THE MINISTER AND THE HOSPITAL

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

Part II—Hospital Worship

ED: This brings us to another important situation in which I know ministers are involved and indeed I have been involved myself, more than once. It does raise questions about what a minister is doing when he conducts worship in a hospital. Perhaps you have some general observations that you would like to make before we discuss some of the details.

SM: I think, chaplains, part-time chaplains and ministers who conduct services in hospitals should work on the voluntary principle. I believe that no form of worship should be imposed on any patient in a hospital. It is all too easy to inflict worship on a captive audience who are too ill and are bed-bound and cannot escape. Worship is for those who are well enough and want to attend.

ED: Could I just ask how far that voluntary selection is carried out by the staff before diets of worship take place.

SM: In the hospital in which I work we have a service in the Infirmary chapel, volunteers go round the wards and there they ask if anyone wishes to attend and the sister or the nurse in charge generally invites any who wish and are well enough to go. It is a case of saying "this is happening and if you want to go you are welcome". I'm a bit worried about the sister I meet in the corridor who rubs her hands and says "I did well for you on Sunday, Mr McGregor, I got thirteen men to go to the chapel". It savours of the big whip—detailing the "volunteers".

ED: There is perhaps some times a little pressure!

SM: If I could just go back to the previous question and add this postscript. I am equally worried about sisters who say to the escorts when they call; "nobody wants to go to chapel here" without even making the offer to the patients.

ED: Such things do sometimes take place (as ward-services) where one feels that some of the patients are not always there of their own free will.

SM: When I came to the Infirmary I found that ward services were conducted in the middle of wards and that they were a mixed blessing. Some patients and staff appreciated them and others didn't. I have some hair-raising stories about things I

have heard said in the middle of acute wards. I once heard someone quoting Savonarola to a group of patients saying, "as Savonarola said so many years ago 'It's not how a person lives that matters, but how a person dies' ". Terrible things like that are sometimes said in the Lord's name in a ward and they don't do the image of the church any good. But I'm glad to say we now have most of the services in ward day rooms and patients who are well enough and want to go can go there.

ED: That is a comparatively new development which is very essential in a long-term hospital I would think. That is something that ministers who have to do with smaller hospitals might think about—the use of the day-room for worship.

SM: The small informal service with perhaps a guitar instead of a piano if no piano is available.

ED: I would think perhaps twenty minutes is long enough for that type of service?

SM: Twenty minutes is long enough. The time before and after should be spent in speaking with patients, because though they appreciate the service, they also appreciate some one who takes the trouble to come round to ask how they are.

ED: You would suggest that the person who conducts the service should do that.

SM: Yes the group should spread round the ward visiting not only those who have attended but also those who have not simply to say "how are you today?"

ED: I take it what you have said about patients would apply equally to staff? They are free agents to come and go.

SM: That is right. Ward staff are now so thin on the ground that I do not think it is realistic to expect that many of them will be free to attend worship in hospital.

ED: That is a point which must be appreciated. They are probably trying to do three people's work.

SM: Particularly at the week-ends and on Sundays.

ED: You mentioned the guitar which has the merit of being very portable. What about suitable music if there is such a thing?

SM: Praise should generally be chosen in a way that recalls that patients don't have too much "puff" and anything that is too long or too heavy is beyond the capacity of most patients.

ED: In a short service we perhaps must think of only two items? A number of short things are preferable to a great lengthy hymn?

SM: Yes, I would think so. Three or four reasonably brief items. One of the problems is that sometimes visitors

conducting services ask patients if they have any choice and the patients are often stumped and will most likely come up with Ps. 23 or "Abide with me"—the thing that they last sang at the crematorium—and this can have a disastrous effect on the group taking part in the service and can end with excessive emotion and floods of tears. Praise should be familiar. Repetitive songs led by guitar singing groups are usually appreciated—simple, tuneful and rhythmic. Keep the pitch low and restrict the number of verses, and try and choose the hymns so that the words are appropriate. The content of worship in hospital should, as far as possible be positive, hopeful and reassuring. One must avoid over-emotional content and we should avoid raising questions in our services which there is not time to take up and follow through with each individual taking part.

ED: I think you have a list which we could include in the text here.

SM: I have one or two suggestions. I have noted some Psalms and Paraphrases: Ps. 147, 103, 106, 67, 46, 92, 27—sections of these are very appropriate. Of the paraphrases, I like 2, 38, 39, 22, 61, 63, 60, 54, 48, 58. Verses must be chosen selectively, so that the most meaningful verses are included and the others excluded. Good material is to be found both in RCH and in CH3 and there are other contemporary hymns which I find appropriate. There's one in *Songs of the Seventies:* "O, Christ the healer we have come . . . to pray for health . . . to plead for friends" . . . very good words . . . spot on for hospital use. In the new supplement *New Praise*—a good hymn called "The healing God" is suitable for use in hospital. There is quite a selection and I think that intelligent choice of praise can add quite a lot to the service.

ED: Have you any thoughts about prayers and addresses?

SM: Short, as far as possible. There should be a balance between material which belongs to the hospital and to the experience of the patient in hospital and material which belongs to the world outside the hospital. The hospital service must try to contain a bit of both. It shouldn't be so absorbed in hospital that it forgets the world outside, nor should it be so irrelevant to the hospital that it dodges some of the very difficult issues which come up from time to time in hospital and in the experience of patients.

ED: I remember speaking to a group of long-term patients about the criteria they might apply as Christians to the reading material which came to hand during their stay in hospital.

SM: That kind of advice might be quite helpful. Generally speaking the themes which recur in hospital focus on the life of Jesus the healer. People do see the health service as a continuation of the work which he began, for which his life is both inspiration and example. The other theme which is tremendously important in hospital is that of the suffering Jesus—a God who isn't remote and uncaring, distant and unmoved by man in his weakness and infirmity, but a God who is incarnate and who shares human suffering, human misery, human pain, human death, and who triumphs over them. These are the basic themes which are most related to hospital worship. Perhaps I should also say that the sacrament of Holy Communion is tremendously important in hospital and is something I should like to see celebrated much more frequently than it is—broken body, blood that's shed, life through death, redemption, suffering. These themes which are central to the communion are also central to the life and experience of people in hospital.

ED: Perhaps I can raise a query with you about this. In the situation where the minister or the chaplain is coming in, would you see the situation that he makes all the provision for the communion himself in the sense that he brings his own elements and everything with him?

SM: I think most hospitals now have a communion set and if they don't then under the King's Fund regulations it is incumbent on the Health Board or the Hospital Administration to provide the chaplain with the equipment necessary for the celebration of worship. Thus bread and wine should be provided, and so should the vessels.

ED: That would be a matter of arrangement with the hospital administrative authorities rather than with the individual ward staff?

SM: I think that is true. The provision would be for the whole hospital and not for any particular ward. This would apply to whole-time and part-time chaplains. I think visiting ministers who come in to celebrate communion may find it more convenient to bring their own portable set with them.

ED: Is there any difficulty about celebration with an individual patient? Is any embarrassment likely to arise?

SM: Not much embarrassment. I think occasionally one wants to widen it out and include people say in a four-bedded side ward. To offer one communion and exclude the others can be embarrassing to the patient concerned and to the others present. One has to be alert to the solidarity which patients feel with one another.

ED: Yes I can see that the situation with a small group is particularly important. Would you have any views about screening off a bed for this service or would you think this was making too much of it?

SM: If I were taking communion to an individual in a ward I would certainly pull the screens round.

ED: How much demand is there for this?

SM: Not a lot of demand; only occasionally.

ED: I have found it varied very much. I have been in a situation in the country where to a fair extent the tradition was against it and I always made the practice of offering people the opportunity and was surprised sometimes at those who accepted and also equally surprised at those who refused.

SM: The recent tradition of the Church of Scotland is not strongly sacramental and members will not ask for communion as frequently as members of other traditions.

ED: What about the relationship of the hospital to the parish minister? Here there are communication problems. The parish minister very often doesn't know what goes on in hospital. He is often just a fleeting visitor.

SM: Recently in Scotland we have witnessed the integration of the Health Service. This means that hospital health provision is now integrated with community health provision, and there is a much greater awareness within the hospital that hospitalisation is very often just an episode in the life of a patient and that his real life belongs in the community from which he comes and to which he will return. For that reason there is a greater openness to visits from general practitioners and parish ministers. There is a greater awareness of the fact that the roots of illness are very often to be found in the community and in the life style of the community rather than in the life of the individual patient himself. There is thus a sense in which mere treatment in isolation in hospital and neglecting to do anything about this can be unproductive. This gives rise to a greater awareness of the relationship between the hospital and the community and parish ministers are seen in the context of that openness. Various interesting things are happening. Many of us who are full-time chaplains are working to improve the information and support service that we give to parish ministers. It is now being recognised that if a person does have a minister that that minister should be informed promptly after the patient is admitted, provided that the patient wants to see him. The new computerised records system in Edinburgh is helping here. There are other interesting things happening where a hospital ward cares for a

particular district (and this is happening up at the Royal Edinburgh Hospital). The Chaplain has arranged meetings between the staff of the ward and ministers serving that sector of the city which is served by the ward. Nothing but good can come out of this inter-professional encounter and exchange of views. Attitudes of rivalry and hostility can give way to feelings of trustfulness and co-operation and the patient, I am sure, benefits from all this.

ED: Perhaps the welfare side is outwith our scope.

SM: The only comment I would make is that the Social Work Department does become involved in welfare problems. In my meeting with my colleagues in the Social Work Department, I always try to alert them to the fact that the minister and the congregation, if doing their work properly, are one of the many caring agencies in the community which can given support to patients during hospitalisation and after discharge, and also to the relatives of patients.

ED: As a minimum the minister at least ought to be known to or know of, say, the almoners in any particular hospital that he visits regularly. I have usually found almoners helpful and cooperative.

I would like to sum up. Supposing we think of a young minister going hospital visiting in his first charge what would you put forward as main things to be said to him? How would you suggest visiting time should be organised? What would be the most sensible techniques to adopt?

SM: Six pieces of advice to a novice. Perhaps I could take up these points and then mention what ought to be included in how he best uses his time.

ED: Theories are perhaps necessary, but not the last word, and this may apply here also for the novice visitor. Perhaps we should round off with your recommendations.

SM: (1) Hospital visiting should be a priority in pastoral work.

(2) Be sensitive, perceptive, confident, open, and give the patient your undivided attention.

(3) Don't arrive at a bedside with any preconceived ideas of what you are going to do. It is a mistake to follow stereotyped procedure at each visit—to ask the same questions, always to end with a reading and a prayer. That shows that your mind is closed and that you are not really open to the needs of each patient.

(4) Co-operate as fully as you can with the ward staff.

(5) Make yourself available but don't impose yourself on patients.

(6) Listen twice for every once you speak.

I'm always dismayed when patients say of their parish minister, "My, isn't he an interesting man". It is good that he is interesting, but isn't it a pity he felt he had to go in and do all the talking. I think, when we are visiting in hospital, we should be listening more than we are talking. We should be encouraging the patients to write the agenda of the meeting and to talk about the things they want to talk about—very often deep and important problems in their lives.

ED: Thank you again, Stewart, for your great help on all these topics.