship and Baptisms may be desirable in hospitals under certain circumstances. Baptism is an initiation rite which parents of hospitalised babies often treat in a rather superstitious fashion, fearing that, if their baby dies without being baptised, it will be prevented from entering into the Kingdom of Heaven. Others with a strong spiritual faith may feel more at peace knowing that their child has been baptised. Whilst the Anglican Church requires an ordained minister to preside over the Holy Communion preparation of consecrating the bread and wine, their lay chaplains are authorised to perform urgently requested baptisms of babies or adults. In fact, this may be done by any baptised person, trained or otherwise, in an emergency. It is suggested, however, that if the baptised person survives, a further form of baptismal blessing be ultimately performed by an ordained person.

The Jewish representative reiterated the difference in their hospital ministry to others. No formal service would be rendered, the patient would say his/her own prayers or the Rabbi would pray with them, but it is always very flexible. There is no
baptism in the Jewish faith but, at the age of 13 years, when a boy is considered to have reached manhood and ready to assume duties and responsibilities, an initiatory rite of passage called a Bar Mitzvah is celebrated. On the Sabbath closest to a boy’s 13th birthday it is customary for him to read sections of the Torah and to deliver an address in the Synagogue, after which he usually receives gifts and attends a celebratory feast. Rather than being an acceptance into the Jewish faith, as Baptism is into the Christian Church, it is an acknowledgement of the boy’s coming of age in both his faith and life generally. Although there is no rule to prevent it, it is very unlikely that a Bar Mitzvah would be celebrated in a hospital except under extreme circumstances.

f. Suggestions for Additional Chaplaincy Tasks

Finally, each of the hierarchy was invited to discuss any other task that they thought a chaplain should perform as part of their role. Only four participants offered any suggestions, as follows:-

Anglican: ‘To act in ways which help a person to move towards Christ and to exercise faith in Him’.

Catholic: ‘The Bishop - Co-operation with fellow chaplains adds significantly to the effectiveness of all’.

Presbyterian: ‘A statement of duties should be formulated for each individual chaplain’.

Baptist: ‘Where possible help churches and groups to understand the process of hospitalisation and its consequences’; when asked how he would try to achieve this the participant replied that he is often invited to speak at services and in groups where he describes the chaplain’s work. He speaks of the significance of a person’s time in hospital and openness to spiritual things during that traumatic time.

As the results of this survey show, the hierarchy are confused on many aspects of chaplaincy, particularly concerning ethical issues, and their expectations frequently do not correspond with the expectations of other participants in the survey. The hierarchy were divided in their views regarding routine visits to all patients (Question 7), with 44.4% saying ‘yes’ and 55.6% saying ‘no’. In response to
Question 35 (Would you expect the chaplain to have access to patients’ medical records) only 11.1% of the hierarchy said ‘yes’, with 77.8% saying ‘no’ and 11.1% ‘don’t know’. In contrast, the chaplains themselves recorded 58.3% ‘yes’; 36.7% ‘no’ and 2.2% ‘don’t know’ for this question. When asked their opinion as to the chaplain’s most important tasks (Question 51), the hierarchy placed ‘witness’ (77.8%) at the top of the list, more than 30% higher than did the chaplains and higher still than the patients or medical staff. Only 11.1% of the hierarchy considered the ‘comforter’ tasks to be the most important, whilst all other groups, with the exception of the junior doctors, stated ‘comforter’ as their first choice.

The questionnaire replies by the foregoing hierarchy were included in the overall statistical results in Chapter 3, to enable comparisons against answers supplied by patients, chaplains and medical staff.
CHAPTER 5

SURVEY OF THREE LIVER TRANSPLANT UNITS AS TO THE ACTUAL TASKS BEING PERFORMED BY CHAPLAINS IN AUSTRALIAN HOSPITALS - JULY 1994-JANUARY 1995

Complete the tasks required of you for each day
Exodus 5:13

INTRODUCTION

The object of this section of the thesis is to ascertain the actual tasks being performed by chaplains and to assess whether chaplains, when fully integrated into the hospital system, are a significant factor in the overall care and recovery of patients. This survey was deemed necessary by the researcher when a consistent chaplaincy role expectation could not be achieved from the first survey discussed in Chapter 3. As noted in the Methodology Chapter 2, research was conducted into the relationship between staff and chaplains in the Liver Transplant Units of The Austin Hospital in Victoria, The Royal Prince Alfred Hospital in New South Wales, and The Princess Alexandria Hospital in Queensland. A short written survey was distributed to participants which consisted of two main open-ended questions divided into subsections. (See Appendix XIII). This was to encourage participants to express their feelings without the limitation of closed-responses. Unstructured personal interviews were also conducted with participants by the researcher, to discuss questionnaire responses and encourage further relevant comments.

Of the 60 questionnaires distributed, 20 to each unit, 37 (61%) were returned. The highest return was from RPA (80%), followed by PAH (60%) and then The Austin (45%). The lower figure for The Austin was due to the smaller staff numbers in the Unit compared to the other LTUs and the delegated distributor’s inability to enlist more participants. The participants in the three LTUs consisted of: 20 nurses, including some who were generally trained, clinical nursing coordinators, theatre nurses and transplant coordinators; 14 doctors which included medical, surgical, anaesthetist, pathologist and heptologist participants; one occupational therapist; one physiotherapist and one LTU administration clerk. No completed surveys were received from social workers; it is unclear whether they were not approached by the delegated distributors or whether they declined to participate. However, the personal interview with a Royal Prince Alfred social worker is discussed later in this Chapter. The only personal information requested on the questionnaire was the name of the
hospital at which the participant worked and their occupation. Where necessary, the complete answers given anonymously by the participants to the open-ended questions are tabled in Appendix XIV, with general summaries and comments on each question recorded below.

The 'lengths of stay' of patients in the Liver Transplant Units were also surveyed, the results being calculated and compared to assess whether the extent of chaplaincy input in the Units may or may not have contributed to an earlier discharge of patients, thus constituting a cost saving to the hospitals. This was done over a lengthy five year period to counteract possible variables.

An attempt has also been made to assess whether chaplaincy input influences the amount of sick leave taken by staff members. The less staff sick leave taken, the less need for replacement staff arises, again constituting possible cost saving.

1. LIVER TRANSPLANT UNITS SURVEY.

The results of this survey indicate that the three LTUs involved utilised the services of their chaplains in different ways. This prompted varied responses from the staff as to the value and extent of chaplaincy involvement in their individual Unit. It is not the intention of the researcher to compare the performances of the chaplains concerned; it is assumed they are fulfilling their duties in the manner deemed suitable by the unit administration with whom they work. Rather, the intention is to compare the three systems which are being used and then attempt to ascertain whether any one particular system is more beneficial to the Unit and to the hospital as a whole. As noted above, the lengths of stay of patients in each unit over a five year period were also assessed, to determine whether the unit with the greatest chaplaincy input differs from the others in respect of these statistics. Whilst it may not be possible to show that the chaplain is solely responsible for a patient's earlier discharge, an attempt will be made to show to what extent, if any, the chaplain's input influences this aspect. Other variables may contribute towards the date on which a patient is discharged: for example, the number of transplantations carried out in the unit; whether or not a patient also requires treatment for a condition unrelated to the transplantation; the need to retain a patient in hospital until an organ becomes available and whether the patient was from interstate or overseas, in which case he/she may need to remain hospitalised until able to travel. However, it is assumed that, over the five year period of the survey, the effects of such variables would be similar in each of the three LTUs concerned. The faster patients can be discharged and replaced by others, the higher the rate of cost
saving to governments and hospitals. A detailed explanation of this is shown under item 4 of this Chapter.

The following survey questions are dealt with separately on a combined unit basis and the results emphasize the differences between the three units.

Question 1(a): What has created the most trauma/stress for you as a member of the LTU team? (See also Appendix XIV). The answers varied, with some participants commenting on the stress caused by a range of different things: both the donor and recipient dying; by patients on waiting lists not receiving a transplant in time through lack of a donor; by post-transplant deaths, particularly unexpected ones; by death of young patients; and by dealing with the families of LTU deaths, especially those where young families are concerned.

The responses can only be understood against the backdrop of organ transplant practises in this country. The elimination of many pre-transplant deaths, and consequently much of the resultant trauma/stress involved, could be achieved if the general public were made more aware of the life-saving benefits of organ donation. For varied reasons, religious, racial, fear of accelerated death and lack of knowledge, many people are reluctant to offer to become potential donors or to allow this transplant upon the death of a loved one. As medical science improves, more complicated transplantation will become available and the need for suitable organs will rise proportionately. Unfortunately, in addition to the lack of donated organs, a large number of those which are offered are unusable due to the presence of undetected disease or other unsuitability. It is not uncommon for a desperately ill patient to have to wait for two or three donated organs before one can be used. Whilst there are spasmodic pushes to promote organ donations, Australia has one of the lowest organ donation rate in the western world.¹ Although heart, liver, kidney and pancreas transplantation is well established in Australia, with tissue transplantation developing rapidly and the transplantation of corneas, heart valves and bone also well established and effective therapies, the full benefit of these skills to Australians is limited by the non-availability of organs and tissues.² In advocating education in favour of organ donation, this researcher considers that such education needs to be directed publicly to the ‘fit and well’ and not merely to those emotional relatives at the bedside of a dying patient. The following research regarding ethical issues concerning transplantation has been compiled from a National Health and Medical Research Council (NHMRC) paper

---

² Ibid., p.1. NHMRC.
prepared by the Australian Health Ethics Committee. When attempting to educate prospective donors and/or their families it must be kept in mind that Australia has a multicultural community. All members of the community need to feel assured that their views regarding any type of transplantation are respected culturally, ethically, spiritually and religiously. Some religions and cultures attach great significance to the treatment of someone’s body after their death. Organ and tissue donation may be considered as one of the final acts of the donor, one for which he or she wishes to be remembered in death as a memorial of their life. Organ donation involves an ethical decision because it is intended to benefit others whilst, at the same time, it will affect surviving relatives and friends.

One problem which arises when trying to educate people to consider organ donation earlier in their lives, is that many do not want to think or talk about death. However, there are many good reasons for considering it carefully. Firstly, if a person dies unexpectedly, relatives may be faced with the question of donation on someone’s behalf without knowing their wishes in this regard. Secondly, the prospective donor may like to be sure that his or her wishes are known and that they will be carried out. Family discussion is important and completion of donor cards and driver’s licence notations are also useful.

Prospective donors and relatives need to know what happens at the time of death to allay some of the fears and myths attached to organ donation. One great fear many people appear to have when considering organ donation, is that the donor might be pronounced dead and organs or tissue removed whilst they are, in fact, still ‘alive’. To allay such fears the statutory definition of death is Australia, with the exception of Western Australia which has not adopted such a statute, is that a person is dead when there is irreversible cessation of circulation of blood in the body of a person or when there is irreversible cessation of all functions of the brain of the person. The term ‘brain dead’ denotes irreversible loss of consciousness and irreversible loss of brainstem reflex responses and respiratory centre functions, or irreversible cessation of intracranial blood flow. Before clinical confirmation of a brain-death diagnosis can be established an appropriate period of observation must be afforded and examination by two medical practitioners must be made, independently of each other, before brain-death can be certified. Various blood tests are performed on donors for the benefit of the ultimate recipients of organs, for which no charge is made to the family. Before organs are removed from a deceased body, the family is usually allowed to stay with the body, although the logistics of donation sometimes limit this time. Ventilation is

---

continued until the body is taken to the operating theatre by the medical personnel. If
the family wish to spend further time with their relative’s body after the organs are
procured, this is allowed, indeed it is often an important part of the grieving process.
Transplantation does not affect funeral arrangements.

Prospective donors and relatives should be advised that sometimes organs
cannot be given to recipients for medical reasons and, providing consent has been
given, they may be used for research. In such cases this must be approved by an
Institutional Ethics’ Committee. On rare occasions when no suitable Australian or
New Zealand recipients are on the waiting list, organs may be offered to overseas
patients free of charge, however hospital charges are sometimes met by overseas
governments or humanitarian agencies.

It is suggested by the NHMRC that prospective organ donors and/or relatives
should be encouraged to consider the following questions:

How would I feel if I needed a transplanted organ?

How does organ donation fit with my religious, spiritual and moral
beliefs?

How would I feel if a friend or relative needed an organ?

What do my other family members think about organ donation?

Have I made my wishes about organ donations known to my family?

If I decide I want to donate organs how will this affect my family?

Am I satisfied that I understand the concept of ‘brain death’ as a way of
determining death?

Do I feel that I could trust the medical staff involved if I were ever in a
situation to be a potential organ donor?

How do I think of my body after death?

Are there some organs I would like to donate, and not others?

Will my family try to carry out my wishes?

Will counselling be available for my family if they need it?

Am I satisfied that respect will be shown to my body?

Are there other people I would like to consult?

Paper 2 prepared by the Australian Health Ethics Committee raises a further
aspect of transplantation education which needs to be discussed briefly. This is in
regard to donations during life from relatives, as sometimes occurs with kidney,
tissue, and bone marrow transplantation. Living donations can have added psychological consequences of which all concerned should be made aware. These include changes in relationship; feeling of ownership towards the recipient; guilt if donation fails; debt of gratitude felt by the recipient towards the donor where they may feel locked into a creditor-debtor relationship and feel never able to pay back the debt.4

If prospective transplant donors and their relatives can be educated early enough, statements like the following one from Tony Baker, a former Uniting Church chaplain at Westmead Hospital may be reduced. Baker notes that ‘chaplains are faced with the task of ministering to people who have to make very emotional decisions at the very point when they are most vulnerable and usually in no state to make any decision’.5 He was referring to a request by doctors that the organs of a certified ‘brain dead’ patient be used ‘in order to give somebody else the choice of a better life’.6

A South Australian nursing professor has criticised Australia’s organ donation program because of its neglect of the effects of these donations upon the donor’s family. Professor Alan Pearson from the Adelaide University states:

The main problem for donor families is they are quite invisible in the whole debate compared to the big science of doctors and how great it is for the recipients .... Because most organ donors are young and usually die as a result of traffic accidents, the onus is usually on parents to give consent ... But most people haven’t really thought about what it really means, Parents agree because they are told it is a good thing to do. They will feel better about the death because at least the donor didn’t die in vain - it’s a myth. In most cases, one year later the parents didn’t feel that giving the gift of life was any comfort.7

Professor Pearson argues that there is no moral wrong in performing transplants, but considers the fault lies in our inability to discuss the issue coherently. He goes on to say that:

this has generated a society ignorant of the whole scenario leaving the families involved feeling left out with no real support during or after the event. This feeling is further complicated by Australia’s confidentiality laws.8

---

6 Ibid., p.20.
7 Pearson, Alan, ‘Organ donor programs neglect family needs’, Australian Hospital, Feb/March, 1996, p.3
8 Ibid., p.3
This researcher agrees with Professor Pearson's further comments that we must be wary of adopting any type of program in which transplant coordinators work in hospitals and attempt, in any way to pressure bereaved families to consent to organ donation. The majority of relatives are greatly distressed at such times and may be coaxed into agreeing to donate the organ of a loved one; an action which they may later regret. Such pressure is exerted on bereaved families in Spain to the extent of offering to honour the donor by naming a school or similar building after them. As the Spanish have no confidentiality laws to restrict them, this type of thing can be done and their organ donation rate has doubled in recent years. In Australia a different situation exists, with strict privacy laws in place to protect the names of donors. The NHMRC sets out the following guidelines regarding privacy measures:

7.1 Confidentiality of information is essential. Transplantation often attracts media attention and it is essential that the anonymity of the donor and the recipient and their families is preserved.

7.2 Disclosure of identifying information about a donor and recipient by any medical practitioner or member of hospital staff or members of the transplant team is prohibited by respective State and Territory laws.

7.3 Any disclosure of information which could link the donor and recipient may result in a breach of these laws. Identifying information may include the date of death of the donor or the date a recipient has received a transplant.

7.4 Difficulties with confidentiality may arise in clinical units which care for both the donor and recipient, and in smaller regions. All staff must be aware of the need for confidentiality, and the importance of their individual sensitivity and vigilance in this regard. Media coverage must be handled with great care to avoid loss of anonymity in this situation.

7.5 In some situations, the next of kin wish to know when the organ or tissue is transplanted and some basic information about the recipients. Similarly, the recipient may wish to write an anonymous letter to the donor family. Such letters may be forwarded via the donor transplant coordinator or the person who sought consent for the donation. Thanks-giving Services provide a common venue for donor families and recipients, but caution may be necessary to avoid the risk of breaching confidentiality. A reminder should be given that legislation does not permit the release of identifying information, although disclosure may be possible with the consent of the person to whom the information relates, and for bona fide research purposes.

Attempts must be made, as mentioned previously, to encourage the community to understand and address this issue whilst they are 'fit and well'. Such measures would go a long way in alleviating much of the trauma and stress expressed by the

9 Ibid., p.3.
survey participants concerning donor deaths. Suggested chaplaincy involvement in this regard is discussed in the recommendations of Chapter 5.

Other participants considered that working conditions caused them the most trauma and stress: being woken in the middle of the night, then working for many hours; poor staff mix with enrolled nurses and new graduate nurses who are unable to participate fully in their share of patient care; understaffing; being on call plus having to do daily ward rounds seven days a week every week, causing fatigue. These are problems which need to be addressed by hospital authorities with a view to providing more staff for the LTUs. The financial situation of most hospitals is a contributing factor when allocating staff numbers, but these above comments indicate that cases of staff fatigue, trauma and stress are being created by poor working conditions. The comment by one participant that two-faced backstabbing of nursing co-workers causes the most trauma and stress, could have its roots in the working conditions of overworked, overtired staff.

The question of ethics was also a concern for some participants, who found it traumatic and stressful when a decision had to be made between two patients for one available organ. Some also found it difficult to accept organs being given to people whom they considered likely to engage in self-destructive behaviour post-transplant. Examples were given as alcoholism and driving abuse. Another participant found decision-making concerning clinical problems stressful when the ultimate outcome is unclear or where the outcome is known to be adverse, but unresolvable.

One statement by a participant which causes this researcher some concern is that trauma and stress are caused by having potential donors and recipients in the same unit. It is hoped that, if this is indeed occurring, Australia’s strict privacy rules are thoroughly adhered to and that the recipient and donor families are not aware of the situation. Although there have been some successful cases where the organ transplant recipient and the donor family have met and forged a meaningful relationship, this is an extremely complex, emotional area and ‘the jury is still out’ as to the merits or otherwise of such action.

Question 1(b): Have you discussed this problem with the Unit chaplain? All participants from PAH replied negatively to this question, their reasons being stated under 1(e). With one exception, RPA participants also answered ‘no’. The one exception qualified their answer by stating ‘only as part of a team’. This does indicate a general rather than specific involvement of the chaplain and staff in this LTU. The Austin Hospital, however, recorded 50% ‘yes’ and 50% ‘no’ replies, with one participant who had given two replies to question 1(a), stating they had discussed death with the chaplain, but not the subject of transplantation of alcoholics. The other
affirmative replies were all in reference to death problems, whilst another participant who replied negatively had also stipulated that giving transplants to potential post-transplant self-destructive patients was the most traumatic/stressful factor. The indication is that the staff at The Austin seek the chaplain's help for their spiritual guidance, but not with regard to their own personal views on ethical issues.

Question 1(c): Was the chaplain helpful? As no participants from PAH or RPA had spoken to the chaplain regarding their stress problems, this question was not applicable, with the exception of the previously mentioned RPA participant who had related to the chaplain as part of a team with others. All The Austin participants who had referred their stress problems to the chaplain stated that the chaplain had been helpful.

Question 1(d): Can you say how the chaplain helped you? This question again drew only one comment from RPA and none from PAH. The RPA participant stated that the chaplain helped as did others. The comment indicates that the chaplain's input in this instance was probably part of the weekly LTU meetings to which the chaplain was invited.

The Austin participants all gave similar answers as to how the chaplain had helped them. They spoke of debriefing sessions and ward staff and memorial services to help deal with grief and loss, stating that the chaplain is available to talk to staff members on an individual level, being a sounding board, someone non-medical to talk to. The chaplain had also helped one participant by detailing the family situation of a deceased patient to help the staff member relate to this family.

Question 1(e): If you did not discuss a traumatic/stressful situation with the chaplain, is this because:

i) One was not readily available?

Two participants at both PAH and RPA stated that no chaplain was available. The low percentage of negative replies would indicate isolated cases; however, comments recorded under 1(e) iii may refute this. The Austin participants all specified that their LTU chaplain was always readily available. Although these results appear to indicate that the staff in all three LTUs consider their chaplains would be available if required, further comments recorded in the survey, together with views expressed by personal interview participants, do not support this. Amongst such comments were: 'we do not have an allocated chaplain'; 'I have not met the chaplain, although I have been here for seven years'; 'I didn't know the chaplain was available for the staff'; 'I
do not think the chaplain would be available at two o’clock in the morning’; ‘I doubt if the chaplain would see the 3 a.m. workers’.

ii) *You do not feel he/she could have helped?* (See also Appendix XIV).

A number of reasons were given as to why participants did not think the chaplain could have helped with the identified trauma/stressful situations.

The PAH participants made comments such as:

- ‘I feel that they should not be party to details of medical information’
- ‘We have a good team spirit to debrief and an excellent social worker’
- ‘Staff counsellors are available’
- ‘Inappropriate - demands of the job’
- ‘Chaplain is more to help patients, not the staff’
- ‘I usually deal with these issues myself’

There were similar reasons given by RPA:

- ‘Inappropriate’
- ‘Discuss problems with friends and colleagues’
- ‘I don’t know my chaplain well enough’
- ‘Logistics problem, not spiritual/belief one’

With regard to The Austin, the only reason given was that other preferable support was available from family, peers and friends. One participant who preferred to engage other help went on to say that he/she was not religious and would have felt uncomfortable discussing stress problems with the chaplain. He/she did not feel it was the chaplain’s role to discuss such problems.

The most significant point to arise from these replies is that a proportion of LTUs staff accept much of the stress involved as a ‘normal’ part of their work and prefer to talk to family, friends and colleagues, or to cope with the problem alone, rather than to approach the chaplain. Some do not consider the chaplain sufficiently part of the Unit team to be privy to medical information and consider their role solely for the benefit of patients, not staff. In such cases the standards set by the various chaplaincy ruling bodies mentioned in the introduction to this thesis, are not being achieved.

iii. *Any other reasons?*

Participants from PAH made comments along the lines of ‘didn’t think of discussing problems with the chaplain’ or ‘it never occurred to me’, plus ‘we do not
have an allocated chaplain to the Unit’, with an Austin participant offering the oftenmentioned comment that they did not feel it was the chaplain’s role. These statements further endorse the findings of the first survey where the confusion and ambiguity concerning the chaplain’s role became evident. Comments made by a number of RPA participants, however, disturbed the researcher. One stated: ‘I have not met the chaplain (I’ve been here seven and a half years). I would have difficulty talking about stressful things with someone I’ve never seen before’. The second comment was worded ‘I have never met him/her. I only work two evening shifts 13.15 to 22.00 p.m.’. Although regarded as an evening shift, 13.15 p.m. is just after midday. A third participant did not know that the chaplain was available for the staff which is an entirely different matter from that of electing not to consult the chaplain.

A number of issues arise from these comments. As previously stated, the RPA Liver Transplant Unit chaplain is not employed specifically to minister to the Unit, but has to incorporate this Unit into his other duties. This does not, in fact, leave a great deal of time to specialise in the LTU. The fact that staff of long-standing have never seen a chaplain and others do not know of their availability to staff, indicates that some restructuring may be required so as to promote a clearer awareness amongst staff of the chaplain’s role and availability. Having made this statement, however, it must be added that any staff member who is really interested in meeting a chaplain and discovering the extent of his/her ministry, has the option of seeking him/her out in the Chaplain’s Department office.

Question 1(f): Do you consider discussing problems with the chaplain helps to reduce staff sick leave?

i. For yourself

Only one participant from each of the three LTUs answered ‘yes’ to this question, all others replying ‘no’ or ‘don’t know’. Some added comments alongside their replies, such as: ‘most staff don’t use the chaplain for this purpose’; ‘not appropriate to discuss my personal problems with the chaplain’; ‘I feel the chaplain is there for the patients’ pastoral needs’; ‘the chaplain does not have any input in nursing staff matters’. It thus appears probable that very few staff members had actually discussed personal problems with chaplains, and so it is not possible to gauge whether the chaplain’s help would have reduced the number of sick days taken by staff. This does not, however, eliminate the possibility that the chaplain’s influence on the Unit as a whole could reduce stress and lower staff sick leave statistics.
ii. For others

Similar answers were given to this question as (f) i., with only a slightly higher affirmative result. The PAH recorded one ‘yes’, one ‘may be’ and one ‘possibly’; RPA, one ‘yes’ and one ‘possibly’; The Austin recorded three ‘yes’.

Question 2(a): Is the chaplain involved in decision-making of the Liver Transplant Unit? The general consensus of the PAH participants on this question is ‘no’. One participant working in an out-patient capacity did, however, express the opinion that, depending on the individual’s beliefs, the availability of open discussion and counselling can be of enormous value, particularly where the patients are faced with the choice to retransplant or not, and where the patient and family confront the issues of death and dying. Royal Prince Alfred, by contrast, recorded eight ‘yes’ replies (one qualified with ‘very occasional’); five ‘don’t knows’; one ‘not appropriate’; only one ‘no’ and one ‘no answer’. This result could indicate that those staff members who attend the weekly LTU briefing meetings are aware of the chaplain’s input, whilst the others are not. This points again to the fact that the chaplain is involved at a team level, but not sought out by individual staff members.

All the participants from The Austin, however, answered affirmatively, apart from one question mark. One participant added that every member of the team has involvement in the decision-making, but the chaplain does not have first say; their voice simply an opinion, and is offered more as a counsellor than chaplain. The operative word here is ‘team’ and the chaplain is clearly considered an intricate part of The Austin LTU team by this participant. The subject of team involvement and holistic medical treatment of patients will be discussed in the Chapter 5 recommendations, as will the question of the chaplain’s role as counsellors.

Question 2(b): Is the chaplain helpful in assessing a patient’s suitability for a transplant? (See also Appendix XIV). Whilst little was said on the subject by PAH participants, with all stating ‘no’ except one who considered the chaplain may give some input as an assessment panel member, both RPA and The Austin participants commented at length. There was only one definite ‘no’ reply by RPA, with seven ‘yes’ and six ‘don’t know’. One participant considered the chaplain’s input in assessing a patient’s suitability for a transplant as being ‘not applicable’. The reason given was that RPA does not accept or reject a patient on whether they are Christian/atheist/agnostic; religion does not come into it. In response to this, the question does not state that a patient will be accepted or rejected on the chaplain’s assessment, it merely asks if such an assessment of the patient’s suitability would be helpful. As other participants from RPA and The Austin point out, the chaplain’s
input is valuable regarding a patient’s personality and coping skills. By being involved in the social and spiritual assessment of the patient and his/her support network, the chaplain can often determine whether the patient is ready for a transplant. This information may be helpful in deciding whether the patient requires psychological, spiritual or some other form of emotional help during the time leading up to the transplant. All The Austin participants answered ‘yes’ to this question with the exception of one question mark.

These results reflect the different chaplaincy involvement experienced in the three LTUs which were researched. The Austin Unit shows that the chaplain can make a significant contribution to the smooth running of these units and can be a valued member of the team. This will be discussed further in Chapter 6.

Question 2(c): Is the chaplain’s input a help in the execution of your work personally? (See also Appendix XIV). No comments at all were made by the PAH participants, all stating an emphatic ‘no’. Two RPA participants stated ‘yes’ with the remainder ‘no’ or ‘don’t know’, whilst two-thirds of The Austin participants said ‘yes’ and one-third ‘no’. It was again evident that The Austin Hospital LTU regards its chaplain differently from the other surveyed units. The indication is that, being employed directly by The Austin LTU and being solely responsible for it, the chaplain’s position has brought about a change the attitude of the staff and made her an integral part of the overall Unit team. This must be regarded as a clear response to the contentious question of whether ecumenical Unit/set wards or denominational general chaplaincy is the most advantageous.

Question 2(d): Is the chaplain’s input a help to the overall running of the Unit? (See also Appendix XIV). This question produced a large number of quite lengthy comments. However, again the PAH participants did not consider the chaplain’s input to be of help in the overall running of the Unit. Only two participants answered ‘yes’, with one of these stating that patients were helped, but not staff. All indications are that the chaplains play only a minor role in the running of the PAH Liver Transplant Unit.

By contrast, The Austin recorded a hundred percent affirmative response to this question. Royal Prince Alfred participants were divided in their views, six recording ‘yes’, three ‘no’ and the remainder ‘don’t know’. One participant declared that the chaplain didn’t help her personally and therefore can’t help the overall running of the Unit as she is part of it. She goes on to state that she doubts whether the chaplain has seen anybody from the theatre except possibly the Clinical Nurse Consultant who attends meetings. This participant also thought that the chaplain may only see ‘key’
people and not the 3 a.m. workers, adding that she would say that is fairly typical at big hospitals. This participant concluded by stating that she did not consider this to be a good situation. This comment further indicates the possibility that, as far as the staff are concerned, the chaplain is involved generally but not individually. The participant’s view that most large hospital chaplains are not available for theatre staff at 3 a.m. may well be true. However, a participant from The Austin commented that their chaplain is remarkable in that she may be found to be at the hospital at 2 a.m. in the morning if she feels the situation warrants her being there.

The above survey results highlight the different levels of chaplaincy input in the three separate LTUs and, as stated in 2(b), an endeavour will be made in Chapter 6 to ascertain whether any one method is more conducive to the smooth and efficient operation of these LTUs.

2. UNSTRUCTURED PERSONAL INTERVIEWS WITH SELECTED LIVER TRANSPLANT UNIT STAFF MEMBERS

In an endeavour to understand fully the methods being adopted in each of the selected LTUs and the involvement of the chaplain in the overall running of each Unit, a number of unstructured personal staff interviews were conducted by the researcher.

a. The Austin Hospital

The Austin Hospital was the first to be visited. The researcher was invited to be present at the weekly LTU meeting. These meetings are regularly attended by all the staff members connected with the Unit, including doctors, nurses and allied health workers, and the chaplain, in order to discuss case histories and any other relevant business. At the meeting attended by the researcher the chaplain asked questions, which were readily answered, and staff members asked the chaplain’s opinion on a number of occasions. It was evident that the chaplain, who is paid by the LTU itself, was an accepted member of the team. The chaplain in question is a lay chaplain attached to the Unit ing Church, but works in The Austin LTU in an ecumenical capacity. The researcher was also invited to another weekly meeting, this being attended by the social workers, the LTU clinic nurse and the chaplain. The intention of these meetings is to pool patient information and discuss ways in which the patient may receive the most appropriate and beneficial help. This chaplain performs many functions, one of which is serving as the liaison between the fund raising Friends of Liver Transplant Patients groups and the Unit.
i. Interview with The Austin Hospital LTU Director - (See also Appendix XV)

The Director was interviewed at length and explained that his way of running a transplant unit was a new concept in Australia based on a broad overseas model. His idea was to run a unit completely on an integrated team basis, with all members being of equal importance. This included the chaplain. The concept created a few problems at first, with some members feeling their professional standing was being threatened. The chaplain was included, to the extent of being present in the operating theatre. This practise was questioned at first, but the advantages of this seemingly unusual procedure were soon also realised and accepted. The Director stated quite emphatically that there are times when not to have the chaplain around would be impossible. This aspect was further discussed with the theatre sister in Appendix XVI.

ii. Interview with The Austin Hospital LTU Theatre Nurse - (See also Appendix XVI)

As the Director had done, the theatre nurse also stated that a few problems had arisen during the early stages of the implementation of the model, particularly with regard to the chaplain being present in the theatre during operations. These, however, were overcome. She further stated that she could not envisage the Unit without the chaplain and that she encouraged other nursing staff to talk to the chaplain about their problems rather than to each other. Her main reason she gave for this was that she feels the chaplain treats conversations with confidentiality, whilst nurses are inclined to gossip amongst themselves.

iii. Interview with The Austin Hospital LTU Clinic Nurse - (See also Appendix XVII)

This participant considered that the chaplain’s worth lay in acting as a non-medical person who could readily liaise with doctors. Again the chaplain’s presence in the theatre was mentioned, and the suggestion made that knowledge of the chaplain’s presence in the theatre reassures patients and families. The chaplain is able to liaise with families during the long operations and let them know what stage of the operation had been reached. This nurse also considered that the chaplain’s assessments of patients’ spiritual readiness, help provided to staff when patient deaths occur and the funeral services she conducts, are advantageous to the Unit. It was also specifically stated that the chaplain is always available.
iv. Interview with senior nursing staff of The Austin Hospital liver transplant wards (See also Appendix XVIII)

A number of ward charge nurses were interviewed, with similar comments made by each. One described the chaplain as a support for the team, not just part of it, further stating that the chaplain shares common ground with other professionals. These ward staff members were in agreement concerning the chaplain’s spiritual assessments of patients and relatives and her availability to listen to staff. One stated that she calls the chaplain before the social worker because the chaplain is always on call, even in the middle of the night, whereas social workers are only available during set hours and not at nights. Another charge nurse considered that the availability of the chaplain to listen to the staff helps alleviate stress, resulting in less sick days being taken and contributing towards cost saving measures. As will be seen from the transcripts of these interviews in Appendix XVIII, the indication is that the system and methods of chaplaincy at The Austin are generally approved by the senior nursing staff of the LTU.

v. Interview with The Austin Hospital LTU chaplain

This chaplain has been attached to the LTU since 1989. During the interview, the chaplain described the difficulty and challenge involved in establishing a ministry within such a specialist unit. Both the social workers and she herself were encouraged to have input in the assessment of patients for transplant. The chaplain talked of basing her assessment on a pastoral diagnosis which she described is a process of recognising, blessing and strengthening those areas of a patient’s life which give meaning and direction, and those which touch the spiritual dimension which holds their life force. In this way, she said, a patient with a poor medical diagnosis may present with a strong and healthy pastoral diagnosis which holds them in good stead for the reality of transplantation.

The chaplain spoke of what she called the ‘hidden heart’ of the hospital: the operating theatre. Here she became aware that the theatre staff are a closed community within the hospital, yet still had the same needs for support and encouragement as other staff members. Eventually the chaplain developed a close relationship with the LTU theatre staff and was given a key to the theatre. She considers her presence in the theatre has proven to provide a link with the rest of the Unit.

The chaplain also described various forms of liturgy she conducts for ward staff following the death of patients, the annual Service of Thanksgiving for donor families and transplant recipients and their families, and the preparation of a special service which could be used in an Intensive Care Unit when a patient is brain dead and the life support has to be disconnected. This Service also provides for those situations where the family have made a decision to agree to organ donation.
In 1993 a survey was conducted by the chaplain titled 'Quality Assurance Study Report on Chaplaincy to the Liver Transplant Unit, The Austin Hospital'. The results of this survey are tabulated under Appendix XIX. It will be seen from this study that the majority of patients and their principal support persons who were surveyed indicated that they received benefit from their relationship with the chaplain. A further survey conducted at The Austin requested personal comments from patients and relatives regarding their association with the chaplain (Appendix XX). A number of patients taking part in this survey made comments such as: 'the chaplain’s words had more impact on me than if they had come from a medical member of the team'; 'it seemed important that the chaplain was separate but complimentary to the medical staff'; 'the chaplain helped me to organize home issues and address such issues in a non-fearful manner'; 'the chaplain was very reassuring to my family'; 'the chaplain gave hope and encouragement to me and my family'; 'even though I am not religious I found the chaplain understanding of my problems'. Similar comments were made by the relatives: 'the chaplain was a caring person who had time to look at the human rather than the medical needs of the patient and family'; 'as the medical staff caring for the patient changes frequently, the continuity of the chaplain’s care and support was very comforting'; 'you need to talk through your fears and needs with someone besides the doctors'; 'we cannot praise and thank the chaplain enough for helping us step by step along the terrifying and overwhelming road'. The results of this survey emphasise the needs of patients and their relatives for the non-medical support of a chaplain during transplantation procedures; they also show that support for the relatives is as important to the patient, as support for the patient is to the relatives. The participants taking part in this survey indicated that they had experienced varying needs and that these had often been met by the chaplain.

b. Princess Alexandra Hospital

The next hospital where interviews were conducted was the Princess Alexandra Hospital, which was found to operate in a manner entirely different from The Austin. As indicated by the written survey results, the chaplain was not considered to be an integral team member of the PAH Liver Transplant Unit; no specific chaplain was, in fact, allocated to the LTU. The Anglican chaplain appeared to have the closest involvement, particularly when the transplant coordinator, a former transplant recipient with no chaplaincy qualifications, was not available.
i. Interview with the Assistant Director of Nursing at Princess Alexandra Hospital

This Assistant Director explained that there is not specific transplant chaplain in the LTU, but a former patient is paid by the Post-transplant Unit as a Unit coordinator, and acts as support to staff and patients. She is highly involved with the Unit in all ways other than spiritual, as she is not employed as a chaplain. The Assistant Director stated that the coordinator worked from her own experience as an earlier recipient. The Assistant Director also stated that, in his opinion, the social worker/chaplain relationships were not good at PAH generally, being almost competitive, with support for either one depending on the head nurse’s or doctor’s preferences.

ii. Interview with the Princess Alexandra Hospital LTU Coordinator

The coordinator advised that she was involved with recipient patients at all stages, but had no connection with donor procedures or donor families. The coordinator’s duties involved: meeting potential recipients from the airport when necessary; educating and counselling patients before assessment; finding accommodation when necessary; issuing beepers; and giving general support until the transplant is effected. The coordinator takes a very special interest in each patient, often inviting them out to dinner or for coffee, in an endeavour to create a trusting relationship between them as she introduces them to the various stages of transplantation. Unlike the chaplain at the Austin Hospital, the coordinator does not stay in the theatre during the operation, only until the patient becomes anaesthetised. The coordinator has had no formal theological training and stated that she does not perform pastoral duties, however, indications are she does, in fact, afford a considerable amount of pastoral ministry to patients and staff without nominating it as such. It was not her intention to replace the chaplain, however, she appears to perform many of the duties being carried out by The Austin chaplain.

On a personal level, the co-ordinator serves as an inspiration to new transplant patients by her own achievements; she was a participant in swimming events at the World Transplant Games in Manchester.

Indications of the Princess Alexandra LTUs lack of association with chaplaincy as a whole are given by Gillian E. Douglas, RN., ICU, Cert. Clinical Nurse Consultant and Michelle Daly, the Senior Social Worker at PAH, in a study titled The Donor families experience of Organ Donation. This seventeen page study details various forms of support offered to alleviate stress by coordinators and social workers. The study makes no reference whatsoever to chaplains.
c. Royal Prince Alfred Hospital

The last LTU hospital to be researched was Royal Prince Alfred where this researcher was again invited by Professor Sheil, Head of Transplantation Surgery, to attend a weekly meeting. There were 26 people at this meeting including surgical and medical doctors, nursing staff, representatives of all allied health professions and the chaplain. All developments and queries which had occurred during the previous week were discussed at length and in depth. The gastro-enterologist registrar to Professor Sheil for the past year gave a general patient run-down and any relevant aspects were discussed. It was, for example, noted that one patient was from Katmandu and needed special support, another patient was described as an emotional wreck, whilst a baby who had received a cut-down liver had developed breathing problems and died. At this point, Professor Sheil spoke directly to the researcher, stating that there were certainly problems in the LTU which warrant the services of a chaplain. Professor Sheil’s remark was interpreted by the researcher to be an indication that he supported the presence of the chaplain in the LTU.

i. Interview with Royal Prince Alfred Hospital LTU Coordinator
(See also Appendix XXI)

Two interviews were conducted with this coordinator, one before distribution of the written survey (Appendix XXI) and one afterwards. During the first interview the coordinator stated that he considered the chaplain to be part of the team, ministering primarily to the patients, not staff. The coordinator said he himself would approach the chaplain regarding work problems, but not personal, for which he would see his own priest. He agreed that the chaplain could be more integrated in the LTU, but he, the coordinator, did not consider this to be necessary. He further stated that he would not want the chaplain in the operating theatre because it is already crowded. He made other comments regarding chaplaincy training and methods of payment, feeling these should be kept within the Church to avoid the possibility of the chaplains’ losing their spiritual identity.

The second interview with this coordinator was less general. He considered my line of questioning in the written survey had an inherent bias, stating that because ‘B’ follows ‘A’, it does not mean that therefore ‘A’ caused ‘B’. This is assessed to mean that because questions relating to the chaplain’s involvement (B), followed the question concerning trauma and stress experienced by the medical staff (A), this does not mean that chaplaincy is the only way to solve a traumatic situation. The coordinator stated that the chaplain’s role is/was never intended to assist him in the overall running of the Unit. The co-ordinator claimed that the survey was far too pointed and does not anywhere actually address the LTU chaplain’s role at RPA,
stating that he had already discussed their chaplain's areas of responsibility during the first interview.

A further criticism of the survey was expressed by one of the medical practitioners who said that there were no questions regarding help for Unit members from other members of the team. He felt that spiritual and personal issues were discussed by staff with each other either directly or indirectly (mostly the latter) and that, whilst the chaplain is important here, so are others.

Both these gentlemen did not appreciate that the survey was designed to ascertain, in the view of the staff, what the chaplain, not other staff members, did in their particular LTU. The difficulty that they had identified in the survey was that it was attempting to cover a number of different systems being used in the LTUs, both those that involve high chaplaincy involvement and those that do not. The researcher's understanding of the coordinator's concerns over the survey is that he considered the wording of the questions was more appropriate for one type of LTU than another, this, in turn, reflecting upon the individual chaplains concerned. This was not the researcher's intention.

**ii. Interview with Royal Prince Alfred LTU Social Worker (See also Appendix XXII)**

The social worker stated that the relationship between chaplains and social workers was informal. She had sometimes approached the chaplain informally and voluntarily to discuss professional problems regarding patients, but had not discussed her own personal problems. She stated that staff usually sought the help of the Staff Counselling Service. The social worker considered chaplains contribute towards the care of the whole person. She had no concerns over chaplains being present in the operating theatre, but she felt chaplains would be less independent if paid by the hospital.

**iii. Interview with Royal Prince Alfred LTU Staff Hepatologist**

Professor Geoff McCaughan holds a senior position as staff hepatologist in the Unit. He stated that a full-time liaison psychiatrist was available for assessments, but suspects the chaplain is under-utilised. He supported the principle of using the chaplain more extensively, although he did not think he would be available at 2 a.m. Professor McCaughan was fully aware of the spiritual needs of his patients, which he considered may be helped and understood by a chaplain, or the patient's own minister. He stated that he did not know whom he would consult in the case of any traumatic situation encountered by himself.
iv. Interview with the Royal Prince Alfred Liver Transplant Unit Dietitian

The dietitian considered that most of the staff would go to the psychiatrist for personal help. She was not sure of the reason, but felt it was probably a case of availability. The psychiatrist was also called upon by staff for the mental well-being of the patients. The dietitian felt considerations of a professional versus spiritual nature were involved. She stated that the nursing sisters often counselled their staff, whilst others had their own ways of dealing with problems. She added that the patient and relatives, however, were more inclined to require spiritual help.

Commenting on The Austin Hospital chaplain’s role, the dietitian considered that an involvement of that depth would require the chaplain to obtain some psychology training. This will be discussed in Chapter 5 where recommended chaplaincy training methods are addressed.

v. Interview with the Royal Prince Alfred Hospital LTU psychiatrist (See also Appendix XXIII)

The psychiatrist stated that as a consultant psychiatrist he had no right of access to patients or staff; he had to be approached and asked for help. He spoke of the roles and personality differences between RPA and The Austin Hospitals. He said RPA was very hierarchical; the surgeon was boss and made the decisions. The aim was good medical care, bad holistic care being simply a waste of time. He added that the LTU team performed dynamically under the head surgeon’s direction. The system was structurally different to The Austin Hospital LTU, where the Unit Director had a more holistic approach.

This contrast in methods was evident to the researcher when attending the LTU meetings at both hospitals. Royal Prince Alfred gave the impression of being a very businesslike team and with a ‘matter of fact’ approach, and sense was that they had a job to do and were intent on doing it well. The Austin Hospital LTU staff were equally intent on succeeding in what they were doing, but in a more holistic way. They were not concerned only with the physical well-being of the patients, but also in treating the whole person, including their spiritual, emotional, psychological and general daily needs.

vi. Short interviews with three Royal Prince Alfred LTU staff members

A number of short interviews were conducted with staff at the RPA Hospital. An interview was conducted with the Director of Nursing responsible for the entire nursing staff at RPA. During this interview staff/chaplaincy relationships were
discussed, at which time the Director stated that ‘there is an Employers’ Assistance Program with three or four trained counsellors experienced in psychology and counselling’, adding that there is a counsellor ‘specifically for the nurses’. This appears to indicate that the staff are encouraged to consult these counsellors when problems arise rather than the chaplains.

A newly graduated nurse said that there was never time to talk to patients and that she found this stressful. She said ‘it would be great to talk to the chaplain, but after four months I still have not met him’. Asked why she had not initiated such a talk, she replied that she did not want to contact him through the switchboard, fearing that the operator or other staff members on her ward may overhear her conversation. She was not aware that he could be contacted by going directly to the Chaplains’ Department office. She said new nurses counselled each other, a situation which she found unsuitable for herself in that she felt the need to talk to someone more experienced.

A further, and highly significant, point was made by this young nurse concerning the training talks given at the Nurses’ School. These included familiarisation talks by counsellors, psychiatrists, registered nurses and a number of allied health experts, but none by chaplains or pastoral workers. She considered this to be an unfortunate omission.

The transplant ward nursing unit manager stated that the chaplain who attended the Unit was ‘spot-on’, adding that ‘there is a great need for communication with families, donors and recipients. The chaplain is needed to help donor families who have not had time to grieve. I have no objection to the chaplain being in the operating theatre to give on the spot help’.

vii. Interview with a Royal Prince Alfred Hospital post liver transplant patient  (See also Appendix XXIV)

Although the researcher did not request to interview any patients at RPA, one 18 year old who is known personally to the researcher, voluntarily gave a statement describing his association with the chaplain during time spent in the LTU. This former patient stated that, whilst he found the chaplain to be friendly during his short visits, they did not engage in any ‘deep’ conversation and the patient did not consider that the chaplain had influenced his attitude towards his transplant in any way.

viii. Interview with Royal Prince Alfred LTU operating theatre clinic nurse consultant

This interview provided the researcher with considerable information as to procedures adopted in the theatre and in the LTU as a whole. Whilst stating that the chaplain was beneficial at times, this clinic nurse consultant explained that she herself
is instrumental in giving support to her specific team and in encouraging them to support each other. Many of her points have already been published in her own articles.

In one article\textsuperscript{11} the co-ordinator discusses the distress caused to most theatre staff when asked to assist with procurement surgery; the process of extracting organs from a body for transplantation. This usually entails procuring the organs from a deceased body; occasionally a single kidney may be donated by a living relative to a close family member. She goes on to explain how her team has come to terms with some of these issues, as nurses in a donor hospital where organs are procured. This, the consultant stipulated, ‘is where the Red Cross Co-ordinators have been and still are invaluable. They visit potential donor hospitals and talk to intensive care and operating room nurses and allay any fears they may have’.\textsuperscript{12} These Red Cross Co-ordinators encourage the staff to ‘open up’ and tell them all the factors which are worrying them in an informal atmosphere. The consultant has devised one way of alleviating her nurses’ stress during procurement surgery by encouraging them to go into the recipient operating theatre where a patient is being prepared to receive the donor’s liver. ‘In this way the procurement nurse becomes involved with more positive aspects of transplant surgery and in many instances is able to say hello to the patient before induction’.\textsuperscript{13} This also gives the nurses the opportunity of discussing immediately any problems or traumatic feelings with the theatre consultant or other staff members.

The consultant is highly involved with the patients from the time of their admission to the LTU for transplantation. She visits the ward in order to meet the patient, after which she organises for them and their relatives/support to visit the operating theatre with her and another staff member. The patient is changed into operating theatre clothes and is familiarised with the operating equipment:

This exercise has two uses, one the patient gets to know a few faces which helps considerably when they come for their operation and two, they are not afraid of all the equipment because they have seen it and had it explained to them. Conversely it allows the theatre staff to meet the patient and relatives.\textsuperscript{14}

\textsuperscript{12} \textit{Ibid.}, p.33.
\textsuperscript{13} \textit{Ibid.}, p.34.
\textsuperscript{14} \textit{Ibid.}, p.34.
After the transplant, theatre staff visit patients on the wards to follow their progress. In another paper, she stated that LTU support is given by a multidisciplinary team at RPA, including a chaplain, social worker, liaison psychiatrist, dietitian, medical team and surgical team. This is the only reference to the chaplain that could be found in either of the quoted articles. During the researcher’s conversation with the theatre consultant, however, the impression was gained that she was not dismissing the worth of the chaplain in any way, merely that she considered it part of her role as the theatre consultant, with the assistance of the nurses’ counsellor when necessary, to deal with her nurses’ traumas and the stress caused through their work. Indications are that this is part of the accepted role of the theatre consultant at RPA. Their operating room theatre manual states: ‘Nurses in the operating theatres care for patients’ physical emotional and spiritual needs before, during and after surgery’. It is reasonable to assume that if nurses are expected to afford patients emotional and spiritual care, then the same could be expected by the consultant to her staff. This highlights the different systems being used in the RPA Liver Transplant Unit from that of The Austin Hospital. In the one, the latter chaplain does collectively, what is being done by separate individuals at the former.

The survey and interview results show very clearly that chaplains are, in the view of the staff, ministering differently in the three LTUs. There could be a number of reasons for this: the personality of the chaplain is a factor; time available for LTU involvement; chaplaincy requirements of the Unit; patient/staff help preferences, i.e. chaplain, own religious minister, psychiatrist, counsellor or social worker; different State attitudes towards chaplains and religion as a whole. Or it may simply be a case of local solutions for local problems, that there are different problems and levels of anxiety and that the staff of each Unit feel that the system they are following is right for them.

The concern of this thesis is the input of chaplaincy and whether such input is being utilised to its best advantage. To this end, an endeavour will now be made to ascertain whether the level of involvement of chaplains has any bearing on shortening the lengths of stay of patients and/or reducing staff sick leave, thus constituting a cost-saving to the hospital involved and serving as an indication of the beneficial role of the chaplains in alleviating stress and other debilitating symptoms associated with transplant surgery.

16 Ibid., p.4.
3. **PATIENTS’ LENGTHS OF STAY IN THE THREE SURVEYED LIVER TRANSPLANT UNITS.**

Patients’ lengths of stay statistics for the years 1990 to 1994 inclusive were obtained from The Princess Alexandra Hospital, The Austin Hospital and The Royal Prince Alfred Hospital. As can be seen from the following tables, The Austin shows the best results, but is closely followed by PAH, with RPA recording the highest average length of stay figure.

**Table 53:** Number of patients and number of days hospitalised in the Liver Transplant Unit at Princes Alexandra Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
<th>Average Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>1991</td>
<td>28</td>
<td>32.55</td>
</tr>
<tr>
<td>1992</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>1993</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>1994</td>
<td>38</td>
<td>31</td>
</tr>
</tbody>
</table>

1990-1994 total patients = 144 (Average 28.8 per year)
1990-1994 total average length of stay per patient 29.31 days - including pre-operation and I.C.U. stay.

**Table 54:** Number of patients and number of days hospitalised in the Liver Transplant Unit at The Austin Hospital.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
<th>Average Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>16</td>
<td>25.10</td>
</tr>
<tr>
<td>1991</td>
<td>22</td>
<td>24.27</td>
</tr>
<tr>
<td>1992</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>1993</td>
<td>22</td>
<td>31.2</td>
</tr>
<tr>
<td>1994</td>
<td>22</td>
<td>23.8 (1 in ward for only 3 days)</td>
</tr>
</tbody>
</table>

1990-1994 total number of patients = 105 (Average 21 per year)
1990-1994 total average length of stay per patient 26.7 days - including I.C.U. but excluding pre-operation stays.
Table 55: Number of patients and number of days hospitalised in the Liver Transplant Unit at Royal Prince Alfred Hospital.

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Patients</th>
<th>Average Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>1991</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>1992</td>
<td>49</td>
<td>34</td>
</tr>
<tr>
<td>1993</td>
<td>41</td>
<td>33</td>
</tr>
<tr>
<td>1994</td>
<td>33</td>
<td>38</td>
</tr>
</tbody>
</table>

1990-1994 total number of patients = 198 (Average 39.6 per year).
1990-1994 total average length of stay per patient 36.8 days - including I.C.U. but excluding pre-operation stays.

It will be noted that the PAH figures include pre-operation days which, under normal circumstances, would be minimal, since transplants are completed as soon as practicable.

While many variables are involved in this type of research, it cannot be discounted that the results appear to indicate that, where a non-medical member of the team is liaising and drawing patients, relatives and staff members together, the patients are being discharged at a faster rate than otherwise. The patients of the The Royal Prince Alfred Hospital, where the chaplain and co-ordinator work under a different system to both The Austin and Princess Alexandra Hospitals, remain in hospital for a longer period. There could, of course, be a number of explanations for this, such as the fact that RPA performed almost double the average yearly number of transplants compared to The Austin and a quarter more than PAH. A higher number of transplants performed during a particular period, the greater the possibility that a number of patients will be hospitalised for long periods: Such a situation might have some influence on the survey figures; to what extent, however, cannot be ascertained. The initial selection process and type of patients accepted, may influence these figures, together with the extent and effectiveness of the chaplain’s pastoral diagnosis in conjunction with the medical diagnosis, effective time spent with the patient by non-medical team members, staff shortages and varying medical procedures. An effective pastoral diagnosis may alert the medical team to a patient’s seeming lack of spiritual strength, which may slow down physical healing and general recovery processes.
Nevertheless, it is argued that the considerably higher figures shown for the RPA patients lengths of stay may very well be reduced if an alternative form of chaplaincy were to be initiated. How such cost saving can be achieved by this is explained in Section 5 of this chapter. As noted in an article written by the researcher and Lindsay Carey, this research may well answer the request of some hospital administrators that chaplains show proof that their input actively contributes towards an earlier discharge of patients.\(^\text{17}\) As one administrator states, ‘If you can demonstrate to me that the patients you (chaplains) visit leave the hospital an average of, say, two hours earlier than other patients, I can tell you, in dollar terms, what that means to the hospital’.\(^\text{18}\)

Although, as seen in Chapter 1, the religious, administrative and financial aspects of the first hospitals were mainly controlled by religious bodies, present day chaplains are not usually identified by reference to the hospital finances. As noted by Elliot and Carey, ‘this approach to assessing chaplain ministry raises issues of the purpose, outcome and ethics of chaplain ministry which many would no doubt wish to debate’.\(^\text{19}\) It is not suggested that chaplains should compromise their spiritual teachings or pastoral gifts in any way, only that it may be fruitful for hospitals to seriously consider the chaplains’ role through the eyes of the clinical staff and medical administrators, as well as those of the patients. This consideration may ultimately lessen the ever-present risk that hospital administrators may view the chaplains’ role in a diminishing capacity due to the increasing emphasis on medically associated allied health workers. One area where this is clearly exemplified is in the treatment of grief. Once the widely accepted domain of the chaplains, grief has been scientificised, with specialised grief counsellors who hold psychology or similar degrees taking over the role.

4. COST SAVINGS TO GOVERNMENTS AND HOSPITALS CREATED BY REDUCING PATIENTS’ LENGTHS OF STAY IN HOSPITAL

Broadly stated, hospitals receive an annual budget from the Federal Government based on their expenditure from the previous year. The onus is then on the hospital to stay within this amount or raise funds through charitable avenues.


\(^\text{19}\) Elliot/Carey, *op.cit.*, p.75.
Whilst pensioners and low wage earners are treated free of charge, other public hospital patients are required to pay a Medicare Levy to the Government which is ultimately passed on to the hospitals. A cost saving occurs when a patient is not hospitalised long enough to utilise all of the Medicare Levy which they have paid during the year. Conversely, if a patient remains in hospital after their Medicare contribution has been exhausted there is no charge for the remainder of their stay.

If a patient is resident after midnight and remains in the hospital until midnight the next day, this constitutes a one day charge. It is not usual to charge the patient for the day if they are discharged before 10.00 a.m. However, if this patient is discharged early enough in the day for another patient to take their place, then both patients can be charged for that day. Charges for patients admitted under worker’s compensation and accident claims are primarily calculated on a 24 hour clock basis and, regardless of the time of discharge, the full 24 hours are covered under the various insurance schemes. Again, such patients’ beds can be re-allocated. Similar cost savings are achieved with regard to private patients covered by Hospital Benefits Funds. Whilst it is beneficial to the hospital to accommodate private paying patients who qualify for higher benefits to be paid to the hospital, it sometimes occurs that a patient will elect to become a public hospital patient and only use their benefits fund to cover their doctor’s fees. In such cases the Medicare Levy conditions apply and the length of stay becomes relevant. There are also occasions when a patient enters hospital in a private capacity but, due to the lengthy duration of their stay, their medical benefit funding is cancelled. If the patient does not continue to be treated in the private section of the hospital, they then become public patients.

The shorter the patients’ stay, the less medication is required, services of allied health staff such as physiotherapists are reduced, and a quicker turn-over of patients reduces the number of beds required which, in turn, cuts nursing costs. In principle this should help to reduce hospital waiting lists. Therefore, if a chaplain can contribute towards the earlier discharge of a patient by reducing their stress level, it would constitute a cost saving. If able to eliminate or reduce the levels of stress suffered by patients, the chaplains could be considered a definite asset to the hospital, both in terms of reducing the lengths of stay of patients and also by reducing the amount of medication required.

5. LIVER TRANSPLANT UNITS’ STAFF SICK LEAVE

An effort was made to assess whether the chaplains input at Princess Alexandra, The Austin and Royal Prince Alfred Hospitals influenced the LTUs’ staff sick leave in any way.
Princess Alexandra advised that all sick days are added up and divided by all
the rostered days per roster (4 weeks) to make a percentage. During the period
6.4.1992 to 4.4.1994, a total of 26 rosters), the average percentage of sick leave
amounted to 3.75%.

The Austin presented their figures in a different format, as under:

\[
\begin{array}{ccc}
1.7.91 - 30.6.92 & \text{Total number of sick hours} & 7612.00 \\
& \text{Total number of hours worked} & 01791.00 \\
\end{array}
\]

Sick leave hours taken represent 3.77% of total hours worked.

\[
\begin{array}{ccc}
1.7.92 - 30.6.93 & \text{Total number of sick hours} & 10083.75 \\
& \text{Total number of hours worked} & 226196.60 \\
\end{array}
\]

Sick leave hours taken represent 4.45% of total hours worked.

\[
\begin{array}{ccc}
1.7.93 - 30.6.94 & \text{Total number of sick hours} & 10926.50 \\
& \text{Total number of hours worked} & 261582.85 \\
\end{array}
\]

Sick leave hours taken represent 4.17% of total hours worked.

When variables are taken into account, such as seasonal influenza and cold
epidemics, and gastronomical viruses in the separate States, there would not appear to
be a significant difference in the amount of staff sick leave taken by The Austin and
PAH. The research could not, however, be completed, as the Director of Nursing at
RPA would not release the relevant data concerning staff sick leave, stating that this
was against the Hospital’s policy.

The only assessment which could be made from this incomplete research was
the indication that if The Austin chaplain’s input influenced the rate of sick leave in any
way, then the PAH co-ordinator was equally influential considering the similarity of
the results. It cannot be shown whether the RPA Liver Transplant Unit, which does
not place as great an emphasis on the spiritual and holistic aspects of medicine as the
other two surveyed Units, would have recorded a higher or lower rate of staff sick
leave. The researcher would have liked to compare the sick leave figures for all the
Units to ascertain whether differences, comparable to the patients’ lengths of stay
figures existed. Had such differences been evident, a stronger case for closer
involvement of chaplains and staff may have emerged.
6. MEASURING THE EFFECTS OF STRESS

Since our concern in this study has been in determining chaplains’ contributions to reduced levels of stress in patients, an attempt was made to define the meaning of stress and record various medical conditions which such stress may cause. Stress is, however, difficult to define, as Michael Marmot and Nicola Madge note:

Stress is very difficult to measure and presents different measurement challenges from diet or blood pressure and serum cholesterol, for instance, for which established routes can be located whereby a specified cause can lead to a specified outcome. The case of stress is quite different. There is disagreement about the meaning of the term, there is disagreement about how it should be measured, and there is lack of understanding about quite how aspects of the psychosocial environment might actually made a person ill.20

In the scientific world, stress is recognised as a multi-faceted response, influenced by a vast array of experience, thoughts, fears, pressure, tension, shock and attitudes. Researchers are presently becoming increasingly aware of the all-pervasive influence stress plays in our lives. It has become associated with ulcers, asthma, glaucoma, hypertension, cardio-vascular problems, diabetes, cancer, arthritis, rheumatism and allergies.21

In August, 1996, Melissa Sweet, a medical writer for The Sydney Morning Herald, reported that:

doctors have identified a bizarre new syndrome which leaves stressed children with stunted growth and an unusual eating disorder. The finding suggests that some children respond to stress in unusual ways, such as developing a voracious appetite while staying at normal weight. However, the syndrome is reversible; sufferers removed from their stressful environment quickly return to normal growth, hormonal and behaviour patterns.22

This syndrome indicates quite clearly how psychological factors can affect physical functioning and how, when stress is reversed, physical health improves. This report is substantiated by an article in The Lancet which documented the research carried out on 29 boys and 22 girls at Great Ormond Street Hospital for Children in London

between 1986 and 1994. All the children were of short stature, with high levels of stress. The syndrome does not appear to have been given a specific name, the researchers simply referring to it as ‘a new stress-related syndrome of growth failure and hyperphagia’\textsuperscript{23} in children, associated with reversibility of growth-hormone insufficiency’.\textsuperscript{24}

After studying 59259 patients who underwent surgery in two hospitals in 1984, Doctor George Fulop of Mount Sinai Hospital in New York City concludes that emotionally distressed patients stay longer in hospital. He found that those with extreme anxiety or depression stayed in the hospital an average of eight days longer than untroubled patients.\textsuperscript{25} Daniel Goleman quoted Fulop’s findings in The New York Times in 1991, also adding that in these days of high-technology and high turnover medicine, some physicians are urging that the lost art of comforting be revived, stating ‘they are spurred by a steady march of scientific findings demonstrating how heavily patients’ emotional states can affect the course of their diseases’.\textsuperscript{26}

Whilst not a medical experiment, a good example of psychological factors affecting physical functioning was exhibited by an experiment which became known as the ‘Hawthorne effect’. This was conducted at the Western Electric Company’s Works in Chicago from 1927 to 1932. The experiment involved putting two groups of workers doing the same job into two separate rooms, one with an increased light charge. The prediction was that the room with the higher illumination would increase its productivity. This did, in fact, happen, but unexpectedly the productivity of the room where no lighting change took place also increased. Furthermore, when the degree of higher illumination was gradually lowered back to the original level, the increased productivity still continued. It was not until the group was working under conditions of bright moonlight, that productivity actually decreased.\textsuperscript{27}

It was many years later that this phenomenon was explained and labelled the ‘Hawthorne effect’. Whilst the initial purpose of the research was to determine

\textsuperscript{23} Hyperphagia was defined as a persistently abnormal pattern of food-seeking or eating behaviour characterised by stealing food, nocturnal searching for food, and gorging and vomiting when liberal access to food was available.


whether different lighting conditions affected product results, the eventual result showed that increased productivity was actually achieved because one group of workers was segregated and made to feel their status was higher than another group; the lighting was not relevant. As Charles Perrow states:

Lighting had been changed in one group and not the other group, but the researchers had neglected a more important change that had occurred for both groups - namely, that management had put them into special rooms to control the lighting and thus had segregated them from the rest of the workers and treated them as something special. In short, the real change had been that management had taken an interest in the two groups of workers. They were given special treatment and special status as compared to the rest of the workers. The attention apparently raised morale, and morale raised productivity.28

When looked at from a medical perspective, the results of this experiment indicate that a hospital patient’s morale may similarly be raised when they feel their emotional, spiritual and psychological needs are cared for, not just their physical problems, which in turn could very well lower the patient’s level of stress.

Recommendations and conclusions drawn from this survey will be discussed in Chapter 6.

28 Ibid., p.80.
CHAPTER 6

CONCLUSIONS

You know how to interpret the appearance of the sky, but you cannot interpret the signs of the times
Matthew 16:3.

INTRODUCTION

John Hinkle states that ‘Jesus spoke of the need to discern the signs of the times as a key element in spiritual awareness. Those who failed to discern the signs of the times were rebuked’. The text from Matthew quoted above is as equally relevant today as it was in Biblical times.

It was found that Hospital Chaplaincy in the Context of Religion in Contemporary Australia has many links with the past. As shown in Chapter 1, there has always been a relationship between religion and sickness/medicine, although this relationship has changed a great deal as the modern practices of medicine have developed. As physical procedures and knowledge have improved, reliance on magic and the ‘gods’ as ways of curing sickness have almost vanished. There is, however, still considerable support for faith healing, with many churches conducting healing services at which believers are anointed with oil and prayers offered for their individual ailments. The Old Testament belief that sickness is a punishment by God for sins has gradually diminished and, with the advent of many private hospitals and medical practices founded and administered fully by physicians and wealthy citizens, and now by government bodies, the treatment of the sick has virtually been removed from the jurisdiction of the religious bodies and has become almost wholly secularized. However, some religious bodies have continued to fund their own institutions and work alongside secular hospital administrators, whilst the clergy and pastoral workers of all denominations have continued to visit the sick in hospitals and in their homes.

The pastoral element in hospitals clearly remains an important factor. This is substantiated by a circular issued by the New South Wales Health Department in June,

---

1998, concerning chaplaincy services to the NSW health system. This circular stated that:

This circular and the model plan for chaplaincy services and pastoral care services in hospitals take into account changes that have occurred regarding chaplaincy and pastoral care services in the health system. They apply to hospitals and to community based facilities and services. Health services will need to consider access to chaplaincy services across the continuum of care and ensure appropriate services are available. Co-operation and religious tolerance should be promoted and encouraged to ensure the needs of our diverse community are met.²

This circular indicates that all hospitals are required to facilitate chaplaincy or pastoral care services and opens the door to financial negotiations between the NSW Government and the Health and Welfare Chaplains Association. At present in NSW, some government funding is allocated for prison and psychiatric hospital chaplaincy, but not for general hospitals. The other two States in which research was conducted for this paper, namely Victoria and Queensland, have different rules: the Victorian Government partly financially supports chaplaincy in general, including hospital chaplaincy; the Queensland Government does not financially support either hospital or prison chaplaincy, only assisting psychiatric and military veterans’ repatriation units. Indirectly, some government finances may be allocated to chaplaincy departments by individual hospitals electing to re-allocate some of their general funding to chaplaincy; this may take the form of salaries to chaplains or pastoral workers, allocation of a room or stationery supplies.

Today’s medical procedures such as transplantation, open heart surgery, in-vitro fertilization, and so on, require a more sophisticated form of hospital religious ministry than in the past. Matters of ethics often occur; problems regarding loss of independence often need discussing; general effects of major surgery or excessive hospitalization need addressing. It was found, however, that opinions as to whether the chaplain should be involved in ethical matters often differed amongst the various groups surveyed for the present research. For instance, expectations of the chaplain consulting with medical staff on ethical issues such as abortion, IVF., life support systems and so on, drew mixed responses, with the chaplains and senior medical staff recording a high percentage of ‘yes’ replies, whilst the patients recorded ‘no’ or ‘don’t know’. The conclusion is that many doctors are confused as to the Church’s stance on such issues or that they have their own inhibitions where medical ethics are concerned. Conflict between the Church and the medical profession regarding ethical issues has created a continuing connection between the two.

---

The diversity of modern procedures suggests that hospital chaplaincy needs to become more specialised, with chaplains being trained for ministry in specific areas of sickness. One very significant change which has occurred during the development of medicine is the increased average life expectancy. This has resulted in more dementia related sickness amongst the elderly and it is considered that his is an area which would particularly benefit from specialised religious ministry. Other areas are: transplantations; HIV/AIDS related illnesses; psychiatry and paediatrics, to name a few.

From the results of this present research, indications are that hospital chaplaincy would benefit generally if more specialized ministry methods were to be adopted. Whilst such methods are developed in some hospitals, there is a general need to recognise the signs of the times and adapt religious ministry accordingly. This claim is not meant as a criticism of past chaplaincy ministry, but as an encouragement for future chaplains and religious bodies to have the foresight and courage to make changes when and where needed.

1. COMPARISONS BETWEEN THE PRESENT RESEARCH AND THAT CONDUCTED PREVIOUSLY BY RESEARCHERS IN AUSTRALIA, NEW ZEALAND AND THE UNITED STATES

When comparing the present research with other Australian and New Zealand surveys, all the surveys indicated that ordained clergy or trained and qualified members of the laity would be considered acceptable to perform chaplaincy duties. It was also expected that chaplains would hold ecumenical services of worship in the hospital; however, many of the patients did not attend claiming that they were not aware of the facility. This may indicate a lack of communication generally between chaplains, staff and patients. The surveys also showed that most chaplaincy visits were made routinely, with few being initiated by patient request. However, most of the visited patients indicated satisfaction with the chaplain. The statistics show that large numbers of patients are not being visited, supporting a conclusion that it is essential for chaplains to initiate visits, as patients may not request ministry which they want and need. A lack of available chaplains is a further possible, and indeed probable, cause for patients not receiving visits.

The importance of celebrating Holy Communion and other Sacraments at patients’ bedsides was not ranked highly amongst the chaplain’s tasks in the majority of surveys; the comforter role being ranked as the most important and most expected. Confidentiality was also considered very important.
Age, gender and religious preference had minimal influence on the general results of the Australian and New Zealand surveys. Whilst the elderly were more inclined to request to see a chaplain, and some of the younger participants had little knowledge of chaplaincy procedures, these age trends were not consistent across the board. It is generally concluded that the Australian and New Zealand surveys contained similar questions and that the results were similar.

When a comparison of the Australian and New Zealand research was made with that of the Lutheran General Hospital in Illinois, it was concluded that, whilst the presence of Australian and New Zealand chaplains is valued, the United States chaplains sometimes appear to be afforded more prestige by other staff members.

There were indications that age and religious preferences of patients were more important variables in the Lutheran survey in assessing the value patients placed on chaplaincy.

The policy of unit chaplaincy was supported in the American research, regardless of religious preferences, and the benefits of this is also demonstrated by the chaplaincy procedures being practiced at the Austin Hospital here in Australia. This topic will be discussed further in the recommendations section of this chapter.

As in the Australian research, past and present, the Lutheran survey also indicated that role communication needed improvement.

A major difference, however, occurred between the Lutheran and the other research. This was the positioning of the ‘liturgist’ group of questions in order of importance to other groups. Whilst all placed the ‘comforter’ role as the most important, the majority of Australian surveys listed ‘witness’ in the second position. The Lutheran survey placed ‘liturgist’ above ‘witness’. The only conclusion that can be drawn from this is that the Americans may be more demonstrative where their religion is concerned than the Australians.

As in Australia, it was not considered greatly important to have a chaplain of the same faith, the important issue appearing to be the necessity that a chaplain of some faith will be available at all times.

A difference between the thesis survey and the Lutheran research concerned the chaplain’s role in assisting staff with both work and personal problems. The present survey recorded a higher ‘yes’ percentage by patients than the medical staff, whereas the Lutheran survey indicated a higher medical staff ‘yes’ response. As noted in Chapter 1, this difference could be either a change across time in patient views since the Lutheran research was conducted, or an American/Australian variation. More American chaplains are employed directly by hospitals than Australian chaplains, giving them similar professional recognition to that of the medical and other staff members. The probable result of this is that American staff would relate more freely to
chaplains with regard to both work and personal problems than would Australian hospital staff to their chaplains. It is concluded, therefore, that the American/Australian variation is the reason for the above difference.

The conclusion drawn from comparing the Lutheran and Australian surveys are that American chaplaincy has a higher profile, and is accepted as part of the hospital professional team. Indications are that their is less marginality connected with chaplaincy in America than Australia, where the majority of chaplains are still employed by various religious bodies. However, based on the number of patients who claimed they had not been visited in the American research, the indications are that a similar shortage of available chaplains exists there as in Australia.

The holistic and power of prayer research conducted in America evidences a positive effect on patients. Whether or not this is directly caused through a form of Divine intervention or indirectly through the power of positive thinking, the results show that religion can influence a person’s health and recovery, thus supporting a claim in both America and Australia that hospital chaplains are a necessary asset to the general hospital system.

2. OVERALL SUMMARY OF RESEARCH

The first survey research indicated that considerable inconsistency and confusion existed between the participating groups of patients, doctors, nurses, and chaplains as a whole, and also amongst single individuals within the groups. The only questions with which most participants were in agreement were those pertaining to the comforting of patients and relatives by the chaplain, and the chaplain’s role as a witness of God’s love and concern. The responses to questions concerning the chaplain’s participation in staff, resource, ethical, counsellor and liturgist matters, by all groups were inconsistent, participants frequently appearing to respond to questions in a way which affected them personally, rather than the way in which such questions may relate generally to the expectations of the role of chaplaincy. The research showed that a number of the participants who once attended church ‘regularly’ were now only occasional church-goers (see tables 50, 51, 52). Perhaps in keeping with this, when participants were asked to rank expected tasks of the chaplain’s role in order of importance, the offering of the Blessed Sacrament of Holy Communion was not placed highly.

As will be shown in this chapter, some of the conclusions to be drawn from this survey are the following: the role of hospital chaplains could profitably be promoted differently, in order to eliminate existing confusion as to what the chaplain
‘does’ and who he or she ‘is’; lay chaplaincy is acceptable, providing appropriate training is obtained; and in order for hospital chaplaincy to be sufficiently effective, the present number of existing chaplains needs to be increased. The researcher’s recommendations as to how this may be achieved are included later in this chapter.

Interviews held with the various denominational hierarchy showed that they were all adamant that the status of chaplains within their own denomination is exceedingly high and also that lay involvement in chaplaincy is acceptable. However, half of the participants in the Expectations of the role of Hospital Chaplains survey stated that they thought all chaplains would be ministers of the church, indicating that they did not know very much about chaplaincy. Whilst patients who had received a visit from a chaplain generally considered that a high standard was met, not enough of the surveyed patients had been visited. Reasons for this could have been that the patient was not in the ward when the chaplain called, or that there was not enough time available time for the chaplain to visit every patient. The latter case would indicate that more chaplains are needed to adequately perform the tasks expected of them.

Whilst the majority of the hierarchy stressed that hospital chaplaincy generally is regarded as an extremely high profile form of ministry, this view was not shared by one of the hierarchy who considered that there is an adverse attitude towards chaplaincy in some denominations, classifying it as a ‘Cinderella’ ministry. In addition to lack of funding, this may account for the shortage of ordained ministers/priests who choose hospital chaplaincy as their full-time ministry. It is considered, therefore, that the hierarchy’s view of chaplaincy as a high profile form of ministry may be open to interpretation. This statement is not meant to imply that chaplaincy should not be regarded as high profile, but that it is not always considered as such. This is not through any fault of individual chaplains, rather the fault of a system that is in need of an overhaul. The researcher’s recommendations offered below make suggestions as to ways in which the status and profile of chaplains may be raised.

The results of the Expectations of the Role of Hospital Chaplains survey showed that participants considered chaplains to have an overall value and that they are expected to be part of the team. The extent to which this is happening varies from hospital to hospital. On the whole there was confusion by all groups as to what they expected the expression ‘chaplain’s role’ to mean. There was little consistency in the replies either within or between groups. The exception was that there is no doubt the ‘comforter’ role is that most clearly expected of the chaplain, with the ‘witness’ role a close second. Although it was expected that chaplains would perform ‘liturgist’ tasks, these did not rate highly in order of importance. This strengthens a case for more involvement by trained lay chaplains, as Consecrating the bread and wine for the Sacrament of Holy Communion is the major difference between ordained clergy and
lay chaplains in some denominations. With the diminishing number of candidates entering theological colleges for ordination, and the increasing need for chaplains of all denominations, more emphasis needs to be placed on training of the laity.

With so much inconsistency in the individual expectations of the chaplaincy role by all groups, it is difficult to assess conclusively how the medical staff and patients view the role of chaplains, by comparison with the views of the chaplains themselves. However, the patients and chaplains’ replies disagreed the most, with female patients in particular disagreeing with male chaplains. In some instances the percentage of ‘yes’ and ‘no’ replies in particular groups was very close, suggesting that, although the group calculations show one thing, there is inconsistency of replies amongst the individual participants. Senior medical staff and nurses showed the least overall disagreement with the chaplains; however, the majority of the combined doctors and nursing groups disagreed with the patients on more questions than they agreed. The inconsistency of replies indicates reason for concern in that there appears to be a lack of information available regarding very basic aspects of chaplaincy. Participants, including some chaplains themselves, did not seem to understand the role of chaplains or the tasks are expected to perform.

Perhaps surprisingly, denominations/religions and gender did not influence answers to any great extent, but the age of participants did play some part in survey replies. The conclusion here is either that religion becomes more important to these patients as they approach the end of their lives or that religion was more significant to them when they were younger that it is to the present younger people. Some of the more experienced senior doctors and nurses were also more inclined to value the chaplain’s input on their wards.

The majority of participants expected that chaplains could be male or female, but six of the chaplains themselves expected they would be male only. This again indicates confusion by chaplains of their own role. About half of the participants considered a chaplain would be a minister of the church, with the remainder considering they could either be a minister or a lay person, providing formal training to perform the required duties had been obtained. The researcher’s recommendations with regard to chaplaincy training are recorded below.

Almost two-thirds of the participants expected that chaplains would minister ecumenically when required, thus indicating that they considered the chaplain’s ministry to be the word of one God, not simply the word of one particular denomination.

Whist a high percentage of participants stated they would welcome a routine visit by a chaplain, only a small number said that they would specifically request to see a chaplain. A reason for this could be that people may not realize that their help is
beneficial and so more chaplains are needed to show this. If the situation ever arises where the local parish clergy replace hospital chaplains, such clergy would, in all probability, visit only their own ‘flock’ unless specifically asked to visit someone else. The result of this would primarily be that only patients who attend church would receive hospital visits. It is important, therefore, that hospital chaplains strive to increase their status in the future to ensure the continuation of their hospital ministry. The higher the profile, both within the Church and within the hospitals, the greater the chance of acquiring chaplaincy funding.

The question of counselling by chaplains and the form this should take produced uncertainty amongst all participants. This is an area where chaplains must be careful not to overstep their boundaries and intrude into the disciplines of other staff without liaising with them, or without the relevant training. The chaplains themselves had varied views as to what they considered would be expected from them with regard to the ‘counsellor’ role. The individual hospital to which they were attached had a definite bearing on their replies. Whilst different types of hospitals will, to some extent, require different forms of chaplaincy, the high percentage of uncertainty regarding the ‘counsellor’ questions highlights the need for greater interaction between various medical institutions and religious bodies. The Health and Welfare Chaplains Association and the College of Chaplains do hold meetings and conferences at which they can discuss their ministry with each other, but much more interaction between chaplains and other medical disciplines appears to be necessary.

The senior doctors and nurses held a high expectation that the chaplains would be liaison persons between patients and staff when necessary, and a high percentage also expected the chaplain would conduct pastorally related lectures. These are activities which should be expanded in an attempt to forge closer relationships and understanding between chaplains and staff. In the latter case, chaplains need adequate training in this aspect of their work.

Chaplains are also expected, by the majority of participants, to hold services of worship in the hospital. However, the administration of Holy Communion and performance of Baptisms in hospital are not considered part of the chaplain’s role as a matter of course, but only if requested. Whilst some hospitals conduct separate denominational services for the patients and staff, ecumenical services, combining key elements of different religions/denominations, are also frequently conducted.

A great number of participants stated that they used to attend church regularly but no longer do so. This does not, of course, necessarily mean that they have not retained their own personal relationship with God. It does, however, probably mean that they do not have any contact with a parish minister and, thus, without the availability of a chaplain in the hospital, they would have no opportunity of receiving
any required spiritual assistance during hospitalisation. As stated above, the majority of patients indicated that they would not specifically request pastoral or spiritual help. The reasons for this may be that: they do not realise that such services are available; they do not want to be a nuisance; they feel self-conscious about asking; or that they do not think it will help.

The two most significant points arising from this ‘expectations of the role of chaplains’ survey are, firstly, that the number of patients who stated they had not received a chaplaincy visit indicates a definite need for a greater number of hospital chaplains; secondly, that there is a great deal of confusion and ambiguity amongst all groups as to their expectations of the chaplain’s role.

This scenario prompted the conducting of the second survey to assess what actual tasks are being performed by chaplains. It was decided to conduct the survey in three different States, utilising hospitals containing similar specialised units. For this purpose three Liver Transplant Units were selected: those of The Austin Hospital, Victoria; Royal Prince Alfred Hospital, New South Wales; and Princess Alexandra Hospital, Queensland. Only one LTU operates in each of these States. Royal Prince Alfred and The Austin Hospitals were founded much earlier than Princess Alexandra, all three being public hospitals. Each contains many specialised units requiring specific skills; the high profile Liver Transplant Units belong to this category. However, the three Units are operated very differently. The Austin Unit has an holistic approach to the patients, concentrating on physical, spiritual, emotional and psychological needs, with extensive chaplaincy input for both patients and staff to the point of inviting the chaplain to be present in the operating theatre during transplantations. This particular chaplain receives her salary from the actual Unit funding. The RPA Unit places its priority on the physical aspect, of the patient’s well-being, with the chaplain playing an important, but small part in the team; their chaplain’s role is primarily with the patients rather than the staff. The PAH Unit is different again. Whilst, to a certain extent, adopting an holistic approach, this Unit does not greatly utilise chaplaincy, electing instead to employ the services of a former transplant recipients to assist present patients. This coordinator performs much of the same duties as the first chaplain, minus any pastoral involvement or being present in the theatre during transplant operations. Although the transplant coordinator’s duties mainly involve the patients, she has a close working relationship with many of the medical staff.

In order to assess any advantages or otherwise in the three different systems, the lengths of stay of patients in each unit were compared over a five year period. The results of this showed that the unit with the most chaplaincy input recorded a faster average discharge rate than the other two. The unit utilising the coordinator without the pastoral aspect but with a strong personal involvement was not excessively higher. The other system, which did not
utilise the chaplain, recorded considerably longer lengths of stay. The two units which recorded the shorter lengths of stay provided a more personal approach to patients, whilst the other, adopting a more business-like attitude, recorded the longer period. Medically all three units are beyond reproach, all achieving outstanding results, but the absence of a non-medical team member to assist with spiritual and emotional factors appears to have extended the recipients' time in hospital. It is not meant to imply that the older traditionally-run unit does not have individual staff members who take a personal interest in the patients' welfare and emotions. However, the key to procuring shorter hospital stays for patients appears to be an approach which incorporates having one special person to whom the patients can relate from the start to finish of their transplantation. In one case this is a chaplain, in another a co-ordinator, indicating that it does not necessarily have to be a chaplain, although the LTU patients who received the additional benefit of the chaplain’s pastoral role were, on an average, discharged earlier.

A quicker turnover of patients also constitutes a cost-saving to governments and hospitals which cannot be ignored, and presumably, is a reflection of improved rehabilitation on the part of the patient. The conclusion drawn in this thesis is that something more than physical medical treatment is needed for patient rehabilitation; this, in many cases, could be the spiritual and emotional comfort afforded by chaplains as it appears evident that when the pastoral role is added to other healing benefits, the patient’s recovery is faster. As previously noted the co-ordinator of the Unit with the second-rated results, states that she is not a pastoral worker and, whilst performing an excellent service with good results, the work she does is well-suited to a trained chaplain's role with the additional benefit of pastoral and spiritual help. It is considered that chaplains should not be letting opportunities like this escape them.

A further attempt to assess the differences in the three unit systems was intended, by calculating staff sick leave. Again, the first chaplain was instrumental in ministering to staff with a view to minimizing stressful situations. The amount of sick leave taken by the first unit’s staff was again comparable to the unit utilising the co-ordinator. However, this research could not be completed as the hospital to which the third unit is attached would not release their sick leave figures, stating that it was against their hospital policy.

As with the Expectations of the Role of Hospital Chaplains survey, there was no inconsistency in the actual tasks being performed by chaplains. Despite the fact that the three surveyed units are in different States, it is considered that the extent of differences in the chaplaincy duties are excessive. Of the three, The Austin Hospital Unit, with its own heavily involved chaplain, shows the best all-round results and this type of unit and ward chaplaincy is recommended. The testimonials from patients, relatives and staff of The Austin shown in Chapter 5 support this type of chaplaincy,
which encompasses all facets of the LTU, including ministry to the theatre staff during surgery when needed. The presence of the chaplain at the time trauma occurs, as in the theatre situation, contributes towards minimising effects of such trauma at a later stage. The fact that The Austin chaplain is employed and paid directly by the LTU in an ongoing capacity signifies the high esteem with which she is held and makes her an integral part of the Unit team, not an external visitor on the perimeter. Whilst, as stated previously, some hospitals do already adopt various forms of unit and ward chaplaincy, any attempt to introduce an Australia-wide system as used by The Austin Liver Transplant Unit, would involve significant changes in chaplaincy training and administration.

The recommendations below may be considered too innovative by some, who may feel that the basic spirituality and purpose of chaplaincy would be lost, or at least damaged, by expanding its role. However, this research indicates that changes certainly need to be made if hospital chaplaincy is going to survive in the current theological and financial climate.

3. RECOMMENDATIONS

The Australian College of Chaplains has prepared a list of proposals which indicates the purpose of the College. These proposals show that the College is aware of the need to enhance the prestige and standards of chaplaincy by endeavouring to: provide recognisable standards of pastoral and professional competence among chaplains; promote awareness of such standards among chaplains, churches and institutions; encourage chaplains to pursue further education in the theology, philosophy and practice of chaplaincy; initiate research projects and programmes to develop the understanding of the philosophy and practice of chaplaincy; assist chaplains in developing their pastoral identity alongside other professionals; and promote among churches and institutions greater awareness of the need for particular educational opportunities for chaplains. In addition, most hospital chaplaincy Policy and Procedure Manuals include their own individual requirements of chaplains relating to qualifications, task expectations and lines of authority.

These proposals are, on the face of it, very admirable; they advocate a high quality of training and professionalism of the kind this researcher would like to see implemented for all hospital chaplains, visiting parish clergy and hospital pastoral workers. Unfortunately, it is considered that the College is ‘putting the cart before the

---

horse’ by proposing to develop chaplaincy alongside other professionals, and further the education of chaplains, whilst the present narrow training methods exist. Theology is the basic root of hospital chaplaincy, however medical and scientific developments necessitate the expansion of the chaplain’s present role. It is considered that qualifications for admission as a Fellow of the College need to be modified. At present there is too great an emphasis on theological and self-awareness training only, and not enough on pastoral counselling, basic general counselling, basic psychology and people skills. (See 2b below).

Amongst the theological requirements for acceptance as a College Fellow is, at least, three year’s full-time tertiary theological education (or part-time equivalent) at an acceptable institution. Exceptions to this are sometimes made for persons who are unable to meet this requirement but believe they do, nevertheless, qualify theologically; an assessment of their theological qualifications may then be made by one of the Australian and New Zealand Association of Theological Schools. All applicants must also have completed at least 1200 hours of clinical pastoral education or its equivalent, which incorporates self-awareness sessions and patient case verbatims. The College also requires that applicants be actively engaged in chaplaincy for a minimum of 20 hours per week. The concept of the Australian College of Chaplains has been viewed as the standards setting arm of the Health and Welfare Chaplains Association.4

Whilst the theological standards and qualifications set by the College of Chaplains need to be retained, it is considered by this researcher that an additional postgraduate course, specifically designed for chaplaincy, is warranted. Recommendations for this are shown below. See 3b).

A further point arising from the above, is that the high standards of the College are designed primarily as a guide for full-time, paid chaplains who have completed theological degrees and many hours of clinical pastoral education. There are many others, of various denominations, who are ministering in hospitals in a part-time or voluntary capacity who have not had such an extensive training. Many are members of the laity who have undertaken minimal hospital ministry training, but have received approval from the religious bodies to minister in a hospital, often performing similar duties to those of the full-time chaplains. The general lack of funding for chaplaincy careers in Australia may discourage many assistant chaplains or pastoral workers from extending their studies; under the present conditions only limited possibilities exist for them to obtain a paid position on completion of such further studies. Regardless of this situation, it is considered that any person acting in the capacity of a chaplain, assistant chaplain, or pastoral worker, should be governed by the same high standards recommended by the College of Chaplains’ if chaplaincy is to be considered alongside

---

4 Australian College of Chaplains, op.cit., pp.5-6.
other hospital disciplines. This is not intended to discourage lay persons from becoming chaplains; rather it is intended as an incentive to encourage them to become better qualified. This situation also applies to parish clergy who combine hospital chaplaincy duties with their other work; many do not complete CPE courses, but rely on the minimal pastoral training received whilst studying for their theological degrees.

a. Theological and Pastoral Educational Methods

For many years, Clinical Pastoral Education courses have tended to dominate chaplaincy training. This approach has been taken, not only by the College of Chaplains, but with pastoral theology in general in Australia and the United States of America. This is in contrast to the United Kingdom where CPE, with its limitations, is not the dominant model for training chaplains.

The central focus of CPE has been the nurturing of self-awareness, verbatim, small group interaction and reflection which, as noted by Denham Grierson, ‘has been a rich, creative and innovative exercise in ministry over the last 50 years or so. The debt generations owe to the CPE movement is immense’.\(^5\) However, Grierson then adds, ‘but the sun is setting on the present paradigm. The foundations have begun to shake. Intuition as well as experience tells us that if we are not yet standing in the middle of a collapsed paradigm, we soon will be’.\(^6\) Established orthodoxies are being swept away by structural changes and reconstruction in society generally, which will necessitate the emergence of new paradigms for pastoral care training, together with educational, health, welfare and community services. Hospital chaplains and pastoral workers are going to need more than theological and self-awareness training to survive in the way society is moving. As noted by Grierson, ‘spirituality is a hard idea to market. The growing need to justify oneself in economic terms means that the warrant of being a representative of the Christian faith is now subsidiary to being a competent professional in pastoral care’.\(^7\) This indicates that the present CPE program needs to be extended and opportunities for advanced qualifications made available. A postgraduate course as suggested below, would accommodate this by maintaining the roots of pastoral care and, at the same time developing skills pursuant to functioning in this changing society.

There is a radical move to community care out of institutions which requires a redefinition of role for many hospital staff members, including the role of the chaplain/pastoral worker. This is a universal situation and from the American


\(^6\) Ibid., p.24.

\(^7\) Ibid., p.25.
perspective, Gordon J. Hilsman believes that 'grafting as in tree and plant grafting is a metaphor for what needs to happen to CPE at this time of changing health care structures and objectives'.

Physicians and nurses are changing their styles of practice with new structures for inpatients, higher outpatient numbers and an increasing focus on preventative care. As noted by Grierson above, this trend will necessitate new competencies to the ministry of hospital chaplains and Hilsman also writes of changing paradigms, saying that 'if some modern prophets are right, there is a paradigm shift taking place in health care chaplaincy, and a consequent vast need for further training that may be significantly different from traditional CPE'.

Clinical Pastoral Education programs need to be structured in conjunction with other health care systems to prepare certified and experienced chaplains capable of working in integrated system configurations of health care.

It is probable that shifting paradigms in chaplaincy and pastoral care are being influenced by increasing candidacy changes for the ordained ministry in Australia. In the past, students were typically young males of Anglo-Saxon background who were either single or married heterosexuals, from largely homogenous denominational and theological cultures. Today they are often female, many of Asian or other cultural backgrounds, sometimes divorced, sometimes homosexual, and may come from a variety of ecclesiological and theological perspectives. From an educational stance, there is an increasing intake of older students into theological training centres, often possessing a wealth of individual learning, experience and understanding.

This means that, as Stephen Reid notes:

The ideal of a content-driven curriculum in which students, beginning from a common starting point go through the procedures of learning information and skills necessary to doing theology and ministry within a reformed, evangelical tradition, and then applying this knowledge and skill to a uniform kind of pastoral ministry, is no longer likely to be relevant.

A theological education which only imparts information about theological doctrines, traditions of Church, ministry and sacraments is no longer adequate training for a

---


10 Hilsman, op.cit. p.12, ‘Grafting CPE’.


12 Ibid., p.28.
pastoral ministry in a diversity of communities.\textsuperscript{13} This was supported in The National Church Life Survey 1996 which indicated that whilst, overall, 78\% of Anglican and Protestant senior leaders felt their training had adequately equipped them for their present work, the Anglican leaders showed an above average level of dissatisfaction with their specific training as pastors.\textsuperscript{14}

When discussing the present versus the future regarding theological education in Australia, Dennis Kirkaldy notes:

Theological education has tended to be re-active rather than pro-active. There has been a continual tension between meeting the needs of the present and making the kind of preparations that are required to take theological education into the future.\textsuperscript{15}

In the United States, most clergy undertake some counselling and psychology courses during their seminary training. Protestant clergy who pursue additional training invariably complete CPE and pastoral counselling training in accredited hospitals, churches or pastoral psychology centres. During the past decade, however, much ambiguity has developed due to the rapid expansion of pastoral counselling training within academia rather than in churches, hospitals or free-standing institutes. Colleges and universities often focus on a distant commitment to ecumenical study and encourage the growth of lay ministry within the church. However, as noted by Paul Giblin and Jay Stark-Dykema, ‘few of them have the theological training to warrant the image of “bearer of the tradition” and much ambiguity surrounds the public dimensions of their ministry, their set aside status and processes for their ecclesial validation and accountability’.\textsuperscript{16} In contrast to this, the type of course suggested below would be a purely postgraduate chaplaincy course to be pursued following an approved level of theological training by either ordained or lay persons.

As noted above, the CPE movement has been a valuable training tool for chaplains and pastoral workers for many years, however, some aspects of it are open to criticism. Christopher Newell has raised the question of ethics arising out of the

\textsuperscript{13} Ibid., p.28.
CPE verbatim method when course participants repeat to other participants information which a patient may have considered to have been given in confidence. As Newell notes:

Significant issues of consent arise, in that many admitted to the teaching hospital environment may expect nursing and medical students to use case stories and to discuss cases, but other disciplines predominantly do not figure in the minds of people. Not only do we not get consent, but our interpretation is not checked, in that we have no quality assurance or representation of the interests of patients........We might ask whether or not we do justice to notions of confidentiality in our use of narrative, especially in small centres where people actually know who the so-called depersonalised person is.\footnote{Newell, Christopher, ‘Pastoral Care and Ethics: Some Reflections’, in Ministry, Society and Theology, Vol.11, No.2, Nov.1997, pp.105/6.}

Newell is right in that permission is not sought from patients by CPE course members to discuss a case with other course members, nor is the patient given an opportunity to check the correctness of the CPE participant’s interpretation of events. This could, as suggested by Newell, certainly involve a question of ethics. Newell criticises the ‘inflexible pedagogy of curriculum and teaching’ and questions why ‘a recognition of prior learning and different skills and competence’ are not considered. He also asks why ‘the physically demanding routine of face to face attendance is the norm as opposed to recognising different ways of being in community, which is at the heart of the CPE experience’.\footnote{Newell, op.cit., p.108.} New ways of learning are needed for the rurally isolated and others who may not be able, for various reasons, to attend face to face CPE courses following initial theological study at rural institutes. Although not an ideal solution as a replacement for face to face teaching, where the opportunity to ask questions and participate in group discussion is available, preliminary correspondence CPE courses may be appropriate. Beyond this, CPE supervisors are needed who are willing to visit and conduct courses in isolated areas. If a uniform postgraduate course, as suggested below, were to eventuate, it is hoped that such a course would become available in some rural institutes.

There is a need to expand advanced CPE training for specific issues and Christopher Newell suggests pastoral training for specific issues is one way of doing this. Newell was involved in a successful seminar held as a continuing professional development workshop by the Tasmanian Chapter of the Australian Health and Welfare Chaplains Association in November, 1997. The title and focus of this seminar was ‘Okay, I have a disability, but am I sick?’ and addressed the social nature of disability and its manifestation in pastoral care. By utilising people with disability
and their pastoral carers, and by introducing role plays regarding living with disability, bio-psycho-spiritual aspects of disability were introduced which encouraged a change to the often misunderstood world view of disability. More seminars of this nature would assist chaplains and other pastoral workers in providing care for people with disabilities in both institutional and community settings and could be used as a model for other specific issues.\textsuperscript{19}

Suggested ways to enhance pastoral carers’ proficiency, comes from America by way of George M. Furniss who notes that openness to social theory is increasing in the recent pastoral care literature of such writers as Archie Smith, Charles Gerkin, James Fowler and Don Browning, where a sociological perspective is being incorporated into their work.\textsuperscript{20} Furniss notes that ‘the sociologist asks how individuals are shaped by their society and how society can be influenced and changed by individuals’.\textsuperscript{21} The value of sociology for pastoral care is seen where a pastoral worker informed by the socialists’ viewpoint displays a conscious understanding of the cultural context of individual problems.\textsuperscript{22} As Peter Berger observes, ‘it is “bad Faith” for people to have the distorted view that they are helpless victims of the way things’.\textsuperscript{23} Chaplains/Pastoral workers can be instrumental in helping to overcome feelings of alienation, meaninglessness and powerlessness in patients.

Also from America comes a critical review of clinical pastoral care practices, in which Michael S. Koppel\textsuperscript{24} notes that contemporary educational theorist Mary Elizabeth Moore considers the integration of the case study method and process thought are suitable for clinical pastoral education. This conclusion is drawn from


\textsuperscript{21} Furniss, \textit{op. cit.}, p.359.

\textsuperscript{22} Ibid., p.359.


Moore's statement that 'a case helps bridge the gap between theory and practice; helps develop skills of discernment and decision-making; and introduces "real life" into academic settings.' Koppel notes also that Knowles believes life experience can serve as a learning resource, but Koppel points out that life experience may also serve as an impediment for learning, his reason being that 'studies in various learning settings, and with different populations of chaplains, may yield detailed evidence to describe the possible factors involved that may either stimulate or stifle learning.'

b. Recommendations for Required Training and Qualifications

In order to raise the status and prestige of hospital chaplaincy, it is recommended that it becomes a profession in its own right, not merely an offshoot of mainstream theological professions. To achieve this it is considered that a comprehensive degree course needs to be established, possibly through theological colleges, which will equip chaplains with the knowledge to expand their present role in hospitals or other medical institutions. To achieve the level of professionalism which would place hospital chaplaincy on a par with other allied health professionals, it is considered that a degree course is warranted. Such a degree course should be designed on an ecumenical basis as a postgraduate course to be completed after a person has completed acceptable training in the theological beliefs of their own denomination or religion. The course should be open to both ordained ministers/priests and members of the laity.

Suggested subjects for the course include:

* Present Clinical Pastoral Education Course material
* Basic theology of all religions/denominations
* Pastoral counselling
* Basic general counselling,
* Grief counselling
* Post-hospitalization counselling
* Basic psychology
* Basic social work
* Basic speech pathology
* Obstetric patient counselling and ministry

---


* Dementia awareness and ministry
* Ways to conduct effective pastoral lectures to medical and other hospital staff
* Ministry to relatives
* Ethics and law - legal and religious/denominational
* Ministry to transplant patients and donor relatives
* Ministry to paediatric patients
* Ministry to geriatric patients
* Ministry in outpatient departments
* Ministry to people with psychiatric and mental disabilities
* Ministry to people with physically disabilities

A number of colleges run various courses for ordained ministers and the laity, such as the United Theological College in North Parramatta, NSW, and the Melbourne College of Divinity in Kew, Victoria. These courses could be used as a basis for a specialised chaplaincy course which would train candidates to specialise in a chosen area, rather than pursue basic pastoral duties alone. They would have an all-round training which would enable them to assimilate into the hospital on a more intrinsic basis. This type of training would not detract from the present pastoral and spiritual duties of the chaplain, but would give them a greater understanding of other disciplines and promote team work between themselves and other staff members. Such a course is not intended to displace other disciplines, but to allow chaplains to relate to psychologists, counsellors and social workers in a knowledgeable way. Most allied health disciplines overlap with each other at times, and so this is to be expected in this case as well. When this occurs, a chaplain with an understanding of other disciplines is in a better position to discuss a case with an allied health worker to the patient’s advantage. The chaplain’s principal contribution to the hospital team is his/her theological expertise. However, basic knowledge of related disciplines, such as psychology, counselling and social work, would contribute towards making the chaplain a core member of the team. With correct training, the danger of the chaplain’s overstepping into other disciplines should be minimised. The patients and staff should benefit greatly from the chaplain’s all-round knowledge. It is not suggested, however, that Australia should adopt the cross-training model which has been implemented at the Mercy Hospital in San Diego, California, where a project called Creative Actions Reflecting Excellence (CARE 2000) commenced in June, 1990. This project was designed to help hospital patients become more focused. For two to three weeks, staff at the hospital received intensive training learning the roles of other caregivers. Josie Gable-Rodrigues, the Orthopaedic Unit chaplain was taught to give bed baths,
take vital signs, document intake and output, CPR, interview and admit patients, turn and walk orthopaedic patients and some physical therapy skills. It was not expected that chaplains, nurses, physical therapists, case managers or social workers would not master their own expertise and continue to perform their own duties, the cross training goal of the CARE 2000 model was to change staff attitudes from ‘that is not my job’ or ‘I’ll get your nurse’ to I can do that for you’. As Gable-Rodriguez says, this translates to the chaplain occasionally passing meal trays, transporting patients, making beds and helping to admit patients. This, in effect, extends the chaplain’s role and also gives the chaplain an opportunity to assess a patient whilst helping another staff member. Gable-Rodriguez further feels that, as a CARE 2000 chaplain, he is more visible and involved with the Orthopaedic Unit, staff and patients. Surveys conducted since the CARE 2000 model began reflect a significant increase in patient satisfaction, together with a quicker discharge of patients. This is despite some confusion and ambiguity that the cross training model holds for some patients. Gable-Rodriguez believes there is a place for cross-training in hospitals, but that the spiritual and emotional needs of patients must always be the chaplain’s first consideration.27

Whilst, as noted above, it is not suggested that Australia should instigate this CARE 2000 model, the completion of a postgraduate degree course by chaplains based on the above recommendations, would enhance their status in the eyes of many hospital administrators and staff members to a level rivalling that of other professionals in the hospital.

Whilst such a postgraduate degree may not be considered relevant or necessary by some chaplains or pastoral workers, the writer believes it is something which should be seriously considered if chaplaincy as such is going to survive in the future. The basis for this statement is that an increasing number of allied health professionals are now performing duties which were once considered the domain of chaplains. Grief counselling is a typical example of this: in the case of Westmead Hospital, for example, a grief counsellor with no theological or pastoral training is employed by the Hospital to counsel friends and relatives, when necessary, following the death of a patient. Other examples are those special counsellors employed to assist hospital staff with traumatic and emotional problems, as has been shown in the case of Royal Prince Alfred Hospital: special counsellors are also commonly employed to relate to Aboriginal patients. Social workers, psychologists and psychiatrists are increasingly involved with patients, spending much time dealing with such problems as drug or alcohol dependency, HIV/AIDS related cases and depression. The possibility exists that a continuing expansion of allied health disciplines may relegate

hospital chaplaincy to the point where chaplains are simply redundant. This highlights the need for chaplains to be accepted on a similar level as allied health staff, who require various qualifying degrees to perform their duties.

From an analysis of 60 articles appearing in six health care journal issues in the United States, Larry VandeCreek has concluded that ‘interdisciplinary health care authors neglect professional chaplaincy when they discuss spirituality’. He is concerned that if professional chaplaincy is not included in discussions by those who speak out and establish themselves as authorities about spirituality, then the health care decision-makers will reasonably conclude that chaplaincy is not valuable. Such a view of chaplains by institutional policy-makers can lead to the assignment of spiritual care being given to other professions. A valid point raised by VandeCreek is that, whilst journals geared towards religion and health may be important to the religious sector, the preferred target should be the professional community who will listen to research language. To focus merely on those who believe religion to be a clinical important factor, is squandering the opportunity to target those professionals and their respective fields that resist the idea that religion is clinically relevant. Chaplains can also enhance their status by responding to requests for inter-professional presenters at seminars during which the opportunity arises to educate other professionals about the role and functions of professional chaplains. The professional chaplaincy group is small in the United States, as in other countries, in comparison to other professional groups and their program is not academically recognised on the same level as medical, nursing and allied health programs. For professional chaplaincy to thrive, therefore, it must redefine its values and be heard by the decision-makers. Chaplaincy must stand up for expertise in religion and spiritual care. VandeCreek considers that ‘it will require both firmness and cooperation with health care colleagues, who, in the process of reforming themselves, will gladly claim the profession of spiritual care for themselves without sufficient regard for adequate training or expertise’.

c. Recommendations for Extended Chaplaincy Involvement

In addition to normal routine hospital rounds, the above training course would equip chaplains to become involved in specific areas where chaplaincy could be

29 Ibid., p.418.
32 Ibid., p.432.
advantageous. The following areas are recommended as possible extensions to basic hospital chaplaincy:

i. Hospital Day Surgeries and Outpatients' Departments

Hospital day surgeries and outpatients’ departments are introducing more and more complex procedures which can be extremely stressful to patients. Cancer sufferers undergoing radiotherapy or chemotherapy treatment in oncology departments are particularly vulnerable due to the uncertainty of whether such treatment will be successful, the after effects of the treatment causing nausea, loss of hair and depression. It is considered that meaningful ministries could be developed in these day surgeries and outpatients’ departments to help combat the stress associated with such symptoms. Unfortunately, these areas often appear to be neglected by ward chaplains

ii. Speech Pathology

Financial cuts to health, education and community services have increased the need for greater professional teamwork. One strand of the medical profession which has been affected by these cuts is that of speech pathology. This is one area, in particular, where ‘hospital chaplains are sometimes a neglected human resource available to speech pathologists as a ministry to both staff and patients’. With more services, less funding and fewer therapists, the speech pathology profession is one which would benefit from teamwork with the chaplaincy profession rather than striving alone with their problem solving.

iii. Post-Acute Care Services (PACS)

Post-Acute Care Services and Hospitals in the Home programs are operating through many hospitals now. Ann Brown, Manager of the Prince of Wales Hospital Post-Acute Care Service in Sydney, advises that Hospitals in the Home provides an alternative to hospitalisation for selected patients of any age. She stated that the levels of patient and carer satisfaction are high, but costs are lower than hospitalisation. She adds that no social workers are involved in their scheme as they are not usually needed. For PAC patients, any problems of a social work nature would have been addressed whilst the patient was in hospital; for Hospitals in the Home patients, the visiting team would be aware of the patient’s situation and any relevant problems. The

scheme has not been extended to include chaplaincy visits, although the Manager stated that a chaplain's visit may sometimes be applicable and helpful. Financial costs and the availability of chaplains may be contributory to their omission from the scheme. This is unfortunate, as many of these patients would have similar needs to those of hospitalised patients, such as pain, fear, loneliness, depression or confusion.

iv. Long Term Nursing Home Care

Many long term nursing home residents suffer greatly, often searching for ways to regain some meaning in their lives. Many have suffered great loss, losing a spouse, their home and friends, their independence and their vigour; a caring, understanding chaplain may well be able to help such people. An extension of hospital chaplaincy could be instigated to visit nursing homes which do not have chaplaincy services of their own.

v. Home Visits to People with Physical and Mental Disability

People suffering different forms of disability may sometimes benefit from the ministry of a chaplain, particularly if they are unable to attend church. For those living in group accommodation, a form of church service may be applicable, whilst others may benefit from individual ministry.

vi. Ministry to Dementia Sufferers

This is an area with unlimited opportunity for chaplaincy ministry, both in hospitals and nursing homes. Kay Melbourne notes this:

It is difficult for us to guide confused residents through the Life Review Process, so helpful to all ageing people. However, involvement in old familiar forms of worship and religious practices will be a catalyst for reminiscence and serve as a prompt for these residents to recall their roots - their identity. Our challenge is to find appropriate ways to enable these residents to be strengthened by familiar faith expressions and religious observances rather than threatened by them.35

Hospital staff often find dementia patients difficult to handle. At such times the chaplain can become a valuable member of the team, spending time at the bedside, often creating a calming effect on the patients by telling them that they are not alone, that Jesus loves them and is always with them. Quiet words such as this, together with a simple prayer, will commonly settle such patients down, regardless of the stage to which their dementia has progressed. Although reactions vary depending on circumstances, in this researcher's experience gained whilst regularly conducting

devotions at the dementia specific Chesalon Nursing Home at North Parramatta, it is very rare for the chaplain not to recognise some form of spiritual awareness in dementia patients at these times. Dementia patients living in their own homes may also benefit from pastoral visits, as do nursing home residents. Some residents may respond to a familiar prayer or hymn, while others may like to be shown a particular picture of a biblical scene or a church, or place which has meant something to them in the past. There is a great need for chaplaincy, not only to the dementia sufferer but also to their carers, who often feel isolated and lonely, unable to visit friends or attend church. Carers are often forgotten; many do not realise the stress involved in looking after dementia patients. There is most certainly a great need for ministry in the field of dementia.

vii. Ministry to Obstetric Patients

A special ministry to new parents is required. Psychological and spiritual needs of both mothers and fathers often arise, particularly if the baby was unplanned, stillborn, premature or is born with some kind of deformity or mental abnormality. The parents of such babies often have a mixture of pent-up emotions, including guilt, fear, anger and grief. These emotions can create stress or depression and the presence of a chaplain is often warranted.

viii. Paediatric and Geriatric Chaplaincy

Both these areas afford a potential for specialised ministry, not only in hospitals and nursing homes, but in residences of physically or mentally disabled children and the elderly. There is also an opportunity here for an extended ministry to parents and carers. Again, this could deserve an extension to hospital chaplaincy.

ix. Ministry to Rehabilitation Patients

Many patients find rehabilitation a difficult and frustrating process, particularly when this is long-standing. They become bored and impatient where the progress is slow. These patients are invariably discharged from a general type hospital to a smaller, specially equipped facility, where the services of a chaplain are frequently needed.

---

36 Elliot, Hazel, ‘Religion, Spirituality and Dementia: pastoring to sufferers of Alzheimer’s disease and other associated forms of dementia’, Disability and Rehabilitation, Vol. 19, No. 10, 1997, pp. 435-441. The views expressed here and in this article are endorsed by the Nursing Director of the North Parramatta Chesalon Nursing Home.
x. Ministry to Transplant Patients and Donor Relatives
Transplant patients may have problems coming to terms with the fact that someone has had to die for them to live; this can be a very traumatic situation for the patient. Discussing topics such as ‘continuing life’ in an eschatological sense with a chaplain may be invaluable towards the patient’s transplant acceptance. Similarly, the transplant donor’s relatives have special needs; not only have they lost someone who was important to them, but they also have to accept that, due to the strict Australian privacy laws, a complete stranger is continuing to live with part of their relative in his or her body. A highly specialised ministry is needed for these people.

d. Recommendations for Increased Lay Chaplaincy Input
With the wide variety of ministry available to chaplains, it is recommended that trained lay chaplaincy be strongly promoted. It has been shown that many more chaplains could be utilised if funding were to become available for such positions. Indications concerning the continuing fall in numbers of ordained ministers/priests suggest that the use of more trained lay chaplains is warranted. It has also been shown that many patients and staff members do not attend church; there is the possibility that these patients/staff members may feel more comfortable with and better able to relate to a lay chaplain.

e. Recommended Funding Procedures
At present chaplains are being paid by several different methods, some by their religious body, some by the hospital at which they minister and some by individual parish churches. For some, ordained ministers and lay chaplains, there is no funding available and their ministry is executed on a voluntary basis. Methods of funding vary in different States, with some governments, including Victoria, allocating grants to religious bodies for chaplaincy on a percentage pro-rata basis and others, like New South Wales, providing assistance only for prison and psychiatric hospital chaplains, not for general hospital chaplaincy. The method adopted in Victoria is that a certain total sum of money is allocated and a percentage distributed to each religious body based on the number of people officially listed as belonging to that body. If the status of chaplains were to be raised, governments may be prepared to negotiate where funding is concerned.

The recommendation is for chaplaincy funding to become more centralised, with a common source of revenue and payment of salaries to chaplains. By knowing the amount of funding available for chaplaincy, administrators would be in a position to prepare suitable chaplaincy programs. For many years the majority of chaplains’ salaries were paid by religious bodies; however, much of the available funding for
chaplaincy has been withdrawn or greatly reduced. This eliminates the payment of salaries to chaplains by religious bodies, even providing for additional funding from governments. The alternative is for governments to allocate specified funding to hospitals for chaplaincy so that the hospitals may then employ the chaplains.

There is a risk that such a method could cause a conflict of interests in that, as the employer, the hospital may consider it has the right to dictate the terms of the chaplains’ ministry, which may be different from those required by the various religious bodies. Concrete guidelines would thus need to be negotiated between the governments, hospitals and religious bodies for this system to work. In the case of the The Austin Hospital where the chaplain’s salary is paid by the Liver Transplant Unit direct, this chaplain has received complete freedom from the hospital as to the manner in which she conducts her ministry; she is an accepted member of the LTU team on these grounds. The chaplain’s acceptance by other staff members on a professional level similar to that of other allied health workers has largely contributed to the success of The Austin system. This would appear preferable to the system operating at Royal Prince Alfred Hospital, where the LTU chaplain is paid by his religious body. Whilst being given freedom as to the way in which he conducted his ministry, he is not accepted as part of the team to the extent of The Austin chaplain. Many chaplains may fear that traditional spirituality and pastoral care would be adversely affected if a system such as the one suggested were to be implemented, preferring to remain primarily under the jurisdiction of the Church with hospital approval, rather than under the hospital with Church approval. Despite this, it is still the recommended method of funding, and it is possibly the only long term method available when the diminishing religious funding for chaplaincy is taken into account.

f. Unit and Set Ward Chaplaincy

It is highly recommended that chaplains and administrators seriously consider the benefits of ecumenical unit and set ward chaplaincy. This provides patients with their ‘own’ chaplain, and gives non-religious patients the opportunity to receive a routine chaplain’s visit which can be extended if requested. The benefits of this have been illustrated by the successful ministry being conducted in the Liver Transplant Unit of The Austin Hospital, where the chaplain is part of a team providing holistic care for patients, not just physical healing.

g. Ethics Committees

A further recommendation is that more chaplains endeavour to be selected to serve on Hospital Ethics Committees. This is an area where the chaplains’ expertise and guidance could be positively utilised by other Committee Members, particularly
when interpretations regarding the Church’s stance on controversial issues are required. As a member of the Ethics Committee, the chaplain would seen as someone whose opinion is considered important and a valued contribution to the hospital.

h. Pastoral Lectures to Staff

Also recommended is the implementation of measures whereby chaplains may give or instigate pastoral lectures to hospital staff, both medical and administrative. Such lectures give the chaplain an opportunity to explain his/her pastoral duties towards the patients, relatives and staff. In this way, staff will come to know the chaplain better and it will, hopefully, encourage them to approach the chaplain privately if the need occurs.

4. RESEARCHER’S CONCLUDING COMMENTS

Governments, hospitals, religious bodies and chaplains themselves ought seriously to consider the feasibility of implementing all, or at least some, of the above recommendations. Such changes would take time and much reorganisation; they could not be achieved overnight. Whilst some may consider many of these suggestions to be quite unfeasible and unnecessary, this research indicated that this is not the case. With foresight, courage to accept change, patience, dedication and hard work, these recommendations would be achievable. Indeed, it is considered that they are necessary if chaplaincy is going to keep pace with the scientific growth of medicine in the future. It is important that the future of hospital chaplaincy is protected by ensuring that adequate training and funding will be available in 10 or 20 years’ time; that chaplaincy will be given due priority by religious and medical bodies; and that governments, hospitals, religious bodies and chaplains will negotiate these changes among themselves, and so work together to achieve these objectives.
BIBLIOGRAPHY


Antoninus, ‘Circa medicos’ in *Confessionale*, s.v.

Antoninus, *Summa theologiae*.

Aquinas, Thomas, *Summa theologiae*, 2-2, 64, 8,2


*Austin Hospital Annual Report, 1993.*


Davoren, Ron, ‘Perceptions on the Role of Hospital Chaplains’, *Quality Assurance Survey of the Medical and Nursing Staff at Concord Repatriation Hospital*, 1993.


Elliot Hazel and Carey Lindsay, ‘The Hospital Chaplain’s Role in an Organ Transplant Unit’, in Ministry, Society and Theology, Vol.10, No.1, July 1996.


Florell, John Loren, Crisis Intervention in Orthopedic Surgery, a dissertation for the degree of Doctor of Philosophy, Northwestern University, USA, 1971.


Howe, John,  *The Order and Manner of the Proceedings in the First Erection of the Three Royal Hospitals of Christ, Bridewell and St. Thomas the Apostle*, 1582.


McGuirk, Jenny, ‘Developing Ministry Within a Specialist Unit’, an address to the *Australian Health and Welfare Chaplains Association*, University of New South Wales, 1994.


Minucius, Felix, *Octavius*, 2.43.


New South Wales Health Department, Circular issued by Michael Reid, Director General, File No.A4534, Circular No.98/42, 19th June, 1998.


New South Wales Legislative Assembly Sub-Committee's Report of Sydney Infirmary (Votes and Proceedings, 1870.


Oxman, Thomas E, et al., in Psychosomatic Medicine, 57/1, Jan/Feb. 1995.


Pearson, Alan, ‘Organ donors programs neglect family needs’, *Australian Hospital*, Feb./March, 1996.


*Princess Alexandra Hospital - Brisbane South Regional Health Authority Annual Report*, 1994/5.


Royal Prince Alfred Hospital - Central Sydney Area Health Service Brochure.


St. Vincent’s Hospital Archives, Hospital Review, November, 1967 and 110th Annual Report, 1968, St. Vincent’s Hospital, Darlinghurst.


Sydney Morning Herald Newspaper, 16th, 17th, 20th September, 1870, a Fairfax ‘rights’ publication.

Tertullian, Apologeticum and nationes, 1.15.

Tertullian, De Anima, 25.5.


Thwaites (ed.) Early Western Travels, 1748-1846 ii, 1904.


APPENDIX I

COPY OF LETTER RECEIVED FROM ROYAL NORTH SHORE HOSPITAL AND COMMUNITY HEALTH SERVICES DATED 7TH APRIL 1993, REGARDING RESEARCH APPROVAL BY THEIR NURSING RESEARCH ADVISORY COMMITTEE.

Dear Ms. Elliot,

NRAC CODE: 935

The Nursing Research Advisory Committee, (NRAC), has approved your research proposal entitled “Expectations of the Role of Hospital Chaplains” subject to a few modifications. Sue Harvey (your NRAC link person 438-8460) has contacted Keith Little to discuss this further.

As it is part of NRAC’s policy to keep track of current research in the hospital could you keep me informed of your progress.

(Signed)

Rosa Portus, Chairperson, Nursing Research Advisory Committee.
APPENDIX II

COPY OF LETTER RECEIVED FROM ROYAL NORTH SHORE HOSPITAL AND COMMUNITY HEALTH SERVICES DATED 30 APRIL, 1993, REGARDING THE RESEARCH APPROVAL BY THEIR ETHICS COMMITTEE.

Dear Ms. Elliot,

Re: RNSH Protocol No. 9302-25(M) - H Elliot

Expectations of the Role of Hospital Chaplains.

Thank you for providing a revised application for your study on the above protocol. In addition, the MREC were informed at the last meeting on 21 April 1993 that all the requirements of Nursing Administration had been met.

I am now pleased to inform you that your protocol has been approved.

In order to comply with the Guide-lines for Good Clinical Research Practice (GCRP) in Australia, and in line with RNSH MREC policy, may I remind you that it is the Chief Investigator’s responsibility to ensure that:

A report is provided to the MREC at the completion of the study.

The MREC is notified as soon as possible of any changes to the protocol. All changes must be approved by the MREC before continuation of the research project. This includes notifying the MREC of any changes to the staff involved with the protocol.

Yours sincerely,

(Signed) Gillian M. Shenfield, Chairman, Medical Research Ethics Committee
APPENDIX III

COPY OF LETTER RECEIVED FROM MOUNT DRUITT HOSPITAL AND COMMUNITY HEALTH SERVICES, DATED 19 FEBRUARY, 1993, RE RESEARCH APPROVAL.

Dear Ms. Elliot,

I refer to your correspondence of November 1992 regarding your thesis entitled ‘Expectations of the Role of Hospital Chaplains’ and would confirm my telephone advice of 17 February 1993 that approval is granted to undertake the survey, as indicated, at Mount Druitt Hospital.

Please accept my apology for the delay in forwarding this advice. There has been some concern within my Organisation regarding the time that study of this type might entail for our chaplaincy staff. However, on review, it is anticipated that their involvement will need to be for short periods of time only and, accordingly, the Hospital would be pleased to provide access on the basis detailed in your original correspondence.

Could you please arrange access to the Hospital through the Head of the Chaplaincy Department, Sr. Therese Dougherty, who can be contacted on 625 1599.

The Hospital wishes you every good fortune with your study and looks forward to a copy of the completed report.

(Signed)

Colin Osborne, Executive Director.
APPENDIX IV

COPY OF LETTER RECEIVED FROM GREENWICH HOSPITAL (HOME OF PEACE), DATED 26 MAY, 1993, RE RESEARCH APPROVAL.

Dear Ms. Elliot,

Request to conduct Survey on ‘Expectations of the Role of Hospital Chaplains’

I must apologise for the delay in giving notification that your research project, to be conducted at Greenwich Hospital, has now been approved by the Home of Peace Hospitals Ethics Committee. Dr. Geoffrey Glassock has already advised you that the Ethics Committee has given approval of your project proceeding, as outlined in your proposal with the questionnaire you submitted.

I have now advised the Director of Service at Greenwich that approval has been given and that they may facilitate the staff and patients taking part.

I enclose a copy of the Research Report and it would be appreciated if you would let us know how the project is progressing/when completed.

With good wishes,

Yours sincerely,

Signed: T.J. Philips, Chief Executive Officer.

Mr. R. Cadman, General Manager; Dr. S. Wilson, Director of Clinical Services; Miss B. Fox, Director of Nursing; Dr. P. Macaulay, A/Director of Palliative Care.
APPENDIX V

*The Anglican Church of Australia.*

*The Catholic Church - Archdiocese of Sydney.*
Father Brian Lucas, Press Officer and Cardinal's representative on policy matters.
Bede Heather, Bishop of Parramatta, also completed the questionnaire, but due to overseas commitments he was unavailable to be interviewed at the requested time.
Any relevant differences between Bishop Bede's and Father Lucas' replies have been discussed in Chapter 3.

*The Baptist Church of New South Wales.*
Rev. John Edmondstone, Director of Home Ministries.

*The Uniting Church in Australia.*
Rev. Harry Herbert, General Secretary, Board of Social Responsibilities.

*The Salvation Army.*
Major Shirley Bruce, Secretary, Territorial League of Mercy.

*The Presbyterian Church in New South Wales.*
Colin Llewellyn, Executive Officer, Social Service Department completed the written survey but was not available to be interviewed. His Assistant Executive Officer, Alan Dearn replaced him.

*The Seventh-Day Adventist Church.*
Pastor Adrian Craig, President of the Greater Sydney Conference of the Seventh-Day Adventist Church.

*The Jewish Orthodox Church.*
Rabbi Raymond Apple, Senior Rabbi of the Great Synagogue, Sydney.
### APPENDIX VI

#### Doctors

<table>
<thead>
<tr>
<th>D.a. Sex</th>
<th>Male □</th>
<th>Female □</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.b. Religion</td>
<td>Christian □ (denomination)</td>
<td>Buddhist □</td>
</tr>
<tr>
<td>D.c. Age:</td>
<td>20 - 29 □</td>
<td>30 - 39 □</td>
</tr>
<tr>
<td>D.d. MedicalSpeciality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX VII

Registrars, Residents and Interns

I.a. Sex
Male □ Female □

I.b. Religion
Christian □ (specify denomination)..........................
Buddhist □
Moslem □
Jewish □
Other □ (please specify).................................
No Religion □

I.c. Age:
20 - 29 □
30 - 39 □
40 or over □

I.d. Year commenced medical training?..........................
### Nurses

<table>
<thead>
<tr>
<th>N.a</th>
<th>Sex</th>
<th>Male □</th>
<th>Female □</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.b</td>
<td>Religion</td>
<td>Christian □</td>
<td>(denomination)..........................</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buddhist □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moslem □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jewish □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other □ (please specify)......................</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Religion □</td>
<td></td>
</tr>
<tr>
<td>N.c</td>
<td>Age:</td>
<td>Under 20 □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 - 29 □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 - 39 □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40 - 49 □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 - 59 □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>60 or over □</td>
<td></td>
</tr>
<tr>
<td>N.d</td>
<td>Position held:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N.e</td>
<td>Years of experience:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX IX

Patients

P.a. Sex
Male ☐ Female ☐

P.b. Religion
Christian ☐ (denomination)..........................
Buddhist ☐
Moslem ☐
Jewish ☐
Other ☐ (please specify)......................
No Religion ☐

P.c. Age:
Under 20 ☐
20 - 29 ☐
30 - 39 ☐
40 - 49 ☐
50 - 59 ☐
60 - 69 ☐
70 - 79 ☐
80 or over ☐

P.d. How long have you been in hospital? ............................................

P.e. Why are you in hospital? .................................................................
**APPENDIX X**

**Chaplains**

<table>
<thead>
<tr>
<th>Ca.</th>
<th>Sex</th>
<th>Male □</th>
<th>Female □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cb.</td>
<td>Religion</td>
<td>Christian □ (denomination)</td>
<td>Buddhist □</td>
</tr>
<tr>
<td>Cc.</td>
<td>Age:</td>
<td>Under 20 □</td>
<td>20 - 29 □</td>
</tr>
<tr>
<td>Cd.</td>
<td>Position held:</td>
<td>..........................................................</td>
<td></td>
</tr>
<tr>
<td>Ce.</td>
<td>Are you ordained □</td>
<td>or lay □</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>C.f.</td>
<td>If lay, are you a member of a religious order?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.g.</td>
<td>If not of a religious order, do you receive any remuneration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.h.</td>
<td>From whom do you receive such remuneration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.i.</td>
<td>Are you <em>formally</em> authorised by a Church Authority?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.j.</td>
<td>Are you a member of a local parish acting as a lay visitor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.k.</td>
<td>Have you completed a C.P.E. or equivalent course?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.l.</td>
<td>If so, where?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.m.</td>
<td>Duration of course?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.n.</td>
<td>How long have you been attached to your present hospital?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Expectations of the Role of Hospital Chaplains

1. Do you know that there are hospital chaplains?  
   Yes ☐  No ☐

2. Do you expect a Chaplain will be:  
   Male ☐  Female ☐  Either ☐  Don’t know ☐

3. Do you expect a Chaplain will be:  
   A minister of the Church ☐  A lay person ☐  Either ☐  Don’t know ☐

4. Do you expect a Chaplain will be:  
   Trained in chaplaincy ☐  Not trained in chaplaincy ☐  Either ☐  Don’t know ☐

5. Do you expect that all Chaplains will be of the Christian faith?  
   Yes ☐  No ☐  Don’t know ☐
6. If a patient is non-Christian would you expect the Chaplain to represent all faiths? 
   Yes ☐
   No ☐
   Don’t know ☐

7. Do you expect that a Chaplain will routinely visit all patients? 
   Yes ☐
   No ☐
   Don’t know ☐

8. Would you welcome such a visit? 
   Yes ☐
   No ☐
   Don’t know ☐

9. Will you specifically request to see a Chaplain whilst in hospital? (Patients only) 
   Yes ☐
   No ☐
   Don’t know ☐

Would you Expect a Chaplain to

10. Have access to patients, relatives and staff at most times? 
    Yes ☐
    No ☐
    Don’t know ☐

11. Push a religious approach? 
    Yes ☐
    No ☐
    Don’t know ☐
12. Pray with patients individually? Yes ☐ No ☐ Don't know ☐

13. Help patients to formulate their own prayers? Yes ☐ No ☐ Don't know ☐

14. Pray privately for individual patients? Yes ☐ No ☐ Don't know ☐

15. Pray or read scriptures during every visit? Yes ☐ No ☐ Don't know ☐

16. Be trustworthy with confidentiality? Yes ☐ No ☐ Don't know ☐

17. Listen to the patients? Yes ☐ No ☐ Don't know ☐

18. Show care, compassion and kindness? Yes ☐ No ☐ Don't know ☐
19. Be a witness of God’s love and concern?  
   Yes ☐  No ☐  Don’t know ☐

20. Discuss patients’ fears and anxieties?  
   Yes ☐  No ☐  Don’t know ☐

21. Discuss matters of faith?  
   Yes ☐  No ☐  Don’t know ☐

22. Give spiritual comfort?  
   Yes ☐  No ☐  Don’t know ☐

23. Help patients examine their lifestyle to improve health (i.e. stop smoking, drinking, worrying, over-exertion)?  
   Yes ☐  No ☐  Don’t know ☐

24. Help patients to clarify and understand their own feelings and emotions.  
   Yes ☐  No ☐  Don’t know ☐

25. Help patients to use their hospital experience positively?  
   Yes ☐  No ☐  Don’t know ☐
26. Promote reconciliation between patient and God?  
   Yes □  
   No □  
   Don’t know □

27. Defend when a patient is angry or disillusioned with God?  
   Yes □  
   No □  
   Don’t know □

28. Discuss sport, entertainment or any other topic if a patient shows a desire to do so?  
   Yes □  
   No □  
   Don’t know □

29. Listen to patients’ complaints concerning hospital administration or staff and report such complaints to persons concerned?  
   Yes □  
   No □  
   Don’t know □

30. Assist patients during a crisis?  
   Yes □  
   No □  
   Don’t know □

31. Assist relatives during a crisis?  
   Yes □  
   No □  
   Don’t know □

32. Help patients face death?  
   Yes □  
   No □  
   Don’t know □
33. Help relatives cope with death of patient?  
   Yes ☐  
   No ☐  
   Don’t know ☐

34. Answer questions from patients  
   pertaining to their medical condition?  
   Yes ☐  
   No ☐  
   Don’t know ☐

35. Have access to patients’ medical records?  
   Yes ☐  
   No ☐  
   Don’t know ☐

36. Visit a patient before an operation?  
   Yes ☐  
   No ☐  
   Don’t know ☐

37. Administer or arrange for administration  
   of the Holy Communion to patients if  
   requested?  
   Yes ☐  
   No ☐  
   Don’t know ☐

38. Hold services of worship in the hospital?  
   Yes ☐  
   No ☐  
   Don’t know ☐

39. Baptise in hospital if requested?  
   Yes ☐  
   No ☐  
   Don’t know ☐
40. Conduct lectures for medical staff on pastoral concern subjects?
   Yes ☐
   No ☐
   Don’t know ☐

41. Help hospital staff with personal problems?
   Yes ☐
   No ☐
   Don’t know ☐

42. Help hospital staff with work problems?
   Yes ☐
   No ☐
   Don’t know ☐

43. Consult with medical staff on ethical issues (i.e. abortion, IVF, life supports, etc.)
   Yes ☐
   No ☐
   Don’t know ☐

44. Counsel patients on ethical issues?
   Yes ☐
   No ☐
   Don’t know ☐

45. Be part of a team with doctors and nurses for the overall care of patients
   Yes ☐
   No ☐
   Don’t know ☐

46. Be an integral part of the whole hospital system?
   Yes ☐
   No ☐
   Don’t know ☐
47. Liaise with Parish clergy concerning individual patients?
   Yes ☐
   No ☐
   Don’t know ☐

48. Be employed by:
   The Hospital ☐
   Religious Body ☐
   Government ☐
   Other ☐

49. Do you think the guidelines for the Chaplain’s role would be formulated by:
   The Hospital ☐
   Religious Body ☐
   Government ☐
   Other ☐

50. Do you consider the Chaplain’s role to be advantageous for a patient’s well-being during hospitalization?
   Yes ☐
   No ☐
   Don’t know ☐

51. What do you think is the most important task of a Chaplain?
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

52. Is there any other task that you think a Chaplain should perform?
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
53. Do you attend Church
   Regularly
   Occasionally
   Weddings/Baptisms/etc.
   Never

54. Did you ever attend church (i.e. as a child or before illness)?
   Regularly
   Occasionally
   Weddings/Baptisms/etc.
   Never

55. If you have ever been a hospital patient were you visited by a Chaplain?
   Yes
   No

   (This question was omitted for the patients and reworded as under)

PATIENTS ONLY

55. Have you been visited by a hospital Chaplain during this stay in hospital?
   Yes
   No

56. Have you been visited by a hospital Chaplain during any previous hospitalization?
   Yes
   No
APPENDIX XII

Additional Statistical Data Relating to Section 2.

WITNESS QUESTIONS

Question 19: Would you expect the chaplain to be a witness of God’s love and concern?

Only 2.2% (1) of the overall participants answered no to this question, with 85.9% (396) yes; 10.2% (47) don’t know and 1.7% (8) no answer. There were no significant variances for this question, but 2 of the chaplains answered don’t know.

Question 21: Would you expect the chaplain to discuss matters of faith?

The majority of the overall participants expected the chaplain to discuss matters of faith; 79.2% (365) yes; 11.5 (53) no; 7.6% (35) don’t know and 1.7% (8) no answer.

Question 22: Would you expect the chaplain to give spiritual comfort?

Only 1.1% (5) overall participants replied negatively to this question, whilst 94.4% (435) answered with a direct yes; 3.5 (16) don’t know and 1.1% (5) gave no answer. Of the 26 participants who did not expect the chaplain to give spiritual comfort, more than half were patients.

Denomination/religion/no religion, gender, age or hospital were not significant.

COMFORTER QUESTIONS

Question 17: Would you expect the Chaplain to listen to the Patients?

Yes 97.8% (451); No .2% (1); Don’t Know 0.2% (1); No Answer 1.7% (8).

Question 18: Would you expect the Chaplain to show care, compassion and kindness?

Yes 98.5% (454); No Answer 1.5% (7)
**Question 20:** Would you expect the Chaplain to discuss patients’ fears and anxieties?

Yes 90.9% (419); No 3.3% (15); Don’t Know 4.1% (19); No Answer 1.7% (8).

The majority of no and don’t know replies came from firstly, the patients and secondly, the nurses. There were no relevant factors regarding denominations, hospitals, etc., and whilst two/thirds of the patients answering no were male, all the nurses were female.

**Question 28:** Would you expect the Chaplain to discuss sport, entertainment or any other topic if a patient shows a desire to do so?

Yes 89.8% (414); No 4.6% (21); Don’t Know 5.0% (23); No answer 7.7% (3).

The no and don’t know answers were fairly evenly spread across all groups, other than the combined chaplains who unanimously replied in the affirmative.

**Question 30:** Would you expect the chaplain to assist patients during a crisis?

Yes 95.4% (440); No 2.0% (9); Don’t Know 1.5% (7); No Answer 1.1% (5).

**Question 31:** Would you expect the chaplain to assist relatives during a crisis?

Yes 94.1% (434); No 2.6% (12); Don’t Know 2.0% (9); No Answer 1.3% (5).

**Question 32:** Would you expect the chaplain to help patients face death?

Yes 96.3 (444); No 7.7% (3); Don’t Know 2.2% (10); No Answer 9% (4).

**Question 33:** Would you expect the chaplain to help relatives cope with the death of a patient?

Yes 95.2 (439); No 1.5% (7); Don’t Know 2.0% (9); No Answer 1.3% (6).

The 7 participants who answered no and 6 of those answering don’t know were patients. All the no replies came from the Royal North Shore Hospital and most were Catholic, but it is not considered a high enough percentage to be of any consequence.

**Question 36:** Would you expect the chaplain to visit a patient before an operation?

Yes 79.0% (364) No 8.9% (41); Don’t Know 10.2% (47); No answer 2.0% (9).
COUNSELLOR QUESTIONS

**Question 24:** Would you expect the chaplain to help patients to clarify and understand their own feelings and emotions?

Participants were much more in tune with this question, replying with 83.5% (385) yes; 7.8% (36) no; 6.9% (32) don’t know and 1.7% (8) no answer.

The patients and nurses recorded the highest no and don’t know percentages, but these were not considered high enough to be significant, neither were any other statistics relating to this question.

**Question 25:** Would you expect the chaplain to help patients to use their hospital experiences positively?

*Yes* 83.5% (385); *No* 5.2% (24); *Don’t Know* 9.8% (45); *No answer* 1.5% (7)

Again, no significant dissensions occurred.

RESOURCE QUESTIONS

**Question 29:** Would you expect the chaplain to listen to patients complaints concerning hospital administration or staff and report such complaints to the person concerned?

The overall figures for this question were 55.5% (256) yes; 32.8% (151) no; 8.9% (41) don’t know; and 2.8% (13) no answer.

**Question 40:** Would you expect the chaplain to conduct lectures for medical staff on pastoral concern subjects?

There was a surprisingly high percentage of don’t know replies to this question, with 52.1% (240) yes; 22.6% (104) no; 23.4% (108) don’t know and 2.0% (9) no answer.
**Question 45:** Would you expect the chaplain to be part of a team with doctors and nurses for the overall care of the patient?

*Yes* 74.6% (344); *No* 13.2% (61); *Don’t Know* 10.4% (48); *No Answer* 1.7% (8).

The no replies were spread fairly evenly across the groups, with the junior doctors recording the highest no percentage of 21.2% and the patients 17.7% don’t know.

No other elements appears significant.

**Question 46:** Would you expect the Chaplain to be an integral part of the whole hospital system?

*Yes* 82.9% (382); *No* 7.6% (35); *Don’t Know* 7.2% (33); *No Answer* 2.4% (11).

Again the junior doctors and patients recorded the highest no and don’t know responses, but none of the other figures appear to be of relevance.

**Question 47:** Would you expect the chaplain to liaise with parish clergy concerning individual patients?

*Yes* 72.9% (336); *No* 9.5% (44); *Don’t Know* 14.8% (68); *No Answer* 2.8% (13).

**LITURGIST QUESTIONS**

**Question 37:** Would you expect the chaplain to administer or arrange for administration of the Holy Communion to patients, if requested?

*Yes* 91.8% (423); *No* 3.0% (14); *Don’t Know* 3.9% (18); *No Answer* 1.3% (6)

There were no significant factors amongst the no and don’t know responses.

**Question 38:** Would you expect the chaplain to hold services of worship in the hospital?

*Yes* 83.3% (384); *No* 7.2% (33); *Don’t Know* 7.2% (33); *No Answer* 2.4% (11).
Question 39: Would you expect the chaplain to Baptize in hospital if requested?

Again, the majority of participants were in accord with each other and other groups, recording 85.7% (395) yes; 5.9% (27) no; 5.9% (27) don't know and 2.6% (12) no answer.

SMILE! YOUR HAVING A GREAT DAY
APPENDIX XIII

LIVER TRANSPLANT UNIT SURVEY

HOSPITAL__________________  OCCUPATION________________

1 (a) WHAT HAS CREATED THE MOST TRAUMA/STRESS FOR YOU AS A MEMBER OF THE LIVER TRANSPLANT UNIT TEAM?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(b) HAVE YOU DISCUSSED THIS PROBLEM WITH THE UNIT CHAPLAIN?

YES  NO

If “yes” proceed to (c)  If “no” proceed to (e)

(c) WAS THE CHAPLAIN HELPFUL?___________________________________________

(d) CAN YOU SAY HOW THE CHAPLAIN HELPED YOU?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(e) IF YOU DID NOT DISCUSS A TRAUMATIC/STRESSFUL SITUATION WITH THE CHAPLAIN, IS THIS BECAUSE -

i) One was not readily readily available______________________________________

ii) You did not feel he/she could have helped________________________________

Why not?________________________________________________________________
  ________________________________________________________________________

iii) Any other reason______________________________________________________

  ________________________________________________________________________
1 (f) DO YOU CONSIDER DISCUSSING PROBLEMS WITH THE CHAPLAIN HELPS TO REDUCE STAFF SICK LEAVE?
   i) For yourself - YES NO
   ii) For others - YES NO

2 (a) IS THE CHAPLAIN INVOLVED IN DECISION-MAKING OF THE LIVER TRANSPLANT UNIT?
       YES NO

(b) IS THE CHAPLAIN HELPFUL IN ASSESSING A PATIENT’S SUITABILITY FOR A TRANSPLANT?
       YES NO

If ‘yes’ - HOW?

(c) IS THE CHAPLAIN’S INPUT A HELP IN THE EXECUTION OF YOUR WORK PERSONALLY?
       YES NO

If ‘yes’ - IN WHAT WAY?

(d) IS THE CHAPLAIN’S INPUT A HELP TO THE OVERALL RUNNING OF THE UNIT?
       YES NO

If ‘yes’ - IN WHAT WAY?
APPENDIX XIV

LIVER TRANSPLANT SURVEY ANSWERS

Question 1 (a) - What has created the most trauma/stress for you as a member of the Liver Transplant Unit?

Princess Alexandra Hospital

* Death of a patient
* Nil - I see patients post T/P with generally positive outcomes, even patients awaiting T/P are not usually in acute situations.
* When a diseased liver is invested into a patient and the patient then died, e.g. no one's fault, just stressful.
* Having potential donors and recipients in the same unit. Death of a T/P patient after operation.
* Death
* Patients not surviving
* None so far
* Organ donor operations on children
* On call: Daily ward rounds (seven days a week every week).
* Death of recipient patient
* Death of a patient
* When patients you know very well have problems with their new T/P and don’t make it through and die.

The Austin Hospital

* Patient death
* Two people dying, donor and recipient - Transplantation of alcoholics
* Death of patient awaiting/having received a T/P.
* Death of a patient
* Death of a young patient
* The amount of time and money being spent on people who were likely to continue with self-destructive behaviour (alcoholism/driving abuse) post-transplant.
* The loss of a patient after a long struggle with their illness
* Death of young patients that I know well
* Unexpected death of patient 7 days post-transplant.

Royal Prince Alfred Hospital

* When my patients die, especially shortly after liver transplantation
* Getting up in the middle of night and working for many hours on not much/no sleep. But just because this issue causes the most trauma it doesn’t mean it is the only trauma/stress
* Seeing patients die on the waiting list
* Long hours - degree of patient illness
* Patients dying unexpectedly
* Death of long term patient
* Watching the stress engendered in my colleagues
* Fatigue
* Death of long-standing patient associated with suffering and close personal involvement with family - Sudden death of young patient with young family usually in the setting of infra-operative death or acute liver failure
* Death of a patient
* Decision making in unclear and unresolvable clinical problems
* Death
* Caring for patients pre-transplant who deteriorate - only one patient can have a transplant, i.e. ethics in choosing between patients for transplant
* Poor staff mix, i.e. enrolled nurses and new graduate nurses who are unable to participate fully in their share of patient care
* The understaffing, especially when it is really busy
* The two-faced backstabbing amongst nursing co-workers

Question 1 (e) ii) - If you did not discuss a traumatic/stressful situation with the chaplain is this because you do not feel he/she could have helped? (The following reasons were given by participants who felt the chaplain could not have helped).

**Princess Alexandra Hospital**

* These are medical problems. I feel that they (the chaplains) should not be party to details of medical information.
* It's not avoidable and we have a good team spirit to debrief and an excellent social worker.
* Not seeing the patient daily while well and sudden deteriorating crisis developing and staff counsellor available if necessary.
* Don't know
* Inappropriate - Demands of the job
* I usually deal with these issues myself
* Staff counsellor available
* Because the chaplain is more to help our patients not the staff

**The Austin Hospital**

* I was able to turn to my husband and close friends for the support I required. I am not religious and would have felt uncomfortable discussing this with the chaplain
* Our chaplain is an emphatic and supportive person, she could have and would have helped if asked
* I don't feel I need a chaplain to talk to - I talk to peers, etc.

**Royal Prince Alfred Hospital**

* I don't know my chaplain well enough
* It is a logistics problem, not a spiritual/belief one
* Yes
* I felt the stress was appropriate and did not need resolution. Also I am Jewish
* Staff members tend to rely on each other for support, as everyone understands the difficulties
* Thought to be inappropriate
* Not appropriate to the nature of the problem and associated stress
* I discuss problems with my friends and fellow colleagues. Our chaplain is friendly and approachable. I have just never thought of approaching him when feeling stressed out.

Question 2 (b) - Is the chaplain helpful in assessing a patient’s suitability for a transplant?

**Princess Alexandra Hospital**

* All participants answered ‘no’ with the exception of one recording the following comment -
May give some input as assessment panel member. Depending on the patient’s own outlook and needs. May decide not to have surgery.

The Austin Hospital

* Yes - contributing to knowledge about the patient - from a different perspective
* Yes - By being involved in the social and spiritual assessment of the patient and his/her support network. She can at times develop a real friendship with a patient and is able to determine from their conversations whether the patient is ready for a transplant.
* Yes - If the chaplain is able to relate well to the patient and family then her view of the overall emotional state of the patient and family can be of use. As a member of the team the chaplain can express her opinion - however, I feel this is more as the role of counsellor than chaplain
* Yes - Often able to assess coping skills and support structures. Patients often more likely to confide in chaplain
* Yes - Assessing psychological state and if patient is prepared to accept another person’s organ
* Yes - She brings individual skills, personal/professional, which contribute to the teams decision-making processes
* Yes - Helping decide if people are appropriate for T/P.
* Yes - Very helpful in assessing patient’s understanding of the procedure and ability to cope

Royal Prince Alfred Hospital

* Yes - To ensure that there is no religious conflict with accepting the transplant
* Don’t know
* Yes
* Yes - Stability of outlook of patient
* Yes - His input and suggestions as a non-medical member of the multi-disciplinary team
* No
* Don’t know
* Don’t know
* Yes - His input is valuable re patient’s personality and coping skills. General spiritual beliefs of patients are considered
* Not applicable - we do not accept or reject a patient on whether they are Christian/atheist/agnostic - it does not come into it
* Yes - Provides useful input on psychological issues and spiritual questions where relevant
* Yes - The chaplain makes an excellent judge of character and is useful in assessing a patient’s coping ability and general philosophy
* Don’t know
* Don’t know
* Don’t know

Question 2 (c) - Is the chaplain’s input a help in execution of your work personally?

Princess Alexandra Hospital

* Every participant recorded a ‘no’ reply without comments.
The Austin Hospital

* Yes - Staff liaison, dealing with spiritual needs of patients and families
* Yes - She can explain patients' feelings, moods and ascertain what we can do to assist the patient
* Yes - She is usually available to sit with patient and family if there are any questions/patient is upset and requires reassurance and support that cannot be provided by the nursing staff due to their heavy workload
* No
* Yes - A great support to me as a Christian in the workplace
* Yes - Able to relate to patients in a way I am unable to and often don't have enough time to
* No
* No
* Yes - Very helpful in assessing patients' understanding of the procedure and ability to cope. Enormously helpful in my personal dealings with distressed relatives

Royal Prince Alfred Hospital

* No
* No - But it would be beneficial to talk about death/dying, life in the hereafter, reincarnation, etc.
* Don't know
* No
* No
* No
* Yes - Difficult decisions sometimes need to be made - His input is considered and therefore of value
* No
* Yes - One of several members of the team providing input about how the patient and family are coping. Suggestions on how to deal with patients and family.
* No
* No
* Don't know
* No

Question 2 (d) - Is the chaplain's input a help to the overall running of the Unit?

Princess Alexandra Hospital

* Yes - Helps patients, not really staff
* No
* No
* No
* No - Many patients find a need to have spiritual guidance available during their hospital stay and many have continued with this path following successful surgery. However, I feel if any patients or relatives tend to lean towards 'God' in their hours of uncertainty staff members have made all necessary arrangements for the hospital chaplains to call on their patients. Other than routine visits some patients have expressed that they want NO visitation from chaplains while in hospital.
The Austin Hospital

Yes - Liaison with staff and debriefing after stressful situations
Yes - She is very valuable to the patients and staff in times of sadness. The patients seem to open up to her whereas they don't open up to nursing staff
Yes - As previously stated our chaplain is incredible in that she may be found to be at the hospital at 0200 in the morning if she feels the situation warrants her being there.
Yes - Everyone's input is useful - we all look at patients from different views, however, if patients are not religious, the role of the chaplain is as counsellor if they have good counselling skills
Yes - Seen as a resource and support person for all staff when having difficulty with illness/death/difficult patients, and for providing a link with patients, families, etc.
Yes - Provides an opportunity for staff and patients to speak about their feelings and thoughts in an appropriate manner
Yes - She brings individual skills, personal/professional, which contribute to the teams decision-making processes
Yes
Yes - Above reasons, plus provides emotional/psychological support for staff, patients and relatives

Royal Prince Alfred Hospital

Yes - Any help to the patient is a help to the Unit
No - If s/he doesn't help me personally, then s/he can't help the overall running of the Unit as I am part of it. I would doubt if the chaplain has seen ANYBODY from the theatres except may be the Clinical Nurse Consultant as she is the one who attends meetings - so if you don't go to meetings you don't meet the people. May be the chaplain sees only 'key' people - not the 3 a.m. workers! I would say that is fairly typical at big hospitals. This is not a good situation. Thank you for your interest
Yes - Positive influence with patients
Yes - Support for families of patients in the Intensive Care Unit
Yes - His non-medical opinions and thoughts
No
Don't know
Don't know
Yes - His input is valuable re patients
No - Not applicable - the chaplain is not required to assist in the overall running of the Unit
Yes - One of several members of the team providing input about how the patients and their families are coping, questions on how to deal with patients and family
Yes - Patients feel care for and speaking to the chaplain reduces stresses which makes for improved recovery
Don't know
Don't know
Don't know
APPENDIX XV

Interview with Dr. Bob Jones, The Director of The Austin Hospital Liver Transplant Unit

This way of running a Transplant Unit was a new concept and I had only a broad overseas model to base it on. I gathered together a core of interested participants and asked them what they considered they could contribute to the Unit, exactly what and how they would do things. The idea was to establish a Unit run completely on an integrated team basis. Each prospective participant gave a professional description of their discipline, including doctors, nurses, allied health workers, chaplain and so on. Everyone knew what would be done by each other and it was explained that they would all be of equal importance in the team. The emphasis was on team work, not just in name, but practice. This created a few problems at first and a few noses were out of joint. Some felt their professional standings were being threatened and feared others would overstep into what they felt to be their domain. The allied health staff were more formalised than the medical staff, the social workers, in particular, due to their training, held back at first waiting to be asked questions and they had to be encouraged to intercept and say ‘hey, hang on, I don’t agree there’. It took time, but eventually a real working team emerged, individuals no longer feel professionally threatened and if it will help a patient for team members to overlap disciplines, this is discussed and done. For instance, a patient may take to the chaplain and not like the social worker, or vice versa. It is obvious the one they feel more comfortable with will do more good, so the situation is discussed and the patient’s needs best met. Each team member now turns to other members for help and guidance. Our weekly meetings keep everyone completely informed about every patient, their progress, needs, problems, etc.

The chaplain’s inclusion to the extent of being present in the theatre during operations was questioned at first, but the advantages of this seemingly unusual procedure were soon realised and accepted. (This aspect was further discussed with the Theatre Sister). Jenny is the one who becomes most involved with the relatives and their dependence on her and their need of her presence is quite obvious. I think proof of her need by these relatives is shown when a patient dies, because through her involvememnt with them during the whole pre-transplant process, these relatives invariably ask Jenny to perform the funeral service. To me this is proof of the chaplain’s worth without any need to produce academic evidence. Believe me, there are times when not to have Jenny around would be impossible.
APPENDIX XVI

Interview with Ann Hayden, Theatre Nurse at The Austin Hospital since 1974.

The feedback I get from many patients is that without Jenny they would have given up the idea of a transplant or would have suffered depression. When theatre nurses have problems I always suggest that they ring Jenny. I know of four definite cases where they have done this and have been helped. When nurses ask me why they should talk to Jenny and not other nurses, I say that confidentiality is very important and that whilst other nurses may gossip amongst themselves, what they say to Jenny will not be repeated.

She always seems approachable, she has a cheerful smile and is easy to talk to. When she walks into the theatre you can feel her presence, everyone seems to relax more knowing she is there.

Procurements are very traumatic for the nurses, all the donor’s organs are usually taken, not just their livers and the body is very disfigured. Jenny’s help at this time is unquestionable and immeasurable, she goes with the nurses to the morgue and prays with them. She really helps them through it. The theatre nurses are very caring and they visit the transplant patients before their operations, it is all part of the team work that has built up.

There were a few problems at first, particularly about Jenny being in the theatre. One of the anaesthetists queried it, but he accepted her presence when I explained the assets involved.

Quite frankly I couldn’t envisage the Unit without her.
APPENDIX XVII

Interview with Pam Wilton, The Austin Hospital Liver Transplant Unit Clinic Nurse

Jenny has wonderful patient and family rapport. It is nice to have someone who is not medical, but who can liaise with doctors quickly.

The knowledge that Jenny will be in the theatre reassures patients and families and she is able to liaise with families during the long operations and let them know the stage the operation has reached and how it is going. This is a great reassurance to families to know if things are going well without having to wait until it is completely over. This assurance is very important to the family.

Jenny is also able to assess the spiritual readiness of patients for transplants.

She helps staff deal with death and holds services for them - she helps staff grieve. She is also asked to take funeral services by families. It is nice for staff to know they can grieve. They build bonds with patients.

Jenny is available always. Patients often ask to talk to Jenny after the operation to help with after-care problems. She has wonderful skills.
APPENDIX XVIII

Interviews with Senior Nursing Staff of The Austin Hospital Transplant Wards Roger Nicholls, Charge Nurse, Ward 7A Medical - Pre-Transplant.

Jenny is a support for the team, not just part of the team. Nurses get upset sometimes, particularly when patients die. Jenny holds memorial services for the staff to help them come to terms with it. She is a team counsellor and an individual counsellor. Clinical Pastoral Education base responses alone are not enough, some chaplains never improve. Chaplains should get to know the staff. Jenny shares common ground with other professionals and works with the social workers.

Caring for the spiritual side is necessary because science has its limits. Chaplains definitely contribute.

Jacqui Skewes, Associate Charge Nurse, Ward 8A Surgical, Post-Transplant.

(Four years on ward, also students clinical teacher at the Royal Melbourne Institute of Technology)

Jenny has regular meetings with social workers, when patients’ home and social lives are discussed, so that a complete picture of all backgrounds is known by all concerned.

Jenny is definitely an asset to the team. I have more to do with Jenny than the social worker and occupational therapists and I feel more comfortable with her.

She has a part to play in choosing patients for transplants. Her opinion is sought in assessing the spiritual dimension of patients and relatives as part of the overall assessment of emotional suitability to cope positively with a transplant.

Jenny is always available to listen to staff, this helps alleviate stress, resulting in less sick days being taken and contributing towards cost-saving measures.
Helen Berry, Charge Nurse, Ward 8A, Surgical, Post-Transplant

The chaplain is patient and nurse advocate. She is called on by myself before the social worker because the chaplain is always on call, even in the middle of the night. Social workers are only available during set hours, not nights.

The chaplain is involved in the whole family unit, not just with patients. A close relationship develops. Jenny is often asked to officiate at patients funerals, as relatives consider she has been most involved.

Staff discuss how they feel with Jenny, they can express their feelings, not just talk.

Bob Jones and Peter Angus call on Jenny for social circumstances. Her opinion is sought as to whether a patient is suitable for a transplant.

Jenny Hancock, Intensive Care Unit Charge Nurse

The Liver Transplant Intensive Care Unit has no separate floor as such for transplants, it is part of the overall Intensive Care Unit. We had our own chaplain in ICU for two years, but the funding was needed elsewhere and no more was available. We now use the general chaplain. Having our own chaplain can be an advantage providing that chaplain is the right person and has the right sort of personality. If not it can work adversely. One great asset of having the right regular chaplain is that it frees up medical staff from the bedside. The chaplain's listening skills encourage patient stress release, resulting in less need for constant medical attention, as well as the actual physical time spent at the bedside by the chaplain relieving the nurses presence.
APPENDIX XIX


Quality Assurance Study Report on Chaplaincy to the Liver Transplant Unit, The Austin Hospital.

The survey was conducted between 1st June and 30th June, 1993. Sixtyseven surveys went to patients and sixtyseven to primary support persons. Returned: 40 patients (59%) and 38 support persons (56%). The overall response rate totalled 58.2%.

The questions put to patients were:-

Did you feel heard and understood by the chaplain?

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>82.5%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>12.5%</td>
</tr>
<tr>
<td>A little</td>
<td>Nil</td>
</tr>
<tr>
<td>Not at all</td>
<td>Nil</td>
</tr>
<tr>
<td>No answer</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Did you get the kind of pastoral care and chaplaincy service that you wanted?

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>82.5%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>7.5%</td>
</tr>
<tr>
<td>A little</td>
<td>Nil</td>
</tr>
<tr>
<td>Not at all</td>
<td>Nil</td>
</tr>
<tr>
<td>No answer</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Did the chaplain help you to clarify what you wanted for yourself deep down?

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>44.0%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>37.5%</td>
</tr>
<tr>
<td>A little</td>
<td>3.5%</td>
</tr>
<tr>
<td>Not at all</td>
<td>2.5%</td>
</tr>
<tr>
<td>No answer</td>
<td>12.5%</td>
</tr>
</tbody>
</table>
Questions put to principal support person:-

Did you feel heard and understood by the chaplain?

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>81.5%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>8.5%</td>
</tr>
<tr>
<td>A little</td>
<td>2.6%</td>
</tr>
<tr>
<td>Not at all</td>
<td>Nil</td>
</tr>
<tr>
<td>No answer</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Did you receive the kind of pastoral care and chaplaincy that you wanted?

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>86.8%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2.7%</td>
</tr>
<tr>
<td>A little</td>
<td>2.7%</td>
</tr>
<tr>
<td>Not at all</td>
<td>Nil</td>
</tr>
<tr>
<td>No answer</td>
<td>7.8%</td>
</tr>
</tbody>
</table>
APPENDIX XX

Comments pertaining to chaplaincy made by patients and relatives of The Austin Hospital Liver Transplant Unit

Patients

* My feelings of concern and guilt that someone had to die so I could live were allayed by Jenny and her words had more of an impact on me than if they had come from a medical member of the team.

* The chaplain has enormous potential to be a most effective link between doctors and the family.

* Personally your chaplain’s support enabled me to help organize home issues and address such issues in a non-fearful manner. I was able to face surgery knowing I had voiced my wishes in a planned manner.

* The chaplain’s support seemed to strengthen me from ‘within’. I find this hard to explain but I started to feel good about myself and what I had achieved.

* Even though I am not religious I found the chaplain very easy to talk to and understanding of my problems. She was very reassuring to my family and helped them a great deal both before and after my transplant.

* It seemed important that the chaplain was separate but complimentary to the medical staff.

* From the beginning, which was a very difficult time, Jenny helped me to come to terms with and understand a lot of things. She gave hope and encouragement to me and my family.

Relatives

* I found it very helpful to be able to communicate my concerns during the pre and post transplant periods to a caring person who had the time to look at the ‘human’ rather than the medical needs of the patient and family.

* The service was of enormous comfort to me and I consider the experience would have been a very lonely one without help.

* During an extended stay in hospital when the medical staff caring for the patient change frequently, the continuity of the chaplain’s care and support was very comforting.
* You need to talk through your fears and needs with someone besides the doctors. It is good to know they are there at any time you need them, that you can pour out your troubles and anxieties and know that when you have finished you feel all the better for it.

* We cannot praise and thank the chaplain enough for helping us step by step along the terrifying and overwhelming road.

* The chaplain helped me not to feel guilty about someone dying to save another.

SMILE! YOU'RE HAVING A GREAT DAY
Interview with Graham Kyd, Royal Prince Alfred Liver Transplant Coordinator

I consider the chaplain is part of the team re patients. He attends Unit meetings with other allied health staff. He ministers to patients primarily, not staff. I would be prepared to approach Don re work problems, but for personal problems I would see my own priest.

I would not want chaplains in the theatre because it is crowded already. I do agree, however, that chaplains could be more integrated.

The suggestion of a special chaplaincy course should be kept within the Church or it may lose its spiritual essence. Similarly, if chaplains were paid by the hospital like other staff there is a chance of the chaplains being swallowed up and being grouped with social workers and psychologists, again losing their spiritual identity.
APPENDIX XXII

Interview with Beth Cambridge, Social Worker, Royal Prince Alfred Liver Transplant Unit.

Chaplain Don Dufty attends weekly patient management meetings. He is a general chaplain, not only for the LTU. He is of the Uniting Church denomination. The staff hepatologist, Professor Geoff McCaughan runs the Unit. The chaplain is asked for his opinion re patient assessment for transplantation.

The relationship between the chaplains and social workers is informal - the chaplains are not, for instance, invited to geriatric meetings which social workers attend. I have sometimes approached the chaplain informally and voluntarily to discuss professional problems re patients, but have not discussed any personal aspects concerning myself. I would consider I have a good relationship with him. There is a Counselling Service made up of 5 counsellors to which most of the staff go when they have problems. I don’t think the chaplain should or could do what the psychiatrist does, however, I consider chaplains are necessary and contribute towards the overall care of the whole person.

If chaplains were paid by an organisation they could become less independent. Independent chaplaincy has advantages.

I have no problem with chaplains being in the operating theatre.
APPENDIX XXIII

Interview with Dr. Rob Gribble, Psychiatrist to Royal Prince Alfred Hospital Liver Transplant Unit.

As a consultant psychiatrist I have no right of access, I have to be asked for help.

History and personalities at The Austin Hospital may be different to RPA. Don is useful to have around. Role is something developed in a team - local things for local councils. Roles and personalities differ and change in each Unit with different levels of anxiety requiring local solutions for local problems. Royal Prince Alfred is very hierarchical - surgeon is the boss - makes decisions - aim is for good medical care - bad holism a waste of time. The whole set-up is dynamic. The Unit is as much Professor Sheils Unit as Bob Jones’ Unit is his. However, Professor Geoff McCaughan is more important on the wards where there are medical rather than surgical problems. The Melbourne and Sydney Units are structurally different.

Psychiatrists are forgotten quickly by patients - it is the same with chaplains. People remember events, not ambience.
Interview with Andrew Harrington, Royal Prince Alfred Hospital Liver Transplant

Patient

Doctors and surgical team assessed me, together with an intern, a social worker (not greatly involved) and a dietician. They spoke to both myself and my carer. The transplant co-ordinator was not part of the assessment team, only the staff connected with the ward.

I saw the chaplain fleetingly - 5 to 10 minutes at a time. I was pleased to see him and was glad he came, he made me feel good, but he did not involve himself enough to have any influence on my attitude towards my transplant. The chaplain did not see my mother alone.