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IMAGES OF INADEQUACY: AN EXAMINATION OF SOME THEORETICAL MODELS OF HOSPITAL CHAPLAINCY

Stephen Pattison

It has been said that the unexamined life is not worth living. This then is an examination of some theoretical models of hospital chaplaincy which might influence, or be adopted by, ministers. Firstly three popular works on hospital chaplaincy are examined for the explicit and implicit models which they present. These are Norman Autton's *Pastoral Care in Hospitals*, Heije Faber's *Pastoral Care in the Modern Hospital* and Michael Wilson's *The Hospital – a Place of Truth*. Following this, a structural model of chaplaincy is advanced and then a 'new' incarnational model is put forward.

While this is a study of theoretical models, its practical importance is not negligible. All chaplains act according to certain beliefs and assumptions anyway, either consciously or unconsciously, and this governs the use of their time. It is thus crucial that they should be critically aware of their own assumptions if they are to act wisely and effectively.

First, then, Autton's book which is probably the most widely read small book by part-time and full-time Anglican chaplains of English and Welsh hospitals. Autton himself has a distinguished chaplaincy record and at one time served as Director of Training of the Church Assembly Hospital Chaplaincies Council, so this book and others by him are widely regarded as authoritative. The purpose of the book is to try and give the introductory information, both practical and theoretical, which a clergyman might need for starting as a hospital chaplain. It is very prescriptive in tone, setting down just one way of doing chaplaincy and even describing the attitudes which a chaplain must have (cf. p.18ff 'What the chaplain should have'). This in itself is not a crime, but leads one to suspect that behind all this lies a very narrow vision of what a chaplain can be. So it turns out to be.

Autton himself writes that 'the concept of his (i.e. the chaplain's) work in hospital must be clear and well-defined in his own mind, for unless he himself knows what he is about he has little right to expect others to understand his position and so appreciate his role among them. His role as chaplain must be as meaningful as medicine itself. His position must not be less professional than that of other members of staff, and his skill and science not less marked than those of the surgeon' (p.1). Again on p.30 he writes 'He can merely resign himself to his inability to establish his identity with any degree of satisfaction or success. When a chaplain knows who he is and what he is really about in the hospital situation, *then* he is given the capacity and grace to bring health and wholeness into a sick community. Until then he will only breed anxiety and disease'. With such remarks as these we begin to realise that Autton's chaplain is a man of iron, professional to the fingertips, self-contained and *arrived!* He is not insecure, he is the one who has got there and so has grace to help others on the way. This man is confident and super-human. His professional image is basically the good old paternalistic Anglo-Catholic priest.

Admittedly this priest has adopted some of the insights of psychology, sociology and counselling (cf. p. 13 and Ch. 7 'The Chaplain and His Training'), but he is still basically the sacramental man (in all senses), as can be seen for example on page 128 where we are told of his bible reading,

devotional reading, daily recitation of the divine office, annual retreat and spiritual director (he needs these to support him because he spends most of his time giving out and not receiving. He prays on behalf of those who do not pray and 'operates' an altar: 'At the altar all his ministry will find its fulfilment He will bring to the altar the work of the surgeon operating on the heart of a young child and at that precise moment he becomes as vital a member of the theatre team as those who stand before another table where new life is being given and blood shed'. (p.128) This is indeed then a man set apart, 'separated and unique' (p.2)! He is a professional pray-er, a man with 'remedies' (p.2) and confidence because he knows exactly why he is there. In fact Autton virtually subsumes medicine beneath the chaplain's sacramental role.

Autton's chaplain is perfectly relaxed and confident in his sacramental role. He knows what he is doing and why, but has he opted out of the human race? We have deliberately caricatured this position; as we noted above Autton has many useful insights. Sacramental ministry, prayer etc. are important, we neglect them at our peril. Nonetheless such a ministry exercised by one less able than Autton himself could easily become blind, stunted, disconnected and automatic, notching up communicants rather than furthering communication and isolating the chaplain from mankind rather than drawing people closer together. It also largely ignores the pastoral and sacramental ministry exercised by lay Christian staff (cf. R.A. Lambourne *Church, Community and Healing* and, we suspect, makes the chaplain feel above and beyond the hospital rather than within it. Admittedly his task is different and is pursued with separate values and means, but the chaplain should perhaps be more involved in the humdrum lives of the therapeutic team than he appears to be in Autton's book.

Heije Faber's book, *Pastoral Care in the Modern Hospital* comes from a very different stable from that of Autton. As a Dutch Calvinist academic clergyman, deeply interested in pastoral psychology, Faber has written a more fragmentary book which discusses the problem of the sufferer and his place in modern society, the modern hospital and its objectifying of patients, the patient in hospital, some of the pastoral problems faced, the minister and his conversations, as well as the minister's role in hospital (ch.5).

Perhaps talking of 'the *modern* hospital' rather than just the 'hospital' is significant, for altogether the book seems far more reconciled to the twentieth century than Autton's does. Faber, for example, recognises the hierarchical arrangement and 'the therapeutic team'; accordingly Faber's chaplain tries to integrate himself into this structure.

Faber sees the chaplain as essentially an alien body in the hospital, one who stands between staff and patient (p.17). He has his own task as a servant of the Gospel and representative of Christ, this being to do with the well-being of the patient. This task is complementary to the main therapeutic task of the hospital. The chaplain's way of caring is one of many ways, 'one which fits in with all the others', so he is a man 'who is in a real sense a colleague, a fellow-worker with Doctor, nurse and social worker' (p.69). The chaplain exercises his task in the domain of the Doctor and stands within the hierarchy of which the Doctor is the head (p.71). He has to 'stake a claim for his kind of caring for the patient'. (p.73). The chaplain then is one who works within the team structure but is essentially an alien, a guest (p.72). He has to feel at home in the hospital while his task requires that he keeps a

certain distance from it (cf. p.33). He will in any case experience a distance from such a place which makes him feel uncertain because of its technical sophistication as well as the suffering which goes on therein, confronting him with many 'boundary situations' e.g. death (cf. p.35).

From the above we can see that Faber's chaplain is a man who agonises much more than Autton's about his own and others' roles in hospital. Faber frequently says that a chaplain must make his role clear to other staff so he can be accepted by staff etc., but does not really spell out what the role or task of the chaplain is. He gives a passing mention to the basic idea of the chaplain being representative of the church and being the minister of word and sacraments, but does not really go on to explain what this means in the hospital setting. We can gather that the chaplain is not above the hospital like Autton's. His *work* does not transcend that of the other staff members who are involved in the main purpose of the hospital, while the chaplain seems to be a respectful hanger-on or guest. He certainly has no magic remedies!

Perhaps the notion of pastor or shepherd can tell us more about Faber's chaplain than anything else. The chaplain, far from being in patriarchal, hierarchical security, walks with his sheep, the patients, in the heat of the day (cf p.18 ff). He tries to get alongside the patient where he is in his 'boundary situation', and to do this his principal tool is the pastoral conversation. 'He is tempted subconsciously to identify with the attitude of the staff . . . , regarding patients as the objects of pastoral care . . . he wants to 'treat' or manipulate them with the tools of his trade . . . The genuine minister sees people in front of him and tries to enter into relationship with them if that is their desire — he tries only to be there, to be available: above all he attempts to listen and where this would be real in their situation, to journey with them for a while in the light of the Gospel. Every patient and every situation with which the minister is confronted will then become unique' (p.17). Again 'He comes to help; he seeks to give support to overcome sickness with faith and to open up a liberating perspective on faith' (p.78).

Another striking image by which Faber describes the minister is that of the clown who is essentially alone while also in a team, an amateur amongst experts, one who is trained but who must also be spontaneously creative (cf. p.84ff).

This is all very good and stimulating, as far as it goes, but we must criticise Faber. Firstly, his view of the chaplain is very fragmentary and partial, as we noted. Secondly and more important, what is Faber's chaplain doing that any Christian (or non-Christian) could not and should not be doing? (i.e. what is distinctively 'ministerial' here?) Again, what about the Christian community present in the staff and ministering in their work to the patient? Despite his emphasis on the chaplain's membership of the therapeutic team, it seems to be he alone who is the Christian minister and the staff seem to be used by the minister to get at the patient, rather than being people worthy of pastoral care themselves. On top of these criticisms we finally add that Faber seems to have no underlying theology of why the chaplain should get alongside the patients, nice though this idea is. Indeed, apart from saying that it has always been a role of clergy to look after the sick, Faber seems to have little rationale for the ordained minister being there at all. Why does he give out sacraments? What does it mean to be a preacher of the word of God in hospital? These areas are completely ignored.

Faber's chaplain then is a liberal, humanist, professional type, open-minded, sympathetic (even empathetic?), aware, well-trained in personal relationship skills and almost entirely patient-centred in his ministry. He is respectful of the therapeutic process, which makes him feel slightly lost, but into which he wants to be integrated. He agonises about the problems he meets, what roles he and others should be playing and he has no idea what his ministry has to do with theology, beyond thinking that Christian tradition says it is a good thing to be with the sick.¹ After reading Autton with his view of the hermetically sealed-in sacramental man, one cannot but be grateful to Faber who, one suspects, wrote his book to try and counteract the arrogance, and idiocy of 'sacramental' chaplains who blunder into hospitals and think they have all the answers (having special contact with God), and that the place should revolve around them. However we have to question whether Faber has an adequately based concept of chaplaincy.

Michael Wilson is an Anglican, medical Doctor and priest, working in a theological department. The book, *The Hospital – A Place of Truth* is a study of the hospital chaplain's role in English hospitals and arose from the need to discover what this role was, in order that appropriate chaplaincy facilities should be provided at the new teaching hospital in Birmingham. The book is very comprehensive and includes survey material showing the attitudes to and expectations of various members of staff to chaplains. However, before considering the roles of the chaplain at all, in the introductory essays of the book Wilson considers the hospital and its place in society, a task only partially undertaken by Faber and Autton, both of whose books take the hospital axiomatically as it is and basically try to show how a chaplain should fit in.

Wilson, on the other hand, attempts a substantive rather than a functional definition of the hospital and its purpose, but this is in many ways a vision rather than a reality: 'The primary task of the hospital is to enable patients, their families and staff to learn from the experience of illness and death how to build a healthy society.'² This is in many ways a surprising definition, firstly because it does not uphold the commonly held assumption that a hospital is primarily about cure and care, and secondly, because it implies that the hospital has a positive social role. The emphasis, then, lies on health, life and community/society, rather than on individual sickness. Wilson goes on to show that often hospitals are not places of mutual learning and community building, but rather places of fragmentation, aloneness, sickness and strife, where patients are treated as objects on the clinical model and their symptoms receive attention, while the social causes of their disease are neglected. Dependency rather than learning relationships are created and perpetuated, and people encounter only 'parts' of each other. Some give and others receive, never do the twain *share*.

Wilson looks at the task of the church in hospital *before* he looks at the role of clergy and thereby acknowledges that ministry (as well as health) is for people, not just ministers. For too long the work of ministry has been identified with clergy, and has been regarded as individual and professional rather than congregational (cf. these ideas with R.A. Lambourne *Community, Church and Healing* which shows how ministry takes place by the whole body of Christ not only in the 'official' sacraments but also through the service of Christian lay people in 'the sacrament of the cup of cold water'). The Christian worker in the hospital is in solidarity with his colleagues, but is

also detached, in the sense that he questions the hospital's objectives and attitudes by reference to his understanding of the purposes of God (cf. p.31). This means that the Christian serves his fellows in the hospital, but he also responsibly criticises the hospital and its policies in a mature son-like way.

Having said all this, we can move on to the chaplain who should, in Wilson's view, really embody the learning, non-sickness centred and non-objectifying attitudes which all in the hospital ought to have. He will have many roles, formal and informal, prophet, priest, administrator, counsellor, teacher, evangelist, healer, judge, servant, but beyond all these, his role is to be himself. He is to be a person, himself; to be the same person within the hospital as without, in his professional life and without it: 'The man who makes a consistent attempt to be himself in these different roles, to be truthful in his role relationships, will make integrity and truth possible for others' i.e. allow them to learn about themselves and others (p.55). The key word here is 'integrity', which comes from not dividing the sacred from the secular, the sick from the healthy etc. Flowing from this, the minister of word and sacraments will not try to gain a respectable professional image (cf. p.52), but in the face of a highly professional institution he will remain an amateur, a generalist, one whose work is that of prayer and communication in thought, word and deed: 'His most powerful work is reflective and contemplative in a stillness which contrasts with that of hospital colleagues . . . ward staff expect to see the chaplain busy visiting. Their demands may make him feel guilty because he appears to leave so much undone. But if he neglects the hard, skilled work of prayer, his words and activities will be shallow' (p.52).

It seems from this utopian-sounding model as if the chaplain belongs to a different order from others in the hospital. He is to present a radical challenge by his life and works to the hospital, achieving little in orthodox terms, opting out of doing into being, thereby questioning the doers. Wilson sees for the chaplain a socratic role, as a person who being trusted by all, can ask questions from a frame of reference beyond the hospital. He suggests that chaplains should be trained so as not to accept the hospital ways of thought uncritically (cf. p.96). In this way chaplains can act as a resource.

Wilson's chaplain, then, is a spiritual man like Autton's. He does not try to compete with the professionals, to 'do' things, to find a role but rather is a generalist. He is a universal man, relating to all equally as people and always trying to be himself. He questions the assumptions of the hospital while identifying with its members. In many ways this chaplain seems to be the first-fruits of the kingdom of God, the ideal man and example, in his confronting the hospital with its own integrity and being over against its fragmentation and 'doing'.

Wilson's is the most complete and attractive model so far, not least because it affirms the ministry of the chaplain to all in the hospital, his connection with the whole church, the ministry of all Christians (and others), the need to look for health rather than weakness and to question the hospital's assumptions. Nonetheless Wilson is open to some criticism. Once again there is little theology to justify this ministry. Again, is not this new, 'alternative' human being in danger of standing above and beyond the hospital, (a little bit like Autton's chaplain), and of losing contact with ordinary mortals because of his extraordinary *modus vivendi*, which might arouse more suspicion and envy than trust? Might he not also be somewhat open to spiritual pride because of his own superiority and 'alternativeness'?

and see the failure of his ministry and ability to get on with people as a sign of success, so that he does not question whether he really is behaving appropriately. Lastly and perhaps most importantly what does 'being himself' actually mean? We know that we change our manner, way of speaking, attitude, even our values, according to the company we are in; and anyone who has read Goffman's *Presentation of Self in Every Day Life* has to take seriously the fact that we are constantly changing our roles, consciously and unconsciously. How then are we to know that the role we choose to label as 'myself' is *really* myself — do other people perceive it as 'myself'? This question seems fairly fundamental and Wilson does not really explain what he means by 'being himself' although we can perhaps see what he is getting at. This idea, then, needs to be 'unpacked' or earthed!

Michael Wilson has hinted at the need for the chaplain to question the mores and assumptions of the hospital, and has pointed out the need to see individuals and institutions as part of a *wider* society. We now propose to extrapolate these views and develop a model of the chaplain as active structural reformer.

The books by Faber and Autton represent a fairly typical Christian position, essentially conservative, of working within the given structures to treat the symptoms of the individual sufferer. Christians have also tended to believe that ministers are there to deal with the 'spiritual' health of the patient (cf. Wilson Op Cit. p.107 quoting from a NHS Memo 'In all hospitals Hospital Management Committees and Boards of Governors should give special attention to provide for the spiritual needs of patients and staff. . . .'). There are two problems inherent in such a view. The first is that the spirit/rest of person dichotomy is now seen as a false dualism, a person is a whole person. Secondly, even if there were a spiritual part to people, how do we know where it starts and body, or whatever the rest is, ends. The incarnation, where Jesus assumed the whole of man's nature, suggests, and practice confirms, that it is impossible to divide flesh and spirit. The one influences the other profoundly and so a person's material life will continuously influence a person's prayer life and understanding of God. Unless a chaplain wants to uphold this fragmentation and dualism he must be as aware of a person's material position as of his 'spiritual' state.

It has been said that 'the only way God can appear to a starving man is in a loaf of bread'. A similar argument must surely apply to people with senile dementia. A chaplain may not be able to get through to them with the words of the New Testament or even sacraments, but he can try to improve their conditions onwards by pressing authorities for more money and trying to cultivate more caring and understanding attitudes amongst the staff. Similarly, talking about God and his love to one who has been thrown out of her relations' home because she is suicidal or alcoholic, is impertinent and irrelevant to God's love in that situation.³ Such a person needs a secure place to go, but also pressure needs to be brought to bear on the relevant authorities to provide more support for those who cannot cope and their relations before, rather than after, the crisis occurs.

In many ways what is being talked about here is preventative chaplaincy. Like doctors, clergy have in the past provided elastoplast to bind up wounds and have focussed on the presenting symptoms of the individual patient actually *in* hospital. This alternative view gets away from the bedside, from personal religion, from the administration of New Testament reading, prayers

and sacraments and demands a journey into the grey world of structures, bureaucracy and power politics, within the hospital and without. For too long clergy have assumed that their responsibilities end with the individual, thus they have added their complicity to the injustices of the present system. As Paulo Freire has written, 'washing one's hands of the conflict between the powerful and powerless means to side with the powerful, not to be neutral' (*Reader in Political Theology* edited by Kee p. 100), and again that 'the hearts of men cannot be transformed while the social structures which make those hearts sick are left unchanged' (p.100).

Christian clergy are often guilty of 'anaesthetic' and 'analgesic' practices which make, or try to make, the iniquitous tolerable and thus they uphold, quite unconsciously, the system as it is. This is usually the way that most suits the powerful minority, both in society as a whole and in the hospital.

If the hospital is a microcosm of society, is it surprising that people are treated as objects, as machines in for spare parts? After all, we do live in a capitalist system where men have become alienated from their work, from themselves and from each other, so that people are merely used and only regarded as valuable for the commodity value of their labour, and where money has become the main mode of relationship. If, as Marx writes, 'manufacturers prosper most where the mind is least consulted and where the workshop may be considered as an engine, the parts of which are men' (*Capital* Vol. 1 p.483) and social institutions reflect the relations of production, is it surprising that people are objectified in hospital and are alienated from responsibility for their own health? It could well be argued that the distribution of money around the hospital is determined by the labour value of those being treated; so, for example, the old who are useless, and often psychiatric patients, are regarded as having very low priority over against those who are, or will be, productive, 'useful' and active. If the underlying ideology of the hospital is a capitalist one (and certainly the way of running hospitals, distributing money etc. suggests this may be so), then the chaplain may even have to become a revolutionary to really deal with an inhuman situation and minister in an effective, full and preventative way to the so-called 'spiritual' needs of the patient. Even if he does not take such an analysis as absolute, at least he should try to take structures seriously, if only because they affect all our lives all the time. By affecting structures by reform or revolution he can touch the lives of thousands whom he could never see individually and he may even prevent their needing a hospital bed.

Chaplains, in trying to affect structures, might imitate Jesus by proclaiming the Gospel in word and action (cf, *March* Ch2 v.1-12; Jesus forgives *and* heals). They could inform people and raise issues in seminars, informal contacts, letters etc., and they should not confine their attempts to the internal hierarchy, but should be prepared to work to try and influence health boards and the Ministry of Health (these being the sources of money and power). As ordained ministers they have access to churches outside the hospital. Perhaps they may even find they should join political parties in order to act on the main structures of society which decide on public expenditure etc., and try to ensure that man controls his own future.

To be blind to structures will ensure man's continued alienation and depersonalisation, both within the hospital and outside. It will guarantee the failure of many attempts on an individual level to induce 'spiritual health' and postpone any real wholeness for most of mankind. It must therefore

concern chaplains in selecting their roles and modes of ministry.

Having seen that a wide variety of models is available for chaplaincy we must now ask how a chaplain should try and decide which roles and models are appropriate to his ministry. Before doing this we must define the chaplain's essential function. Unless he is to be a do-gooder indulging his benevolent instincts at the expense of the church, he must surely regard himself as a minister of the Christian Word and sacraments. Thus we are asking the question 'How should a chaplain as a minister of Word and sacraments behave? We are seeking norms for chaplaincy. Are there any common denominators? Is there any one mode of behaviour or set of roles which can be adopted by all chaplains? (Should, for example, all chaplains attempt to model themselves on Autton's chaplain, or become trained counsellors?)

Our answer to such questions is emphatically negative. It is our belief that there can be no standard model for chaplains and that no roles or images (providing they are not harmful to other people) should be ruled out. If it is accepted both that people are different in terms of temperament, situation and talents, and that the Word is communicated in more ways than verbally and in church buildings, then it can be seen that there can be no clearly prescribed chaplain's role. (Indeed perhaps one of the problems about chaplaincy is that people are not willing to explore the variety of different ways in which their vocation might be followed. It could be argued that Church of England clergy emphasise spirituality and distribution of the sacraments, to the partial or total exclusion of counselling and other human skills, while more Protestant ministers may do exactly the opposite.)

We would want to contend very strongly that it is essential that chaplains should be flexible in terms of the roles they select, in order that they may respond appropriately to God and to human need in particular situations. If maximum flexibility is not employed, needs will be ignored or only partially met. In saying this we are advocating a policy wherein a chaplain may legitimately act as, or appear to be, something else, e.g. a social worker, but underlying this will be the 'meta ethic' of the chaplain's basic role as minister of word and sacraments. We are suggesting that this basic role can only be a meta ethic (in the Kantian sense) and that the outworking of this meta ethic in actual situations allows for many permutations of practice between different individuals. In other words, we would see the role of minister of word and sacraments as being an 'ideological' role which provides an end, but does not dictate specific means or modes of action by which the end must be attained.⁴

This view opens up an enormous vista of valid chaplaincy praxis which can accommodate many different roles. To some, such a wide choice of action might seem attractive, but many may be frightened by the freedom and responsibility which is imposed on the individual by it. It certainly means that chaplains may have to abandon pre-conceived ideas about their own and others roles, and that trust in God's guidance become paramount. Inevitably there will be uncomfortable insecurity and anxiety if clergy are no longer sure of what they ought to be doing in the hospital. If the Anglican cleric can no longer see himself only as a person who gives out sacraments and lets God do the rest, or his Presbyterian brother can no longer see himself only, or primarily, as a skilled counsellor, there is bound to be the anguish of growing

pains, uncertainty as well as joy. However we would maintain that this anxiety and uncertainty could be one of the chaplain's greatest assets, putting him precisely in the same place as those he is trying to minister to. This may enable him to be a humble equal, providing he is not crippled by his own lack of assurance. Ministry by superiors to inferiors is a form of patronisation and is perceived to be so by those who are patronised, however dimly. Only if the minister is perceived to be an equal, entering into the person's own situation of fear and anxiety can it be of most use and effect. Here we come back to Faber's image of the shepherd genuinely walking with his sheep in the heat of the day, and welcoming the opportunity to be truly alongside them in spirit during their trials. (Faber's other image of the clown who acts originally and creatively in different circumstances is also apposite in talking of this kind of ministry.)

Perhaps these ideas can be better grasped if we put an 'umbrella' over them characterising this as an incarnational model of ministry. If we are called to imitate Christ and co-operate in his work of making God's rule and presence a reality on earth, it is surely not presumptuous to look to his life and ministry to find guidance and analogy for our own.

Firstly then let us look at the incarnation itself. In Jesus Christ God became man (cf. especially Phil 2 v.6). There are many dimensions to this event but there are two which we want to emphasise here. Firstly that God redeems man by becoming *as men are*. The God-man assumes the totality of human nature to the extent that he is indistinguishable from other men. Throughout the synoptic Gospels the question is asked 'Who is this man?' and as the account goes on the answer becomes clearer and clearer – the man is God (cf. Mark 8 v.29, and 15 v.39). Even if the New Testament does not have a properly developed doctrine of the divinity of Christ, such as that of the Fathers, the implications of later doctrine are contained within it. For our purposes the thing to note here is that God comes down to man's level in order to save him, he does not promulgate a decree from on high. Existentially interpreted this is of the highest significance, for people cannot accept things totally from those who are above them. Jesus sought equality with man rather than with God, in order that men might come to God. It was because of this that he was truly able to get alongside the dregs of society and show the unloved and underprivileged the way to God. The price of this was heavy, demanding that he leave home, forfeiting friends, possessions, respectability, orthodoxy and security. Thus Jesus knew anxiety, uncertainty and loneliness, which culminated in the desolation of the cross (cf. Mark 15 v.34). It is our contention that it was only by his entering completely into the situation of those that he came to save with his own anxiety, that Jesus had any credibility with them. So it must be with ministers. They must be prepared to experience continuing loneliness, uncertainty and anxiety in their lives if they are to be able to minister to the needy. They should therefore welcome anxiety and insecurity, for winners cannot minister to losers.⁵

Our second point is related. On Jesus' road to Jerusalem he was constantly behaving in unpredictable ways in order to be obedient to God and to meet human need. (Thus he bade the children come to him, while he could display extreme anger in turning over the money-changers tables in the Temple. Similarly he was prepared to break man's law, even religious sabbath law, in order to heal a man with a withered arm (cf. Mark 2 v.8 – 3 v. 6). In all his

contacts with people Jesus was infinitely flexible and variable, and this can be seen particularly in those with the sick. Obviously the Gospels record miracle stories in an exemplary and very stylised way, but it still seems appropriate to us to make the point that Jesus' ministry was original, flexible and variegated. We suggest that this gives an example, if not an imperative, to all ministers to explore freely all the roles which their job may demand, in order that they may better serve God and man. Rather than seeking a static and ultimate role as 'sacramental man', 'counsellor' or any other *one* role, a chaplain should become a refugee on the road to Jerusalem, travelling with Jesus and his fellow men to crucifixion and resurrection. Maybe, if he attempts to travel light, leaving preconceptions of self behind, he may glimpse the Holy City from time to time en route!

NOTES

1. Again he is very much an individual, not really concerned with the wider Christianity community outside the hospital walls, which in fact ordained him!
2. Wilson Op Cit. p.6
3. Cf. Epistle of James, especially Ch. 2 v 14ff.
4. For a discussion of ideology and praxis c.f. Fierro *The Militant Gospel* p. 236ff.
5. On the constructive use of anxiety cf. Hiltner and Menninger and especially Tillich.

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SHOULD PASTORAL CARE BE TAUGHT IN HOSPITALS?

David Lyall

One of the developing influences in theological education in recent years has been the growth of hospital-based courses of pastoral training, a development which finds its fullest expression in the Clinical Pastoral Education movement which had its origin in the United States in the nineteen-twenties.¹ This development has not however met with universal acclaim, one of its strongest critics being the late Bob Lambourne.² This article seeks to explore some of the underlying issues in the debate and, in the light of recent research, to assess the strengths and limitations of hospital-based courses in pastoral care with regard to the training of ministers.