CLINICAL PASTORAL EDUCATION IN AN AMERICAN HOSPITAL

by Gerald Farrell, M. M.

Last March, as I walked into the medical ward of St. Luke's Hospital in New York City, the head nurse said, "Chaplain, would you see the Korean young woman just admitted yesterday. She's very sick." I went to the patient's bedside and found a 26 year old young woman suffering from joint pains and a high fever. When I greeted her in Korean, her eyes widened in surprise, and then she burst into tears. Knowing very little English and feeling very lonely, she was overwhelmed to find someone who could talk to her in her native tongue. Then she told me her story.

Last year she had travelled from Korea to Brazil, where she became sick with what the doctor had called "lupus". She recovered and came to New York City, where she started college two months ago. Studies were difficult because she knew little English. Then, just a few days ago, she came down with the same illness, but more serious this time. We talked for a while and then I left to let her get some rest. I looked for the resident doctor assigned to her and found that his diagnosis was "lupus erythematosus", an incurable disease which would shorten her life considerably. He said that this was a severe attack and that to recover she would need the best medical care plus a good fight on her part. At present she was depressed by this setback and homesick. Knowing that I speak Korean, he asked me to visit her often and try to keep up her spirits. He said that a cure for lupus might be found during her lifetime. And so began a two month's hospital course for her.

The disease involved nearly all her organs as time went on - skin, joints, gastro-intestinal tract, kidney, heart and brain. She was on massive doses of steroids which helped for a while, but there were bad relapses, and twice she was very close to death. With each relapse she became weaker and thinner. I visited her daily, helping to communicate her needs to the doctor and nurses and their instructions to her. Nearly every day I met separately with the doctors and nurses to discuss her condition. She told me she'd been baptized as a Methodist, and I encouraged her to unite her sufferings with those of Christ. In her periods of discouragement I pointed out that she was young and had a lot to live for.

During one remission she told me of her anxiety about hospital costs. She had found out that her ward bed was costing $94.00 a day plus the cost of medicines. We arragned for a social worker attached to the hospital to look into her case, and she was greatly relieved to learn that a special fund could be used for her expenses. Also, while she was feeling better, we arranged to have a recreational therapist visit her. She planned to improve her morale by teaching her how to set her hair, but another relapse prevented this from taking place.

We notified her parents in Korea about her serious condition, and in April her mother flew to New York City to see her, As soon as she saw her daughter's emaciated condition, she began crying. For three days she was at her bedside constantly, crying most of the time. She needed

a diversion, because her crying was only tiring her now and hurting her daughter's morale. But a diversion was difficult to find, because she knew no English at all. Finally, I learned that a Korean Methodist minister lived only ten minute's walk from the hospital. I took the mother to meet him and we found that, by chance, the two were orginally from nearby towns in North Korea. After chatting for about an hour the mother was more relaxed, and she felt better when the minister promised to visit her daughter in the hospital.

For another three weeks the disease dragged on. Then one Sunday morning the hospital called to tell me our patient had just died of an overwhelming infection. I went and offerred what comfort I could to the mother, and together we arranged for the funeral. The mother was non-Christian, but she wanted a Christian burial, so we arranged for a brief funeral service in the Methodist Church.

This case was unusual because of the language difficulty that made the mother and daughter so dependent on me. But it illustrates the work of a counseling chaplain in that it shows how he must relate not only to the patient, but also to the doctor, nurses, relatives, social worker, recreational therapist, and other clergymen. Our teamwork was needed to give the patient the maximum support possible. In this case disease was too much for all our efforts, but in many cases teamwork was lifesaving.

An example which brings out better the pastoral aspect of clinical pastoral education is the following. A sixty year old man was brought to the intensive care unit in coma one day when I was on duty there. I read his chart and learned that he had walked to the Emergency Room with a headache and had lapsed into a coma while there. The doctor diagnosed a stroke and notified his wife. She was already there when I arrived. She told me that their family was Catholic and that she was glad to talk to a priest. She was still dazed from the sudden news about her husband. Yesterday, she said, he had been well and full of vitality. New he was suddenly helpless and close to death. A flood of memories came back to her of happy days they had shared and plans they had made for the future. She began to weep as she realized now that these plans couldn't be realized. The doctor had told her that vital centers in the brain had been badly damaged and the chance of recovery was slim. She began to talk of her husband's faith. It had been a quiet faith, revealing itself especially in his generosity to others. As she talked about her husband's faith, she also revealed her own deep faith. This was being tested now as she began the struggle to accept God's will as she knew she must. For my part there was no need of offering advice. She merely wanted someone present who shared her faith while she went through her crisis. By the end of the second day she had finished her crying and was now calmly resigned to the inevitable death. Her husband lasted ten days after admission, never once regaining consciousness. She was with him until the end. I was not there the night that he died, but the doctor who was present told me later that he found her faith inspiring.

The priest, minister or seminarian who takes a course in Clinical Education not only works with patients on the hospital wards, but also receives an education designed to help him relate better with others in pastoral work. Our program at St. Luke's Hospital was a fairly typical American program. Seven of us (two Angilcan priests, a Baptist minister, a Presbyterian minister, two Lutheran seminarians and I) worked under a trained supervisor, an Anglican priest. Each of us were assigned to three wards which we visited every afternoon, meeting all newly admitted patients. Of these a small number wanted our assistance, and this we gave as long as it was

needed.

Mornings were devoted to studying together as a group. One day weekly the supervisor lectured on psychology. On the remaining mornings we presented interview in turn for group discussion and assistance. These were interviews between chaplain and patient some difficulty had arisen. They were written up from memory after the interview had occurred.

Typed copies were given to all the group members when the chaplain presented his interview for group discussion. The interchange between chaplain and patient were thoroughly discussed so as to bring out all the thoughts and feelings of both and to indicate the source of the difficulty. In this way each chaplain gained a growing insight into why he reacted to the patient as he did and why the patient so reacted to him. After presenting a number of these interviews we became more aware of how we react to others in general.

The group also provided help to each chaplain from its own experience. For example, I presented an interview I'd had with a nineteen year old boy who was a drug addict, the first such case I had seen. His drug habit was using up all his money. He lived alone. eating almost nothing, and was slowly destroying himself. I tried to interest him in education or an occupation anything that would restore his interest in life, but I failed completely. I was depressed about this as I presented my interview, but I was assured by several members of our group, who had counseled many drug addicts, that I had done all I could at the time. Drug addicts, like alcoholics have to "hit bottom", they told me. Only when they realize their plight fully do they want help and profit from it.

We learned not only from fellow chaplains but from patients too. For example, I learned something about prayer from a Negro Baptist minister, whom I visited as a patient. As I started to leave, he asked me to say a prayer for him. I recited the "our Father", knowing he would be familiar with it, and then left. When I saw him next a minister friend was visiting him. Before leaving I asked his friend to say a prayer for the patient. He proceeded to offer a spontaneous prayer to the heavenly Father which touched on all the concerns of the patient - his illness, his wife and children, his congreation, etc. in a beautifully personal way. The patient added his "Amen" from time to time, visibly moved by the prayer of his friend.

After that when patients asked for praying over them I used not only formal prayers, but also the spontaneous, personal type and found it well received by Protestants and Catholics alike. After the first six months of Clinical Pastoral Education chaplains are allowed to devote more time to a specialty that interests them. I was particularly interested in the work being done by a counseling team appointed for the priests and religious of my diocese in Brooklyn. The team consists of three priests and one nun, members of our diocese who were trained and received master's degrees in Pastoral Counseling as well as a full course of psychoanalysis. Six years ago one priest was assigned to this work. Post Vatican II changes brought stress to many priests and religious, and when they heard of the help offered by his counseling, the volume of his work increased rapidly so that a second and third priest and then a nun were added to the team. All four are busy full time now. In order to maintain high professional standards and provide for on-going education this team of four meets twice a week, once with a psychiathist and once with a psychologist. They present interviews of their more challenging cases for his guidance and their own discussion. I attended these conferences for several months and became acquainted with the special problems involved in this type of counseling and with the good results this team is

achieving. An indication of their success is the fact that priests from a number of American dioceses have visited and observed their work with the intention of initiating a similar counseling service for priests and religious of their own diocese.

As part of our training, our group attended a two-day conference sponsored by Cancer Care Incorporated, entitled "The Patient with a catastrophic illness". The main speaker was Dr. Elizabeth Kubler-Ross. A professor of psychiatry at the University of Chicago, she is known internationaly for her book entitled "On Death and Dying", published in 1969. This book is the fruit of four years of research on a subject which is poorly understood and generally feared, the phenomenon of dying. Let me quote from her book the passage telling how she got involved in this work.

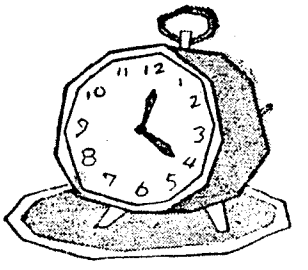
> "In the fall of 1965 four theology students of the University of the Chicago Theological Seminary approached me for assistance in a research project they had chosen. Their class was to write a paper on 'crisis in human life', and the four students considered death as the biggest crisis people had to face. Then the natural question arose: How do you do research on dying, when the data is so impossible to get? When you cannot verify your data and cann ot set up experiments? We met for a while and decided that the best possible way we could study death and dying was by asking terminally ill patients to be our teachers. We would observe critically ill patients, study their responses and needs, evaluate the reactions of the people around them, and get as close to the dying as they would allow us."

Then follows her description of their first interviews at the bedside of dying patients. These interviews proved so instructive and fruitful that the seminarians were gradually joined by doctors, medical students, and chaplains. The following quotation describes their present procedure.

> "We see each terminally ill patient once a week. We ask him for per mission to tape-record the dialogue and leave up to him entirely how long he feels like speaking. We have moved from the patient's room to a little interviewing room which we can be seen and heard but we do not see the audience. From a group of four theology students the class has grown to up to fifty, which necessitated the move to a screen window set-up. When we hear of a patient who may be available for the semi nar we approach him.··· and after a brief introduction state the purpose of our visit clearly. I tell each patient that we have an inter-disciplinary group of hospital personnel eager to learn from the patient. We emphasize that we need to know more about the very sick and dying patient We then pause and await the patient's verbal or non-verbal reactions. We do this only after the patient has invited us to talk···When the patient agrees, the doctor has granted permission, and arrangements have been made, the patient is brought personally by us to the interviewing room···We usually rephrase the purpose of the interview on our way to the interview room, during which time we emphasize the patient's right to stop the session at any moment for any reason of his own. We again describe the mirror on the wall which makes it possible for the audience to see and hear us.
>
> Once in the interviewing room the conversation flows easily and quickly, starting with general information and going to very personal concerns as shown in actual recorded interviews, a few of which are presented in this book.
>
> Following each session the patient is brought back to his room, after which the seminar conti nus. No patient is kept waiting in the hallway. When the interviewer has returned

to the classroom, he joins the audience and together we discuss the event. Our own spontaneous reaction are brought to light, no matter how appropriate or irrational. We discuss our different responses, both emotional and intellectual. We discuss the patient's response to different interviewers…we study his strengths and weaknesses as well as ours in the management of this person and conclude by recommending certain approaches that we hope will make the patient's final days or weeks more comfortable."

With experience Dr. Kubler-Ross found that the reactions of the patient from the time he first realized he was dying until the time of death fell into a characteristic pattern of five successive stages: denial, anger, bargaining, depression, and acceptance. She devotes a chapter to each of these stages. For anyone charged with helping the dying patient, whether medically or spiritually, this book is invaluable and I recommend it highly.



하루는 일생이다. 선한 일생이 있음같이
선한 하루가 있다. 악한 일생이 있음같이
악한 하루가 있다. 하루는 짧은 인생으로
보아 이것을 소홀히 할 수 없음을 알게 된다.

<内村鑑三>