2014

Equipping Elders and Deacons from the Gethsemane French Seventh-day Adventist Church for Effective Visitation in Healthcare Settings

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ABSTRACT

EQUIPPING ELDERS AND DEACONS FROM THE GETHSEMANE FRENCH SEVENTH-DAY ADVENTIST CHURCH FOR EFFECTIVE VISITATION IN HEALTHCARE SETTINGS

by

Brian Ladiny

Adviser: Siroj Sorajjakool
ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: EQUIPPING ELDERS AND DEACONS FROM THE GETHSEMANE FRENCH SEVENTH-DAY ADVENTIST CHURCH FOR EFFECTIVE VISITATION IN HEALTHCARE SETTINGS

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Date completed: April 2014

The Problem

Gethsemane French Seventh-day Adventist Church with a total membership of 1,200 serves a large diverse urban community in Brooklyn, New York. Church elders and deacons have little or no training on visiting the sick. No previous efforts to equip church elders and deacons for effective visitation in the healthcare setting have been attempted in order to re-affirm their mission to serve and visit those who are sick. This project aims to increase and enhance the knowledge of lay leaders to effectively visit the sick in the healthcare setting.
The Method

Three training sessions on visiting the sick in the healthcare setting were conducted and implemented at Gethsemane Church in Brooklyn, NY during the month of May 2011. The training sessions provided theological foundations, theoretical analysis and clinical skills on visiting the sick in healthcare settings. Instruments such as pre-session and post-session interview questionnaires, pastoral verbatim reports and evaluation forms were collected and analyzed.

The Results

Three elders, two deacons and three deaconesses were trained. All of them agreed to apply these visiting skills during their personal visitation in the healthcare setting. They all endorsed that a trained lay visitation team would be very beneficial for the Church. Eighty five percent of the participants felt very comfortable sharing visiting tips with other elders and deacons. Ninety percent of the participants wished for and felt that more time should have been spent during the training sessions on exploring the art of visiting non-Adventist patients.

Conclusions

Training lay leaders for effective visitation of Adventist and non-Christian patients in healthcare settings demonstrates positive impact on church growth. This finding suggests that implementation of this project to other local churches in Greater New York Conference would help church members to establish a friendship ministry of compassion and care to non-Adventist patients. This project, however, acknowledges
directions for further research, recommendations, and reflections on equipping church leaders for effective visitation in healthcare settings.
Andrews University
Seventh-day Adventist Theological Seminary

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A Project Document
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Brian Ladiny
April 2014
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Roger Dudley  Date approved
DEDICATION

This project is first and most of all dedicated to God, my Father and Educator who has sustained me throughout this journey. I would like to express sincere thanks and gratitude to my God-given wife, Esther Jocelyn-Ladiny, who has during the course of this project uplifted my spirit for excellence and undergone different circumstances of life with me from our engagement, marriage, and birth of our newly born son, Bradley Elie Ladiny. Also, special thanks to my proud parents, Wibain and Marie Ladiny for their support through fervent prayers and motivation. Overall, to God be all the glory and honor.
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LIST OF ABBREVIATIONS

CPE   Clinical Pastoral Education
NIV   New International Version
NKJV  New King James Version
RSV   Revised Standard Version
SDA   Seventh-day Adventist
TDNT  Theological Dictionary of the New Testament
CHAPTER 1

INTRODUCTION

Personal History

Today we are facing great medical problems in our society. People are getting sick every day. It seems that those who are sick are giving more attention to miracles than doctors’ words. Patients often seek for spiritual counselors, advisors, prayers, and miracles to occur. This is where chaplains have their roles in the healthcare field. Chaplains place a high importance on their role of providing emotional support to patients, families, and staff members. They address patient issues relating to death and dying, and they are called upon when ethical issues arise (Handzo, Flannelly, Galek, Weaver, & Overvold, 2006). They provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in distress (VandeCreek & Burton, 2001). This is why I have chosen this path of obtaining a doctorate degree in ministry with an emphasis on hospital chaplaincy.

My passion and desire to embark in this project has its root back in 2005 when I served as a volunteer student chaplain at Lakeland Regional Care Center in Berrien Springs, Michigan during my seminary training at Andrews University. It was such a joy and a delight for me, every Sabbath, to take a group of students from the campus to the Lakeland Regional Hospital Center. It was then that I discovered that those who are sick are in great need for spiritual counsels and prayers. The majority of patients do believe in the power of prayer. I love visiting those who are sick in the hospital and at home. It
gives me the true sense of living on earth. VandeCreek (2004) talks about the result of a chaplain’s visit. He says, “The chaplain’s visit contributes to the readiness of the patient to return home, to faster recovery, and makes the hospitalization easier” (p. 341). I do believe that hospital chaplaincy ministry is one of the vital, rewarding and exciting ministries. It makes me think deeply about humility, self-denial, and God’s given power to save the life of someone who is in need.

Earning a doctoral degree in ministry with the emphasis on healthcare chaplaincy will help me in acquiring and developing skills to train elders and deacons/deaconesses on how to effectively visit church members and their non-Adventist friends in the healthcare setting. Spiritual care plays a great value in a patient’s life and plays a significant role when cure is not possible and people question the meaning of life (VandeCreek & Burton, 2001). Studies have shown that family members of the sick come to view chaplains as part of the family themselves; they see them as relatives who comfort, support, and show their concern for them in various ways (Flannelly, Galek, Tannenbaum, & Handzo, 2007). These findings further demonstrate the importance of equipping church leaders to form a spiritual support group ministry to attend to those who seem to be neglected and without hope in the healthcare setting.

From the result of these findings, I have developed a strong interest in bringing time-tested spiritual resources that focus on transcendent spiritual meaning, purpose, and value to church leaders. I thank God for Andrews University innovative DMin program that allowed me the opportunity to implement and evaluate an intervention for this predicament in my congregation. For this is the raison d’être of the project that each church leader would adequately be equipped and trained to bring each patient’s physical,
spiritual, and mental sickness and grief toward God who is the great chaplain and physician, the ultimate Source of true healing.

**Statement of the Problem**

The Gethsemane French Seventh-day Adventist Church with a total membership of 1,200 serves a large diverse urban community in Brooklyn, New York. There are 11 major hospitals, six hospices, 40 long-term cares, and 23 rehabilitation centers in the vicinity of the church. Although this church is the largest Franco-Haitian church in the Greater New York Conference, with 12 elders and 150 deacons and deaconesses, it has little impact on the surrounding healthcare facilities. The church does not have a visitation ministry for its own shut-ins, those hospitalized, and those in long-term care. Church elders and deacons have little or no training on visiting the sick. Church members appear to feel that it is the pastor’s responsibility to care for those in physical crisis. No previous efforts to equip church elders and deacons for effective visitation in the healthcare setting have been attempted in order to re-affirm their mission to serve and visit those who are sick.

**Statement of the Task**

The task of this project is to create a health ministry spiritual support group utilizing a selected group of church elders and deacons/nesses from the Gethsemane French Seventh-day Adventist Church. This spiritual support group will be trained and equipped to provide spiritual care in visiting church members and others from the Haitian community who are sick in healthcare facilities in Brooklyn, New York. This health
ministry visitation program will be evaluated, reported and available for replication in other churches in the Greater New York Conference.

**Justification for the Project**

Gethsemane French Seventh-day Adventist Church has served in the Crown Heights community for the past 25 years. Yet its participation in developing and creating ministries for the sick and shut-ins in healthcare setting has been minimal. Our sick and shut-in church members in hospices and long-term care facilities often feel neglected when they do not receive adequate visitation and spiritual care from their local church elders and deacons. Local church members and even church leaders tend to leave this work to the pastor. There is little evangelistic opportunity to develop a friendly relationship with a healthcare facility in the church community.

**Expectations From This Project**

This project will help in providing different approaches for Gethsemane French Church lay leaders to reach out to those who are sick and shut-ins in a healthcare facility that is near the church. This project will support the pastoral staff of Gethsemane French Church in providing spiritual care to sick and shut-in church members. This project will also help to develop a Spiritual Support Group in the local church to minister to non-Haitian Seventh-day Adventists in healthcare settings. It will eventually supplement strategies for the Gethsemane French Church to establish strong relationship with its local healthcare facilities. In addition, this project should increase my knowledge and enhance my understanding of pastoral care in healthcare setting. Furthermore, this project is intended to offer strategies to other pastors of the Greater New York Conference to train, equip, and mobilize their local church leaders for effective visitation in healthcare setting.
Delimitations

This project is delimited to a selected group of elders and deacons/deaconesses from the Gethsemane French SDA Church to be trained and equipped for effective visitations in healthcare settings. Participants are limited to visit only patients to whom they are familiar or associated with. They are allowed to visit Seventh-day Adventist church members and their relatives and friends who are non-Adventist and/or non-Christian believers. Participants are restricted to conduct random and unannounced visit to patients at any healthcare institution. Thus, this project is delimited for participants to minister effectively to both Seventh-day Adventist members and their non-Christian friends, relatives, colleagues, and associates at a healthcare institution in Brooklyn, New York.

Limitations

During the involvement of this project, I was an associate pastor at Gethsemane French Seventh-day Adventist Church. Unfortunately, toward the end of the month that I completed the project, I was transferred to a newly formed district of two churches: Mahanaim Seventh-day Adventist Church in Brooklyn, NY and Canaan Seventh-day Adventist Church in Brentwood, NY. My transfer to a new district and responsibility did not allow me to fully supervise the spiritual support group after the training session, to evaluate an ongoing outcome of the project, nor to establish strong relationship with local healthcare facilities in the vicinity of Gethsemane French SDA Church.
**Definition of Terms**

The following terms are defined as they are used in this project document:

*Acute Care Setting*: Setting that refers to Intensive Care Unit (ICU) and Cardiac Care Unit (CCU), Emergency Room (ER), Operating Room (OR).

*Bikur Holim*: This term refers to the visitor carefully assessing the patient’s situation.

*Episkope or episkeptomai*. The latter is mostly used in the Septuagint where we have the rendering “to visit.” It combines the various senses of “to look upon, to investigate, to inspect, to test, to be concerned about, to care for.”

*Friend-Relationship*: The art of providing an ongoing spiritual support based on a mutual friendship without proselytizing.

*Healthcare Setting*: It is a term that refers to medical centers, hospitals, nursing homes, rehabilitation centers, long-term care, and behavioral centers.

*Lay Visitation Team*: It is another name attributed to the Spiritual Support Group. This team may be comprised of any church member including elders and deacons/deaconesses. However, the purpose of this team is to visit people (members and non-members) at any location – in their homes, at hospitals and/or nursing homes.

*Long-term Care Setting*: Setting that may refer to nursing homes and rehabilitation centers.

*Midrash*: A collection of explanatory works on the Torah.

*Non-Christian Patients*: Term refers to individuals who have no knowledge of the Christian faith and do not belong to any Christian denomination.

*Non-Adventist Christians Patients*: Term refers to individuals who are Christians
but who are not members or adherents of the Seventh-day Adventist faith.

*Paqad:* Hebrew terms which means “to seek out, visit, seek to someone/something.” Hence, it conveys the idea of seeing attentively or in an examining manner to someone or something.

*Religion:* In this study, it is a social and cultural structure or construct; it is usually taken to represent a formal set of doctrines and the social institution that maintains them.

*Religiosity:* A term that can be characterized as representing a dimension of religion that has been variously called private, experiential, non-organizational, informal, and individual.

*Social visitation:* Social network such as close relatives, friends, classmates, co-workers, colleagues, neighbors, doctors, nurses, social workers, patient’s advocates, lawyers, or any individual who may not be associated with any faith.

*Spirituality:* Term used throughout the project document to represent the individual's subjective experience of the sacred, which may take place inside but mostly outside the institution.

*Spiritual Support Group:* A trained group of elders, deacons and deaconesses to provide quality spiritual care by visiting the sick and shut-ins of Gethsemane SDA Church and other Haitian non-SDA members.

**Description of the Project Process**

The Biblical and theological motives and rationale for visiting the sick will focus on four areas. First, biblical foundations for visiting the sick will be explored, as well as the early church model of visitation. Second, the rabbinical ethics on visiting the sick will be
examined. Third, spiritual insights from Ellen G. White concerning sick visitation will be analyzed. Fourth, a scriptural analysis of selected passages in the book of Job will be studied to create a theological reflection and framework for visiting the sick in healthcare settings.

Contemporary literature will be reviewed. This will include books, journals, and articles related to religion and health, pastoral care, pastoral visitation in healthcare setting, spiritual support group, equipping the laity for healthcare ministry, statistics on spiritual support group visitation, impact of religion on health and other related works that scholars in the field of healthcare chaplaincy have contributed.

The current and update list of Gethsemane sick members in healthcare settings will be explored as prospective individuals to visit. A spiritual support group will be created with a selected number of elders and deacons from Gethsemane Seventh-day Adventist Church. This group will compose of 10 church leaders: four elders, three deacons, and three deaconesses.

Three bi-weekly training sessions will be conducted at Gethsemane Seventh-day Adventist Church medical room. Training Session I will provide Biblical and theological motives and rationale for visiting the sick. Special attention will be given to the power of Scripture, songs, and prayer when visiting Seventh-day Adventist sick members. Training Session II will focus on acquiring practical skills such as do’s and don’ts, what to say and not to say and how to terminate a visit in hospitals, hospices, nursing home and/or long-term care residences. Training Session III will discuss verbatim reports, interviews, and pastoral and self-reflections based on previous visits.
Also, group members will be required to undertake two bi-weekly visits to a healthcare facility in Brooklyn, New York. The spiritual support group will be divided into five teams of two; each team will contain one elder and one deacon/deaconess. Each team will be required to do at least two visitations in a healthcare setting: (a) Visiting a regular Seventh-day Adventist church member; (b) visiting an individual who is not a member of the Seventh-day Adventist Church. Each team will write two verbatim reports and present one report at Sessions II and III.

Qualitative data for the purpose of assessing the project will be used in a form of short-interviews to evaluate the spiritual support group visiting skills and to make further recommendations. This project should be completed before August 2013.
BIBLICAL/THEOLOGICAL MOTIVES AND RATIONALE
FOR VISITING THE SICK

This chapter suggests some biblical and theological principles that can contribute to developing strategies for equipping Church elders and deacons for effective visitations of nursing home residents, hospital patients, and elderly shut-ins. Biblical and theological motives and rationale for visiting the sick will focus on four areas. First, biblical foundations for visiting the sick, as well as the early church model of visitation, will be explored. Second, the rabbinical ethics on visiting the sick will be examined. Third, spiritual insights from Ellen G. White concerning sick visitation will be analyzed. Fourth, a scriptural analysis of selected passages in the book of Job will be studied to create a theological reflection and framework for visiting the sick in healthcare settings. Overall, this chapter lays out the biblical and theological ground for visiting the sick; it points to the value of visiting the sick.

Biblical Motives for Caring for the Sick

This section discusses the biblical foundations toward visiting the sick as it relates to love, compassion, and care. A special attention is given to Biblical understanding of sickness in Biblical literature as well as the value in ministering to or caring for the sick, and the early church model for equipping church leaders for visitation. What is visiting the sick? Does God care about those who are sick? What does the Bible say about visiting the sick? This study, however, is not limited to creating a theological framework for “visiting the sick” in healthcare settings.
Biblical Understanding of Sickness:
A Theology of Love, Compassion and Care

Biblical teaching reveals underlying moral principles and values which inform us of the nature of loving relationships and the pattern of life that God intends and desires for the sick. In the Old Testament sickness is generally presented as occurring as a result of personal sin or from association with others who have sinned, including groups or nations. There are also numerous occasions when sickness has no connection with sin, but is associated with fallen humanity in general.

The Israelites understood illness as both the natural result of mortality and as punishment for sin (Saxey, 1987). God was the physician and the chaplain, sending sickness, cure, and spiritual hope to allow His people to reflect on their own mistakes. “I will kill and I make alive; I wound, and I heal; neither is there any that can deliver out of my hand” (Deut. 32:39, RSV); “For He inflicts pain, and gives relief; He wounds, and His hands also heal” (Job 5:18); “Come, let us return to the LORD. For He has torn us, but He will heal us; He has wounded us, but He will bandage us” (Hos 6:1). Therefore, it is imperative to note that God allows sickness to show his act of love, compassion, and care for the sick. Specific instances of providing care in the biblical texts can bring valuable insight in terms of establishing structures, priorities, and principles for healthcare visitation. A collection of healthcare practices from ancient Israelite priests primarily in the Old Testament book of Leviticus can serve as biblical models for understanding sickness and care of the sick in the Old Testament era.

Levitical rituals and laws are primarily concerned with theology where the holy being is separated from the unclean. This explanation is expressed in a number of texts
(Lev 11:44-45, 13:25, 30). These texts theologically explain the role of priests and Levites in declaring people healed or clean with specifically curative treatment (Saxey, 1987). Although the Levitical rituals and laws are primarily concerned with theology, little evidence is shown when providing a biblical model of spiritual care to the sick. It appears that nothing could be done, except abide by God's law (Deut 7:12-15) to avoid being sick.

Levites were responsible for declaring what was clean and unclean; they did not engage in medicine in a therapeutic or even a diagnostic capacity, for their declarations pertained to ritual purity (Saxey, 1987). Moreover, Leviticus 13 discusses the response to one afflicted with a skin disease, normally called leprosy. Such a person was considered ritually “impure” and physically “unclean.” Leviticus 13: 45–46 stated that he shall dwell outside the camp and ‘‘he shall call out, ‘Unclean! Unclean!’’’ The Leviticus purpose of these actions seems to have been to isolate this afflicted person (Sheer, 2008). He shall be placed outside the camp and shall be obligated to make public announcements, shouting: ‘‘Unclean! Unclean!’’ and assured that he would remain apart from the community.

According to Sheer (2008), the Talmud, a Jewish interpretation of the Hebrew Bible, interpreted the public announcement of a leper differently: ‘‘He must declare his sorrow to the public so that the public will ask for mercy on his behalf.’’ Sheer (2008) firmly argues based on the Talmud that the shouting of ‘‘Unclean! Unclean!’ was not a warning to sustain the isolation of the afflicted; it was a call for social connection, compassion and prayer” (p.104). It was a call for social love, compassion and care which stresses that the biblical model of “nurturing” and “care for the sick” is vital and of good and honest relationships. In the search of this connection with others, Sheer (2008) comments that
the notion “Unclean! Unclean!” was an invitation for public sympathy and empathetic prayer on behalf of the afflicted to overcome his exclusion from the community” (p. 105).

The law became the framework of the people's lives and existence and at the heart of the law was love (Saxey, 1987). Indeed, it was through the law that God was able to show His love for the people, whilst it was through the law that the people could show their love for Him. Love then, was the basis of the demands of the law and was also the motive for obeying it (Deut 6:4-6) because “paramount to the law was the command to love God wholeheartedly and to love one another” (Field, 1995, p. 13). The Old Testament, therefore, embodies an affirmation of life and the importance of healthy bodies as mortals relate to God. The Old Testament teaches a reason for compassionate service and reverence for life by recognizing the divine in human beings. Saxey (1987) notes “Israel's theology was peculiar in asserting that illness involved simply the patient, God, and the natural world of mortality” (p. 126).

The Hebrew word paqad for visit has a religious content only when God is the subject of the action. It denotes an unchanging, mutable attitude on God’s part. It combines the various senses of “to visit,” “to be concerned about,” “to care for,” in description of the act in which the Lord intervenes in a special incursion into the course of life of an individual or of a people, mostly Israel (Kittel, 1964 vol. 2, p. 602). God's loving action also manifests itself in the New Testament. It is His love that evoked Him to send Jesus His son to die for humankind in order to save it from the penalty of sin and death (Jubilee Centre, 1998). Throughout Jesus’ ministry He demonstrates the importance of ministering to the sick and the rejected of His society (Luke 4:17-19). Jesus' life, ministry, death and resurrection also demonstrate the depth of God's love, compassion
and care to our sick humanity (Phil 2: 5-10). Jesus continued with the Old Testament command to love God wholeheartedly and to love one's neighbor as oneself (Deut 6:4-5; Matt 22:37-39).

**Love Your Neighbor as Yourself**

Love your neighbor as you love yourself (Lev 19:18; Matt 19:19; 22:36-40; Mark 12:31; John 15:12; Rom 13:9; James 2:8) is one of the biblical foundations for visiting the sick. The purpose of ministering to the sick is an act of love. God mandates us to love our neighbor as we love ourselves. Jesus makes a great emphasis on commanding us to love our neighbor as He says, “…You shall love your neighbor as yourself. There is no other commandment greater than these” (Mark 12:31). The principle behind visiting the sick should be expressed through love, compassion, and care for the afflicted one. Therefore, God commanded His people to be loving, compassionate and merciful towards the orphans, windows, the less fortunate, and the sick (Ex 22:21-27, Lev 19:9-10, 14, 34, Deut 24:14-15).

Writers of the New Testament generally understood that God's love prompts believers to love others (Eph 5:1-2) and that love for God's people is love shown for Jesus (Heb 6:10; Matt 25:34-40; 1 John 4:20). In accord with the Old Testament, they understood that evidence of a genuine love for other people was a sign of obedient love to God (1 John 5:2) (Field, 1995, p. 10-11). Texts elsewhere indicate that as we obey the command to love one another and also partake in each other’s problems we are showing compassion, which itself is an active response to the needs of others (1 John 3:11-18, Gal 6:2) (Parkyn, 1995, p. 244). Associated with love and compassion are the vital laws which instruct us to visit one another. In the Old Testament, social rules and stipulations
highlighted the understanding that Israel had been called by God to be a caring community (Jubilee Centre, 1998; Atkinson, Field, Holmes, & O'Donovan, 1995). This call is emphasized in Deuteronomy and its concern for social justice, the poor, widows, orphans (Jubilee Centre, 1998). In the New Testament, Jesus continues with this command to care by instructing church leaders to care for each other (John 15:12). The Gospel of John defines this love as being the same love that exists between the Father and Son which is then given to all those who believe (John 3:16).

This type of love is being essential for the recognition of personal worth in sickness. Keeble (1995) notes “Care is an example of the love described in John 3:16; it loves to the end and is costly and giving” (p. 215-216). According to Apostle James, “loving your neighbor as yourself” is the fulfillment of the royal law (2:8). Visiting the sick shows an act of genuine love and it fulfills the royal law which makes the visiting person fulfill one of God’s greatest commandments (James 2:8). Pastoral care for the sick, therefore, expresses the goodwill and love for patients who are abandoned in healthcare settings. It is required for all God’s leaders to demonstrate their love by creating a habit of visiting the fatherless, the weak, and the feeble in long-term care setting (James 1:27; Atkinson et al., 1995). Genuine love is demonstrated by genuine care; genuine care is, therefore, supportive and it is the responsibility of pastors, church leaders and church members to genuinely care for the afflicted ones. As care comes from this love it becomes an all-embracing and prevailing covenant and begins on a simple everyday level (Jubilee Centre, 1998).
Ezekiel 34: An Old Testament Mandate for Caring for the Sick

Ezekiel 34 depicts the ideal biblical command for visiting the sick by the spiritual leaders. Verse 1 starts with command from the Lord to Ezekiel to prophesy against the Shepherds [leaders or pastors] of Israel. Ezekiel 34: 3–6, 8 states:

You, shepherds of Israel, who have been tending yourselves! Is it not the flock that the shepherds ought to tend? You partake of the fat, you clothe yourselves with the wool, and you slaughter the fatlings; but you do not tend the flock. You have not sustained the weak, healed the sick, or bandaged the injured; you have not brought back the strayed, or looked for the lost; but you have driven them with rigor, and they have been scattered for want of anyone to tend them; scattered, they have become prey for every wild beast. My flock wandered through all the mountains and on every high hill; My flock was scattered over all the surface of the earth, and there was no one to search or seek for them…“As I live,” declares the Lord God, “surely because My flock has become a prey, My flock has even become food for all the beasts of the field for lack of a shepherd, and My shepherds did not search for My flock, but rather the shepherds fed themselves and did not feed My flock;”

The Hebrew root [bqr] baqar occurs only seven times in the Old Testament (Lev 13:36; 2 Kings 16:15; Ps 27:4; Pro 20:25; Ezek 34:11-12). In these contexts, baqar connotated a visit, examination, investigation, or special care. Three of the seven occurrences were in Ezek 34:11 and 12. For thus said the Lord God: As a shepherd cares for [root: bqr] his herd in the day when he is among his scattered sheep, so I will care for [root: bqr] My sheep and will deliver them from all the places to which they were scattered on a cloudy and gloomy day.

In the context of [qzx] chazaq, visiting the sick, Ezek 34:4, 16 provide two occurrences where a biblical motive for visiting the sick is important. Verse 4 states:

“Those who are sickly you have not strengthened [qzx] chazaq, the diseased you have not healed, the broken you have not bound up, the scattered you have not brought back, nor have you sought for the lost; but with force and with severity you have dominated them. Verse 16 states: “I will seek the lost, bring back the scattered, bind up the broken...”
and *strengthen* the sick [root: qzx]; but the fat and the strong I will destroy. I will feed them with judgment.”

The Hebrew root [xbx] *Chabash* has a sense of making strong, making bold, encouraging or bringing relief and comfort to the sick (Gen. 48:2; Job 4:3; 27:6; Lev 25:35; Ezek 34:4,16). The overarching theme, which is underscored repeatedly throughout Ezekiel 34, is that God loves and always cares for His people. He shows both empathy and sympathy for His people by emphasizing His personal engagement with them. God proclaims (verse 11): “Here am I!” He is with them in their affliction [sympathy]. “I am going to take thought for my flock and I will seek them out” “as a shepherd seeks out his flock.” The tenderness of that caring image of a shepherd would never be lost on His people’s mind.

According to Sheer (2008), the finale of the text brings the unit to full circle: “And I will grant them a covenant of friendship (v. 25)” and “. . . they shall dwell secure and untroubled (verse 28).” The national healing is due to the covenantal relationship [empathy] between God and His people. Greenberg (Anchor Bible, Ezekiel 21–37, 1997) in his commentary reviewing the meaning of *baqar* said: the Hebrew root, [bqr] is from the strong sense of “examine, inspect, check (for presence = absence of something).” Greenberg (1997) also stated that *baqar* in Ezekiel meant an investigation, and that the translation of the rabbinic term, *Bikkur holim*, was “visiting the sick,” in its weaker sense. However, when the rabbis depicted *Bikkur holim* in the texts I cited previously, they clearly used this term in both senses, to mean, a) visitation with the intent, and b) to examine or inspect. The purpose of *Bikkur holim* was to visit the sick to ascertain whether a further intervention was in order, and to identify its nature (Sheer,
Ezekiel 34 provides the rabbis a definition of *Bikkur holim*, and these biblical verses are served as the source for this technical term itself. Sheer (2008) argues that the purpose of visitation in Ezekiel 34 is remarkably congruent with the rabbinic conceptualization of *Bikkur holim*. The genesis of visiting the sick should have a sense of caring and empathizing. Sheer (2008) implies that the driving force behind *Bikkur holim* is one’s sense of responsibility for the ill. Without such empathy, he argues, *Bikkur holim* would not occur. As in Ezekiel, the initial element in *Bikkur holim* was the “‘visitation,’” by which the individual was simply present with the sick. “No words or deeds accompanied this visitation” (Sheer, 2008, p. 110).

Therefore, Ezekiel 34 demonstrates the divine mandate of visiting the sick. It presents the kind of caring that needs to be expressed by one’s presence at bedside. Sheer (2008) notes such presence as “an expression of the bond between the parties” (p. 110). There must be bond that exists between spiritual leaders and the ill. Developing a passion to visit the sick in healthcare settings would help elders/deacons/nesses of Gethsemane SDA Church to create a bond of love and compassion for the ill.


Matthew 25:35, 36; 42, 46 present the pivotal biblical foundation for this project:

…For I was hungry and you gave Me food; I was thirsty and you gave Me drink; I was a stranger and you took Me in; I was naked and you clothed Me; I was sick and you visited Me; I was in prison and you came to Me…. for I was hungry and you gave Me no food; I was thirsty and you gave Me no drink; I was a stranger and you did not take Me in, naked and you did not clothe Me, sick and in prison and you did not visit Me.
In the New Testament, *episkeptomai* for “to visit” connotes the sense of “to be concerned about someone” or “caring for others.” *Episkepkomai* has a deeper meaning than “to seek out to someone.” In Matthew 25:35, 42, Jesus places the men of all nations (v.32) under the same command and judges them according to the measure of their fulfillment. Man has to realize that he does not exist of and for himself, but of and for the other. This is to be expressed in his actions. But God is present in this existence with and for others (Kittel, 1964, Vol. 2, p. 603). James 1:27 points out what is pure and undefiled religion, which is visiting the fatherless in their affliction.

Jesus tells his followers that the judgment in the last day will have many surprises. He says those who will inherit the Kingdom of God are those who feed the hungry, clothe the naked, give shelter to the homeless, and who visit the sick and those in prison (Matthew 25:31-46). Visiting, in these verses, is described as coming “to see how others are doing,” “to lend support,” “to care for,” “to express solidarity with them” and “to look after their needs.” One of the best examples of pastoral visitation in the New Testament is reflected in the joy of sharing life together which occurs when Paul visits his friends in the faith, and is referenced when 2 John’s author writes of the pleasure of being “face to face” rather than just corresponding with “paper and ink” (2 John 1:12).

The biblical word *laos* from which we get our word “laity” has nothing to do with amateur or secondary status within the church (General Conference, 2009). Church elders and deacons are also called *laos* since they don’t have the theological training to be hired as pastors of a particular congregation. Nevertheless, visitation in healthcare setting is not reserved only for pastors but it is the duty of all church leaders and officers. The Greek word used for church leaders in the New Testament is *episkopos* which has the
same root as *episkeptomai* meaning “to visit” or “to care for.” Thus, church leaders have a great responsibility, which is “to visit,” “to pay careful attention” and “to empathize” to regular church members’ feelings.

James 5: 13-16: An Apostolic Mandate for Praying With the Sick

Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed.

This passage is a direct example of an apostolic biblical mandate of visiting the sick by elders. The Greek word used for sick here is *asthenew* which means “to be weak” “to be without strength.” This concept does not apply not only to sick people in the hospital, but in all aspect of healthcare facility where people are being weak, neglected and sometimes condemned with a trial and without hope. The same word is used in Matthew 10:8 when Jesus commands His disciples including James to go, preach the gospel and heal the sick. Healing the sick is a theological mandate from our Lord (Mark 16:18). When *asthenew* is in the present tense, it connotes the idea of “being sick continually” or “being constantly in pain.” The apostle demands that such person herself must call the elders of the church, *proskalesasqw*, which indicates urgency for help. Care for the sick is urged in 1 Thess 5:14 and Matt. 10:8 (help the sick). In other words, if anyone is being sick, they are required to call for the elders. It lies upon sick people as a duty to demand a visit from elders, and to desire their assistance and their prayers (Henry, 2008).

It is the duty of church elders to pray over the sick when they visit them at any healthcare facilities, when thus desired and called for. The apostle James urges elders to
pray over the person who is being sick. The text does not say to pray at the church for the sick, but it emphases the need of a face-to-face visit from elders to lay hand on the sick person. In the times of miraculous healing, the sick were to be anointed with oil in the name of the Lord.

Expositors generally confine this anointing with oil to such as had the power of working miracles (Henry, 2008; Lockyer, 1988). In Mark’s gospel we read of the apostle’s anointing with oil many that were sick, and healing them (Mk. 6:5, 13). The use of olive oil was one of the best remedial agencies known to the ancients (Lockyer, 1988). They used it internally and externally. Some physicians prescribe it today. It is clear both in Mark 6:5, 13; James 5:15 that medicinal value is attached to the use of the oil and emphasis is placed on the worth of prayer (Henry, 2008; Lockyer, 1988). The Association of Professional Chaplain endorses the practice of anointing for the sick in healthcare settings. The Association agrees that it is the responsibility of the healthcare facility staff to demonstrate respect for a patient's desire for chaplaincy care and other religious/spiritual services, and to provide necessary access. Hospital staff should honor the dignity to the patient and family by addressing religious and/or spiritual needs throughout the hospital stay. If a specific rituals or activities such as anointing is requested by a patient or his/her legal guardian that must be for specific religious/spiritual services by a patient or his/her legal guardian (when the patient cannot communicate his/her own wishes directly) should be honored, where possible and appropriate.

The Bible places a great value in praying for the sick (Acts 9:37-40; 19:12; 28:8, 9). Church elders should always ask to offer a prayer of faith when they visit the sick. By the words of James here, that it was a thing enjoined in cases where there was faith for
healing. There must be an extraordinary measure of faith from elders when anointing, and in those who are anointed, an extraordinary blessing may attend the observance of this direction for the sick (Henry, 2008). The apostle James says: *The prayer of faith will make the sick well* (v. 15). The Greek verb used here is for “made well or healing” is *soso*; it denotes a sense of both physical and spiritual healing. There is a possibility that the visited person could be healed both physically and spiritually from the prayer of faith offered by elders. Prayer over the sick must proceed from, and be accompanied with, a lively faith (Matt. 21:21; Heb. 11:1; 6; James 1:6). Henry (2008) argues that there must be faith both in the person praying and in the person prayed for. The prayer of faith is crucial for any visit in healthcare settings it should be accompanied with mutual forgiveness and confession of sins (v. 16).

**Rabbinic Law and Ethics on Visiting the Sick**

In Rabbinic ethics, the Hebrew term for “visiting the sick” is *bikur holim*, whereas, *bikur* means “‘examination,’” and *holim* means “the sick.” *bikur holim* means more than a regular visit; it conveys the idea of “an extend aid to the sick” (Bikkur Cholim, 2009; Sheer, 2008). Hence, the rabbinical notion of *bikur holim* is referring to the visitor carefully assessing the patient’s situation (Berlat, 1977). Attention is paid to the *complete* patient, that is, the physical condition, mental disposition, and spiritual attitude, as these are viewed as interrelated in Judaism (Allen, Katz, Rabinowitz, Stern, & Zucker, 2009; Sheer, 2008).

According to the Jewish tradition in visiting the sick, *bikur holim* is an essential religious and ethical obligation (Sheer, 2008). The Jewish responsibility of visiting the sick pertains not only to those with temporary illnesses or injuries, but also to nursing
home residents, long-term hospital patients and elderly shut-ins. Jewish Rabbis added nothing to the development of the thought of divine visitation (Allen et al., 2009). Visiting the sick plays an important role in rabbinic ethics (Bikkur Cholim, 2009). It is one of the works of love, and a religious duty or deed for every Jew to perform. According to one rabbinic opinion (Shab., 127a, as cited in Kittel, 1964, Vol. 2 p. 603), the visitation of the sick, the sheltering of strangers, the helping of the newly married poor, the comforting of the sorrowing, and attendance at funerals are all cultural duties.

In the first century Jewish culture, illness was contagious. Almost all those who were sick and the lawbreakers in prison were ritually unclean. Many who visited such persons forget themselves in love for others. They are compassionate for those who are in need and would be surprised by any reward for their kindnesses. Several rabbinic literatures show the value of visiting the sick: For instance, clothing the naked, visiting the sick, comforting the sorrowing and burying the dead are mentioned in Sota, 14a (as cited in Kittel, 1964, p. 603). In Sir. 7:35 (39), (as cited in Kittle, 1964 vol. 2 p. 603), it is read: “Be not negligent to visit the sick, for by such conduct thou wilt reap love.” R. Aqiba (Ned., 40a., as cited in Kittle, 1964, p. 603) is more severe saying: “If any will not visit the sick, it is as thou he shed blood.” All of these rabbinic literatures demonstrate that the Jewish people had a great responsibility toward visiting those who reside in nursing home, long-time hospital patients and elderly shut-ins.

Sheer (2008) emphasizes that it baqar is the time of visitation that engendered the various acts that might follow “on account of” being present at the sick house. He notes that bikkur holim is seen as visitation of the “outgrowth of human compassion and empathy” (p.110). Bikkur holim can also be viewed as investigation or assessment
whereby empathy inspires the visitation motivated action (Bikkur Cholim, 2009). The Midrash, a collection of explanatory works on the Torah, teaches also the importance of visiting the sick. Visiting the sick, according to the Midrash would alleviate suffering as it is written, “One who visits the sick relieves the sick person of one sixtieth of his suffering” (Leviticus Rabba 34, Ned., 39, as cited in Kittel, 1964). The point of this visitation is not merely to show sympathy or to convey wishes for recovery, but above all to pray for the sick man (Kittel, 1964, pp. 602, 603).

With delightful and profound complexity, in rabbinical literature, it is an important commandment to visit the sick and to petition for compassion on behalf of the sick as if to give the sick life (Bikkur Cholim, 2009). Prayer in rabbinic ethics is the most important way to support the sick. Prayer is offered to focus on the spiritual needs of a dying patient/member or the elderly. The Jewish community makes a strong emphasis on offering prayers to God on behalf of the sick. Prayer is taken seriously both as individual and/or community. Hillel (2006 para. 5) puts it this way, “We may pray for the person’s recovery, both independently or in a communal prayer service. The mi she-berakh (literally, “may the One who blessed”) is a prayer for the sick and a near-universal Jewish custom to offer this unique prayer.”

The Jewish people greatly respect the hours of visitation in healthcare setting. Too much visit can also do harm instead of bringing a blessing, as Rabbi Hillel (2006, para. 2) expresses it this way, “There are Jewish customs which offer insight as to how to properly visit the sick, so not to overwhelm them or cause additional anxiety.” Jewish visitation in the healthcare settings focuses on prayer, meeting the financial and the spiritual needs of the patient/members of the synagogue. Financial gifts along with
prayer both play a major role in visiting the sick. The Jews are obligated to give their financial support toward the sick. Hillel (2006 para. 4) discusses this phenomena saying, “Tzedakah, the Jewish obligation of giving, is another traditional way to honor the sick. By making a contribution to a valuable cause, one demonstrates concern and compassion for the sick, thereby taking a moment of difficulty and turning it into a catalyst for good deeds.”

Ellen G. White Insights on Visiting the Sick

Ellen G. White is one of the pioneers of the Seventh-day Adventist Church. Her writings are considered to be inspired by God and provide divine counsels to the people of God living in the last days. The theological framework of this project is also constructed from the writings of White as follows (a) equipping church leaders for visiting the sick, (a) visiting non-Christians individuals, (c) praying with the sick.

Insights on Equipping Church Leaders for Visiting the Sick

Church elders and deacons’ visits are not always as appreciative as the pastor’s visits to the sick. Members have the tendency to believe that elders or deacons’ visits are not pastoral and that only the pastor’s visit is most significant to them. White (1895) strongly disapproves such beliefs and concepts as she states, “Many members of the church have been deprived of the experience which they should have had, because the sentiment has prevailed that the minister should do all the work and bear all the burdens” (para. 2). Thus the minister will not have to perform all the labor himself. Members should learn that elders and deacons’ visits are as important as the pastor’s visit.
One of the significant aspects of this visitation project is to train and equip church leaders for ministry. Equipping the laity to minister to others is something that White greatly values. She encourages ministers to train church members and share their work of visiting the sick with them. Ministers should take the officers and members of the church into their confidence, and teach them how to labor for the Master.

The youth in our churches should be also involved in visiting the sick. White (1897, para. 3) says, “There are youth in our churches who could be educated to do a work for the Master in visiting the sick, in running on errands of mercy. This work has not been done, because no attention has been given to the matter.” This is a powerful statement because since the time that this letter was written little training and/or no effort have been made to educate, train and equip the youth for visiting the sick.

Most churches have a list of sick and shut-ins. Those shut-ins often feel neglected and/or put aside by the church community. White (1908, para. 8) further argues that it is the duty of every church to feel an interest in its own poor. God has left a work to do in visiting the sick and none whose names are on the church books should be left to suffer year after year from sickness without a visit from the pastoral staff of the church.

Insights on Visiting non-Adventists

White gives us the perfect strategy in visiting individuals who are not professing our faith. “In your care of the sick, act tenderly, kindly, faithfully, that you may have a converting influence upon them. And as you present the grace of truth in true disinterested service, angels will be present to sustain you” (White, 1907/1932, p. 196). Based on such counsel, visiting non-Adventist Christian believers should be done with
great tact and respect. Church elders and deacons/deaconesses should not seek to impose doctrinal beliefs on their local church member-patients as well as non-church member-patients in healthcare setting. Visiting the sick is not engaging in a Bible study. Church elders and deacons/deaconesses should act tenderly, kindly, respectfully and faithfully in ministering to patients by presenting an atmosphere of mutual understanding of the grace and love of God especially toward non-Adventist believers.

**Visiting the Sick is not Preaching to the Sick**

White invites us to follow the method that Christ uses in ministering to the sick. While preaching may be one of the great tools to reach souls for Christ, it is not the only way to present the gospel. White (1905) focuses on the most valuable things in Jesus’ ministry saying, “During His ministry, Jesus devoted more time to healing the sick than to preaching; His miracles testified to the truth of His words” (p.19). One of the main objectives of chaplains and spiritual caregivers in healthcare setting is to meet the sick at their spiritual level with God. White (1900) values this notion very well, as she states, “To take people right where they are, whatever their position or condition, and help them in every way possible, this is gospel ministry” (p. 301).

Gospel ministry is not about preaching only. Gospel ministry is about developing methods and strategies to show care and compassion to those who are suffering. Luke presents his gospel in a marvelous way. Although Luke is not a disciple of Jesus Christ, however, he is a medical missionary. In his work as a physician he ministered to the sick, and then prayed for the healing power of God to rest upon the afflicted ones. Physical healing is bound up with the gospel commission (White, 1905, p. 140).
Elders and deacons/deaconesses have to be led by the Holy Spirit to carefully minister to both church member-patients and non-church member patients. They must be trained to know how to visit their relatives, friends, neighbors and colleagues who do not profess the same faith as them. Having a relationship with God through daily prayer and reading of the Word of God, the lay minister will be apt to receive God’s instruction to approach those people. White (1905) comments on this saying, “the words of the living God are the highest of all education. This will give the ministers spiritual strengths; then they will be prepared to minister to all classes of people” (p. 443).

**Format to Follow When Visiting the Sick**

Elders and deacons/deaconesses should learn to respect the laws of health. Many healthcare facilities have rules and regulations. Visiting elders and deacons/deaconess have to respect patient’s privacy, follow hospitals’ signs and direction carefully. White (1905) comments on this saying, “Those who minister to the sick should understand the importance of careful attention to the laws of health. Nowhere is obedience to these laws more important than in the sickroom” (p. 219). White (1900/1977) also points out what ministers should say when visiting the sick in nursing homes, hospitals, hospices and long-term care facilities, saying, “I am ready to help you, and I will do the best I can. I am not a physician, but I am a minister, and I like to minister to the sick and afflicted” (p. 764). I consider this statement to be a model for all elders and deacons/deaconesses to formulate when encountering non-Christian believers. An elder or deacon/deaconess who follows this model will show mutual respect and honesty to the sick individual. This is a polite way of approaching non-Adventist Christian believers. Ministers are not
physicians, but they can offer prayer and spiritual comfort to those who may need their help.

**Praying With the Sick**

White (1900/1977) gives the ideal foundation of true healing in visiting the sick. True healing comes with sincere and fervent prayers. Angels are ministered at the bedside when prayers are offered. She mentions, “When you neglect to offer prayer for the sick, you deprive them of great blessings; for angels of God are waiting to minister to these souls in response to your petitions” (p. 764). In that same vein, White (1892/1990) takes the liberty to show a model of a simple prayer that can be offered at the bedside:

Lord, we cannot read the heart of this sick one; but Thou knowest whether it is for the good of his soul and for the glory of Thy name to raise him to health. In Thy great goodness, compassionate this case, and rebuke disease, and let healthy action take place in the system. The work must be entirely Thine own. We have done all that human skill can do. Now, Lord, we lay this case at Thy feet. Work as only a God can work, and, if it be for his good and Thy glory, arrest the progress of disease and heal this sufferer. (p. 226)

This prayer is a perfect example of a simple prayer that could be used by church elders and deacons/deaconesses when visiting those who do not profess the same faith as them. This prayer is universal and very generic. It can be offered for any religious patient Jews, Buddhist, Hindus, Muslims and Christians; it is very clear, short and concise with no proselytizing motives, except for where it mentions “Lord” to be replaced by “God” or “Most High.” This prayer plays a major contribution to develop guidelines on praying with the sick in healthcare settings.

In short, this section on insights from the inspired writings of White implies there is no greater ministry than to visit the sick, care for them, meet their physical and spiritual needs and bring them to see the Great Physician of the world as we act tenderly, kindly
and faithfully toward them. It is worth ending this section with this powerful quotation, “Nothing will give greater spiritual strength and a greater increase of earnestness and depth of feeling, than visiting and ministering to the sick and the desponding, helping them to see the light and to fasten their faith upon Jesus” (White, 1885, p. 76).

Theological Reflection and Framework on Visiting the Sick:

An Evaluation of Job’s Friends’ Visit

Theological reflection and framework on visiting the sick are being assessed throughout the book of Job to identify some positive and negative approaches, Do’s and Don’ts, on a pastoral conversation with a sick person within the healthcare setting. This theological reflection, however, does not discuss the entire speech of Job’s four friends, however, it will evaluate and extract some pastoral visitation skills that are both beneficial and not beneficial to patients. Pastoral care involves the establishment of a relationship or relationships whose purpose may encompass support in a time of trouble and personal and/or spiritual growth through deeper understanding of oneself, others, and/or God (Newitt, 2010). The first part of this analysis addresses Job’s friends’ purpose of the visit, their feelings and their reactions when they first saw Job. The second part of this analysis challenges the negative approaches of Job’s friends’ statements that are not permitted in pastoral visit. Newith (2010) argues that “Pastoral care will have at its heart the affirmation of meaning and worth of persons and will endeavor to strengthen their ability to respond creatively to whatever life brings” (p.167). The second part highlights several instances where Job’s friends fail to fulfill the affirmation of meaning and worth of Job’s spirituality through their judgmental response.
Positive Nonverbal Skills From Job’s Friends’ Visit

When Job’s three friends, Eliphaz the Temanite, Bildad the Shuhite and Zophar the Naamathite, heard about all the troubles that had come upon him, they set out from their homes and met together by agreement to go and sympathize with him and comfort him. When they saw him from a distance, they could hardly recognize him; they began to weep aloud, and they tore their robes and sprinkled dust on their head. Then they sat on the ground with him for seven days and seven nights. No one said a word to him, because they saw how great his suffering was. (Job 2:11-13, NIV)

Collectively, Job’s friends’ combined acts and physical presence reveals an initial behavioral confrontation. From a therapeutic standpoint, Reynierse (1975) argues that their act of physical presence represents some therapeutic success in the visit. This behavioral therapy must be explored. The first part of this analysis consists of exploring this nonverbal behavior of Job’s friends at the beginning of their visit in which we will extract some clinical principles as to: (a) developing a passion for visiting the sick, (b) establishing the purpose of the visit; (c) observing: face-to-face encounter; (d) shared-emotions; (e) being present; (f) remaining silent; (g) effective spiritual assessment; (h) active and reflective listening.

Developing a Passion for Visiting the Sick

Job’s friends heard about all troubles of Job, each one of them left their own place and made an appointment together to see Job (Job 2:11a). One of the most important aspects of Bikur cholim is a heartfelt desire to visit the sick. Visiting the sick is an act of love based on a covenant. Eliphaz the Temanite, Bildad the Shuhite and Zophar the Naamathite have heard about Job’s disaster, they immediately covenanted to come. The term for friends has a wide range of meanings, including an intimate counselor (I Chr 27:33), a close friend (Deut13:7). Hence, friends in the Old Testament times often
solemnized their relationship with a covenant, promising to care for each other under all kinds of circumstances (Hartley, 1988). The relationship between Job and his three friends gives every evidence of being based on a covenant. Their friendship was such as to bind them to Job even in his suffering and pain (Atkinson, 1992). Visiting the sick should be a matter of love rather than a duty. Church elders and deacons should have a passion for visiting the sick.

Establishing the Purpose of the Visit

Their main goal was to sympathize and comfort Job in his afflictions (Job 2:11b). The three friends came for two purposes. First, they came to condole, that is, to be in sorrow with him. The Hebrew words used here are interesting. “Sympathize” actually translate a word that means “to move about with anxiety and be disturbed, to shake one’s head with agitation” (Zuck, 1992). It derives from the Hebrew word nud from which we get the expression nodding the head. Theirs is a condolence so deeply felt as to be inarticulate, expressible only through those bodily movements by which one undergoes sympathetically the embodied sufferings of another (Janzen, 1985). In other words, these three friends come to hear Job’s story and agree with him.

The second purpose of the visit of Job’s three friends, while grounded in the first, is to comfort (nhm) Job. The precise meaning of this verb has been variously derived and defined. Based on the root of the verb, it can also be described as a “change of mind,” an attempt to ease the deepest pain caused by a tragedy or death (Hartley, 1988), to name the inner self in respect to one’s affections and emotions, understandings and attitudes, intentions and volitions (Janzen, 1985). One of the semantic roots even translates comfort (nhm) as “to breathe pantingly” (Zuck, 1992).
The idea of a person comforting someone means that he or she may sigh and weep. It is when the patient’s pain becomes the visitor’s pain. It is when the visitor feels sorry for the sick and expresses compassion and grief over the patient’s agony. The goal of visitation in healthcare settings is not to persuade, to evangelize, to preach or even to perform or expect a miracle; it is about sympathizing and comforting church members-patients and non-church patients in their sickness. It is about hearing patients’ spiritual needs in order to enable them to cope with their emotional, physical and spiritual pain.

Observing: Face-to-Face Encounter

When they saw him they could hardly recognize him (Job 2:12a). As Eliphaz, Bildad, and Zophar see Job and walk toward him, they are astounded. No matter what the news has said about Job, visiting Job in-person demonstrates something else. The value of in-person visitation in healthcare settings is clearly shown in verse 12a. With the increasing of today’s technology, it is easier to make phone call visits, text visits or to visit via social networks such as MySpace, Facebook, and Twitter in lieu of a personal encounter. However, there is nothing more effective than a face-to-face visitation in healthcare settings. Lay pastoral visitation in healthcare setting is a way to reconnect church members with their church, initiate reconciliation, and establish contact with people in need of prayer and spiritual support. Visiting in healthcare setting provides the human touch, the face-to-face encounter, giving attention to a person for whom we deeply care.

Shared Emotions: Reflective Feelings

They began to weep aloud and they tore their robes and threw dust on their heads
(Job 2:12b). The weeping, tearing of robes, and throwing dust over heads are eastern expressions of mourning which show the vehemence of the affections and passions of Job’s friends, on seeing him in such a miserable condition. Bolton (1986) describes feelings as the energizing force that help us sort our data, organize it, and use it effectively as we shape and implement relevant action steps. The act of good observation involves the ability to respond reflectively. The reflective feelings of Job’s three friends are clearly expressed through their weeping, tearing of robes, and sprinkling dust on their heads because they have seen Job’s weeping, scraping himself and sitting among dust (Job 2:7,8). The visiting elder or deacon/deaconess should be a good observer of body language at the bedside. One of the best ways of practicing reflective feelings at the bedside is asking self-relevant reflective questions such as, “If I were having that experience, what would I be feeling.”

Being Present: Attending and Compassion

Then they sat on the ground with him for seven days and seven nights (Job 2:13a). This is a perfect example of practicing the ministry of presence while visiting the sick. Job’s friends do not start a verbal conversation with him. They do not start singing or even say a prayer. They just literally sit down and observe Job for seven days and seven nights. They do not go home, they make necessary provisions to attend to Job. This shows the degree of their attending and compassion toward Job. They are comfortable chairs available for them to sit on, but they sympathize with Job by sitting with him on the dirty and dusty floor. They are in true compassion by putting themselves into the same humble and uneasy place and posture with Job.

Job’s friends practice attending skills. Bolton (1986) describes this phenomenon
as giving your physical attention to another person. It is listening with the whole body. It is a non-verbal communication that indicates that you are paying careful attention to the person who is talking. It also includes a posture of involvement, appropriate body motion, eye contact, and non-distracting environment. For seven days they just sat down and did nothing but to lament with Job.

Remaining Silent

No one said a word to him (Job 2:13b). Job’s three friends, Eliphaz, Bildad, and Zophar sit down and remain in silence with Job for seven days. They don’t say a word of comfort and encouragement to Job. They simply sit on the dust of the ground and look at their friend suffering. Other passages of scripture say, “There is a time to keep silence, when either the wicked is before us, and by speaking we may harden them (Ps 39:1), or when by speaking we may offend the generation of God’s children (Ps 73:15). Silence is a great tool to use in visiting the sick in healthcare settings. It is not the visitor’s show; patients should be given ample time and opportunity to express themselves. Henry (2008) comments on silence by noting, “We should think twice before we speak once, especially in such a case as this think long, and we shall be the better able to speak short and to the purpose” (p. 660). Silence is an art that trained elders and deacons/deaconesses should practice for effective visitation in healthcare setting.

The art of using the knack to be silent when visiting the sick is a prerequisite for reflective listening. Remaining silent while visiting the sick means to respect and honor the patient’s physical territory and to allow the patient to be his or her own person. Silence is the art of distancing yourself from your own personal views, values, and beliefs in order to let the other person just be. It will help elders and deacons/deaconesses not to
intrude on another’s space in values or religious issues. Job’s friends sit down in silence to observe and assess Job’s reaction in order to diagnose Job’s sickness and the way he is coping with his tragedy.

Effective Spiritual Assessment

The friends saw how great his suffering was (Job 2:13c). This phrase explains the reason why Job’s three friends remained in silence. In being silent seven days and seven nights, they express their sympathy while carefully assessing Job’s suffering in their minds. Job’s three friends are practicing what Bolton (1986) calls effective assertion. Fitchett (1993) describes assessment as a process of information gathering and interpreting. It is the dimension of life that reflects the need to find meaning in existence and in which we respond to the sacred.

Job’s friends sit down in silence to observe and assess Job’s sufferings. He who practices the art of silence in healthcare settings will be fortunate enough to assess the spiritual needs of a patient. This correlates well with what Fitchett (1993) states, “Assessment helps caregivers set goals for ministry rather than responding merely in a spontaneous or impulsive manner; therefore, spiritual assessment has a central place in guiding and evaluating pastoral care” (pp. 16-20).

Job’s friends do not ask him how he feels neither does Job opens his mouth to describe how he feels about the intensity of his sufferings. Job has not said a word regarding his physical, mental and spiritual challenges, yet his friends are able to read his body language and interpret the intensity of his sufferings. They are able to diagnose Job’s spiritual and physical conditions and come to a point that they have to remain speechless for seven days and seven nights. No words could describe their feelings
toward Job. Their body posture speaks volumes about their feelings, self-image, and energy.

Assessing spiritual needs is one of the great tools that church elders and deacons/deaconesses need to explore in visiting the sick in healthcare setting. Spiritual assessment involves gathering and processing information as the visitor remains silent and listens to the patient sharing his or her emotions. The purpose of pastoral assessment is to enhance ministry by accurately identifying problems and needs in the spiritual lives of people with whom we work (Gorsuch, 1999).

Active and Reflective Listening

Indeed, I waited for your words, I listened to your reasoning; while you searched out what to say (Job 32:11, NKJV). I paid close attention to you; and surely not one of you convinced Job or answered his words (Job 32:12, NKJV). In Job 32: 1-5, Elihu is introduced as the youngest among Job’s friends who have waited to speak to Job after the other three friends ceased to answer Job. Elihu literally sits, hears the conversation, then analyzes and assesses what each person has said. He engages in a special kind of involved concentration. Following Job's final defense (Job 27-31) in which Job reaffirms his innocence, Elihu speaks, expressing anger at Job for refusing to admit his guilt and at Eliphaz, Bildad, and Zophar for condemning Job despite the fact that they were unable to answer Job's arguments (Reynierse, 1975). Elihu (Job 32-37) plays a particularly significant role in the therapeutic process. Gordon (1980) captured this essence in his term, active listening, where the listener accurately mirrors the client’s internal mood as a result of carefully assessing his or her words, thought process, feelings, insights and conflicts.
Active listening means being willing to give up something. Elihu gives his time and energy to voluntarily refraining from his own self to listen to others, saying, “I paid close attention to you” (Job 32:12, NKJV). Elihu comes to a point that his belly could not take it anymore saying, “I am full of words, the spirit within me compels me” (verse 18). Active listening involves attending, following and reflecting skills. Elihu carefully attends each conversation, follows each person’s thoughts, feelings, complaints and behavior and lastly he reflects by paraphrasing what each person has said.

Reflective listening is a wonderfully valuable skill. It helps people to understand each other better than ever before, and it further helps them to grow and to discover new things about themselves (Miller & Jackson, 1995). In reflective listening, the listener restates the feeling and/or content of what the speaker has communicated and does so in a way that demonstrates understanding and acceptance (Bolton, 1986). To think reflectively means to consider different possible meanings, underlying intentions and feelings in what a person says (Gordon, 1980). In Job 33:8-11 Elihu is thinking reflectively by restating the content of what Job has communicated:

Surely you have spoken in my hearing, and I have heard the sound of your words, saying, ‘I am pure, without transgression; I am innocent, and there is no iniquity in me. Yet He finds occasions against me, He counts me as His enemy; He puts my feet in the stocks, He watches all my paths.’ (Job 33:8, NKJV)

Elihu makes a reflective summary of Job’s speech. He points out to the content of Job’s discussion. He gathers together points that Job brought up throughout his conversations, and he selects relevant data that will help Job to understand key elements of his situation. Elders and deacons/deaconesses should exercise their reflective listening skills to help them discovering the meaning of what the patient is saying. They should be good listeners who can respond reflectively by paraphrasing what patients are saying and
concentrating on their feeling words in order to infer feelings from the general content of their conversation.

**Negative Verbal Responses From Job’s Friends**

The second part of this analysis explores the verbal responses of Job’s friends toward Job. In the Prologue Job’s friends are portrayed as true comforters. When they witness Job’s horrendous condition, they weep, they tear their clothes, put dust on their heads, and sit in silence with him for seven days. Job initiates the conversation (Job 3), he speaks and complains bitterly about his condition, accuses God of punishing him for no good reason, asks to be let alone so he can die in peace, demands that he be judged by a third party, and so on (Job 3: 3, 4, 8, 26). Job’s friends alternate replying to Job, in each case accusing Job of sins for which he is properly being punished by God. It is in these successive replies, as noted Reynierse (1975), by Job’s friends that “behavior therapy, particularly systematic desensitization is evident” (p. 189).

**Insulting Patients With Accusing Words**

Job’s three friends: Eliphaz, Bildad and Zophar bring their accusations against Job that are often accompanied with brutal insults. For example, in their first responses, Bildad characterizes a speech of Job’s as being a big wind, and declares that his children died because they sinned and thus got what they deserved (8:2-4); and Zophar charges Job with talking nonsense endlessly so as to keep others from stating their piece (11:3) (Moster, 1997). In Job 8 Bildad responds to Job in an equally mild and general manner as Eliphaz's earlier comments. However, while Eliphaz emphasized both punishment for
being evil (Job 4:8-11, 18-21; 5:1-7, 12-14) and the rewards for being righteous (Job 5:9-11, 15-27), Bildad emphasizes only punishment (Job 8:8-22). In his second speech, Eliphaz declares that Job is a fool, brandishing useless and deceitful words and arguments and that his own mouth condemns him (15:2-6) (Nowit, 2010). Bildad continues the assault in Job 18:2-21 emphasizing what is in store for wicked men like Job. Who are you trying to fool? Speak some sense if you want us to answer! Have we become like animals to you, stupid and dumb? Just because you tear your clothes in anger, is this going to start an earthquake? Shall we all go and hide? With each succeeding speech the friends’ antagonism towards Job builds. In his final oration, Eliphaz accuses Job of immense wickedness:

You know that your wickedness is great, And that your iniquities have no limit. You exact pledges from your fellows without reason, and leave them naked, stripped of their clothes; You do not give the thirsty water to drink; You deny bread to the hungry. The land belongs to the strong; the privileged occupy it. You have sent away widows empty-handed; the strength of the fatherless is broken (22:5-9).

This portrayal of the three friends as critical and heartless is supplemented by Job’s ratings against them. They are disloyal, fickle, cowards, liars, quacks, unjust, deceitful, full of empty platitudes, mischievous, mockers, unwise, aggrievers, humiliators, abusers, overbearing, deserters, maligners, offerers of empty consolation, and talkers of nonsense (Moster, 1997).

Defending God

There is a misperception that occurs with the three friends in the Prologue and the Dialogue. However, in the Dialogue, the three friends, are passionately defending the doctrine of Reward and Punishment, repeatedly accuse Job of being a sinner. His friends
are baffled by this existential question: “Why else would God allow him to suffer?” (Moster, 1997). Reynierse (1975) argues that Job 4-5, 8, 11, 15, 18, 20, and 22 represent a gradient of increasing intensity in which Job's friends systematically outline both Job's guilt and the reasons why he is being punished by God. He further discusses that “this gradient is comparable to the graded exposure of conditioned fear stimuli in systematic desensitization” (p. 189). Phillips (2008) notes “the friends of Job manifested an abiding concern to defend the system of divine retributive justice, which, in their mind, was under attack at every utterance of Job” (p. 31). The image of the three friends that emerges from a careful survey of the Dialogue is not one of sympathetic comforters, but rather one of rigid fanatics who are your friends as long as you accept their religious beliefs but who turn on you viciously if you do not (Reynierse, 1975; Moster, 1997; Norwit, 2010).

Overbearing Patients

Job 11:7-20 emphasizes both Job's wickedness and the incomparability of man. Zophar takes the opportunity to ask Job several (six) questions in rapid succession without giving Job an opportunity to reply immediately: “Do you know the mind and purposes of God? Will long searching make them known to you? Are you qualified to judge the Almighty? He is as faultless as heaven is high but who are you? His mind is fathomless what can you know in comparison? His spirit is broader than the earth and wider than the sea. If He rushes in and makes an arrest, and calls the court to order, who is going to stop him?” (Job 11:7-10). In rapid succession, without giving Job a chance to reply, the Voice asks a series of questions or supplies a list of exceptional facts. In total, over 150 questions or facts are exposed to Job in the short space of four chapters (Job 38-
41) (Reynierse, 1975). One of the important communication skills in pastoral care is to avoid talking too much to overwhelm patients. When the pastoral caregiver talks a lot, patients tend to be tiring, often feel bored and bothersome. Pastoral caregivers should learn to talk less and allow patients to do most of the talking.

**Giving Personal Advice**

Pastoral caregivers should not engage on giving advice or passing orders to patients; they should not tell patients what to do nevertheless to go about defending a set of doctrine. In Job 4-5, Eliphaz replies with a relatively mild rebuke which is stated in general terms. In Job 4:7-8 he says to Job, “Stop and think! Have you ever known a truly good and innocent person who was punished? Experience teaches that it is those who sow sin and trouble who harvest the same.” And later (Job 5:6) he states that “Misery comes upon them to punish them for sowing seeds of sin.” Eliphaz shows that is a counselor when he states in Job 5:8, “My advice to you is this: Go to God and confess your sins to him.” There is a difference between “pastoral care” and “pastoral counseling.” Newitt (2010) notes, “there can be a considerable degree of overlap in the skills used in each domain, there is a key difference in the way that boundaries are structured” (p.167). In pastoral counseling, the relationship is based around an explicitly agreed, firm set of boundaries. However, in pastoral care boundaries are typically left unspoken and are more flexible (Newitt, 2010). Expressing words of orders such “you must,” “you should,” “my advice to you,” “take your medications,” “do this,” or “do that.” ect. are not appropriate in providing pastoral care to patients. Pastoral care is about seeking for a deeper understanding of oneself, others, and/or God. It is about seeking the affirmation of
meaning and worth of patients to strengthen their ability to respond creatively to whatever life brings (Newitt, 2010; Roxberg, Brunt, Rask, & Silva, 2013).

**Preaching Doctrinal Sermons**

Eliphaz mentions in first speech that “If it were I, I would appeal to God; I would lay my cause before him. He performs wonders that cannot be fathomed, miracles that cannot be counted (v.8)….Blessed be the man whom God corrects, so do not despise the discipline of the Almighty” (v. 17). Zophar comments: “Surely you know how it has been from of old, ever since man was placed on the earth, that the mirth of the wicked is brief, the joy of the godless lasts but a moment” (Job 20:4). The friends spoke very passionately about what they believed. Job’s words burst forth from his experience of the God in whom he believed. Each was deeply emotional, and often the passion rose from feeling assaulted or offended (Job 4-22). When Job rejected the counsel of the friends, their pride was threatened and their attempts to preach traditional doctrines were increasingly attempts to bolster their own confidence. Pastoral caregivers should keep their beliefs system for themselves. The visit is not about them but it is about exploring the patient’s meaning of life and suffering.

**Solving Patients’ Problems**

Elihu indicates that he is a mediator between Job and God. In Job 33:6 he says, “Look, I am the one you were wishing for, someone to stand between you and God and to be both his representative and yours.” In contrast to the increasingly strong accusations of Eliphaz, Bildad, and Zophar, Elihu is consistently mild toward Job. He acknowledges that
Job has sinned, but gently points out, “In this very thing, you have sinned by speaking of God that way. For God is greater than man” (Job 33:12). From a chaplain’s perspective, Elihu is trying to play the God’s dance. He wants lay out everything smoothly for job because he sees himself as both a representatives of God (Job 36:2) when he says, “Bear with me a little longer and I will show you that there is more to be said in God’s behalf.” Elihu (Job 32-37) is viewed as providing an important source of distraction which shifts Job’s attention from his own afflictions, helplessness, and wickedness to the greatness of God. Pastoral caregivers should not serve as mediators or representatives of God. They should be not boastful about themselves. Pastoral caregivers should be speaking on behalf of God to patients. Pastoral caregivers should be very careful when seeing themselves as God to patients. The role of pastoral caregivers is not to solve patients’ problem; it is to accompany patients in their suffering and emphasize with their emotional situation. Pastoral caregivers should remind neutral and allow patients to make meaning of their sufferings as Beardsley (2009) explains: “Spiritual caregiver offer meaning and depth when the superficial ‘glow’ of spirituality begins to fade” (p. 239).

Summary

The practice of visiting the sick is an ancient one that goes back to biblical days, to the apostolic age. The purpose of visiting the sick is a matter of love, compassion and care. Ezekiel 34 outlines one of the Old Testament mandates of visiting the sick. Jesus places a great value in visiting the sick as a necessity for those who will inherit the Kingdom of God (Matthew 25:36). The apostles Paul and James point out the necessity of church elders to visit the sick, that, their prayer of faith will bring both physical and spiritual healing to the sick (Acts 28:8,9; James 5:14-16).
Rabbinical ethics and laws place a great value in visiting the sick. Jews have a great responsibility to visit the sick in hospitals, nursing homes, long-term care facilities and hospices. Prayer for the sick is very essential in the Jewish community. White gives some spiritual insights on visiting the sick. She puts a strong emphasis on training church leaders for effective visitation in healthcare setting. She encourages church leaders to act tenderly, kindly and faithfully when visiting non-believers. White also highlights the values of prayer and gives us a model of prayer to offer for the sick.

Selected passages from the book of Job give us some theological framework for conducting effective visitation in healthcare settings. It points out to positive and negative approaches in providing spiritual care. Job is visited by four of his friends who sit quietly while listening to and assessing his needs. (Job 2:6-13; 32). The result shows that the presence of Job’s friends is in accordance with the Old Testament tradition (Roxberg, 2011). The friends are coming to, being with, and communicating their compassion and consolation to Job “for they saw that his grief was very great” (Job 2:13). Pastoral considerations in visiting the sick are extracted from his friends’ reactions and behavior toward him. Ideals such as the art of knowing how to be present, remaining silent by the bedside and active and reflective listening are clearly outlined and analyzed. Nevertheless, their visit turns out to be very negative because they were too judgmental and they missed the opportunity to provide adequate pastoral care for Job as to remain on the pit with him and explore his meaning of life. Pastoral caregivers should learn from their visit as they assess negatives and positive approaches from Job’s friends’ visits.

The practice of visiting the sick from a biblical/theological window points out to a wide range of activities performed by an individual or a group to provide comfort and
spiritual care to people who are ill, homebound, isolated and/or otherwise in distress. 

*Bikur holim* can include such activities as: visiting patients in a hospital, hospice, rehabilitation center, or nursing home. Church elders and deacons/deaconesses should develop a passion for visiting the sick. They should follow exercise their active listening skills and be able to offer prayer to effectively minister to patients in healthcare settings.

Visiting the sick is a broad subject. There are a variety of biblical passages and biblical stories that could be used to analyze and to create a theological framework for visitation in healthcare settings. This chapter presents an examination of a small area of the chaplaincy field and acknowledges the possibility for further research, directions and reflection on equipping elders and deacons for effective visitation in healthcare settings.
CHAPTER 3

CONTEMPORARY LITERATURE

This literature review explores current written works on conducting pastoral visitation in a healthcare facility. This includes books, journals, and articles related to religion and health, pastoral care, pastoral visitation in healthcare settings, spiritual support groups, equipping the laity for healthcare ministry, statistics on spiritual support group visitation, impact of religion and spirituality on health and other related works that scholars in the field of healthcare chaplaincy have contributed.

There is a controversy regarding the relationship between religion and health. This controversy has perhaps contributed to the surge of research on religion and health in the last decade (Levin, Chatters, & Taylor, 2005). A FirstSearch and Atla Religion database citation search using the keywords “religion and health” over an earlier five years (2000–2005) revealed 1,209 journal articles and editorials on this subject, whereas the same search in both databases for the most recent five years (2005–2011) yielded 1,997 journal articles and editorials based on religion and health. This per year average of articles between the two time periods represents more than a 65% increase in recent years.

This contemporary literature review is based on journals, articles and editorial written within the past 10 years. It addresses (a) the impact of religion/spirituality on patient’s recovery in acute, hospice and long-term facilities as well as the positive and the
negative impact of religion/spiritual care in patient’s recovery, (b) pastoral care and social visitation in healthcare settings, and (c) theoretical framework for lay pastoral visitation in healthcare settings.

**Impact of Religion/Spirituality on Patients’ Recovery**

Religion and/or spirituality play a major role on patients’ recovery. The health research literature has prompted much discussion on the distinctions between religiousness and spirituality, and reviews of new developments in measurement often turn on contrasting definitions of the two (Greenwald & Harder, 2003; Paloutzian & Park, 2005).

In the religion and health literature, the terms *religion* and *spirituality* are both used. It is important at the outset, then, to spell out what these terms mean. There are a variety of ways in which they are defined, but common themes can be identified (Hebert, Zdaniuk, Schulz, & Scheier, 2009). Religion is a social and cultural structure or construct; it is usually taken to represent a formal set of doctrines and the social institution that maintains them, whereas spirituality represents the individual’s subjective experience of the sacred, which may take place inside but mostly outside the institution (Hebert et al., 2009).

Some have argued that this distinction is overplayed; Hill and Pargament (2003) summarized the difference noting that there is a polarization of religiousness and spirituality, with the former representing an institutional, formal, outward, doctrinal, authoritarian, inhibiting expression, and the latter representing an individual, subjective, emotional, inward, unsystematic, and freeing expression. To put it more bluntly, spirituality is treated as a positive characteristic of individuals and religiousness as a
negative one. However, as the empirical literature attests, many survey respondents fail to
distinguish religiousness from spirituality and describe their spiritual experiences as
taking place in the context of formal religious services (Marler & Hadaway, 2002).

As seen in table 1 below, religion embraces a myth that seeks to explain where
humanity came from, what the purpose of human life is, the moral duties that we must
embrace, and what our destiny is (Rosa, 2002; Marler & Hadaway, 2002). The myth is
embodied in symbolic practices or rituals that sustain it over time and provide spiritual
nourishment and guidance for believers. Spirituality is a more general category and
involves the quest for meaning and a commitment to the transcendence of the ego (Rosa,
2002). The spiritual person identifies making meaning out of one’s existence as a central
human task. The journey into meaning usually involves self-transcendence (Hebert et al.,
2009). That is, people who call themselves spiritual commit themselves to a reality
beyond the self. It might be one’s family, nature, or justice and peace in the society.

Spirituality has both an immanent and a transcendent form. An immanent
spirituality refers to an orientation in which persons believe that all the resources they
need to find such as meaning and self-transcendence can be found within the self (Rosa,
2002; Hebert et al., 2009). The center of transcendent spirituality, however, is located in
God. God takes the initiative in the divine human relationship. Spirituality is the quest for
a deeper relationship with God. In and through this relationship, believers open
themselves to the divine grace that enhances and enriches their spiritual resources.
Table 1

**Spirituality and Religion**

<table>
<thead>
<tr>
<th>Spirituality</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sense of connection to God, the universe or to a higher power (Rosa, 2002).</td>
<td>“An organized system of worship that gives a framework to the relationship we have with the universe and with a higher power” (Rosa, 2002, p. 27)</td>
</tr>
<tr>
<td>A sense of mystery and intuitive sense that we are in a deeper relationship with God (Rosa, 2002).</td>
<td>“An organized and formal system that was created to help human beings understand and maintain their relationship to that mysterious sense of connection” (Rosa, 2002, p.27).</td>
</tr>
<tr>
<td>Search for meaning and purpose</td>
<td>Practical activities, rituals and mythical</td>
</tr>
<tr>
<td>Self-transcendence</td>
<td>Outwardly appearance</td>
</tr>
<tr>
<td>Built on Personal Experiences</td>
<td>Creedal Professions or membership</td>
</tr>
<tr>
<td>Conducive</td>
<td>Systematic</td>
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Idler, Boulifard, Labouvie, Chen, Krause, and Contrada (2009) argue that the social scientific research imagination, at least with respect to health research applications, has been focused on describing the non-institutional, subjective, ostensibly solitary, introspective experiences of individuals. Both religion and spirituality play a great impact in patient’s recovery. The term religiososity is used to describe a person’s religious beliefs, practices, rituals or spiritual life because religiososity embraces both religion and spirituality and there is not much distinction between the two in providing pastoral care to patients in healthcare setting (Idler et al., 2009).

**The art of Effective Visitation in Acute Care Settings**

Studies of patients in acute care hospitals indicate that between one third and two thirds of all patients want to receive spiritual care (Fitchett, Meyer, & Burton, 2000). Pastoral visits in acute care setting, such as Intensive Care Unit (ICU) and Cardiac Care
Unit, play a great impact on patient’s lives. Pastoral visits help patients to develop an optimistic spirit and increase positive coping. Bay, Beckman, Trippi, Gunderman, and Terry (2008), in a randomized controlled study of the effect of Pastoral Care services on anxiety, depression, hope, religious coping, and religious problem solving style, demonstrate that moderate chaplain visits (average total visits time, 44 min) may be effective in helping Coronary Artery Bypass Graph patients increase positive religious coping and decrease negative religious coping.

Although spiritual care is the responsibility of all professional staff in hospitals and other healthcare settings, it is the primary function of professional chaplains, who are spiritual-care specialists (Handzo & Koenig, 2004). Maxwell (2005) suggests that 30-50 percent of all nursing-home residents suffered from depression, thus making them at a higher risk for suicide. Staffing attitude and behavior plays a major role in residents’ life. Barton, Grudzen, and Zielske (2003) address the spiritual challenging of residents’ staff own daily concerns and loss. Hence, new discovery has been made on the impact staff members’ visit have on patients and residents living in an acute care facility.

A national multi-denominational (Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007) study was made of a sample of 349 pastors representing over 80 Christian denominations on their involvement in health related ministries. The results indicated that pastors see a great need for congregations to be involved in health-related services and are willing to become involved if adequate resources were made available.

Chen and Koenig (2006) report from a national survey on health and religion that 78% of Americans of all ages agree that religion is a great help toward their recovery. This same survey was conducted with 745 elderly, medically ill patients who were
initially hospitalized at Duke University Medical Center. Patients revealed that religiousness remained significant even after controlling for physical activity (Chen & Koenig, 2006).

One of the major goals of pastoral visitation is to provide personal comfort and support. Pastoral visitation seeks also after the emotion and the feeling of patients. It is essential for lay visitors or pastors in their visitation to probe for feeling. Such adequate probing for feeling would reveal whether a patient is at peace or not. Steinhauser, Voils, Clipp, Bosworth, Christakis, and Tulsky (2006) analyzed the construct of being “at peace” in a sample of 248 patients with advanced cancer, congestive heart failure, or chronic obstructive pulmonary disease being seen in the outpatient clinics at the Durham Veterans Administration Medical Center and Duke University Medical Center. Participants were asked the extent to which they were at peace. As a result, feeling “at peace” was strongly correlated with emotional and spiritual well-being, faith and purpose in life. Steinhauser et al., (2006) concluded that asking patients in acute care setting about the extent to which they are “at peace” offers a way to begin a discussion of spiritual concerns.

The art of Effective Visitation in Hospices

A Hospice is a facility that is designed to provide care to the physical and emotional needs of people who are terminally ill. Maxwell (2005) relies on understanding the emotional stages of these people. Emotional stages, however, are not easy to diagnose and to comprehend. Some modern insights on sickness and healing focus on either urging a theological approach of care and acceptance (Hamilton, Daaleman, Williams, &
Zimmerman, 2009), or establishing a relationship between the physical and the spiritual (Echema, 2006).

In fact, the spiritual mind affects the physical so much so that when a serious sick person has a strong desire to live and to be cured, he or she often stands a better chance of surviving a serious illness than one who is resigned to die from the outset. This view on physical healing is clearly proven with the understanding on health and wellness. McNamara (2006) believes that our faith communities can encourage us to face suffering with great hope. Smeets (2006) sees serious illness as a matter that concerns one’s worldview, and spiritual support group can potentially make great contribution to help terminally ill residents in hospice facing and/or coping with loneliness in their life.

According to Kirkindol (2001), healthcare facilities provide the care needed to enable a person to enjoy living without the worry of home to care for. This analysis of defining the name of healthcare facilities is consistent with other individuals who have worked in the field of healthcare for many years. Most people that live in hospices have developed a sense of loneliness, and disconnectedness from the social world. Sullivan (2007) considers the natural feelings of people who are living in those facilities as “the end of their lives.” This consideration validates the inner feelings of residents in assisted-living/rehabilitation facilities, who often feel like prisoners condemned without a trial and without hope. They have become powerless and usually depend on the choice of doctors, nurses, physical therapist, social workers, and dieticians.

In a random national sample of 340 patients with advanced illness that investigated factors important to patients at the end of life, Ramsden and Stephens (2001) found that out of nine attributes ranked by patients: “being at peace with God,” was
ranked second in importance, only slightly lower than pain control. Lay visitors should do their best in developing a strategy to lower that kind of emotional, mental, and spiritual pains in hospices. Most of church related-patients in those facilities are missing church services; they are unable to listen to the music, the inspiring sermon, and fellowship with other church members. One of possible suggestions to lower that kind of pain is to actively practice a ministry of being in their presence and listening to patients who are in hospices. Such practice will make them feel that they are important and that their voices and concerns are being heard by the church community.

The art of Effective Visitation in Long-term Care Settings

Studies reveal that frequency of religious attendance is associated with significantly lower levels of pain. Once or more per week religious attendance is associated with the lowest pain scores, and results persisted after controlling for age, gender, and disease severity (Harrison, Edwards, Koenig, Bosworth, Decastro, and Wood, 2005). Church members who are sick or shut-ins at nursing homes or long-term care facilities often feel neglected or isolated from the church family.

Most of them do not have the ability to attend regular church services. Some of them are most likely not to receive daily or weekly visit from a church leader. Although they may or may not receive social visits from their family members, the potentiality of developing emotional, mental and spiritual pain is greater for them. Such pain is a result of feeling abandoned by the church family. The same study mentioned above continues to say that prayer/Bible study and intrinsic religiosity, however, were not significantly related to pain levels (Harrison et al, 2005).
In his book *Bedside manners*, Maxwell (2005) argues differently; he outlines attitudes that spiritual caregivers should apply for effective visitation in long-term care facility. One of the attitudes is to “be willing to get involved.” This attitude explicitly encourages spiritual caregivers to take risks and give part of themselves to the patients. This approach could easily create a clear breach in hospitals/rehabilitation regulations. Justice (2005), on the other hand, argue that visitor needs “to sit down and relax,” rather than take risks. Mottram (2007), on the contrary, focuses on spiritual interventions, which advocate a ministry of presence and listening when visiting hospital patients. Thus, providing a ministry of presence, silence, and active listening is most likely potent and efficient for effective visitation in long-term care setting.

Krucoff et al. (2005) disagree with Mottram (2007). According to Krucoff et al. (2005), in a multi-center randomized clinical trial of two noetic therapies, intercessory prayer and Music, Imagery and Touch (MIT) therapy, a total of 748 patients who were undergoing percutaneous coronary intervention were studied. A total of 371 patients received prayer and 377 received no prayer. While 374 patients received MIT therapy and 374 received no therapy at all, the findings indicated no difference for those prayed for (vs. not prayed for) on primary outcome. Thus, Krucoff et al. (2005) concluded that neither distant intercessory prayer nor MIT therapy significantly improved clinical outcomes.

Koenig et al. (2003) do not endorse Krucoff et al. (2005)’s conclusion on religion and health. Koenig (2000) argue that robust and persistent effects for religiousness effectively have a great impact on long-term care patients and patients who categorize themselves as neither spiritual nor religious tended to have worse self-related and

Pargament, Koenig, Tarakeshwar, and Hahn (2004) make a distinction between positive and negative religious coping. Pargament et al. (2004) endorses Koenig et al. (2003) when stating, “positive religious coping such as seeking spiritual support, benevolent religious reappraisals. This positive coping is in general associated with improvements in health, whereas negative religious coping such as punishing God reappraisal, interpersonal religious discontent is predicted declines in health” (p. 123).

Therefore, a critical analysis based on these arguments from Krucoff et al. (2005); Koenig (2000) and Pargament et al. (2004) may reveal that a ministry of presence, listening, intercessory prayer, and singing has a great significant impact on long-term care patients. Older hospitalized patients or long-term care patients age 50 or older who struggle with religious issues over time may be at risk for worse health outcomes. As recent studies linking religion and health have been conducted in populations of varying ages, religion still plays a major role in the lives of the elderly. Religion may also appear to be a very significant factor in the lives of older adults and may help to explain health outcomes (Martin & Levy, 2006).

Positive and Negative Religious Coping in Patients’ Recovery

Although religion plays an important role to many people with cancer, few studies have explored the relationship between religious coping and well-being in a prospective manner, using validated measures, while controlling for important covariates. Hebert et al. (2009) did a study of 198 women with stages I or II, and 86 women with stage IV
breast cancer. Standardized assessment instruments and structured questions were used to collect data at study entry and eight to 12 months later.

Religious coping was measured with validated measures of positive and negative religious coping. Linear regression models were used to explore the relationships between positive and negative religious coping and overall physical and mental well-being, depression, and life satisfaction. As results of this study, the percentage of women who used positive religious coping -- meaning partnering with God or looking to God for strength, support, or guidance -- demonstrated a moderate amount of 76%. Negative religious coping such as feeling abandoned by or anger at God was much less prevalent; 15% of women reported feeling abandoned by or angry at God at least a little (Hebert et al., 2009).

In this study, positive religious coping was not associated with any measures of well-being. Negative religious coping predicted worse overall mental health, depressive symptoms, and lower life satisfaction after controlling for socio-demographics and other covariates. In addition, changes in negative religious coping from study entry to follow-up predicted changes in these well-being measures over the same time period. Cancer stage did not moderate the relationships between religious coping and well-being. In conclusion, Hebert et al. (2009) argued that negative religious coping methods predict worse mental health and life satisfaction in women with breast cancer.

Positive Effects of Religion/Spirituality on Patients’ Recovery

According to Pembroke (2008) there is a substantial body of research literature that claims to show the generally positive effects of religion and spirituality on a wide range of health outcomes. One of the key individuals in religion and health research,
Harold Koenig of Duke University, notes that of the more than 850 articles on religious involvement and mental health, over two-thirds show an advantage for the religiously active, and that of the more than 350 articles on religious involvement and physical health, over one-half show an advantage for the religious (Koenig, 2000). The epidemiologist Jeff Levin also puts the number of empirical studies showing a positive relationship between religion and health even higher at 75–90% (Levin, Chatters, & Taylor, 2005).

Religious beliefs and practices throughout recorded history have been associated with health and healing practices. All early human civilizations (Mesopotamian, Egyptian, Indian, Chinese, Greek, and Roman) dealt with physical illness in religious or spiritual terms (Koenig, McCullough, & Larson, 2001). People in ancient days use supernatural methods of treatment, which often involved healing rituals, prayers, incantations, or religious pilgrimages. However, Koenig (2000) argues that little attention was paid to the effect of religious beliefs and practices on mental health or social support until the latter half of the 20th century. In fact, recent studies (Levin et al., 2005; Martin & Levy, 2006; Koenig, 2007; Pembroke, 2008; Idler et al., 2009; Berry & York, 2011) sequentially do suggest that religious beliefs and practices contribute to positive emotions such as a person well-being, life satisfaction, and happiness.

Koenig (2007), in a study that examined the impact of religious involvement on time to remission of depression in older hospitalized medical patients with heart failure and/or chronic pulmonary disease (CHF/CPD), notices that patients who attended religious services and participated in other group-related religious activities experienced a shorter time to remission. Koenig (2007)’s further research reveals that the combination
of frequent religious attendance, prayer, Bible study and high intrinsic religiosity, predicted a 53% increase in speed of remission while social support explained only 15% of this effect. Based on this study, patients who are highly religious by multiple indicators particularly those who have received frequent spiritual care, remit faster from depression than those who have received social support.

Negative Impacts of Religion in Healthcare Settings

Rybarczyk, DeMarco, DeLaCruz, Lapidos, and Fortner (2001) indicated that religion does not necessarily promote better recovery or adjustment for a medical rehabilitation population and that negative religious coping compromises daily functioning. Similarly, Rippentrop, Altmaier, Chen, Found, and Keffala (2005) evaluated relationships among spiritual, religious, and health variables for individuals with chronic pain and indicated that worse mental health is more common in individuals who find it difficult to forgive, feel abandoned by God, have a lack of daily spiritual experiences, do not feel supported by their congregations, and do not report being religious/spiritual.

Sociologists and psychologists of religion, in response to the blossoming of research on spirituality and health, have turned to existing measures of religiousness and spirituality. They also developed many new ones that probe the individual's consciousness of his or her own religious and/or spiritual states. Researchers (Idler et al., 2009) appear to have taken the view that the important dimensions of religiousness/spirituality for health research are to be sought in the extent to which individuals acknowledge religiousness and/or spirituality as motivating and orienting influences in their behavior and not in their behavior itself.
People often associate religious services such as religious television and radio program as helpful way for patients to cope with their pain. Koenig, George, and Titus, (2003) (2004) examined the impact of religious television and radio programs on older hospitalized patients. Religion/spirituality was measured by religious TV/radio, self-rated religiousness, observer-rated spirituality, and daily spiritual experiences. Findings revealed that relationships with length of hospital stay depended on the religious variables.

On one hand, patients who constantly rely on religious TV/radio programs and practiced self-rated religiousness are predicted to stay longer in hospital. On the other hand, patients who are observer-rated spirituality and practiced daily spiritual experiences are predicted to have a shorter stay in hospital. Based on those findings, Koenig et al. (2003) (2004) conclude that religious TV viewing or radio listening, however, are associated with worse physical health.

**Religious Attendance and Religiosity**

Studies have found different influences of religion on functional recovery. According to Martin and Levy (2006), religious attendance can be characterized as representing a dimension of religion that has been variously called public, ritualistic, organizational, formal, and institutional. In contrast, religiosity can be characterized as representing a dimension of religion that has been variously called private, experiential, non-organizational, informal, and individual.

Individuals use different types of religion for different purposes and they may view religious attendance as a way to meet people or cope with stress (Berry & York, 2011). Thus, the public form of religion, religious attendance, may act as a resource of
social networks for individuals to draw upon during functional recovery, whereas the
private form of religion, religiosity, is less of a resource or has different relationships to
health for different people (Martin & Levy, 2006).

In support of this interpretation, Himle, Taylor, and Chatters (2012) found that
higher religious attendance was correlated with higher levels of optimism and lower
levels of depression. Others (Idler et al., 2009) found that higher religious attendance was
significantly related to higher levels of life satisfaction. Religious attendance may aid
individuals by allowing them to positively focus their energies on the recovery process. It
is highly important for lay ministers to bear in mind that greater religious attendance
would predict better functional recovery whereas greater religiosity would not necessarily
predict better functional recovery (Martin & Levy, 2006).

**Pastoral Versus Social Visitation in Healthcare Settings**

There is a difference between pastoral and social visitation in healthcare setting.
Pastoral visitation can be easily identified as a religious/spiritual or church related type of
visitation. Social visitation is associated as a secular support from non-religious
individuals (Maxwell, 2005). Pastoral visits are mostly provided by professional
chaplains, spiritual caregivers, priests, pastors, or any religious/spiritual group or
individual. Most pastoral visits in healthcare settings usually include singing of religious
songs, scripture reading, prayers, meditations, sacraments or other religious rituals and
practices. Patients may also receive visits from other social network such as close
relatives, friends, classmates, co-workers, colleagues, neighbors, doctors, nurses, social
workers, patient’s advocates, lawyers, or any individual who may not be associated with
any faith. It is impossible to tell if the beneficial effects are due to church-based social support, support from secular others, or both.

Interest in this issue is not surprising because a vast number of studies (Cohen, 2004) conducted in secular settings reveal that people with strong social support systems tend to enjoy better physical and mental health than individuals who do not maintain close ties with others. Shaw (2005) conducted a study that suggests that feelings of personal control partially mediate the effects of anticipated support on health in a sample of older adults. However, this research focuses on secular anticipated support received from neighbors, and not anticipated support that arises in religious settings.

A more recent empirical study by Krause (2006a) reveals that emotional support from co-religionists offsets the deleterious effects of financial difficulty on health, but assistance from secular network members does not have statistically significant stress-buffering effects. This study consistently maintains that support from religious others may be more efficacious than assistance obtained in secular settings because church-based social networks are more tightly knit. This is due, in part, to the fact that fellow church members share similar worldviews and beliefs (Krauze, 2006b).

Social visitation can take a psychological realm. There is a distinction between psychological and pastoral care in visiting patients in healthcare settings. Ritter (2004) argues that the church has allowed psychology to set all the agenda for establishing the language for clinical conversation, including the use of the Greek word psyche as mind rather than soul. At its core, “psychopathology is the study of wounded souls” (Ritter, p. 434).
Psychologists see soul in the human personality, a capacity for transcendence that hungers for more than science can provide. Psychologists seek to help patients understand their desires for meaning-in-suffering and meeting-in-love run deep (Crabb, 2003). Pastoral care, on the other hand, goes beyond the psychological intervention of patient’s care by helping individuals to find a deeper-meaning in their life and strength and comfort from a higher power. Psychologists recognize that real change, important change, is always a mystery. Chaplains/pastors realize that real change, though always mysterious, can be meaningful to study based on divine intervention. McMinn, Meek, Canning, and Pozzi, (2001) propose a church and psychology collaboration on the issue of psychology and religion in healthcare setting. Such collaboration is gaining attention among professional psychologists, but few training or practical research opportunities are available for those interested in collaborating with religious leaders and organizations.

Healthcare professionals such as physicians, nurses, and social workers visit patients on a regular basis mostly to provide physical and/or mental care. Doctors make their runs every day, nurses and other healthcare staff members except for chaplains, are assisting patients on daily basis. Some physicians or nurses seek to provide a holistic approach to healing by applying spirituality in their conversation with patients. In a more recent research on patient’s care, Williams (2008a) notes (based on the work of Orchard, 2000 and Handzo & Koenig, 2004), that while the physician’s agenda may involve spiritual assessment, nevertheless physicians do not have the training, expertise, or time to provide total spiritual care but rather any such pastoral person–centered-care was the unique contribution of chaplains.
Koenig et al. (2003) acknowledged the potential importance of physicians understanding a patient’s spiritual/religious beliefs and the effective role of chaplains addressing relevant issues. Given a common lack of knowledge about the role of chaplains however, Williams (2008a) argues (similar to Koenig et al., 2003) noted earlier), that there is a need for more dialogue and collaboration between doctors and chaplains which, she argues, can be achieved through: (a) teaching and training, (b) teamwork, and (c) developing credible evidence-based research (Williams, 2008b).

In short, effective pastoral visits provide both social and spiritual support to patients. Religiosity and social support both buffered against anxiety, and that higher social support among the more religious could explain the inverse relationship between religiosity and trait anxiety (Hughes, Tomlinson, Blumenthal, Davidson, Sketch, & Watkins, 2004). Spiritual support brings more value and creates greater positive impact on patients’ recovery than social support. Himle et al. (2012) explore the ideas of church-based social support. They argue that deriving a better understanding of church-based social support is important because this field of inquiry provides one way of linking contemporary research on religion with the classical insights of the grand social theorists. Religious involvement during a visit is often preventative (Krauze, 2006b); it may prevent depression, increase social support, and prevent negative health outcomes (Blumenthal, Babyak, Ironson, Thoresen, Powell, et al., 2007).
Theoretical Framework for Equipping Lay Ministers

For Effective Visitation in Healthcare Settings

Effective and quality health care is based on a sound practice of treating illness and disease with appropriate interventions. These interventions are determined through a rational process of assessment, observation, testing, and discovery. Spiritual care is the least aspect of healthcare that has explored a method of measurement and assessment. Mauk and Schmidt (2004) however, propose three essential supporting structures for measuring and assessing spiritual needs of patients: (a) spiritual history taking, (b) spiritual screening, and (c) spiritual assessment. These three structures lay our theoretical framework for equipping lay ministers for effective visitation in healthcare setting.

Spiritual History Taking

Studies of physicians and patients have highlighted the disparity between attitudes, beliefs, and practice (Ellis, Campbell, & Detwiler-Breidenbach, 2002; Puchalski & Romer, 2000). Specifically, physicians and patients generally hold similar beliefs and attitudes regarding the importance of integrating spirituality and healthcare, yet a gap remains in the practice of integrating the two. This gap also leads health care professionals to leave their comfort zones in history taking, understanding that a full history of every aspect of a patient’s life is crucial to a comprehensive care plan. Likewise, spiritual history is appearing on the radar of healers who wish to understand their patients’ needs as full as possible (Mauk & Schmidt, 2004).

Research suggests spiritual and physical health care of equal importance to many patients (Mueller, Plevak, & Rummans, 2001) with spiritual/religious beliefs significantly influencing patient lifestyle and health practices (Koenig, McCullough, & Larson, 2001).
Several models of spiritual history taking have appeared in recent years, most of which medical professionals, not spiritual care professionals, have developed. Additionally, patients’ spiritual history of beliefs and practices have been found to provide an important source of comfort and strength during times of illness and a means of coping with trauma and other major life stressors, including mental illness (Puchalski & Romer, 2000). Tepper et al (2001) and Puchalski, (2002) empirically demonstrate that a majority of Americans expect their physicians to respect their spiritual beliefs and be able to discuss spiritual concerns with care and respect, especially when seriously ill or near death.

Mauk and Schmidt (2006) adopt and propose three models of spiritual history taking: SPIRIT, FICA, and HOPE. The first model, SPIRIT was developed by Todd Maugans in 1996 for physicians to use when considering spiritual issues with patients. S = spiritual belief system; P = personal spirituality; I = integration and involvement in a spiritual community; R = ritualized practices and restrictions; I = implications for medical care; T = Terminal events planning (advance directives). The second model of spiritual history taking is FICA where F stands for faith or belief, I = importance and influence, C = Community, and A = address. Puchalski and Romer (2000) developed this model to assist in capturing vital information about a patient’s spiritual and religious background. This model is memorable and user friendly, while flexible enough for use with a diverse population. Anandarajah and Hight (2001) offer another model to spiritual history taking. This model is called HOPE where H stands for sources of hope, meaning, comfort, strength, peace, love and connection, O = organized religion, P = personal spirituality, E = effects on medical care and end-of-life issues.
The specific goal of spiritual history taking is to capture salient information about the patient’s beliefs and practices. These three models of spiritual history taking allow spiritual providers to understand how spiritual concerns can complement or complicate a patient’s condition. Through a spiritual history, chaplains or lay ministers may identify themes and issues that may point to a state of spiritual risk for which a patient may benefit from further spiritual assessment and spiritual care interventions to address the risk.

**Spiritual Screening**

Spiritual screening can easily be taken as spiritual history taking. There is a difference between the two. While spiritual history focuses on identifying specific ways in which a patient’s religious life, both past and present, affects his or her medical care, spiritual screening, on the other hand, seeks only to identify and categorize basic religious or spiritual needs (Fitchett et al., 2004). Ledbetter (2008) introduced the Clinical+Coping Score, a new screening tool, which can check with greater precision for patients who show evidence of insufficient coping. This screening tool provides information for subsequent assessment and intervention opportunities. Ledbetter (2008) states: “The model's format enables chaplains to efficiently and effectively document pastoral screening using the hospital's electronic charting program” (p. 367).

Fitchett, Meyer, and Burton (2000) developed two levels of spiritual screening – an upper level and a lower level. The upper level refers to urgent interventions, which are or should be offered to patients as soon as possible. These urgent needs usually come to the chaplain's direct attention from several primary, spontaneous situations or sources. The lower level of contact priority refers to important but not urgent needs. Important
contacts are made as much and as soon as possible, but only after the urgent needs are met (Capernito-Moyet, 2004; Richardson, 2000; Puchalski & Romer, 2000). Urgent and important contacts will be found by the chaplain employing these screening processes that look for significant evidence of insufficient coping by the patient (Ledbetter, 2008).

Mauk and Schmidt (2004) suggested a series of questions that can form a spiritual screening activity that contains a patient’s expressions of his or her religious or spiritual identity or preference, association with a formal religious group, and any other concerns about which the patient would like to ask the spiritual provider. Thus, the goal of spiritual screening is to accurately identify patients with emotional-spiritual-coping needs within limitations of time and other demands for the spiritual provider’s attention.

Spiritual Assessment

Although spiritual screening and spiritual history taking offer important ways to assess patients, a spiritual assessment is indicated when more depth is desire (Mauk & Schmidt, 2004). Hodge in 2001 developed a multidimensional spiritual assessment tool which is considered to be the most extensive spiritual assessment instrument available. As a social worker, Hodge's framework consists of two segments: the initial narrative framework and the interpretive anthropological framework (Hodge, 2001; McLean, 2009). First, in his narrative framework, Hodge (2001) asks several questions in which he seeks a narrative revealing the lifelong spiritual progress made by the individual: questions such as “How important was spirituality to your family?” Second, in his Anthropological Framework, Hodge (2001) asks specific questions pertaining to each of six subsections: affect, behavior, cognition, communion, conscience, and intuition.
“Hodge’s (2001) assessment is commendable for its depth and breadth, provided the assessor had adequate time to invest in its completion” (McLean, 2009, p. 80). McLean (2009) argued that Hodge’s (2001) frameworks are likely too cumbersome for the acute care setting, although aspects of his framework will prove fruitful for one seeking to provide emotional and spiritual care. McLean (2009) also stated “A spiritual assessment may indicate where a person is situated today in his or her spiritual journey, but it can never predict where that person's growth in God will lead that person tomorrow” (p. 81).

Despite all discussions related to spiritual assessment and its impact on patients, the goal of assessment is to form a complete picture of a patient’s spiritual condition; it may not convey where the person’s spiritual growth will be in the future, but it provides adequate intentional and comprehensive treatment for a patient’s spiritual condition, especially spiritual risk (Mauk & Schmidt, 2004). Overall, our theoretical framework on equipping church leaders for effective visitation in healthcare is based on diagnosing patients by applying these three models: (a) spiritual history taking; (b) spiritual screening; and (c) spiritual assessment. Certainly, developing a theoretical framework to equip and train lay members for effective visitation in healthcare setting is compelling and will continue to spark debate and discussion around these topics for years to come.

Summary

This literature review surveys some of the current issues in providing effective spiritual care to patients and residents in the healthcare settings. Visitation in the healthcare setting plays a major impact in patients and/or residents life in a healthcare facility. Current literature in healthcare setting over the past 10 years appeals for more
spiritual caregivers and family members, and staff members to be more sensitive and attentive to sick patients and residents. Above all, providing presence and active listening seems to be important keys to get sick patients and residents in good spirits as they face terminal illness. Truly, developing effective visitation in healthcare setting is “an offering of love” (Kirkindoll, 2001) that will be appreciated by the patients in hospital and residents in long-term care and hospices.

This literature review discusses three major models of spiritual diagnosis: spiritual history taking, spiritual screenings and spiritual assessment that are useful to create a theoretical framework for this project. Each model is fully addressed and expanded on in Chapter 4. These models would help chaplains and/or lay volunteers using spiritual coping tools such as singing, personal prayer, scripture, and traditional texts that can lead patients to moments of spiritual attunement with a Higher Power. Healthcare staff members may experience the burden and vulnerability of constant care-giving of very sick patients. Observing their patients receiving inspiration, emotional support, spiritual comfort, and coping tools can further alert professional caregivers to their patients’ spiritual needs (Meyerstein & Ruskin, 2007). Effective pastoral visits, in that sense, can provide spiritual support to both patients and professional caregivers.

Despite the literature polemic views in the areas of health and religion, there is still much to be understood about the potential benefits and consequences of chaplains, and spiritual caregivers addressing deep spiritual issues with patients. Thus, in the present literature research, we seek to examine the impact of religion, spirituality, religious attendance and religiosity in association with the patient’s functional recovery. We also establish the difference between pastoral and social visitation in healthcare setting. We
lay out a theoretical framework for equipping lay people to provide proper and effective spiritual care to patients in the healthcare settings as an “offering of love.”
Pastoral care like other professions has varying levels of expertise and practice. The world of healthcare is unique, demanding, and challenging. In order to gain respect and recognition, the individual who enters the world of healthcare as a spiritual care provider must come with highly developed skills, knowledge, and other qualifications. This chapter presents the development and implementation of a highly trained “Spiritual Support Group” from the Gethsemane French Seventh-day Adventist Church for effective visitation in healthcare settings.

The chapter is divided into four major sections: Section one discusses the profile of the ministry context as it elaborates on the process of forming a spiritual support group from the Gethsemane French SDA Church and presents the objectives, methodology, expectations of the training sessions. Section two introduces the first session as it provides biblical and theological motives and rationale for visiting the sick. Special attention is given to the power of Scripture, songs, and prayer when visiting Seventh-day Adventist sick members. Section three presents the second session of the training; it focuses on acquiring practical skills such as do’s and don’ts, what to say and what not to say, and how to terminate a visit in hospitals, hospices, nursing homes and/or long-term care residences. At last, section four is the third training session as it discusses verbatim...
reports, interviews and pastoral and self-reflections based on visits made by the spiritual support group during and after the training sessions.

The Process of Forming a Spiritual Support Group

The task of this project is to create a health ministry spiritual support group utilizing a selected group of church elders and deacons from Gethsemane Seventh-day Adventist Church. This spiritual support group is to be trained and equipped to provide spiritual care in visiting SDA church members and Non-SDA Christian patients who are in healthcare facilities in Brooklyn, New York. The purpose, scope and accomplishment of this healthcare visitation ministry will to evaluated, reported and made available for replication in other churches in the Greater New York Conference.

I have been a member of that church for the past 15 years. I left for Oakwood University (then College), then went to the Theological Seminary at Andrews University and studied altogether at both school for almost seven years. Immediately, after seminary, I received a call from the Greater New York Conference to serve the Gethsemane French SDA Church as an associate pastor. I have served this church for the past four years. Gethsemane Church is my home church. Most of the elders and deacons/deaconesses have known me for almost 20 years.

Although the Gethsemane French SDA Church is the largest church in membership in the Greater New York Conference, no previous efforts have been made to train elders and deacons/deaconesses from this church in healthcare ministry. It appears to me that most elders and deacons/deaconesses from this church have never participated in a healthcare visitation training session. Most of the deacons/deaconesses are retirees
and they would love to be part of such program so that they could enhance their skills toward visiting the sick. I was a little concerned about arousing jealousy and envy among these church leaders.

In February 2011, I sought advice from Dr. Siroj Sorajjakool, my advisor; Dr. R. Jean-Marie Charles, the senior pastor of the Church; and Jean-Joseph Junior Lapierre, the first elder. I thought and prayed about a strategic way to form a spiritual support group among elders and deacons. Finally, I listened to the advice given by my peers and colleagues in ministry regarding creating a spiritual support group with a selected number of elders and deacons/deaconesses from the Church to serve as primary spiritual support volunteers for visitation in healthcare settings.

Gethsemane Seventh-day Adventist Church has 150 deacons/deaconesses and 12 elders. The church has a total number of 172 elders and deacons/deaconesses. Selecting elders and deacons/deaconesses to create the spiritual support group was not an easy task. The subjects in this research project are pre-selected. The screening process of elders and deacons/deaconesses seeks to identify individuals who are of a good moral character, practice a spiritual lifestyle, are of legal adult age, and seek to volunteer their time for visiting those who are sick. After much prayer and considerations, I decided to form a spiritual support group with a selected number of elders and deacons from Gethsemane Seventh-day Adventist Church that represent the dynamics of the church.

The selected group is composed of 10 church leaders broken down as follows: three elders, two deacons and five deaconesses. Based on cluster sampling technique and stratified random sample 10 participants are randomly selected from different subsets of the board of elders, deacons/deaconesses. These subsets include characteristics such as
age, sex, language [bilingual French-English], and educational status. At Gethsemane French Seventh-day Adventist church, the board of deacons/deaconesses is divided into different groups: male and female. Within each group, it is divided into two sets: junior and senior deacons/deaconess. A total of 6 deacons/deaconesses are selected from 49 deacons and 101 deaconesses to serve as participants in this project. Within that number there are 2 junior deacons/deaconesses who speak, write and understand both English and French and 4 senior deacons/deaconesses which represent the majority of the board of deacons/deaconesses who cannot relatively express themselves in English and have hard time understanding English.

Gethsemane French Church has no female elders. Four male elders are selected from a number of 12 elders; two elders-in-training namely “junior elders” and two ordained elders namely “senior elders.” Overall these participants show the leadership dynamics of the church leaders (deacons/elders). The terms “junior” and “senior” deacons/deaconesses refer to “young” and “old.” Age rubric for junior deacon/deaconess would be under age 40 and senior deacons/deaconesses would be above 41 years of age. However, the term “junior” and “senior” elders are not used based on age factor but to categorize bilingual elders-in-training (junior elders) and ordained elders (senior elders) who relatively speak French. I spoke to each one of them and discussed the objectives, goals, lengths, and outcomes of the training sessions. They were all excited to be part of the training session.

The table 2 explains the random selection process of participants:
In mid April 2011, I asked two healthcare professionals, who are members of the church, Dr. Cheres Chris-Roi, a medical doctor and Dona-Hario Clermon, a nurse practitioner to serve as clinical instructors during the course of the training sessions. I personally contacted both of them and invited each to take part in the training sessions. They both agreed and decided to help me in that aspect. By the end of April 2011, I already had 10 church leaders selected for the specific task and two clinical instructors. Everyone happily responded to the invitation and all of them were present at all sessions. I received approval from the church board to conduct the training sessions (See Church Approval letter Appendix A). I made the announcement in the church on Saturday, April 30, 2011, a week prior to the beginning of the session. I announced that the training sessions are open to everyone who would like to attend especially elders and deacons/deaconesses.

It took me about three months to engage in the process of selecting individuals for this task. Since the church has 12 elders and 150 deacons and deaconesses, the selection of 10 individuals to form a spiritual support group was not an easy process. More
deacons/deaconesses wanted to join the selected participants. I was tempted to add more deacons/deaconesses because everyone shows interest, but through much prayer and advices gained from my advisors and my peers, I decided to keep the project with the 10 participants that were already selected for the task.

**The Training Sessions**

The training sessions of this project are clearly built upon the theological foundation, the literature review, the research methodology of this project and some clinical pastoral care principles. Each session is projected to last 1 hour and 30 min with a 10 minute break in-between sections. The first session lays out the biblical/theological foundation; clinical principles will also be considered and addressed. Trainees will plan visitations based on the Gethsemane French church roster of sick members in healthcare facilities and from neighbors or friends who are not a Seventh-day Adventists. Trainees will also learn how to write a pastoral verbatim report to chronicle their reflections and self-assessment.

The second session (Training Session II) will discuss conversation essentials in visiting the sick and human and theological dynamics. Trainees will learn and develop adequate skills and receive valuable tips for visiting non-Adventists or non-Christian friends in a healthcare facility. At the time of the second session, trainees are expected to at least have visited one sick member of the church utilizing methodology learned from the previous session. Pastoral verbatim reports will be due at this session. They will be shared and discussed within the group to ascertain learning growth.
The last session, (Training Session III) will discuss the purpose of a spiritual support group in a church. Special attention is given to creating a spiritual support group among the trainees. Trainees will be given an evaluation form to critique the course and a post-interview questionnaire to report on what they learned from the training session. Pastoral verbatim reports will be required, shared, and discussed among peers for learning growth.

Training Session I

The project was conducted during the month of May 2011. Ten people from the board of elders and deacons/deaconesses were chosen to fulfill the demand of the project. The first session started at 4:00pm on May 7, 2011; it was conducted in the church main sanctuary and we had approximately 50 people assisting the seminar. I explicitly told the congregation that the seminar was open to everyone who was willing to attend, however, only 10 people were selected to commit to this project. Each session was videotaped and saved on a DVD. The training sessions were conducted in French-Creole. Consents form and pre-session interview questionnaires were distributed to the whole congregation present at that time (see Appendix B). Only the selected group of elders, deacons and deaconesses were allowed to sign the consent forms applicable for this project.

Objectives of the Training Sessions

Equipping a selected group of elders and deacons/deaconess from the Gethsemane French Seventh-day Adventist Church is commensurate with the chaplain’s assistant basic level of training. At the beginning of the first session, I shared with the congregation the goal of the seminar: to bring biblical rationale for visiting the sick and to help church leaders reconsider and reevaluate their pastoral visitation skills when
visiting Adventist church members and non-Christians. These training sessions will instruct the selected elders and deacons/deaconesses in the following areas: (a) providing a religious protocol for visiting Seventh-day Adventist patients; (b) praying with Adventists, non-Adventist and/or non-Christian patients; (c) helping patients make meaning of their suffering; (d) assisting patients undergoing pain and anxieties resulting from sickness; (e) visiting church members who are sick and/or shut-ins at least once a week; (f) helping Adventist church members or non-members facing terminal illness; (g) meeting and supporting relatives of Adventists or non-Christian patients. I also informed the members of the selected group about their first visitation assignment based on the church roster of sick members and shut-ins to visit in a healthcare facility. I also told them that they would learn to construct a pastoral verbatim report from each visit they made.

**Biblical and Theological Foundations**

A biblical and theological foundations discourse was the first part of this first training session. I laid out some biblical principles that could contribute to developing strategies for equipping Gethsemane French Seventh-day Adventist Church leaders for effective visitations in healthcare settings. I used several texts from Scripture, the rabbinical ethics on visiting the sick, and some spiritual insights from Ellen G. White concerning visiting the sick.

I shared with them practical guidelines for effective visitation in healthcare setting by doing an exegetical and practical analysis of selected passages in the book of Job to construct a theological framework on visiting the sick laying out what is beneficial and what is not beneficial for patients. The positive approach to healthcare visitation includes:
(a) developing a passion for visiting the sick (Job 2:11a); (b) establishing the purpose of the visit (Job 2:11); observation (Job 2:12a); (c3) shared emotions (Job 2:12b); (d) developing a presence ministry (Job 2:13a); (e) the ministry of silence (Job 2:13b); (f) spiritual assessment (Job 2:13c); (g) active and reflective listening (Job 32:11). Such theological/biblical framework was recommended for contemporary application in visiting church members and non-church members in the healthcare setting. The negative approach to visiting the sick in healthcare setting are also taken from the book of Job laying out Job’s Friends’ verbal expressions (Job 4–22): (a) insulting patients with accusing words; (b) defending God; (c) overbearing; (d) giving personal advice; (e) preaching doctrinal sermons; (f) solving patients’ problems.

**Tips for Visiting Adventist Members in Healthcare Settings**

The trainees learned new skills for visiting church members who were in healthcare facilities. They were instructed to develop a passion for visitation, plan the visit, avoid going alone, keep visits short, never diagnose, never prescribe medications, but ask or offer to read a scripture and/or offer a prayer if possible. The group was able to learn how to conduct effective visitation with Adventist members based on five basic elements of pastoral visitation among Seventh-day Adventist members: They were to practice (a) active and reflective listening, (b) sing hymns, (c) bible reading, (d) prayer; and (e) self-assessment.

**Writing the Pastoral Verbatim**

Each trainee was taught how to write a pastoral verbatim report. The trainees learned that the pastoral verbatim report is a recording of a pastoral visit, that a verbatim
report is different from an interview. The verbatim report should be written within 24 hours of the pastoral visit in question. The trainer should receive two copies. Each trainee should prepare one copy per group member and two copies for the trainer. The trainee should leave a two to three inch margin on the left side of the report for comments by others. Each trainee should also do a short reflection report after discussing each other’s verbatim report (see Appendix D).

Accordingly, I explained the focus of a pastoral visit; it is solely for establishing or developing a relationship rather than seeking information from patient, the latter would be the purpose of an interview. Therefore, the primary purpose of the pastoral visit(s) is to develop clear communication between the visitor and the patient. Each trainee was given instructions on how to write a successful and enjoyable pastoral verbatim report based on their conversations with patients during their visits. The purpose of a pastoral verbatim report is to provide a summary of the whole pastoral relationship between the lay visitor and the patient.

**Clinical Principles on Visiting the Sick:**

The second section of the first training session covered clinical principles in visiting the sick. I shared with the group the impact of spirituality on a patient’s recovery. I summarized contemporary and peer-reviewed articles concerning the importance of spirituality on healthcare. Dr. Cheres Chris-Roi made a brief presentation on medical terminology such as NPO (nothing by mouth) and general visitation policy (e.g. special dress, time limitations). Nurse Dona-Hario Clermon taught the do’s and don’ts of visiting a patient in the healthcare setting. Gethsemane French SDA Church has a medical room, well equipped with basic medical materials and equipment such as a
hospital bed, blood pressure monitors, and other first-aid tools. Thus, the second part of the session ended with a clinical practicum at the church’s medical room. Dr. Chris-Roi and Nurse Clermon took the selected group to the church medical room for a role-playing practicum. Group members played the roles of care provider, care receiver, and visitor. They received constructive feedback and discussion on the various role-playing situations. The topics acted out were very helpful and the interaction was dynamic. In response to the request of the participants, the class period was extended one hour.

Training Session II

The second session (Training Session II) was held at 4:00 in the afternoon on May 14, 2011 at the Gethsemane French SDA Church conference room. Topics such as conversation essentials in visiting the sick and human and theological dynamics were discussed. Trainees learned important skills and garnered valuable tips for visiting non-SDA or non-Christian friends in a healthcare setting. A pre-requisite to this second session was for the group members to visit at least one regular church member and to write a pastoral verbatim report on the visit made during the week of May 7-13, 2011. Pastoral verbatim reports were shared and discussed among peers for learning growth. This session lasted about 50 min and covered four areas: (a) conversation essentials; (b) human and theological dynamics; (c) clinical principles on visiting non-Adventists/non-Christians; (d) pastoral verbatim report and analysis.

Conversation Essentials

The main purpose of visiting chronically ill patients is to offer a compassionate “being there” ministry for them (Meyerstein & Ruskin, 2007). The group discovered that
there is a great need to use communication techniques to encourage the patient’s talking and receiving. I taught them how a brief visit can structure and therefore leave less open-ended time, but still can afford the opportunity to let the patient talk about concerns.

One of the important aspects of the training session was paraphrasing. The skill of paraphrasing was explored in theory and through exercise. Paraphrasing is defined as “the act of saying back to the speaker in your own words what you heard the person say” (Miller & Jackson, 1995, p. 62). It gives one the chance to examine perceptions and narrows the interpersonal gap that may occur as a result of decoding the verbal message incorrectly (Gordon, 1980). In addition, the session explored techniques of being a non-anxious presence to the extent that the people served would become comfortable being open. The group agreed that listening skills are an ongoing learning experience.

In this section of the second session, the trainees learned how to make a brief visit using communication skills such as asking open-ended questions, active listening, encouraging, paraphrasing, reflecting back feelings (Bolton, 1986). I explained to the group members their role as lay pastors in the healthcare setting. They were not to interject or impose their own denominational belief on patients. I instructed them that being neutral on doctrinal beliefs will allow the patient to feel focused on and cared about. Listening in silence is sometimes all that is needed when visiting patients who don’t share the same belief as the visitor.

**Human and Theological Dynamics**

Human and theological dynamics provide an understanding of religious and cultural influences in healthcare. Special attention in this section was given on developing communication skills (e.g. assertive listening) to better converse with non-
Seventh-day Adventists. I pointed out and gave a brief overview of the major religious groups and their branches in New York City (e.g. Judaism, Christianity, Islam, modern religions and other religions: Voodoo and Native/indigenous American traditions, south Asians traditions, Buddhist and East Asians traditions). Ethical issues on providing spiritual care for atheists were addressed. The trainees were familiarized with the basic religious faith, practices, and rituals of major religious groups in New York.

Based on what was gleaned from this session, it became necessary to emphasize, as part of this training, that the church’s mission is called to care not to cure. I ascertained the need to emphasize helping non-SDA/non-Christians cope with ongoing situations. Trainees learned how to do an effective visitation among those who do not profess the same faith as them. Each trainee was given the task to establish contact with his/her neighbors and/or to visit a friend who is not a Seventh-day Adventist or Christian at any healthcare facility. Trainees were encouraged to practice honesty and truthfulness, and to maintain purity and integrity in their conversation during their visits.

**Pastoral Verbatim Report and Analysis**

The second training session covered topics of sickness and its implications and pastoral visitation and dialogue. Each trainee shared the ways in which sickness had impacted his or her life or the life of a loved one. In exploring the theological, socio-cultural, psychological, ethical, and self-reflective assessment of their visits, the trainees were given the opportunity to get in touch with their own experiences at times of serious sickness. All of the participants visited a least one Seventh-day Adventist member in a healthcare setting in New York City; they reported that their experiences made them more aware of the fragility of life; as such, their experience of applying the principles
learned in the first session realigned their attitudes toward compassion, care of and love for SDA patients. Overall, the trainees discussed and shared at length how they were able to assess the patient’s anger, sadness, and loneliness and how they were able to provide a ministry of presence and silence for them.

**Clinical Principles for Visiting non-Adventist Patients:**

This is a practicum unit that was held at the Gethsemane medical room by Dr. Cheres Chris-Roi and Dona-Hario Clermon, a practical nurse. Tips for visiting non-Seventh-day Adventist members were addressed and carefully taught. The training also addressed how to conduct one's self when visiting the sick in hospitals, nursing homes, and in their homes. Handouts on topics of infection control, health information laws, and confidentiality were provided. The issues of privacy and confidentiality were discussed at length.

This section also explored cross-cultural issues pertaining to lay pastoral visit in healthcare settings. The choice of scripture was also an important topic. The group was trained to hear scripture with the ears of a care receiver and not a care provider when visiting non-Seventh-day Adventist Christians. As such, the use of scriptural passages that suggest that bad things do not happen to good people should be handled with caution (Chukunka, 2010). The selection of scripture must take into consideration the context of the situation at hand. Of particular concern was the tendency of visitation ministers to choose passages that promise, even guarantee, healing. Such scriptures are to be used with caution since no minister can guarantee the will of God.

Moreover, it is NOT permitted to use scripture when dealing with non-Christians. To get the maximum benefit from scripture, the trainees were instructed to seek the
permission of care receivers to use scripture and to invite care receivers to select a
scripture. Inviting a care receiver to choose the scriptural passage makes the receiver part
of the healing team, increases trust, and returns control to the care receiver. Moreover,
only the care receiver knows which scripture passage speaks to his or her heart
(Chukunka, 2010).

Another important topic shared with the group was not praying, or ending prayers
with “in the name of Jesus” to non-Christians. It is difficult for a conservative Seventh-
day Adventist to accept this concept when visiting non-Christians. As difficult as it may
be, the group was instructed not to mention the name of Jesus when visiting non-
Christians. Suggested manners of ending prayers were provided to the trainees such as:
“In your name, we pray;” “In the name of the Most High we pray;”

Six basic elements of pastoral visitation with non-Christians were developed: (a)
do not proselytize, (b) apply active, reflective, and assertive listening; (c) take the journey
with the patient; (d) be friendly; (e) wishing good health, and (f) self-assessment. The
session concluded with a role-playing exercise and discussions in which some members
played the roles of care provider and receiver and received feedback from observers. The
role-play exercises allowed trainees to practice reflecting, clarifying, and paraphrasing
what the others said. The topics were very thoughtful, useful and helpful and the
interaction was very enthusiastic. In response to the request of the participants, the class
period was extended for another hour.

Training Session III

The third training session was held at Gethsemane French SDA Church on
Saturday, May 28, 2011. During the session, we discussed the purpose of a spiritual
support group in a church. Special attention was given to creating a spiritual support group among the trainees. Dr. Cheres Chris-Roi also explored the role of the spiritual support group interaction with suffering and dying patients. At the end of this last training session, trainees were given an evaluation form to critique the course and a post-interview questionnaire about what they have learned from the training session. Pastoral verbatim reports were shared and discussed among peers for learning growth.

**The Purpose of a Spiritual Support Group**

Developing a spiritual support group at Gethsemane French SDA Church is the main purpose of this project. It is embedded in the theology of implanting small group ministries in church. Trainees learned the importance of small group ministries in the church. They were taught that small group ministry keeps a church spiritually healthy. The Gethsemane French SDA Church has a small prayer group but the church does not have a spiritual support group. I laid out the purpose of forming a spiritual support group with the trainees: (a) to train other church members on how to do effective visitation in healthcare settings; (b) to explore the deeper meaning of someone’s suffering, that is, to read the non-verbal; (c) to provide meaningful pastoral care with non-Adventists and/or non-Christians on a friendship level.

Dr. Cheres Chris-Roi shared near-death experiences from a spiritual and clinical perspective. The section on death and dying was the most intensive. Dr. Cheres Chris-Roi convicted the trainees of the belief that dying should be handled with reverence. The group was taught that the mystery of suffering and dying support the claim that God is at the bedside in a special way. As such, a dying person may see and hear, even though it
may not seem that he or she can. A dying person is alive in a special way and life at that
time is of no less value.

According to Chukunka (2010) treating a suffering and dying person with dignity
is a must for all ministers. Dr. Chris-Roi talked about patients in ICU and CCU. Trainees
were taught to be cautious and monitor their conversations wisely when visiting patients
in clinical care settings. Dr. Chris-Roi expounded on the five stages of grief (denial,
anger, bargaining, depression, and acceptance). These stages were discussed and
examples were given. The trainees shared their own experiences with grief and related
them to the five stages. One significant lesson the group took from this was that non-
Christian patients needed permission to hold open dialogue about death and a safe place
to share those fears without any concern. The fear of being honest about our fear of death
creates its own anxiety.

At the conclusion of Dr. Chris-Roi’s presentation, the group of elders and deacons
from Gethsemane Seventh-day Adventist Church were considered lay-trained in knowing
how to visit with and handling death and the dying with reverence and dignity.

Consequently, they all agreed to be part of this spiritual support group. This group is
composed of 10 church leaders: four elders, three deacons and three deaconesses. The
group was given the opportunity to discuss how to implant the training session for the
benefit of the church.

**Pastoral Verbatim Report and Analysis**

The third training session covered topics of sickness and its implications on
Adventists/Non-Christians, and pastoral visitation and dialogue. Each trainee shared the
ways in which visiting non-Adventists/non-Christians patients had impacted his or her
spiritual life. In exploring the theological, socio-cultural, psychological, ethical, and self-reflection assessment of their visits, the trainees were given the opportunity to get in touch with their own experiences and challenges that they confronted when visiting non-SDA/non-Christians in the healthcare setting.

All of the participants visited at least one non-Adventist or non-Christian at a healthcare setting in New York City. Participants reported that their experiences made them more aware of the fact that they have more Adventist friends than non-Adventist/non-Christian friends. As such, their experience of applying the principles learned in the second session realigned their attitudes toward compassion, care of, and love for non-Adventist patients. Overall, the trainees discussed and shared at length how they were able to assess the patient’s anger, jealousy, sadness, and loneliness and how they were able to provide a ministry of presence and silence for them.

**Discussion and Evaluation of the Training Sessions**

Qualitative data was used in a form of short-interviews to evaluate the spiritual support group visiting skills and to make further recommendations. Trainees were given the opportunity to evaluate their successes and failures: where they did well, what they did well; what they would do differently. Some of the following questions such as: Did personal/religious issues become enmeshed with those who are non-Seventh-day Adventist? How? Where you able to keep enough objectivity to allow the patient to work through his/her issues? Each trainee had the ability to evaluate the training sessions. Dr. Cheres Christ-Roi gave evaluation forms to the trainees for them to evaluate the program at the end of the last session. Dr. Christ-Roi was responsible for collecting all evaluation forms.
Implementation Narrative

This section of the chapter presents a concise narrative implementation of the training sessions and lay visitations conducted in healthcare settings. The Gethsemane Seventh-day Adventist Church has served in the Crown Heights community in Brooklyn, NY for the past 25 years. Yet its participation in developing and creating ministries for the sick and shut-ins in healthcare setting has been minimal. Sick and shut-in church members in hospices and long-term care facilities often feel neglected when not receiving adequate visitation and spiritual care from their local church elders and deacons. Local church members and even church leaders tend to leave this work to the pastor.

There is little evangelistic opportunity in developing a friendly relationship with a healthcare facility in the church community. All of these justify the need for the implementation of a trained spiritual support group at the Gethsemane French SDA church. The implementation of this project has two foci: (a) implementation of a spiritual support group to visit sick or shut-in members of Gethsemane Seventh-day Adventist Church in healthcare settings, and (b) implementation of a spiritual support group to visit non-Christians who are sick or shut-in at any healthcare setting in New York City.

Visiting Adventist Sick and Shut-ins

The group was divided into five small groups of twos. Each small group was required to visit Seventh-day Adventist sick and shut-ins in a healthcare setting in New York. The purpose of this visitation training was to equip church leaders on how to effectively visit church members in healthcare settings. Trainees were taught, “NOT TO
PREACH” when visiting any patient regardless of their religious preferences in healthcare settings. Patients do not need to hear long sermons while suffering. Trainees are there to create a ministry of presence and silence for visiting patients. Visitation tips, clinical principles and elements that were acquired from each training session must be used in interaction with patients. Each trainee must able to assess a patient’s spiritual needs and feelings during and after the visit.

All levels of the church body were covered during the implementation of the visit. Each small group was required to do three visitations. The first visitation was geared towards children in a children’s hospital or a pediatric department within a hospital. The second visit was targeted toward teens and/or a young person in a healthcare setting. The third visit was focused on senior citizens and/or widows/widowers in nursing homes, hospitals or rehabilitation centers. Visitation should last between 15-20 minutes. Trainees were warned not to diagnose or prescribe any medicine to any patient. Trainees were taught not to give patients false hope (e.g. you will be fine, everything will be ok, and/or you will be well by tomorrow). Hands must be washed before and after each visit. They should be aware of the hospital environment and read signs that are posted outside and inside the room. A pastoral verbatim report for each visit was required. Taking notes and writing pastoral verbatim reports were not permitted while conversing and interacting with patients.

Conversations with Adventist patients were to take the form of social exchanges, that is, talking about family, church, school, work, sports—like a basketball game or a football game, and so on. However, the conversation must end on a high spiritual note of encouragement using scripture. A simple visit of church member in a healthcare setting
may involve the reading of scripture, and/or prayer if possible. Nevertheless, the five basic elements of pastoral visitation among Seventh-day Adventist members were used throughout the visitation and were recorded on the pastoral verbatim. The five basic elements were: (a) active and reflective listening, (b) singing hymns, (c) Bible reading, (d) prayer and (e) self-assessment. However, trainees were warned not to disturb the neighbor of the visited patient in the hospital or healthcare facility room. It was crucial for trainees to control and monitor the level of their voices and to keep eye contact on the visited patients when singing hymn, reading Scripture, and praying.

**Visiting non-Adventist/non-Christians Sick and Shut-Ins**

One of the challenging parts of implementing this project was to visit non-Christians (Non-SDA members) who were sick in a healthcare setting. Visiting someone who does not share the same faith was not an easy task. Although recent empirical research (Himle et al., 2012) has shown convincingly that religious devoutness and commitment are usually positively associated with healthy physical, emotional and social functioning, cross-cultural and religious visitation in healthcare setting can create major problems if not handled with respect, acknowledging, and accepting the other’s personal and religious preferences. The rule of thumb in implementing visitation to non-Christians during the session was, “Do Not Proseltize.” Proselytizing is an attempt to convert someone from one religion, belief, or opinion to another.

This spiritual support group of Seventh-day Adventist elders and deacons of Gethsemane French SDA Church were trained to satisfy patients’ spiritual needs through incorporating the spiritual component into the dynamics of a group therapy setting, using supportive, cognitive behavioral and existential techniques. The intention was that visited
patients would be able to develop and strengthen their own inner resources to help them develop coping skills to live more hopefully and purposefully, and feel less of a victim to their illnesses (Himle et al., 2012).

Moreover, the implementation of this project was to help Seventh-day Adventist leaders, elders and deacons, to establish strong friendship with non-Christians. Therefore, the task of implementing this project was that trainees were to visit a least one non-SDA Christian in the healthcare settings. After the second session, trainees were not to visit Seventh-day Adventist members. Trainees were to conduct two visits. The first is geared toward visiting non-SDA friends in a healthcare setting in New York. The second is to visit a neighbor’s family, relative, or friend who was either hospitalized or resided in a nursing room. Trainees were not permitted to visit any patient without his/her consent or without receiving a referral from the patient’s family, relatives or friends.

Trainees were taught that visiting non-Adventist Christians and non-Christians must be social and friendly oriented and less religious. Trainees were expected to follow visiting tips, strategies, and clinical principles learned from the training seminar. Trainees were to avoid discussing religion or doctrinal beliefs with patients. Trainees should stay neutral and let the patient lead the conversation. Trainees were taught not to diagnose or to prescribe any medication to non-SDA patients. If ask to offer prayer, they should avoid mentioning the name of “Jesus.” However, the trainees were instructed that most Christian chaplains in praying for non-Christians often say, “In Your Name,” or simply say, “God.”

Trainees were told that length of visitation of non-Adventist Christians and non-Christians should be between 15-20 minutes. Trainees were paired up in small groups of
twoys to visit non-Christians. Trainees were warned to avoid bringing church singing
groups such as a choir or praise team with them when visiting Non-Christians. Trainees,
in addition, were taught not to give patients false hopes (by saying phrases like, “You
will be fine,” “Everything will be ok,” “You will be well by tomorrow”). Nevertheless,
trainees were told that they may give non-Christian patients positive affirmations, such as
“I wish you good health,” “I wish you a better recovery,” and such other cheerful terms.

Trainees reported that they washed their hands before and after each visit, and that
they took off and laundered their clothes once they got home. They were warned to be
aware of the hospital environment and read signs that are posted outside and inside the
room. Trainees reported that they showed great respect for non-SDA/non-Christians’
faith, acknowledged and honored their religious backgrounds. Trainees allowed patients
to teach them about their faith. Pastoral verbatim reports for each visit were required.
Taking notes and writing pastoral verbatim records on visiting non-Christians were also
not permitted during the visit. Overall, trainees learned to implement the six basic
elements of pastoral visitation in their conversations and interaction with non-Seventh-
day Adventist members: (a) do not proselytize, (b) proper use of active, reflective, and
assertive listening skills; (c) take journey with the patient; (d) be friendly; (e) wishing
good health (f) self-assessment.

**Summary**

The chapter ends with a conclusion that clearly reiterates the main points, and
acknowledges directions for further research and reflection to develop and implement this
project at Gethsemane French SDA Church. Adequate details of the development and
implementation of a properly trained “Spiritual Support Group” from the Gethsemane
French Seventh-day Adventist Church were analyzed for effective visitation in healthcare setting.

The main points of the chapter were discussed in these areas: profile of the ministry context, objectives and expectations of the training sessions, and implementation of a spiritual support group at Gethsemane French Seventh-day Adventist Church. The development of this project involves the training of a selected group of church leader from Gethsemane French SDA. The first session provided biblical and theological motives and rationale for visiting the sick. Special attention was given to the power of Scripture, songs and prayer when visiting church members in the healthcare setting. The second session of the training focused on acquiring communication and clinical skills for effective visitations in healthcare setting. The third training session discussed verbatim reports, interviews, and pastoral and self-reflection based on visits made by the spiritual support group during and after the training sessions. The three training sessions were aimed to train church officers to extend patient’s coping resources, and to offer their presence and to help patients find meaning to their sufferings.

Although there is no structured pastoral/spiritual care program for visiting patients of the same faith or different faith than the spiritual care giver, a well-trained church leader should simply be hospitable and friendly to patients who do not share the same faith as him/her. This chapter also provided tips, communication skills (e.g. active and reflective listen) and clinical strategies for visiting non-SDA Christian and non-Christian patients in healthcare setting. One of the important strategies in visiting non-Christians is to let them lead the conversation. Patients often share what their spiritual coping resources are. With non-religious patients who accept such visits, it is especially
important to respect and follow their comfort levels by careful use of “low key” spiritual language, for example “higher power,” the Man upstairs” rather than “Jesus” or “God.”

Implementation of these training sessions for selected church leaders of Gethsemane French SDA Church is rooted in fellowship and friendship: fellowship with fellow Seventh-day Adventist Church members and creating friendship with non-Adventist believers and non-Christians. In sum, a major purpose of developing and implementing the narrative of such visits is to lift the spirit of the patient (Christian or non-Christian) through: (a) facilitating an inspired feeling of connection with a higher power; (b) helping the patient feel comforted and cared for by God and other people; (c) reducing anxiety and creating greater peacefulness in the patient. Implementing the six basic elements of each type of visitation will give (a) the people of faith a sense of hope, encouragement and something to lean on in difficult times, and (b) the people of no faith, a sense of hope, encouragement and most of all a sense of being cared for, being loved, being thought of by others.
CHAPTER 5

OUTCOMES AND ASSESSMENTS

In chapter 4 we discussed the development and the implementation of this research project. The research project utilizes the qualitative data to assess the project. Outcomes and assessments of this project seek to understand the end results of the training sessions and interventions through both quantitative (surveys) and qualitative data (interviews). End results include effects that elders and deacons of Gethsemane French SDA Church experience and care about, such as change in the ability to conduct effective visitations in healthcare setting.

By linking the training sessions and interventions [visitations] within the clinical context, the goal of outcomes and assessments in this project has become the key to developing better ways to monitor and improve the quality of spiritual care in the church and most of all to establish friendly relationship with non-seventh-day Adventists. The chapter presents an assessment of four expectations from this project. The proposed expectations were:

1. To help provide different approaches for Gethsemane Church lay leaders to reach out to those who are sick and shut-in in healthcare facilities that are near the church.

2. To support the pastoral staff of Gethsemane Church in providing spiritual care to sick and shut-in church members.

3. To help develop a Spiritual Support Group in the local church to minister to non-Haitian Seventh-day Adventists in healthcare settings.
Instruments such as pre-session and post-session interview questionnaires, pastoral verbatim reports and evaluation forms were used in order to measure the learning outcomes of the training sessions. These research instruments were distributed, collected and analyzed to see whether the project meets its expectations. Therefore, based on the expectations mentioned above, this chapter presents four major sections by which the project has been evaluated.

Section I assesses the methodology of the training sessions that will help provide different approaches for Gethsemane Church lay leaders to reach out to those who are sick and shut-ins in a healthcare facility that is near the church.

Section II analyzes both pre- and post-session interviews to assess the leaders’ personalities and their interest in visiting church members in healthcare settings. Special attention is focused on the post-session questionnaire as it evaluates the progress of each trainee and his/her commitment to supporting the pastoral staff of Gethsemane SDA Church by providing spiritual care to its members.

Section III meets objective two of this project by discussing outcomes and assessments of the training sessions to evaluate the benefits of developing a Spiritual Support Group in the local church to minister to non-Haitian Seventh-day Adventists in healthcare settings.

Section IV presents the assessment of the training session based on the completed evaluation form by the selected group of church leaders. Such assessment will eventually supplement strategies for a selected group of elders and deacons from Gethsemane French SDA Church to make frequent visits in local healthcare facilities near the church.
In conclusion, this chapter summarizes the proposed expectations from the project and its final outcomes and achievement based on the ministry context.

Section I: Methodology of the Training Sessions

This project utilizes the qualitative data paradigm for its method of research. This methodology presupposes several criteria in order to maintain academic research integrity. The hypothesis of this project is that equipping church elders and deacons/deaconesses in basic pastoral care skills for healthcare setting will increase the number of skilled elders and deacons/deaconesses of Gethsemane French Seventh-day Adventist Church for effective visitation in healthcare setting in order to create a friend-relationship in preparation for outreach ministries within the healthcare settings.

The research project seeks to perceive and confirm the process that is needed to shape, produce, and train a selected group of elders and deacons/deaconesses to serve as a spiritual support group to reach out to the sick, shut-ins and the feeble. The research project also illuminates the need for such training at the local church and its impact on its members. This project involves the collection and analysis of empirical information from multiple sources, such as first person accounts, semi-structured and open-ended interviews, informal and formal observation materials (O’Leary, 2005). The model used in this project focuses on the first-person account because it is the individual trainee who knows his/her limitations, expectations, experiences, and motives for providing spiritual care to the sick.

In addition, this equipping program seeks to provide a theological and theoretical framework that assists a spiritual support group to adequately and effectively prepare to do visitation ministry in any healthcare setting. The training aimed to be both
professionally enhancing and personally enabling. It will also be a great benefit for Gethsemane Church’s growth.

Qualitative data was best used in this project to interpret how to equip the volunteers in pastoral care. This method was designed to be open-ended to support the new discovery of information. However, the four prevailing forms of data collection associated with the qualitative inquiry for this project are (a) interviews (pre-session and post-session), (b) pastoral verbatim reports, (c) self-reflections and (d) evaluation of the seminar. The data collected from these forms help in providing different approaches for Gethsemane Church lay leaders to reach out to those who are sick and shut-ins in a healthcare facility that is near the church.

This project adheres to establish practices and theory of pastoral visitation. The critical difference in this training program was that volunteers would be trained to perform pastoral care, which traditionally is the role of professional clergy such as board certified chaplains and other spiritual care providers in healthcare settings. The criteria for selection of the elders and deacons/deaconesses includes readiness for pastoral learning, previous lay ministry experience, ecclesiastical support, openness to visiting elderly and non-Seventh-day Adventist sick patients in a healthcare facility. This selection method was based upon the findings from a pre-session interview questionnaire. This method used to pre-screen the selected group demonstrates that the specific training they receive is directly related to what they would do in their role as members of Gethsemane French SDA Church spiritual support group (see Appendix B).

Choice of data collection technique for this project consists of the pre-session interview, post-session interview, verbatim report analysis, and semi-structured
interviews. This program is designed to be semi-self-instructed. Participants are encouraged to assist in the seminar and practice in the medical room of the church. They are required to visit Seventh-day Adventist and non-Seventh-day Adventist patients once a week. They are also encouraged to share significant points of learning and growth from their verbatim reports, with each other. All participants are given a course evaluation at the conclusion of the training session. They are asked to rate their experience in the entire program -- from the time they completed the pre-session interview questionnaire, participated in the training sessions, conducted their visits, completed their verbatim report analysis, to their post-session interview questionnaire and finally the conclusion of the program.

The data collection and DVD records of the training sessions are maintained at the Gethsemane Church pastor’s office and are accessible to very few people. Participants were required to submit verbatim reports to the instructor; however, they got to keep them for future use after they had been discussed with the class. In terms of analysis, reading of the participants’ pre and post-session interviews, verbatim reports, and course evaluations can be considered reliable, qualitative, analytical tools for the benefit of the Church -- they provide insight into different approaches to minister effectively in the healthcare setting.

The role of the researcher in this project is didactic which also involves providing personal instructions and working along with the two subject matter experts, Dr. Cheres Christ-Roi and Dona-Hario Clermon, nurse practitioner. The strongest bias the research has in regards to this project is the intent and purpose of mentioning the name of Jesus or to even conclude prayers in Jesus’ name. The selected elders and deacons of this group
were introduced to a different approach to pray with sick and shut-ins without mentioning
the names of Jesus or to even proselytize.

Overall, this section discusses four prevailing forms of data collection associated
with the qualitative inquiry for this project; (a) interviews (pre-session and post-session),
(b) pastoral verbatim reports, (c) self-reflections and (d) evaluation of the seminar. These
data were collected and evaluated in order to conduct spiritual self-assessments of a
selected group of elders and deacons/deaconesses of Gethsemane SDA Church. Such
assessment developed in this section attempts to provide different approaches for
Gethsemane Church lay leaders to reach out to those who are sick and shut-ins in a
healthcare facility that is near the church.

**Section II: Interview Analysis**

Pre-Session Interview Analysis

Section II discusses the analysis of pre- and post-interview questionnaires. The
questionnaires are instruments used to determine the value of visitation within the
healthcare settings. Follow-up visits in the healthcare settings have been ignored by so
many because they find it arduous and time-consuming. Visitation of the sick is very
beneficial for the pastoral team at any church. Each church leader especially elders and
dacons/deaconesses should effectively visit the sick. Visitation nurtures the church and
measures the spirituality of its leaders (elders/deacons/deaconesses).

Before the training session, I decided to do a pre-session interview as a way to
understand the people’s visitation skills and their willingness to learn. The pre-session
interview questionnaire has 20 questions. Appendix A presents numerical figures of the
pre-session interview questions from the selected 10 elders and deacons/deaconesses
including Dr. Cheres Chris-Roi. Dr. Chris-Roi is a regular member of the church but he is not an elder or deacon of the church. Since he was one of our clinical instructors, he chose to complete the interview questionnaire.

A pre-session interview questionnaire was created to measure the level of interest for visiting the sick from a selected group of Gethsemane church leaders. I, the researcher, sought to evaluate the value of visitation from the group in three major categories (None, Some, A lot) in order to assess three criteria: (a) self-evaluation; (b) passion for visiting Adventists; and (c) interest in visiting non-Christians. Self-evaluation is designed to reveal certain aspects of one’s personality. The second category focuses on their duty to visit church members and the third category explores on their natural desire to visit non-Christians.

I consider only the highest number based on each category (None, Some, A lot).

Out of the 11 people who complete the questionnaire, six are comfortable talking to strangers; nine feel comfortable talking with the elderly; five are some(what) squeamish around blood and trauma; seven would rather visit a friend than write him/her a letter; seven remember people’s name; 10 are likely to listen to people’s life stories and experiences; nine are likely to visit a sick person in the hospital; six are some(what) likely to visit the elderly in the nursing room; 8 are some(what) likely to visit patients in hospices; eight are most likely to enjoy visiting patients in rehabilitation centers; six have had some lay visitation training; nine have often done visitation in hospitals, hospices, and/or nursing homes. Seven of them have never been hospitalized and two remain neutral. Seven of them testify that they feel very comfortable visiting a church member; five of them testify that they feel very comfortable visiting non-Adventist patients; 9 of
them are *some*(what) previously visited non-Adventist friends in the healthcare setting; 8 of them reported that they visited non-Adventist patients only in hospitals.

The pre-session interview questions gave me some knowledge of their personalities and passion for visiting Adventist Christians and non-Christians in the healthcare setting. Most of the leaders manifested a strong interest for visiting church members and testified that they felt very comfortable visiting Adventists. Also, the majority of the group stated that they had done *some* visitation among their non-Adventist friends, while only three confirmed that they had visited non-church members a *lot*.

The result of the pre-session interview questionnaire demonstrated that these church leaders were willing to be trained so that they could effectively visit people who were in healthcare facilities. When church leaders are trained to do such task, the church will be healthy spiritually. This will help the pastoral team to nurture the spirituality of the church through visiting the sick.

The outcomes of the pre-session questionnaire show that Gethsemane French SDA Church is a well-nurtured church because almost 10% of its elders and deacons/deaconesses manifest strong interest for visitation in healthcare setting. Nevertheless, this pre-session analysis reveals that most of the Gethsemane French SDA Church leaders show little interest in visiting individuals in healthcare facilities who are not Seventh-day Adventists. Most of them admitted that they feel *less* comfortable visiting people who do not profess the same faith as them do.

Since 9 of them have *some* previous visit to their non-Adventist friends in the healthcare setting and eight of them reported that they visited non-Christian patients only
in hospital settings, it implies that some of the leaders have previously visited, at least once, a non-Adventist member. In short, the analysis of the pre-session interview also demonstrates that these leaders have already manifested strong interest in visiting the sick in the hospital and that they are a better group to be trained and equipped as the Spiritual Support Team for effective visitation in the healthcare settings.

Post-Session Interview Analysis

At the end of the training sessions, post-session interview questionnaires were distributed. This instrument was used to measure the trainees learning skills from the training session, to evaluate their visitation skills, and to see if they are willing to provide continuous spiritual support to the sick in healthcare settings. Appendix B presents all the data. Eleven participants completed the questionnaire. In response to the question: 

How many non-Adventist sick persons in hospital, hospice, nursing home, and rehabilitation center have you visited? Three reported A lot; seven reported Some, and one reported None. Data reveals that 10 members out of the 11 reported that they have gradually showed interest in visiting non-Adventists/ non-Christians patients in a healthcare setting during the 21 days of the training period.

Out of the 11 participants, 10 reported that they did more than one visit to non-Adventist patients, and one said, none. This told me that the group was able to follow the directions of the assignment and most of them participated in the project. When it comes to visiting SDA members, all 11 participants reported that they have visited Seventh-day Adventist church members in a healthcare setting, however, six reported some, meaning that they did at least one visitation, while the remaining five visited Adventist members at least twice during the 21 days of the training periods. This reveals that most elders/
deacons/deaconesses of Gethsemane SDA Church are much more comfortable visiting church members.

In response to the question: How effectively would you rate your visit to non-church members in hospital/hospice/nursing home/rehabilitation? Three participants reported that they feel very effective, while eight said *some* (what) effective. This proves that there are 8 leaders who may still struggle with interacting with non-Adventist patients in the hospital. Since they did not choose *none*, it means that they have not made progress, but still need more training or they need to do more visitations until they feel comfortable with non-Christian patients, like the three who feel very comfortable. These 8 leaders are willing to do visitation but are still learning to become more effective (See Appendix B).

The question, “How effectively would you rate your visit to regular church members in hospital/hospice/nursing home/ rehabilitation?” received the following response: Seven marked *A lot* and four said *some* (what), meaning that four of them think that they still need to improve on their visitation skills among Adventist church members. Finally, in answering the question: “How helpful was the training session to your visits?,” 10 participants reported *A lot* while one marked *some* (what) which proves that most of the trainees have applied the techniques learned from the training sessions to their visitations.

In sum, this section elaborates on the analysis of the pre-and post-sessions interviews. These instruments were used to decode a brief background of their duty and passion for visiting the sick as well as measuring the acquired skills learned during the sessions. The purpose of conducting the interviews was to evaluate the trainees skills to
see if they can meet the second expectations of this research project, that is to support the pastoral staff of Gethsemane Church in providing spiritual care to sick and shut-in church members. Thus, an analysis of both pre- and post- interview questionnaires reveals that this group has been equipped and trained to conduct effective visitation among local church members and non-Christians. These trained leaders also manifest the desire to train other elders and deacons/deaconesses to do visitation in healthcare settings.

Section III: Outcomes of the Training Sessions

The outcomes of the training sessions are to show evidence of (a) solid biblical/theological rationale for visiting the sick and (b) providing effective spiritual care to patients regardless of their religious background in the healthcare settings. A qualitative exploratory approach was used because the intention was to gain an understanding of the participants' perspectives (Cooper, Gray, Adam, Brown, McLaughlin, & Watson, 2008) and behavior regarding visiting the sick in healthcare settings (Gerrish & Lacey, 2009). This section, through supported research literature, demonstrates how the outcomes and findings of the training sessions helped in creating the formation a Spiritual Support Group in the local church to minister to non-Haitian Seventh-day Adventists in healthcare setting.

Following the completion of the pre-interview questionnaire, I started with the first session. The first session discussed the biblical/theological rationale for visiting the sick. Special attention was given to the book of Job where I extracted some visitations skills and applied them in today’s visitation style. Those who attended the first session enjoyed the presentations and were committed to using the principles garnered when they visited church members. Immediately after the presentation the 10 selected elders and
deacons/deaconesses were asked to go to the church’s medical room for a practicum. Two individuals conducted the clinical aspect of the training and served as clinical instructors. They were Dr. Cheres Chris-Roi and Dona-Hario Clermon, a licensed nurse. The selected people were chosen based on Goodman et al. (2010)’s suggestion on sizing a selected group to generate diverse discussion with equal opportunity for members to contribute.

Unexpected Outcome: Theological Debate and Discussions

One of the major outcomes of the training session was to equip church elders and deacons on how to pray with non-Christians. It has been noticed from numerous studies that there is a significant correlation between religious involvement and positive health outcomes (Waheed, Haroon, Anver, H. Khan, & Khan, 2011). The notion of respecting the patients’ religious belief and meeting the patient where he/she is while suffering (Ellen, 2008), by not discussing religious topics or using Jesus’ name, was not well appreciated by the trainees. Some members were offended and disappointed that a licensed Seventh-day Adventist Pastor would propose not using the name of Jesus in conversations with non-Christians and furthermore completely ignoring His name when offering prayer in such interactions. Other members remained silent and observed the discussion. One member stood up and said, “The Bible says, ‘We need to confess the name of Jesus at all time’ when I go to the hospital, I will preach to anyone, as a matter of fact, I use this opportunity to share Jesus with those who do not know him.” I heard another member groaning and saying very softly, “we are learning some new heresies, the SDA church has changed now.”
Based on the pre-interview analysis, it appears that most of the members have had the chance in the past to visit a non-Christian in the hospital. It was also reported that most of them have a few friends who are not Christians. This finding is also reported in several studies on visiting friends, love ones, non-religious and non-believing terminally ill patients (Waheed et al., 2011; Ellen, 2008). Several biblical texts were shared to show the value and the importance of visiting non-believers in healthcare setting without the intent of proselytizing. One of the key scriptural texts used was I Corinthians 9:20-23, NIV, where the Apostle Paul states the following:

Though I am free and belong to no one, I have made myself a slave to everyone, to win as many as possible. To the Jews I became like a Jew, to win the Jews. To those under the law I became like one under the law (though I myself am not under the law), so as to win those under the law. To those not having the law I became like one not having the law (though I am not free from God’s law but am under Christ’s law), so as to win those not having the law. To the weak I became weak, to win the weak. I have become all things to all people so that by all possible means I might save some. I do all this for the sake of the gospel, that I may share in its blessings. I have become all things to all men so that by all possible means I might save some.

In this passage, Paul expresses his freedom in these passages and teaches how to behave in order to reach out to different kinds of people. Paul, the greatest evangelist, clearly outlines his evangelism skills and strategies in these few verses. Although he belongs to no one, Paul made himself a slave in order to win as many as possible. He brings three groups of people: (a) the Jews; (b) the Gentiles; and (c) the weak. Paul did not speak in favor of the Jewish understanding of the law. He disagreed with the Jews on the interpretation of the law. However, Paul made himself a slave, he lowered himself so that he can win the Jews as he stated to the Jews, “I became a Jew.” Paul had to take off of his comfortable suit so that he could win the Jews. Paul did not let go of God, he did
not become a Jew just to become a Jew, and he became a Jew so that he could win them to Christ.

Paul also used the same strategy of mingling with others to win the gentiles. The gentiles were not descendants of Abraham. They did know all the Jewish rituals and regulations. They were not circumcised and they were seen as unclean people. Paul said he became “under the law” so that he could save them. Paul was a holistic preacher. He saw things as a whole. He had a holistic approach to bring people to Christ. Above all, Paul made an important point that calls all Christian believers to reflection.

In verse 23, Paul states, “To the weak I became weak, to win the weak. I have become all things to all people so that by all possible means I might save some. I do all this for the sake of the gospel, that I may share in its blessings.” Here the Greek word used for weak, literally means feebleness, physical weakness, and being sick. Therefore, Paul became a sick to win the sick. Visiting the sick is entering the patient’s world and letting the patient direct the conversation in support of a good palliative care (Iranmanesh, Haggstrom, Axelsson, & Savenstedt, 2009).

After these passages of the scripture was explained to the group. Some were astonished at my instructions. Personal stories were shared on visiting non-Christians believers in respect of their religion. As a result of the training session, most trainees were convinced of the logic behind the idea of not proselytizing to patients who are non-believers; three of them were confused and still believed, no matter what, that they will still have to mention the name of Jesus when praying with non-Christian believers. Those trainees were raised in a very traditional environment within the Seventh-day Adventist Church. This finding corresponds to what Ellen (2008) notes are some practices in our
lives that have roots in our childhood and as we grow up these practices become stronger and they become the routine of our daily lives. These practices most of the time hinder us from adapting to new principles in our religion.

Expected Outcomes: Creation of a Spiritual Support Group

Another major expected outcome of the training sessions was to furnish the selected leaders with skills on how to establish a friend relationship with relatives and family members of individuals regardless of their religious backgrounds. The training sessions and the visitations lasted for the whole month of May. These training sessions preceded an evangelistic effort that was scheduled to start mid-June. The church was in the process of preparing for evangelism. During the training sessions, members of the program were already making friends with relatives, friends and family members of non-Christians patients. Some of them had already reached out to their non-Adventist neighbors and offered prayer for the relatives or friends who have been hospitalized. They had prayerfully established a friend relationship with them, and followed-up with them through prayers.

As a result of reaching out to non-Adventist patients, some of the patients’ family members and friends have made inquiry about our church and manifest strong desire to come and pray at our church. In fact, one month after the training program, Gethsemane French SDA Church conducted an evangelistic effort and as a result 14 people got baptized. By then the lay personal ministry staff were very excited and enthuse by the training sessions that they decided to do a second evangelistic effort. Normally the church usually conducted its evangelistic meetings once a year. This year the church was able to undertake two evangelistic series. The second evangelistic campaign happened during the
month of November 2011, and another 15 people received baptism. Moreover, visiting non-Christian believers gives our preaching a rich social and moral viewpoint with a strong sense of ethics (Waheed et al., 2011).

Overall, the section discusses the outcomes of the training session as it lays out both unexpected and expected outcomes from the trainees. Nevertheless, one of the major expectations of this project is the formation of a spiritual support group to provide pastoral care to members and non-Christian. The trainees were able to learn how to minister to both religious and non-religious sick patients in the healthcare settings. Most of the trainees gathered themselves and formed a spiritual support group to effectively visit anyone who asks for prayer regardless of their religious status.

**Section IV: Evaluation of the Training Program**

The last section of this chapter explores the evaluation of the training program by the participants and other key individuals. Evaluation forms were distributed to the trainees for them to express their feedbacks. Such evaluation was crucial to assessing the sessions and also to determine if eventually it would be necessary to supplement the present strategies for the Gethsemane Church to establish strong relationships with local healthcare facilities through the trained spiritual support team.

First of all, the trainees had the opportunity to evaluate the cross-cultural training curriculum using a questionnaire (see Appendix C). They rated the topics from 1 to 3 (1 = *very useful*, 2 = *useful*, 3 = *not useful*). Session I: Biblical Foundation and Bedside Manners and Principles on Visiting SDA Church Members were rated *very useful* by all of the trainees. Session II: Conversational Essentials/How to visit non-SDA Patients was rated *very useful* by all of the participants. Session III: Value of Lay Visitation in
Healthcare Setting was rated *very useful* by all of the trainees. Finally, all trainees rated self-care and spiritual reflection on all pastoral verbatim report as *very useful*.

When asked what areas in the pastoral verbatim report they needed further training in, over 90% mentioned self-care. After their visits, the spiritual support group was asked to rate the effectiveness of their training as *very useful*, *somewhat useful*, or *not useful*. All rated the training as *very useful* in the field. All of the trainees reported feeling uplifted after their visits. When it was asked if the trainer met the course objectives and goals, 100% of the members said that they agreed.

All participants agreed that they would apply these visitation skills during their personal visits to the healthcare facility. None agreed to not having learned anything new during the training sessions. All trainees agreed that a lay visitation team would be very beneficial/useful for the Gethsemane French SDA Church. However, 90% of the trainees responded that they would like to be part of a lay visitation team at their church.

Eighty five percent of the participants felt *very comfortable* with sharing some visiting tips with the church leaders. Ten percent felt *less comfortable* to share and 5% remained *neutral*. Overall, all participants agreed that the training sessions were very useful. Nevertheless, when asked in what areas of visitation they needed more training, 90% stated that they would like to explore more on the art of visiting non-Adventists/non-Christians. They enjoyed visiting non-Adventist Christian believers. They were challenged to use all the skills and principles learned from the training sessions to reach out to non-Christians in New York City.

One of the deaconess trainees stated that, “One of the best parts that I learned from this session is paraphrasing,” she continued, “Even though I attend visitation
seminars in my previous years, it was the first time I received such formal training in visiting the sick.” She stated that she was so happy and she gratefully thanked me for selecting her to be part of this wonderful training program.

Observations From two Healthcare Professionals

As mentioned before in this project, two healthcare professionals, Dr. Chris-Roi and nurse Clermon were asked to serve as instructors and advisors for the clinical aspect of the project. Dr. Chris-Roi and nurse Clermon were impressed with the project and grateful to have been invited to participate in its planning and execution. They met with the trainees at the end of the last session as a group and received their feedback in my absence.

The trainees considered lay pastoral care to be very important to the life of the church and acknowledged that the project had already had a great impact on the church. The trainees requested that similar training be provided to the board of elders and deacons/deaconesses. Dr. Chris-Roi and nurse Clermon also participated in the spiritual aspect of the training and recommended that the boards of the deacons and deaconesses, personal ministry leaders, nurses, and other healthcare professionals in the church receive similar theological training. The overall effectiveness of the project was apparent in the increased demand for similar training and improved confidence of the spiritual support group. Thus, a proposal was made for other departments in the church to motivate members to conduct visitation at any healthcare setting in Brooklyn, NY. Youth leaders (AY, pathfinder, adventurers) showed great interesting in making plans to visit the elderly in the hospitals, hospice, rehabilitation, and long-term care facilities in order to let
the healthcare facilities in the community know that Gethsemane Seventh-day Adventist Church cares about and prays for them.

Impact of Spiritual Care on Visited Patients

Visiting is an important part of a patient’s experience of hospice care (Cooper et al., 2008). As part of the curriculum, each trainee gathered into group of two or three to conduct visitations in a healthcare setting in Brooklyn, NY. The group was expected to follow instructions and apply the skills learned from the training session. They were to report their visit conversations following a verbatim format [See Appendix D]. Two visit conversations will be explored as narratives on patient experiences to show the impact of spiritual care on visited patients. One conversation will show a typical visit of an elder to a church Adventist Church member and the other is a visit with a non-Adventist patient in a hospice facility.

Visit Conversation Report I

\( V = \text{Visitor}; P = \text{Patients} \)

\( V-I: \) Good evening Sis. C. How are you doing today?

\( P-I: \) Hi brother O, I am doing fine by God’s grace. I cannot complain. God has been so good to me. I just recently move to this facility.

\( V-2: \) It seems like you enjoy this place.

\( P-2: \) Yes, I am happy because of the Lord. I remember I spent 1 year and 7 months nursing homes. I was transferred to several nursing homes and I undergone several surgeries on my legs. Doctors said that I could not make it (\textit{Sis C drops some tears}). I went to the surgery room with only one person. I told the doctors that they do not have to be worried about me because I have Jesus here with me. And Jesus was definitely there for me and everything went well after the surgery.

\( V-3: \) wow, I am glad that you share those thoughts with me. It seems that you have a strong faith in the Lord.

\( P-3: \) Oh yes, Elder. As you know, Jesus is the only one that I have. I pray every day and go to church whenever someone can help me with the walker to get down the steps.
V6: It seems that you are very confident that the Lord will have a place for you.

P7: Yes, elder. I have faith in the Lord that He has already given me a place to stay when I leave her because my life depends totally on him (C shares some tears)

V7: I can see that you’ve shared some tears; it must be very emotional for you to talk about your life journey with the Lord.

P8: oh! Yes elder. Sorry for those tears (wiping tears from her eyes)...Brother O, these tears are tears of joy and happiness. I have some many stories to tell you, you would have to come again and again. I guess this is not the first and the last visit.

V8: I would love to hear those stories. They are very uplifting and encouraging. Of course it is the first visit, but it would not be the last. I would do my best to come and visit you from time to time to learn more about those stories. You’ve mentioned that you had surgeries on your legs? How are you doing with your legs now?

P9: I am still in pain every now and then. I have a walker to help me walking from time to time. Although I have pain but I learn to manage it because Jesus gives me strength. I do not know what I would do if I did not have Jesus.

V9: It seems that you love Jesus and that he has helped you when you are suffering.

P10: Sorry, Brother, I talked too much...but I cannot help it. I have so many testimonies that I have to share. When I spent 1 year and 7 months in nursing homes; I could not go to church. I had missed church a lot. But when the Lord, put me out of the nursing homes, I said I have to go back to church to share my testimonies because God has been so good to me... brother, I know that you have other places to go but I would love for you to say a prayer and bless my room for me before you leave.

V10: Sure! my pleasure.... Would you like to sing a song before we pray.

P11: Yes, I like to sing Marchez en ta presence # 160 of the French Hymnal (elder and patients sing together and recite PS. 23 then elder prays)

V11: “Lord, God you are a great God. We want to thank you for doing great things for Sis. C. We want to thank you for those tears of joy and happiness. Continue to be with Sis. C. She believes in your word and she remains faithful and confident that you already have a home for her. Help her to stay connected with you every day. In Jesus’ name we pray. (“Amen”)

P12: Thanks very much for thinking about me elder and for visiting me. I really appreciate it. Say hello to your family for me as well as the church family. Tell them I miss them all.

Assessing the Benefits of Spiritual Care

Emotionally, it appears that Sister C. feels lonely and wants to share the goodness of the Lord in her life. Sister C’s initial concern is to find someone whom she can talk
about her spiritual journey with God to strengthen her faith. Sister C feels neglected in the facility. Sister C undergoes surgery on your legs and she is very emotional and appears to reflect on God’s goodness and mercy toward her. Sister C is receiving some spiritual support from the elder. She constantly talks about the Lord as a way to express her spiritual needs. Sister C has been transferred to several nursing homes and has experienced loneliness. Sister C has lost that since of connection and learns to develop her own personal theology about God based on your spiritual journey.

Sister C is very happy to receive a visit from a pastor. Sister C appears to miss church services. She is very appreciative of the visit and sends greetings to all church members. Sister C feels like she is not alone because an elder from the church visits her. She is very comfortable with the elder and is able to share tears of joy and happiness in the Lord. Sister C wants to share her personal testimonies to others especially with the church. This visit allows Sister C to talk about God’s goodness, mercy, and love.

Visit Conversation Report II

Visiting conversation II presents in a form of a verbatim format, the impact to non-Adventist believers at Kings County Hospital in Brooklyn, NY. The patient is a married black woman, diagnosed of Breast Cancer. She is not an Adventist and was referred by her husband whom we came across in front of his building in Brooklyn, NY pouring out some tears. The pastoral verbatim has two parts: Part I address the conversation with the husband and Part II conversation with the wife at the hospital.

V= Visitor; P = Patient; H = Husband

V1: Hello, Mr. It seems that you have something that bothers you.
H1: Yes, [Sharing tears] my wife is in the hospital and she has been diagnosed of breast cancer. I believe that she is about to die and I do not know what to do about that. [The husband was about to leave his building to go to work and he was moving]

V2: Sr. We are church people and we offer pray to those who are sick. Is it possible that we can go and see your wife at the hospital?

H2: Yes…no problem. She is at Kings County Hospital. Her name is M….L. Room #..... please go there and pray with her for me.

V3: Ok may God be with you! Do you want us to pray for you now as you go away.

H3: No I don’t have the time…I have to go to work but you can go to the hospital to pray for my wife.

[The hospital Visit]

V1: Hello Mrs….ML. I am V…..and this is my friend G…. We are from the Gethsemane Seventh-day Adventist Church on Empire blvd. We just met your husband a few minutes ago and he told us to come and pray with you. [Patient was accompanied with four of her daughters surrounding the bed. They came to support her]

P1: Oh yeah…no problem. Come in. I am happy to meet both you. These are my daughters ( K, N, R, A). My husband sent you here right.

V2: We have just met him on the street and he told us to come and offer a prayer for you.

P2: Yes, I need prayer. The doctor says that I am diagnosed of breast cancer and the situation seems to be very bad. I need prayer. You guys can pray for me.

V3: No problem. Before we pray would like to sing a song for you; is that ok with you.

P3: Sure no problem (the daughters were listening attentively to our conversation)

V4: Do you mind if we sing “Amazing Grace” with you.

P4: Sure… I know that song (Church visitors, patients and her daughters sing together. Ask we were singing the patient and her daughters shared some tears. We recite Ps. 23 and then we offer prayer and blessing) Amen!

P5: What a prayer! Thank you for coming to see me and offer this prayer. Even my church people have not come to see me. I really appreciate the fact that both of you came to see me. [her and the daughters ask] what church are you from again. We would like to visit your church.
Assessing the Benefits of Spiritual Care II

This patient is not an Adventist. She is diagnosed of Breast Cancer. The husband feels very distressed and sad about the situation. Although he did not have time to pray with the church visitors but he urged them to visit his wife at the hospital. The church visitors went to see the wife. It happened that all of her daughters were with her. She seems to be happy to see some church people are concerned about her. She notices that her husband is concerned about her health and other people are also concerned about her. She wanted prayer and prayer was given to her. She seems to be disappointed of her church people who have not come to see her, but she is happy to know what that there other people are praying for her. At the end, her and her daughters manifested the desire to come and worship at the Gethsemane French Seventh-day Adventist Church in Brooklyn, New York.

Other Reported Benefits of Spiritual Care to Patients

A group of two trainees visited a sister who had been diagnosed with Alzheimer disease at a long-term care facility in Coney Island, NY. The group left a prayer card with the patient and then departed. A week later a relative of the sister who received the visit came to the Gethsemane Church and reported how his family was greatly appreciative of and felt honored by the visit because this was the first time that his sister has ever received a visit from the church. The relative was so moved by the gesture of the church that he started attending Gethsemane II Company, a daughter church of the Gethsemane SDA Church.
I also had the opportunity to visit another sick member who was visited by the trainees in the nursing home in Brooklyn, NY. She was so excited and reported that two church members came to visit her last week. “The people,” she said, “came right on time. I was so distressed and hopeless after my leg was amputated, but the group came and revived my spirit.” I asked, “How did they revive your spirit? Were they preaching to you?” She said, “No, they were not. They just sat there and told me to talk as much as I want and as long as I want. I was able to express my deeper feelings to them.”

It is amazing to see how lay visitation in the healthcare setting influences a sick person. She added “I wish you or the members would come more often to see me.” Then she started to tell me to greet other church members on her behalf and gave me specific names of other leaders from the Church that she would love to see come to visit her at the nursing home. The purpose of visiting is not to show that religious people can live more than non-religious. Waheed et al. (2011) argue that in some cases the non-religious live longer than the religious. The purpose is to show that religiously strong patients usually live a contented and satisfactory life.

**Senior Pastor's Feedback**

Dr. Jean-Marie Charles, the church senior pastor gave the project his full backing and demonstrated his interest in tangible ways. He presented the project to the church board and had the board members voted for its execution in the church. Dr. Charles, who also served as my mentor and counselor in ministry, was convinced that the training program improved lay leaders’ healthcare visitation skills and he had strongly recommended that other elders and deacons/deaconesses participate in the program in order to make a robust impact on our community.
Summary

This chapter explores the outcomes and assessments of equipping a selected group of elders and deacons from Gethsemane Church for effective visitation in the healthcare settings. Outcomes and evaluations discussed in this chapter provide evidence about benefits and results of the training sessions and visitations. These outcomes of the research can identify potentially effective strategies that can be implemented to improve the quality and value of a lay pastoral care at Gethsemane French SDA Church. The selected group of elders and deacons has helped in translating the findings of the outcomes and evaluations into practical strategies to improve pastoral care in the church and to reach out to the community.

The chapter, supported by recent research literature, also presents an assessment of four expectations from this project which were discussed in four major sections: Section I assessed methodology of the training sessions as it presents different ways to reach out to a sick person regardless of his/her religious belief. Section II explored the interviews and surveys to assess the leaders’ duties, personalities and most of all their passion for visiting the sick. Section III demonstrated how the expected outcomes of the training sessions met one of the project initial objectives which is to work toward the formation of a spiritual support group to minister to both SDA and non-Christian sick individuals in the healthcare settings. Lastly, section IV presented assessments of the training sessions and interventions by the participants and other key individuals regarding the final outcomes of the project and its achievement based on the ministry context.
Furthermore, this chapter provided different approaches for Gethsemane Church lay leaders to reach out to those who are sick and shut-ins in a healthcare facility that is near the church. Following up the training sessions, the pastoral staff of Gethsemane Church greatly benefitted from this project. Out of the three elders that participated in the program, one of them was nominated to serve as first elder of the Gethsemane French Church toward the end of 2011. The newly nominated first elder placed a great priority on providing spiritual care to sick and shut-in church members.

The most striking observation I made was the high level of enthusiasm of the church family and its hunger for the training. I also realized that I should have provided more training sessions for the trainees. As a result of the project, there has been a rise in the number of volunteers who are willing to serve as lay visitation ministers. It has resulted in a growth in service and has improved the ability of the church to serve members in need.

Ellen (2008) defines “support” as anything from helping out with tasks around the home when someone is sick to assisting someone in finding a new job, a dentist, or a day care provider; or it could mean having someone to confide in and share feelings with (p.3). One of the expectations of this project was to develop a spiritual support group in the local church to minister to church members as well as non-Haitian Seventh-day Adventists in healthcare settings. This expectation was not fully accomplished because I was transferred to another church in the middle of the year. However, individual trainees are still visiting non-Adventist friends on a personal level but not as a group.

Most church leaders feel more adequate in creating friendships with non-Adventists/ non-Christians. Trainees insist that their level of communication skills, such
as paraphrasing, has been dramatically improved during this program. This finding is also supported by other research in communication skills (Cooper et al., 2008) which shows that communication is important in all health-care settings so much so that identifying the needs of patients with respect is very crucial (Gray, Adam, McLaughlin, Hill, & Wilson, 2011). I strongly believe and remain positive that this training program will eventually supplement strategies for Gethsemane Church to establish strong relationship with its local healthcare facilities because all trainees were nominated to serve as either elders or deacons/deaconesses.

Visiting the sick is an important pastoral responsibility and privilege for the church. In physically challenging moments, people are doubly blessed when they receive visitation from the pastoral staff (Cooper et al., 2008; Ellen, 2008; Gray et al., 2011). A spiritual support group is valuable and important in the church as it seeks to support the pastoral staff. In short, the outcomes and assessments of this chapter attempts to address the four objectives of this training program, however, it acknowledges directions for further research, studies, and reflection on the subject.
CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Equipping a selected group of elders and deacons/deaconess from the Gethsemane French Seventh-day Adventist Church to effectively visit patients in healthcare facilities is commensurate with the chaplain’s assistant basic level of training. Selected elders and deacons/deaconesses from the Gethsemane French SDA Church were trained in the following areas: (a) providing a meaningful approach for visiting Seventh-day Adventist patients; (b) praying with Adventist patients and non-Adventist or non-Christian patients; (c) helping patients find meaning and purpose of living in their suffering; (d) assisting patients undergoing pain and anxieties resulting from sickness; (e) visiting church members who are sick and/or shut-ins at least once a week; (f) helping church members or non-members facing terminal illness; (g) meeting and supporting relatives of Adventist or non-Christian patients.

The practice of visiting the sick from a biblical/theological window points to a wide range of activities performed by an individual or a group to provide comfort and spiritual care to people who are ill, homebound, isolated and/or otherwise in distress. *Bikur holim* can include such activities as: visiting patients in a hospital, hospice, rehabilitation center, and/or nursing home. Church elders and deacons/deaconesses should develop a passion for visiting the sick. They should exercise their active and listening skills, and being able to offer prayer to effectively minister to patients in the
healthcare setting. Ellen G. White gives some spiritual insights on visiting the sick. She puts a strong emphasis on training church leaders for effective visitation in healthcare setting. She encourages church leaders to act tenderly, kindly, and faithfully when visiting non-believers.

The literature review surveyed some of the current issues in providing effective spiritual care to patients and residents in the healthcare settings. Visitation in the healthcare setting plays a major impact on patients and/or residents life in a healthcare facility. Current literature on healthcare facilities over the past 10 years appeals for more spiritual caregivers and family members, and staff members to be more sensitive and attentive to sick patients and residents. Above all, providing presence and active listening seems to be important keys to get sick patients and residents in good spirits as they face terminal illness. Truly, developing effective visitation skills in the healthcare setting is “an offering of love” (Kirkindoll, 2001) that will be appreciated by the patients in hospitals and residents in long-term care and hospices.

Pastoral care like other professions has varying levels of expertise and practice. The world of healthcare is unique, demanding, and challenging. In order to gain respect and recognition, the individual who enters the field of healthcare as a spiritual care provider must come with highly developed skills, knowledge, and other qualifications. This project presents the development and implementation of a properly trained spiritual support group from the Gethsemane French Seventh-day Adventist Church for effective visitation in healthcare settings. The task of this project was to create a health ministry spiritual support group utilizing a selected group of church elders and deacons from Gethsemane Seventh-day Adventist Church. This spiritual support group was to be
trained and equipped to provide spiritual care when visiting SDA church members and non-Adventist patients who are sick in healthcare facilities in Brooklyn, New York.

The Gethsemane French Seventh-day Adventist Church has a total number of 172 elders and deacons/deaconesses. Selecting elders and deacons/deaconesses to create the spiritual support group was not an easy task. The subjects in this research project were pre-selected. The screening process for the selection of elders and deacons/deaconesses sought to identify individuals who were of good moral characters, practiced a spiritual lifestyle, were of legal adult age, and wanted to volunteer their time to visiting those who were sick. After much prayer and considerations, the spiritual support group was formed with a selected number of elders and deacons from the Gethsemane Seventh-day Adventist Church that represented the dynamics of the church.

The selected group was composed of 10 church leaders: four elders, two deacons and four deaconesses – specifically, two ordained elder, two elders-in-training, the head deacon, a junior deacon, the head deaconess, a junior deaconess, and a senior deaconess. The participants learned how to diagnose a patient spiritual problem through three models that lay out our theoretical framework of this project: (a) spiritual history taking, (b) spiritual screening, and (c) spiritual assessment. A special attention was given toward effective communication skills such as active listening, paraphrasing and the need to develop a ministry of presence, silence and shared-emotions. The selected elders and deacons/deaconess of Gethsemane Church were theologically, theoretically and clinically equipped to implement a spiritual support group at Gethsemane SDA Church.
Familiarization with these skills would allow the selected group to provide pastoral care support to church members and non-seventh-day Adventist patients in healthcare setting. The goal of this training program was (a) to strengthen church elders and deacons/deaconesses toward their calling of visiting their local church members, and (b) to provide a creative approach of establishing friendship with non-Seventh-day Adventist patients and their relatives. This training curriculum, then, was designed to prepare church elders and deacons to convey a ministry of love, compassion and care for anyone who is sick and shut-in in a healthcare facility in Brooklyn, New York.

All Christian believers are called to ministry. Elders and deacons/deaconesses are empowered and expected to do the ministry of the Lord Jesus Christ through the Great Commission (Matt 28:16-20). It is ethically and theologically imperative that church elders and deacons/deaconesses reach out to the sick, feeble, and hurting. In addition, spiritual care is not only limited to church elders and deacons. Spiritual care can be provided by any born-again and spirit-led Christian. Spiritual care is an act of evangelism. Reaching out to hurting people is always a starting point for healing, comfort, and an opportunity for Christ to intervene. It is also possible for God to use unbelievers for His glory.

Each participant understood that visiting the sick is not a preaching engagement. Members were to visit the sick and not preach to them. They did not seek to offer Bible study and/or doctrinal lessons to try to convert a sick person. They learned that spiritual care is best rendered when there is a collaboration and cooperative relationship between the spiritual care provider and the patient. The patient is responsible for his/her
relationship with God. It is the individual’s responsibility to work out his/her own salvation with fear and trembling as he/she is able (Phil. 2:12).

The participants were partnered with Adventist or non-Adventist patients. They were servants as Christ mandates. The primary goal of Christian pastoral care was to create a friend-relationship with patients to carry on the work of Christ in reducing physical suffering. That is true evangelism because it opens hearts to the Bible-based Christ message of redemption, healing, and hope. The participants conducted visitations once a week in a healthcare setting in Brooklyn, New York. The group was divided into five teams of two; each team contained one elder and one deacon/deaconess. Each team was required to do at least two visitations in a healthcare setting: (a) Visiting a regular Seventh-day Adventist church member; (b) visiting an individual who was not a member of the Seventh-day Adventist Church. Each team wrote two verbatim reports and presented one verbatim report at both sessions II and III.

The training session was expected to have a successful outcome. Nevertheless, it was assumed that some members might drop out because of one of two reasons: First, they might believe they were not ready to work with broken people, who had grief and intense emotional and spiritual crises, despite the training offered to them. Second, they might feel odd not to being able to preach and/or provide bible studies, or sets of doctrinal lessons to try to convert suffering patients. However, those who did not want to stay in the program would serve as trained volunteers for the situations they were most likely to encounter when they would visit Seventh-day Adventist and non-Seventh-day Adventist patients in a healthcare setting in New York City.
The first session laid out the biblical/theological foundation; clinical principles were also considered and addressed. Trainees planned visitations based on the Gethsemane French Church’s roster of sick members in healthcare facilities and from neighbors or friends who are not a Seventh-day Adventists. Trainees also learned how to write a pastoral verbatim report to record their reflections and self-assessments.

The second session (Training Session II) discussed conversation essentials in visiting the sick and human and theological dynamics. Trainees learned adequate skills and received important tips for visiting non-Adventists or non-Christian friends in a healthcare setting. As a pre-requisite for the second session members were asked to visit a regular church member and write a pastoral verbatim report from that visit. Consequently, this session covered four key areas for the trainees: (a) conversation essentials; (b) human and theological dynamics; (c) tips for visiting non-Adventist friends; and (d) pastoral verbatim report and analysis.

The last session (Training Session III) discussed the purpose of a spiritual support group in a church. Special attention was given to creating a spiritual support group among the trainees. Trainees were given an evaluation form to critique the course and a post-interview questionnaire to ascertain what they learned from the training session. Pastoral verbatim reports were required, shared, and discussed among peers for learning growth.

The main purpose of this project was to help Seventh-day Adventist leaders establish strong friendships with non-Christians. The project provides a conclusion that clearly reiterates the main points, and acknowledges directions for further research and reflection to develop and implement this project at Gethsemane French SDA Church.
Adequate details of the development and implementation of a properly trained “Spiritual Support Group” from the Gethsemane French Seventh-day Adventist Church were analyzed for effective visitation in healthcare setting. The research project utilizes the qualitative data paradigm. Outcomes and assessments of this project seek to understand the end results of the training sessions and interventions. Outcomes of this research project are clearly measurable by the research methodology employed including interview questionnaires and evaluation forms. End results include effects that elders and deacons of the Gethsemane French SDA Church experience and care about, such as change in the ability to conduct effective visitations in healthcare setting.

Recommendations

This spiritual support group of Seventh-day Adventist elders and deacons of the Gethsemane French SDA Church are trained to satisfy patients’ spiritual needs through incorporating the spiritual component into the dynamics of a group therapy setting, using supportive, cognitive behavioral and existential techniques. One of the expectations of this project was to develop a spiritual support group in the local church to minister to non-Haitian Seventh-day Adventists in healthcare settings. This expectation was not fully accomplished because I was transferred in the middle of the year. However, individual trainees are still visiting non-Adventist friends on a personal level but not as a group.

This project is close to my heart, and I am grateful for the outstanding support I received from the church board, the senior pastor, and the first elder. This project is just the beginning of an educational journey to equip Seventh-Adventist church officers (pastors, elders, and deacons/deaconesses) to effectively visit patients of their
congregation and other non-Adventists. It is practical approach toward outreach ministries in healthcare setting. This project highly recommends all Seventh-day Adventist pastors/elders/deacons to implement this likewise program in their churches by establishing a “Spiritual Support Group” to conduct weekly visits of sick and shut-ins to both Adventists and non-Adventists. This project has increased my knowledge and enhanced my understanding of pastoral care in visiting Adventist patients and non-Christian patients at any healthcare facility.

This project serves as a model for all Adventist churches to develop a “Healthcare Visitation Ministry” to effectively visit sick and shut-ins. The model of healthcare visitation program presented in this project is recommended to be evaluated, analyzed, reported in print and made available for replication to other churches in the Greater New York Conference. Overall, this project potentially seeks to create a handbook for lay pastoral visitation ministry in the healthcare setting for conference administrators, departmental directors, pastors and church leaders in the Greater New York Conference to train, equip, and mobilize local church elders, deacons and deaconesses for effective visitation at any healthcare facility within their community.
April 17, 2011

Institutional Review Board
Andrews University
4150 Administrative Drive, Room 210
Berrien Springs, MI 49104-0355

To Whom it may concern:

On April 9, 2011, Gethsemane SDA Church Board has voted to let Pastor Brian Ladiny organize a seminar at the Church on "EQUIPPING ELDERS AND DEACONS FROM THE GETHSEMANE SEVENTH-DAY ADVENTIST CHURCH FOR EFFECTIVE VISITATION IN HEALTHCARE SETTINGS."

It gives me great satisfaction to give this letter to Pastor Ladiny. We believe Pastor Ladiny will be an outstanding asset to this new DMin cohort. I give him my highest recommendation.

If you need further information, please free to contact me at (917) 257-6009.

Best Regards,

Dr. R. Jean-Marie Charles, D. Min.
Senior Pastor
Gethsemane SDA Church
INSTRUCTIONS

The board of Gethsemane Seventh-day Adventist Church has voted that Pastor Brian Ladiny, the associate pastor of the church, to equip and train a selected group of elders and deacons/deaconesses for effective visitation in healthcare setting. These church elders and deacons/deaconesses will have the opportunity to use these training skills to enhance their duty toward visiting the sick and shut-ins of the church. These church elders and deacons/deaconesses will also be required to visit friends, neighbors and/or relatives who are not members of a Seventh-day Adventist Church. Three bi-weekly training sessions will be conducted at the church medical room: training session I will provide biblical and theological motives and rational for visiting the sick. Special attention will be given on the power of Scripture, songs and prayer when visiting Seventh-day Adventist sick members. Training session II will focus on acquiring practical skills such as do’s and don’ts, what to say and not to say and how to terminate a visit in hospitals, hospices, nursing home and/or long-term care residences. Training session III will discuss verbatim reports, interviews and pastoral and self-reflection based on previous visits. Participants will be involved in two bi-weekly visitations in a healthcare facility in Brooklyn, New York. The spiritual support group will be divided into five teams of two; each team will contain one elder and one deacon/deaconess. Each team will be required to do at least two visitations in a healthcare setting: (1) Visiting a regular Seventh-day Adventist church member; (2) visiting an individual who is not a member of the Seventh-day Adventist Church. Each team will write two verbatim reports and present one verbatim at each session II and III.

WRITTEN CONSENT FORM

I, ________________________________, undersigned that I have received/read/had the instructions of the training sessions on Equipping Church Leaders for Effective Visitation in Healthcare Setting which will be conducted by Pastor Brian Ladiny at Gethsemane Seventh-day Adventist Church. I understand that I will not receive any compensation for any visitation made and that I am giving my informed consent to participate and abide to all rules and instructions given during the training sessions.

_________________________  _______________________
Participant’s Signature          Date

_________________________  _______________________
Witness’ name                  Date
# APPENDIX B

## PRE-SESSION INTERVIEW QUESTIONS

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<th>Questions</th>
<th>None</th>
<th>Some</th>
<th>A lot</th>
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<tbody>
<tr>
<td>1</td>
<td>I feel comfortable talking with strangers</td>
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<tr>
<td>2</td>
<td>I feel comfortable talking with Elderly</td>
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<td>3</td>
<td>I am squeamish around blood and trauma</td>
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<td>4</td>
<td>I would rather visit a friend then to write a letter</td>
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<td>5</td>
<td>I remember people’s name well</td>
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<tr>
<td>6</td>
<td>I like to listen to people’s life story and experience</td>
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<td>7</td>
<td>I feel comfortable to visit a sick person in Hospital</td>
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<td>8</td>
<td>I like visiting the elderly in the nursing home</td>
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<tr>
<td>9</td>
<td>I like visiting patient in hospice</td>
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<tr>
<td>10</td>
<td>I feel comfortable visiting patient in rehabilitation center</td>
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<td>11</td>
<td>How much Lay Visitation training you have had?</td>
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<td>12</td>
<td>How often do you do visitation in hospital/hospice/nursing home/rehabilitation center</td>
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<td>13</td>
<td>How effectively would you rate your visitation in hospital, hospice, nursing home/rehabilitation center</td>
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<tr>
<td>14</td>
<td>Have you ever experience hospitalization?</td>
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<tr>
<td>15</td>
<td>I feel very comfortable visiting a Seventh-day Adventist church member.</td>
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<tr>
<td>16</td>
<td>I feel less likely comfortable to visit non-SDA patient in hospital/hospice/long-term care than a SDA member</td>
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<tr>
<td>19</td>
<td>How often do you visit a non-SDA friend, friends’ relatives/family members in a hospital/nursing home/hospice/long-term care</td>
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<tr>
<td>20</td>
<td>Have you ever visited non-SDA patients in hospital/nursing home/rehab/long-term care</td>
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**TOTAL**
## POST-VISITATIONS INTERVIEW QUESTIONS

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<th>Question</th>
<th>None</th>
<th>Some</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How many non-SDA sick persons in hospital, hospice, nursing home, and rehabilitation center have you visited?</td>
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<td></td>
<td></td>
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<tr>
<td>2</td>
<td>How many SDA sick members in hospital/hospice/nursing home/rehabilitation center have you visited?</td>
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<td>3</td>
<td>How effectively would you rate your visit to non-church members in hospital/hospice/nursing home/rehabilitation</td>
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<td>4</td>
<td>How effectively would you rate your visit to regular church members in hospital/hospice/nursing home/ rehabilitation</td>
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<td>5</td>
<td>How helpful was the training session to your visits?</td>
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<td></td>
<td><strong>TOTAL</strong></td>
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APPENDIX C

EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional)______________________________________              Date:  ________________
Church Position_______________________________________ Years of Experience:____________

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not Useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick 1 2 3
   Session II – Conversational Essentials/How to visit non-SDA Patients 1 2 3
   Session III- Value of Lay Visitation in Healthcare Setting 1 2 3

2. The trainer meets the course objectives and goals
   Agree    Disagree     Neutral

3. I would apply these visiting skills during my visitation
   Agree    Disagree     Neutral

4. I have not learned anything new during the training sessions
   Agree    Disagree     Neutral

5. A Lay Visitation Team be beneficial/useful at my Church
   Agree    Disagree     Neutral

6. I would like to be part of a Lay Visitation Team at my Church
   Agree    Disagree     Neutral

7. I would like to share some Visiting Tips to other church leaders
   Agree    Disagree     Neutral

8. Overall, the training sessions have been useful
   Agree    Disagree     Neutral

9. In what areas in visitation do you feel you need more training:
   __________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

10. Write any comments, suggestions you have for the trainer:
    __________________________________________________________________________________________
    __________________________________________________________________________________________
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional)  MARIE M. PIERRE  Date:  5/21/11
Church Position  Children Ministry  Years of Experience:  15

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:
   - Session I - Biblical Foundation/Tips for Visiting the Sick 1 2 3
   - Session II - Conversational Essentials/How to visit non-SDA Patients 1 2 3
   - Session III - Value of Lay Visitation in Healthcare Setting 1 2 3

2. The trainer meets the course objectives and goals

   Agree  Disagree  Neutral

3. I would apply these visiting skills during my visitation

   Agree  Disagree  Neutral

4. I have not learned anything new during the training sessions

   Agree  Disagree  Neutral

5. A Lay Visitation Team be beneficial/useful at my Church

   Agree  Disagree  Neutral

6. I would like to be part of a Lay Visitation Team at my Church

   Agree  Disagree  Neutral

7. I would like to share some Visiting Tips to other church leaders

   Agree  Disagree  Neutral

8. Overall, the training sessions have been useful

   Agree  Disagree  Neutral

9. In what areas in visitation do you feel you need more training:
   
   [Handwritten: I need more training in general medicine, that way I could understand the people's problems.]

10. Write any comments, suggestions you have for the trainer:

    [Handwritten: The presentation was good. It helped me to know more on how to visit the people in The Hospital, Hospice, Nursing Home. Thank you and may God bless your Ministry.]
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) Virgo Delizaire
Church Position Deacon
Date: 05-21-11
Years of Experience: 4

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/Tips for Visiting the Sick  1  2  3
   Session II – Conversational Essentials/How to visit non-SDA Patients  2  2  3
   Session III – Value of Lay Visitation in Healthcare Setting  1  2  3

2. The trainer meets the course objectives and goals
   Agree  Disagree  Neutral

3. I would apply these visiting skills during my visitation
   Agree  Disagree  Neutral

4. I have not learned anything new during the training sessions
   Agree  Disagree  Neutral

5. A Lay Visitation Team be beneficial/useful at my Church
   Agree  Disagree  Neutral

6. I would like to be part of a Lay Visitation Team at my Church
   Agree  Disagree  Neutral

7. I would like to share some Visiting Tips to other church leaders
   Agree  Disagree  Neutral

8. Overall, the training sessions have been useful
   Agree  Disagree  Neutral

9. In what areas in visitation do you feel you need more training:
   I feel that I need more training visiting non-SDA patients.

10. Write any comments, suggestions you have for the trainer:
    We need more sessions in the future. The pastor did an excellent job on his presentations.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) ___________________________ Date: 5/21/11
Church Position: Elder Years of Experience: N/A

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I - Biblical Foundation/Tips for Visiting the Sick 1 2 3
   Session II - Conversational Essentials/How to visit non-SDA Patients 1 2 3
   Session III - Value of Lay Visitation in Healthcare Setting 1 2 3

2. The trainer meets the course objectives and goals Agree Disagree Neutral

3. I would apply these visiting skills during my visitation Agree Disagree Neutral

4. I have not learned anything new during the training sessions Agree Disagree Neutral

5. A Lay Visitation Team be beneficial/useful at my Church Agree Disagree Neutral

6. I would like to be part of a Lay Visitation Team at my Church Agree Disagree Neutral

7. I would like to share some Visiting Tips to other church leaders Agree Disagree Neutral

8. Overall, the training sessions have been useful Agree Disagree Neutral

9. In what areas in visitation do you feel you need more training:
   Conversational Essentials/How to visit non-SDA Patients and non-Christian.

10. Write any comments, suggestions you have for the trainer:
    The university should make it much more easier to have access to non-Christian patients in different facilities.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional)  
Church Position  

Date: 6.21.2011  
Years of Experience:  

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick  
   Session II – Conversational Essentials/How to visit non-SDA Patients  
   Session III- Value of Lay Visitation in Healthcare Setting

2. The trainer meets the course objectives and goals

3. I would apply these visiting skills during my visitation

4. I have not learned anything new during the training sessions

5. A Lay Visitation Team be beneficial/useful at my Church

6. I would like to be part of a Lay Visitation Team at my Church

7. I would like to share some Visiting Tips to other church leaders

8. Overall, the training sessions have been useful

9. In what areas in visitation do you feel you need more training:

   [ ] We list to me more Bible training
   [ ] We listed more medical

10. Write any comments, suggestions you have for the trainer:

   [ ] You did a great Job and Good
   [ ] Thank you
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional): JOSEPHINE DALENCOURT  Date: 05/20/2011
Church Position: Director, Family Dept.  Years of Experience: 40 years

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick
   Session II – Conversational Essentials/How to visit non-SDA Patients
   Session III– Value of Lay Visitation in Healthcare Setting

   1  2  3
   1  2  3
   1  2  3

2. The trainer meets the course objectives and goals
   Agree  Disagree  Neutral

3. I would apply these visiting skills during my visitation
   Agree  Disagree  Neutral

4. I have not learned anything new during the training sessions
   Agree  Disagree  Neutral

5. A Lay Visitation Team be beneficial/useful at my Church
   Agree  Disagree  Neutral

6. I would like to be part of a Lay Visitation Team at my Church
   Agree  Disagree  Neutral

7. I would like to share some Visiting Tips to other church leaders
   Agree  Disagree  Neutral

8. Overall, the training sessions have been useful
   Agree  Disagree  Neutral

9. In what areas in visitation do you feel you need more training:
   [Handwritten note: I would like to have a better understanding of medical disease to talk to patient better.]

10. Write any comments, suggestions you have for the trainer:
    He did a good job. It's would be better to have these sessions more often.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) ____________________________ Date: 5-31-11

Church Position: Deaconess Years of Experience: 2 yrs

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick
   1
   Session II – Conversational Essentials/ How to visit non-SDA Patients
   2
   Session III – Value of Lay Visitation in Healthcare Setting
   2

2. The trainer meets the course objectives and goals Agree Disagree Neutral 2 3
3. I would apply these visiting skills during my visitation Agree Disagree Neutral
4. I have not learned anything new during the training sessions Agree Disagree Neutral
5. A Lay Visitation Team be beneficial/useful at my Church Agree Disagree Neutral
6. I would like to be part of a Lay Visitation Team at my Church Agree Disagree Neutral
7. I would like to share some Visiting Tips to other church leaders Agree Disagree Neutral
8. Overall, the training sessions have been useful Agree Disagree Neutral

9. In what areas in visitation do you feel you need more training:
   I do not feel comfortable going to hospital but I think I will succeed because of the training.

10. Write any comments, suggestions you have for the trainer:
   I really appreciated the training because I did not know how to be sensitive about people’s feelings. It was well done. I learned a lot.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) ___________________________ Date: ____________
Church Position ___________________________ Years of Experience: ____________

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:
   - Session I - Biblical Foundation/ Tips for Visiting the Sick 2 3
   - Session II - Conversational Essentials/How to visit non-SDA Patients 2 3
   - Session III - Value of Lay Visitation in Healthcare Setting 2 3

2. The trainer meets the course objectives and goals
   Agree Disagree Neutral

3. I would apply these visiting skills during my visitation
   Agree Disagree Neutral

4. I have not learned anything new during the training sessions
   Agree Disagree Neutral

5. A Lay Visitation Team be beneficial/useful at my Church
   Agree Disagree Neutral

6. I would like to be part of a Lay Visitation Team at my Church
   Agree Disagree Neutral

7. I would like to share some Visiting Tips to other church leaders
   Agree Disagree Neutral

8. Overall, the training sessions have been useful
   Agree Disagree Neutral

9. In what areas in visitation do you feel you need more training:
   I think I need more training in the Gospel area because I need a lot of verses to look at.

10. Write any comments, suggestions you have for the trainer:
    I would like to do more visits to the hospital and prisons.
    I would like to do more visits to the prison and prisons.
    I would like to know more about Jesus our Savior.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) __________________________ Date: 05-21-11
Church Position: CEO IN TRAINING Years of Experience: 2

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   - Session I – Biblical Foundation/ Tips for Visiting the Sick
   - Session II – Conversational Essentials/ How to visit non-SDA Patients
   - Session III – Value of Lay Visitation in Healthcare Setting

<table>
<thead>
<tr>
<th>Session</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2</td>
</tr>
<tr>
<td>II</td>
<td>3</td>
</tr>
<tr>
<td>III</td>
<td>1</td>
</tr>
</tbody>
</table>

2. The trainer meets the course objectives and goals

   (Agree) Disagree Neutral

3. I would apply these visiting skills during my visitation

   (Agree) Disagree Neutral

4. I have not learned anything new during the training sessions

   (Agree) Disagree Neutral

5. A Lay Visitation Team be beneficial/useful at my Church

   (Agree) Disagree Neutral

6. I would like to be part of a Lay Visitation Team at my Church

   (Agree) Disagree Neutral

7. I would like to share some Visiting Tips to other church leaders

   (Agree) Disagree Neutral

8. Overall, the training sessions have been useful

   (Agree) Disagree Neutral

9. In what areas in visitation do you feel you need more training:

   People from different denominations, special people, who do not believe in God

10. Write any comments, suggestions you have for the trainer:

    I would like to have the course twice a year in order to be more comfortable and also share my knowledge with other brothers and sisters.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) __________________________________________ Date: 5/24/11
Church Position: Pathfinder Secretary/Year of Experience: ________

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick 0 2 3
   Session II – Conversational Essentials/How to visit non-SDA Patients 2 2 3
   Session III – Value of Lay Visitation in Healthcare Setting 3 2 3

2. The trainer meets the course objectives and goals
   Agree Disagree Neutral

3. I would apply these visiting skills during my visitation
   Agree Disagree Neutral

4. I have not learned anything new during the training sessions
   Agree Disagree Neutral

5. A Lay Visitation Team be beneficial/useful at my Church
   Agree Disagree Neutral

6. I would like to be part of a Lay Visitation Team at my Church
   Agree Disagree Neutral

7. I would like to share some Visiting Tips to other church leaders
   Agree Disagree Neutral

8. Overall, the training sessions have been useful
   Agree Disagree Neutral

9. In what areas in visitation do you feel you need more training:
   ________________________________
   Everything was well done. However, I need more general knowledge on the training.

10. Write any comments, suggestions you have for the trainer:
    □ I think it would be very beneficial for the church in a whole to participate in lay visitation training. Pastor Brian should do it because he did it very well and he made people feel comfortable when they were doing the practice.
EVALUATION FORM OF THE TRAINING SESSIONS

Name (optional) ___________________________ Date: 15 - 21 - 11
Church Position: Elder in training Years of Experience: 2 yrs.

1. On a scale of 1 to 3 (1 = very useful, 2 = useful, 3 = not useful) circle to rate the usefulness of the following training session topics to you:

   Session I – Biblical Foundation/ Tips for Visiting the Sick 1 2 3
   Session II – Conversational Essentials/How to visit non-SDA Patients 1 2 3
   Session III – Value of Lay Visitation in Healthcare Setting 1 2 3

2. The trainer meets the course objectives and goals Agree Disagree Neutral
3. I would apply these visiting skills during my visitation Agree Disagree Neutral
4. I have not learned anything new during the training sessions Agree Disagree Neutral
5. A Lay Visitation Team be beneficial/useful at my Church Agree Disagree Neutral
6. I would like to be part of a Lay Visitation Team at my Church Agree Disagree Neutral
7. I would like to share some Visiting Tips to other church leaders Agree Disagree Neutral
8. Overall, the training sessions have been useful Agree Disagree Neutral

9. In what areas in visitation do you feel you need more training:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

10. Write any comments, suggestions you have for the trainer:
    _______________________________________________________________________
    _______________________________________________________________________
    _______________________________________________________________________
    _______________________________________________________________________
    _______________________________________________________________________
APPENDIX D

HEALTHCARE VISITATION TRAINING PROGRAM

VERBATIM #

The verbatim is an attempt to report as accurately as possible the dialogue that takes place between the chaplain and one or more individuals with whom he/she is engaged in ministry situations. Leave a three-inch margin for supervisory comments.

VISITOR’S NAME: ___________________________ DATE OF VISIT: ____________

NAME OF THE FACILITY: ______________________ PATIENT’S NAME: _________

ADMITTING DIAGNOSIS: ___________ REFERAL: _____________________________

AGE: _______ GENDER: _______ MARITAL STATUS: _______________________

RELIGIOUS AFFLIATION: ___________ LENGTH OF VISIT: _______________

Visit background

1. The Patient
   Summarize what factual information/significant data you have learned about the person before this visit, if the patient is Adventist, state what church he/she is from; if patient is not Adventist, state the referral sources (family, friend, colleague, co-worker, neighbor ect.).

2. Plans for the visit
   Reflect on what you were feeling and thinking about yourself, your plans and expectations about the visit. Note what you wanted to listen for and what you did not wish to do.

3. Context of the visit/observations
   Describe the situation: place, time, circumstances, referral person. As you entered the room, what was your first impression? What did you notice at the beginning of the visit? Note people’s appearance, posture, gestures, facial expressions, attitudes, nervous mannerisms, poise.
Visit transcript

The pastoral role usually prevents taking notes during the conversation, but immediately afterward a stream of key words may be jotted down. Then, at the first opportunity, typewrite key excerpts from the visit as much as is applicable to your purpose as a verbatim. Enter only direct quotations. In parentheses record pauses, interruptions, tones of voice, non-verbal communication and your internal feelings. Prayers should be recorded in full. Reserve all interpretations for the evaluation, keeping the verbatim part of the report without commentary.

Start each speech as a separate paragraph, indicating who is speaking with a pseudonym or initial. Number as follows (in this example, V for visitor and P for patient):

Visiting Non-Adventists:

V-1  Hello
P-1  Who are you?
V-2  I’m …; I was referred/told by…..to come to visit you
P-2  I am …

Visiting church members:

V-1  Hello Sr / Bro……
P-1  Hi Sr / Bro. how are you?
V-2  I’m fine and you
P-2  I am …

Assessments and reflections

1. The Patient
   Reflect on the physical, emotional, psychosocial, cultural, ethnic and spiritual issues or concerns evident in the patient and experience. What was the patient’s initial concern? What is your spiritual assessment? What feelings were present?

2. The relationship
   Analyze what took place. Address what you perceived to be the interpersonal dynamics and relational processes present. Identify the level of rapport, attitude toward the visit, feelings (both yours and those of the patient/resident), etc.

3. The Visitor
   Evaluate how you feel about your responses. Critique your pastoral work, both
positively and in terms of areas of growth and development. Be specific! How well did you do? What did you miss? What would you do differently? Include your feelings and insights gained. Relate your self-critique about the visit.

4. **Spiritual care planning**
   What goals, plans, strategies, and issues would you determine to be appropriate for continued spiritual care ministry?

5. **Theological reflection**
   Reflect theologically on the visit. What theological dynamics, religious issues, faith-realities, spiritual concerns, etc. emerge for you in this experience? How does the experience confront or affirm your theology?

6. **Write-up**
   Reflect on why you elected to write-up this visit and/or present the case to the spiritual support group.
Sample of a Reported Verbatim

VISITOR’S NAME: E. L. __________ DATE OF VISIT: May 11, 2011 __

NAME OF THE FACILITY: Brooklyn Rehab PATIENT'S NAME: J. S.

ADMITTING DIAGNOSIS: Knee Problem REFERAL: Neighbor __________

AGE: 96 __________ GENDER: M __________ MARITAL STATUS: Widower __________

RELIGIOUS AFFILIATION: Roman Catholic LENGTH OF VISIT: 20 mn

Visit background

The Patient
The patient is a widower, a World War II army veteran who rendered combat duty in several countries in Europe. He used to live in the Assisted Living building of Wartburg. He slid from his bed to the floor as he was trying to get up to go to the bathroom and hurt his right knee. He was brought to the hospital, stayed there for several days and after being checked was sent to the Rehab unit of Brooklyn. Aside from this he had other medical issues.

Plans for the visit:
This patient was referred to me by my neighbor. The patient is my neighbor’s cousin. I wanted to make sure I would pay a visit to my neighbor’s cousin. Mr. JS was not Adventist and I wanted to visit for a non-Adventist patient. We got to introduce ourselves to each other but as we were getting started the transport person came to bring him to therapy. I promised Mr. JS I’d come back and see him another time. So on Wednesday I visited him in his room and we had our conversation.

Context of the visit/observations:
When I arrived the patient was seated on the wheelchair that was beside the bed. Judging from the way he was seated in relation to the wheelchair he appears to be a tall but not a heavy person. There was a fiction book on the bed. He had both feet on the foot platform of the wheelchair, with the right leg slightly stretched compared to the left one. He had very little hair and had what seemed to be a couple of small scabs of wounds that was already beginning to heal.
Transcript of the visit (The transcript of this verbatim is a courtesy of Elder Emmanuel Llagan and for purposes of this verbatim the patient is called “Jim”)

V1: (after knocking and entering the patient’s room): Good morning, Jim.
P1: Good morning!
V2: I am Emmanuel. The other day we were about to have our conversation but you had to go to therapy.
P2: Yes, I remember.
V3: (I was still standing) Have you had your therapy yet?
P3: No, but I think I will have it later.
V4: So can we talk a little bit now?
P4: Yes, sure.
V5: I will pull out this chair. (I pull out one of the visitor chairs and set it so that I sit facing him.) How are you feeling today?
P5: Ok, I guess.
V6: Last time when we were talking you were telling me what brought you here to Rehab. Would you mind going over that again for me?
P6: Well, I was at the Assisted Living building in my room. At about 2 o’clock in the morning I felt I needed to go the bathroom. I got up from my bed, and sat on the side of the bed. I usually wear my slippers when moving around. My slippers were on the floor, the left one was near the bed, but the right one was farther away -- about a couple of feet from the bed. I put on the left one and was trying to reach the other one with my right foot. As I was doing that I slid down the bed and I fell right down to the floor on my buttocks.
V7: Oooh -- That must have hurt.
P7: There was a sharp pain on my knee. As I fell on the floor my right knee was bent in the wrong angle pointing toward my back and that hurt very much. I tried to get up but I could not. Fortunately I was able to press the “call button” and someone came to help me get up and put me back on my bed.
V8: Had they taken you to the hospital?
P8: Not right away. In the morning a doctor came and checked me out. He recommended I be taken to the hospital for a more complete check up. I was taken there by ambulance. They did some x-rays there in various positions, and found no fractures. The doctors thought maybe I had some muscle damage on my right knee. (He touches his right knee). See, I can feel a lump here. (He touches his knee and looks at me; it seemed he was inviting me touch it.)
V9: Yes, I can. Is it painful?
P10: Not right now. But when I move my leg or my foot there is a shooting pain. I thought that they would do an MRI but to get into the MRI machine I have to raise my hands way over my head like this (He tries to raise both hands but could not get them all the way up over his head) and I can’t do it. I am 96 years old and cannot do that kind of stretching. One time they were trying to move me from my bed to the wheelchair and they did it quite suddenly it was painful. I knew they were just doing their job, but it was painful.
V11: Was it one person or two persons who were helping you then?
P11: Sometimes two persons; if he is a big man, then just one person can do it. I know they were just doing their job, so I did not complain. But it hurt. My problem now is
what will happen after they discharge me from Rehab. Before this incident I have been able to go by myself to the bathroom from my bed. I am not sure if I could do that after this.

V12: You seem to be scared of how you will move around after they discharge you from Rehab.

P12: I am afraid. Over here at therapy they ask me to take a few steps and walk, using a walker, with someone beside me, but I am afraid that I will fall face down. I could take only two steps then I can’t do it anymore. I do not know if I will go back to Assisted Living or the Nursing Home.

V13: You are not sure of what will happen or where you will go after your stay here at therapy.

P13: I don’t think I can handle things and move by myself at the Assisted Living building. It will be very hard for me to go to the bathroom, get into and out of bed, etc. And there is that pension check that I need to attend to. I think checks expire after a few months or so. All my records are in my room at the Assisted Living. I cannot sign my name now (He shows me his right hand and the crooked, out of shape fingers). My niece who lives in Florida comes once in a while and helps me with these checks. But she has her own family and she may not be coming until after Easter. Father, I don’t have a wife, I don’t have a life. My friends are all gone. And here I am. I am 96 years old. I feel hopeless. Sometimes I ask God why I keep on living.

V14: It must feel sad and depressing to be in your situation.

P14: I feel very lonely and depressed. To get my mind away from these I try to read a book (points to the book on the bed) and listen to the news. But the news stations tell the same news. After you have listened to one or two stations there is nothing new anymore to listen to.

V15: You mentioned your wife. Tell me more about her. How did you meet?

P15: (He pauses, as if thinking. His face seems to lighten up a bit). You won’t believe it, it is like a fairy tale.

V16: Please tell me.

P16: Well, I was a young man then, maybe around 22, and I was in the beach with a friend enjoying ourselves (mentions some beach in New York). These two young women come to me and ask me if I could help them. Apparently they could not get their beach umbrella put up -- one of the ribs of the umbrella broke or got entangled and they could not fix it. I go and fix it for them. We then talked – my friend talked with one of them while I talked with Sylvia (not her real name). I then asked if she wanted to go to the park with me that evening. Sylvia said “Boy, you are fresh! Well, if I am available I will be there; if I am not available I won’t be there.” But she came! After that we saw each other again and went out several times. I have gone out with other girls before but I felt different when I was with her. (While he was telling the story of how he met his wife I noticed that he had begun to smile and the tone of his voice and facial expression had really changed. Finally, he said): One time after we went out and after the evening was over I took her home and told her, ‘Thank you, Sylvia. Good bye now.’ I think I had to go some place to work. But then she said ‘No, JS, this is not goodbye, this is just the beginning.’ I felt really good.

V17: That is such a beautiful story! Thank you for sharing it. How long were you married?
P17: We were married in February ___ 1943. We did not have any children, but that was all right with us. We had each other. She always supported me, encouraged me as I looked for a better job. She passed away in 2008. And now I am alone.

V18: You must be sad and lonely after she passed away.

P18: You know, Father, I felt very sad and depressed after she died. I did not know what was going on around me or what I was doing. I did not know what was going on with me. I saw my doctor and he said I should see a psychiatrist. He gave me the name of a psychiatrist. I contacted her and since I was not sure if I could go to her clinic, she came to my house. Four (4) times she came to my house and talked to me. On the fourth visit she said that that would be her last visit, since I was all right already. Well, I did feel I was already OK. I think I was able to get hold of myself and knew what was going on within me. Then I asked her how much I owed her; I knew it would be a big amount, both the professional fees and the trouble of having to come to my house. She said, “You don’t owe me. I owe you.” I did not understand what she meant. She said, ”You have fought during the war, you have given so much for the country and our people. It is time that we give back to you.”

V19: That was really so very kind of her to do that – acknowledging what you have done during the war for the country. What was it like when you were in the army in WW II?

P19: Oh, I was assigned in Belgium, France (mentions 1 or 2 other countries). One time we were in a boat; there were several other boats, all going to England. There were huge waves shaking our boat. The huge waves kept the boats moving and “protected” them from the enemy’s submarines, but a couple of the other boats were hit. I saw the bodies of some of my army friends floating on the water. I could only watch them; I could not do anything about it.

V20: That must have been such a sad and frustrating experience seeing your friends dying and not being able to do anything about it.

P20: There was nothing I could do. I was asking myself why I was spared and why these fellow soldiers some of whom I personally knew were the ones who died. But I guess that is life. I remember the poem:

“Oh, East is East, and West is West, and never the twain shall meet,
Till Earth and Sky stand presently at God’s great Judgment Seat.”

(He continued to talk some more about his experiences. My eyes were already beginning to be watery. I was touched by the beautiful stories he was sharing -- about his wife, his recollections of WW II, and the kindness of his psychiatrist. I tried to hold back my tears but could not. I got a soft tissue from my pocket and blew my nose. He paused and waited while I was doing that and then he continued. He himself was not teary eyed.)

V21: Oh, that is really a very appropriate quotation. I remember the first line, but not the second. Could you repeat it please? (He repeats the two lines. Then I reply:) Yes, indeed it is only God who knows these things.

P21: (He continued talking about his experiences for a couple more minutes. After a while he says): You know, Father, talking with you has made me feel good. It has given me a sense of hope.

V22: I am very glad to hear that. By the way you mentioned earlier something about God. Would you like us to pray at this time?

P22: Yes.
V23: Let us pray. Dear God you have heard our conversation. You know what is going on in the life of JS – the problem with his knee, the uncertainty of where he will live after he is discharged from the Rehab department and how he will move around. You also heard the beautiful stories about his wife and his experiences and the psychiatrist who helped him. We ask that you will continue to accompany him, and guide him as he goes through this phase in his life. We trust you know what is best for him and that you will help him. We pray in Jesus name. Amen.
P23: (I look up after praying and I see him making the sign of the cross and saying softly): In the name of the Father and the Son and the Holy Spirit. Amen.

(I was about to get up and say goodbye after the prayer but he still wanted to talk, so I remained on my seat and listened. We continued and had some more social conversation; he told a couple of jokes, too. Finally I stood up and said goodbye. )

V24: All right, goodbye for now. Thank you very much for sharing your stories.
P24: Goodbye. I hope to see you again.

V25: Yes, I hope to see you again.

Assessments and Reflections:

The Patient:

JS in his 96 years had gone through a lot and incurred many losses – the emotional pain of seeing comrades in arms die, losing his wife of many years, not seeing his friends any more who probably have already died, and now probably losing his ability to move around by himself. Furthermore, there is the chance that he may lose his “home” at the Assisted Living building and having to move to a nursing home in view of his physical condition. There is also the practical difficulty of possibly not being able to attend to his finances, like encashing his periodic checks, etc. At the same time he has been blessed with beautiful memories of his life, and the kindness of the psychiatrist and his niece who comes occasionally to help him. Despite his advanced age he was mentally alert and very articulate and had this resource of poetry that gave him insight into life. It seemed he continuously fed his mind, as shown by his reading a book when I saw him. But most important, I was pleasantly surprised and impressed that he had the words for the feelings he was experiencing, perhaps better than I could. As our conversation progressed I could sense the increasing animation and lightness as he talked especially when he recalled how he met his wife. Later he even shared several of his jokes.

The Visitor:

This conversation was very affirming for me. He had said that he had felt hopeless, but towards the end of our talk he said our conversation has given him a sense of hope. I think it was good for him to have someone to talk to and who could listen to his stories and how he felt. Somehow our conversation has helped him recall some beautiful memories about his wife, the frustrations and sadness of combat, and then the unexpected goodness of a psychiatrist who helped him sort things out. At some point while he was
telling his stories my eyes were beginning to get watery and I tried to hold back my tears. I remember my pastor once saying it is OK to cry in front of a patient because it shows that you really empathize with them and that you are not “superior” or above them. So I let myself sniff and show tears; though I still tried to hold back, since if I really cried I may not be able to verbalize my responses to what he was saying. I plan to visit him again and find out how if things have become more clear in terms of where he will be living after being discharged from Rehab and also just talking with him.

**The Relationship:**

Initially I was not sure how the conversation would develop. But after a while, as he continued talking and telling his stories I could sense that we were becoming at ease with each other. His feelings about missing his wife certainly resonate with me. When he said that just talking with me gave him a sense of hope, I believe that I was really able to show him that I understood how he felt, and we were really “connecting” with each other. He had so much to say as he went through his life’s challenges; and perhaps there were not many opportunities to persons share these with.

I guessed that he was Roman Catholic when he concluded the prayer and add “In the name of the Father, the Son and the Holy with the sign of the cross. I did not ask him about his church affiliation and neither did he ask me about mine. Perhaps seeing me as an older man, too, encouraged him to open up. What “capped” the visit for me when he said that the visit gave him hope. It was a great gift for me.

**Theological Reflection:**

Losing friends that you have fought with in battle, losing a spouse that you have lived with for decades, gradually losing one’s strength as one ages, and then losing one’s ability to move about and take care of one’s bodily needs all of a sudden are great losses, indeed. These losses bring about great sadness and for some people, depression. Some verses of Psalm 13, one of the lament psalms, capture the pain of loss and grief. “How long, O Lord? Will you forget me forever? How will you hide your face from me? How long must I bear pain in my soul, and have sorrow in my heart all day long?”

When Lazarus of Bethany died, Jesus wept. Did Jesus weep because as a man he lost a very dear friend? Or did he weep because sin and disobedience bring such great pain and sadness to God who loves human beings so much? Perhaps it is both.

Yet loss and grief are an integral part of this side of human existence. We cannot avoid them. At the same time, humans are relational beings. We derive our sense of personhood only as we relate to other persons and commune with them. “It is not good for the man to be alone,” said our Creator. As chaplains our role is to sit with the person who is experiencing loss and grief, listen to him as he talks and shares his feelings, and stay with him. And we pray silently that in so doing the burden is made lighter and a ray of hope dawns on him.
This reminds me of a story:
A young girl was leaving for school, and her mother reminded her to come straight home when her class ended. Thirty minutes late, she finally walked through the front door. Her mother scolded her, “Where have you been?” she asked. “I’ve been worried sick.”
With a concerned face, the little girl replied, “I walked home with my friend Sally. She dropped her doll on the way, and it broke all to pieces. It was just awful!” “So you were late because you stayed to help her pick up the doll and put it back together again?” her mother asked.
“Oh no, Mommy,” she explained. “I didn’t know how to fix the doll. I just stayed to help her cry.” (Dan Clark, Puppies for Sale)

**Plan for follow up visit:**
I plan to visit JS again and find out if the therapy is helping him, and if he has more information about where he will live after he is discharged from Rehab. Chances are he will be moving to a nursing home. This means losing again his home at the Assisted Living building.

**Why this verbatim?**
As I said earlier this conversation with JS was a very affirming one for me; I wanted to share that with the spiritual support group. Also, JS was someone who was in touch with his own feelings, and had the words for it, perhaps better than I did; I wanted to share that kind of conversation, too.
Communication Skills in Visiting the Sick

Visiting the sick is an investment of time and skills learned from a pastoral care program. It includes attention, patience, perceptive listening, exploring the patient’s world, probing for feelings, sincere concern, openness, and communication skills. Below are techniques to help facilitate communication when making visiting a sick person:

**Open-ended questions:**
It is recommended that pastoral caregivers use questions that elicit an in-depth response, one that cannot be answered with “yes” or “no.”

- Use “How” and “What” instead of “Do,” “Did,” and “Were.”
  Examples:
  - Are you feeling upset right now? (Closed)
  - How do you feel right now? (Open)
  - Do you like to read? (Closed)
  - What are some activities that you enjoy doing? (Open)

- Open ended questions are good conversation starters:
  - What was it like growing up in the 1950s (or other date)?
  - How is your family doing?
  - What do you think about____?
  - How do you see that?

- Help the person expand
  - “Tell me more...”
  - “It must be....”
  - “Tell me about it...”
  - “It sounds like...”
  - “What must it like...”
  - “You seem upset...”

- Ask questions to better understand
  - “I’m not sure I really know what you mean when you say...”
• “Let’s go over that one more time.”

➢ Redirect the conversation
• “Thank you for your concern, but I’d really like to hear about...”
• “You mentioned before that...”
• “Let’s go back to...”

As in all verbal communication, tone of voice is very important and can change the meaning behind the question. “Pleasant words are like a honeycomb, sweet to the palate and a cure for the body”—Proverbs 16:24

➢ Review past and present efforts at problem solving
• “Have you talked with anyone about this?”
• “What do you usually do when...?”
• “How do you usually cope when...?”
• “What have you done about this so far?”
• “What seems to be your source of strength when you...?”
• “What choices do you feel you might have?”

➢ Seven ways of asking “How are you?” (Courtesy of Rabbi Simkha Y. Weintraub)
Simply asking “How are you?” may not convey your authentic personal interest and invite an honest, expressive response. Some people who are suffering have criticized this common question because it doesn’t seem to acknowledge the very different course their life has taken—and can encourage automatic expected answers such as “I’m OK” or “Fine, thanks,” which may not be a sincere reply or convey the whole story. Below are some suggested alternatives.
  1. How are you doing with all of this?
  2. How are your spirits?
  3. How are you hanging in?
  4. What do you need the most, right now?
  5. What’s helping you get through this?
  6. What’s been on your mind as you try to cope with all of this?
  7. What are some of the obstacles to your managing/coping?

Avoid double-questions

➢ Asking more than one question at a time makes it difficult for the person to answer one or both of them and double-questions can be overbearing for patients.
• “How are you feeling? Pretty bad, huh?”
• “How are you doing today? Do you feel better now?”
• “How are things going at home and with your family?”
• “Do you have a family? How many children do you have?”

➢ In holding a conversation, ask one question and then wait for the answer.
• I wonder how you feel about….?
Avoid “Why” questions as possible

- At times, “why” questions are used as a way to convey judgment and can be misunderstood.
- Asking “Why?” makes a person feel as though you are attacking his or her ideas.
- Questions can be easily rephrased to avoid any misunderstandings, for example:
  - “Why are you divorced?” vs. “What is it like to be divorced?”
  - “Why did you quit your job?” vs. “How is it that you decided to quit your job?”

- Avoid giving positive hope and certainty in responses like:
  - “Oh, don’t worry. Everything will turn out all right.”
  - “Don’t cry…the Lord will work it out for you”
  - “You will be going home soon”
  - “Oh, yes, I know exactly how you feel. As a matter of fact, let me tell you about what happened to me once…”
  - “What a mistake. You must really regret what you did.”
  - “The Lord will heal you, you will be better soon”
  - “Well, if I were you…”

Applying Active Listening Skills:

- Show that you have heard what the person said by summarizing briefly the meaning of what was said and checking by asking if you understood his or her feelings correctly.

- When you listen, just listen. Do not plan your reply while waiting for your turn to talk. Wait until the person talking finishes. This way you can gather all the information before responding.

- Make a restatement or paraphrase. Reflect the feeling or emotion behind what you think was said.

For example of a visit:

Patient: “No one really cares about me.”
Visitor: “You feel that no one especially is looking out for you?”
Patient: “I just couldn’t tell her because we were never alone. All those other people are always around.”
Visitor: “You’d like to get her alone long enough to tell her.”

- Do not give advice. Help others to see their strengths and recognize their resources and alternatives. Let them come to their own conclusions.

Keep an open mind
➢ Be aware of your own values, religious beliefs, and prejudices. You are participating in another person’s world, not judging it.

**Prayer**

Prayer can be used to gather our strength and to focus before or after a visit. The Lord’s Prayer seems to be a traditionally that can be recited among Christians. Prayer has been an integral part in visiting the sick. It serves for two main purposes: 1) comforting the sick and 2) helping them experience, in a tangible way the presence of their God in their lives.

“May I say a Prayer?”
“May I offer a prayer for you”
“Would you like a prayer said for you?”

Be specific on the prayer
Restate what was said during the conversation. Ask God [man of upstairs], Lord, Jehovah to give strength, peace, serenity, courage, guidance, recovery, healing and hope etc.

**Ending a Visit — Saying Goodbye**

Establish the following routine from the first phone call:

- Keep track of the time
- *Before* it is time to say goodbye, prepare by saying something like "It is almost time for me to say goodbye for today."
- Review the day and time of next visit, perhaps mentioning what you might plan to discuss. Express your enjoyment of the time spent that day.

Sources:

*Shulhan Arukh (16th Century text) & Rabbinic Literature*

*About Being a Visitor: A guide for leaders and visitors. Rabbi Isaac N. Trainin Bikur Cholim. Coordinating Council*
Equipping Elders and Deacons
for Effective visitation in the Healthcare Setting
Training Program May 2011
By
Brian Ladiny, M.Div; DMn Candidate

Understanding the Practice of Visiting the Sick

There is greater need for communal concern and action to sustain people with chronic health problems and isolated living situations as our population ages, as hospital visits become shorter and as geographic distance between family members’ increases (Shulhan Arukh, 16th Century text & Rabbinic Literature)

Visiting the sick has no boundaries or limits, youth may visit the elderly and the elderly may visit the youth; men may visit women and women men, though they may not attend to the other’s intimate needs. A visitor should not spend time with those who are suffering from intestinal disorders, speech problems, or mental disturbances, when the visit is likely to prove difficult or embarrassing to the patient. Better to just say hello and inquire about his needs from a distance. It is best not to visit in the early or late part of the day or at any other time a patient may be receiving treatment. Some say one should not visit his enemy, but others permit it. The patient should never be allowed to feel that his enemy rejoices over his illness. Each case must be judged individually.

Visiting skills are skills for life. They include being fully present, and being a good listener and knowing proper visiting etiquette. These guidelines will help you in communicating your caring intention and being an effective visitor:

1. Try to put yourself in the other person’s place.
2. Put aside daydreams and distraction from one’s own problems or concerns.
3. Be alert to truly being with the person in front of you.

Being a good listener

Listening skills communicate empathy and understanding and can help facilitate a conversation.

Your posture conveys interest:

1. Maintain good eye-contact, sit at eye level if possible.
2. Use non-verbal encouragement such as nodding one’s head or “uh huh…”
3. Lean forward slightly, and relax.
4. Avoid fidgeting, or making impatient gestures like watching the clock.

*Listening:*

1. Remain neutral and non-judgmental, with an open heart. This way you are more likely to really hear what the person is trying to convey. You can help them to put these feelings into words.

2. Reflect what you hear expressed, not how you would react. Listen between the lines to what emotion or feeling is being voiced. For example: “That sounds very hard,” “You are very concerned about what you are going to hear.”

3. Become comfortable with silence. Allow the person time to think and react. This will also convey an acceptance of what is being communicated without judgment.

4. Above all, compassionate listening is being interested in what the person is sharing and being sensitive to take your cue from them. Follow their lead.

Talking about the latest movie you saw or the recent surgery could be equally appreciated.

*Keeping it real*

1. Never say “I know how you feel.” Everyone experiences pain differently; even people who suffer the same ailments perceive it differently. You can say

   “It sounds like you think (feel) it’s pretty bad (sad/mad/glad). I’m here and I’m listening.”

2. Use open-ended questions to keep up the conversation. These begin with

   “How… What… Could you tell me more about…?” Closed-ended questions that are less likely to elicit conversation begin “Who, When, Where.”

3. Try not to mind-read and finish another person’s sentences. When you truly listen actively you may be surprised where the person was going with his/her thought.

4. The visitor should not minimize or laugh off fears expressed by patients, even when they seem exaggerated.

5. Don’t be afraid to clarify or gently explore what you are hearing. When a person is willing, you may ask questions to get to the heart of the matter.
# Dos’ and Don’ts in Visiting Patients in the Healthcare Setting

Brian Ladiny, M.Div; DMin Candidate

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
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<td>2. Offer false optimism or participate in criticism about the doctor or treatment.</td>
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<td>3. Respect the hospital hours for visitation</td>
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<td>4. Carry a picture identity with you (Driver licence, state ID ect.)</td>
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<td>6. Observe signs, notices, and precautions on patient’s door.</td>
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<td>7. Wash your hands before and after each visit</td>
<td>7. Awaken the patient unless nurse gives approval.</td>
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<td>8. Knock before entering a room</td>
<td>8. Bring food, drink, plants, and multivitamins to patients</td>
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<td>9. If possible, sit where you can maintain comfortable eye contact with the patient.</td>
<td>9. Help patients get out of bed or give food or drink without the nurse’s approval.</td>
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<td>10. Listen attentively and probe for feelings throughout the conversation.</td>
<td>10. Preach or offer Bible Study to patients</td>
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<tr>
<td>11. Shape the tone and substance of your conversation from cues by patient.</td>
<td>11. Judge the patient’s emotional and feelings toward God or her belief</td>
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<tr>
<td>12. Excuse yourself when he doctor enters the room unless requested to stay.</td>
<td>12. Ask Doctors/nurses about patients conditions (if you are not an immediate family members)</td>
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<td>13. Let patient lead the conversation as far sharing Scripture, singing, ect.</td>
<td>13. Pray without patients approval</td>
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<tr>
<td>14. Ask patients if they have special needs as you prepare to pray.</td>
<td>14. Give sacraments (communion, eucharist, baptism,</td>
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Equipping Elders and Deacon from
the Gethsemane SDA Church
for Effective Visitation in Healthcare
Settings

Brian Ladiny, M.Div
DMn Candidate

Introduction

• Andrews University & Loma Linda University
• Healthcare Chaplaincy Project
• Comment visiter les malades en
etablissements hospitaliers?
  – 1. Hospital
  – 2. Nursing Home
  – 3. Hospice
  – 4. Rehabilitation Center
  – 5. Any healthcare facility

TRAINING SESSION I

• Biblical and Theological Foundations
• Clinical Principles in Visiting the Sick
• Tips for Visiting SDA Church Members
• Writing the Pastoral Verbatim

Training Session II

• Conversation Essentials
• Human and Theological Dynamics
• Pastoral Verbatim Report Analysis
• Clinical Principles for Visiting non-Adventist
  / non-Christians Patients.

Training Session III

• The Purpose of a Spiritual Support Group
• Pastoral Verbatim Report and Analysis
• Discussion and Evaluation of the Training
  Session
Biblical Mandate

Ezekiel 38
Matthew 25:25-39
James 5:14-16

Love, Compassion, and Care
• Jesus in the Great Commission, “Go and make disciples” (Matthew 28:19). Jesus, however, also said something about caring for the sick. In relating the final judgment of the nations, Jesus said of the righteous, “I was sick and you looked after me” (Matthew 25:36). Furthermore, when He sent out His disciples for ministry, Jesus commissioned and empowered them to “heal every disease and sickness” (Matthew 10:1). In each of the Gospels the healing ministry of Jesus clearly illustrates His concern and compassion for the sick.

Job reçoit une visite:
Une analyse pragmatique

Job receives a visit:
A practical analysis

Devotion by
Brian Ladny, M.Div

Analyzing Job’s Friends Visit
• Positive approach
• Negative approach

Positive Approach (Job 2:11-13)
• Developing a Passion for Visiting the Sick
• Establishing the Purpose of the Visit
• Observing: Face-to-Face Encounter
• Shared Emotions: Reflective Feelings
• Being Present: Attending and Compassion
• Remaining Silence
• Effective Spiritual Assessment
• Active and Reflective Listening

Negative Approach (Job 4:22)
• Insulting Patients with Accusing words
• Defending God
• Overbearing Patients
• Giving Personal Advice
• Preaching Doctrinal Sermons
• Solving Patient’s Problems
EGW on Visiting the Sick

- Insights on Equipping Church leader for visiting the sick
- Insights on visiting non-Adventist Christians
  - Visiting the sick is not preaching to the sick
  - Format to follow when visiting the sick
  - Praying with the Sick

Dos' and Don'ts in Visiting

Dos
- Call first to determine patient availability for a visit.
- Be familiar with the person that you will be visiting or be referred by someone who knows the patient before conducting the visit.
- Respect the hospital hours for visitation

Don'ts
- Be insulted by a patient's words/attitudes or register shock at a patient's appearance.
- Offer false optimism or participate in criticism about the doctor or treatment.
- Touch equipment or sit on patient's bed.

Dos
- Carry a picture identity with you (Driver license, state ID etc.)
- Pray before you leave your house and depend on the Lord to direct your visit.
- Observe signs, notices, and precautions on patient's door.

Don'ts
- Tell patient unpleasant news — including your troubles.
- Whisper when talking to family members or medical staff.
- Break hospital rules or violate confidentiality issues.

Dos
- Wash your hand before and after each visit.
- Knock before entering a room.
- If possible, sit where you can maintain comfortable eye contact with the patient.
- Listen attentively and probe for feelings throughout the conversation.

Don'ts
- Awaken the patient unless nurse gives approval.
- Eat from the patients hospital food.
- Bring food, drink, plants, and multivitamins to patients.
- Help patients get out of bed or give food or drink without the nurse's approval.

La Place de la Religion au sein de l'institution médicale

- Voir le documents (See the handouts)
- Discussing my points of religion and health
- Quelle est la place de la religion au sein des établissements hospitaliers?
- Etablir la différence entre spiritualité et religion.
- Qu'est-ce qu'on entend par une personne "religieuse" et une personne "spirituelle"?
MISSION

• Être présent auprès des personnes malades, âgées, isolées, handicapées... Présence fraternelle respectueuse du cheminement de chacune, sans volonté de prosélytisme et en toute discrétion... (M. Riemer et A. Humeau).
• Accompagner, c'est se joindre à quelqu'un pour aller où il va en même temps que lui.

Mot d'Ordre

Rejoindre la personne malade là où elle en est.

Objectifs du Séminaire

• Évaluation des motivations et prise en compte de l'engagement de servir Christ et d'aller au service des autres.
• Une formation à l'écoute et à l'expression de la vie physique et spirituelle.
• Une présentation du rôle hospitalier et une information sur le monde des malades, dans le respect du carnet de santé, de l'anonymat et de la tranquillité.
• Une formation à la vie de la communauté (par des personnes bénévoles).
• Un rappel des besoins des droits, ainsi que de la psychologie de la personne malade (par des personnes hospitalières).
• Une formation spirituelle sur le foi, le prière, le sens de la souffrance et de l'hospitalisation (par des personnes qualifiées).
• Une connaissance des autres confessions et religions (par des personnes qualifiées).

Lois d'une Visite

• Équiper prioritairement sa visite sur la personne hospitalisée que je rencontre.
• Respecter d'abord la patient dans sa différence avant de rechercher une personne ailleurs, dans un esprit de partage et non de prosélytisme ou d'êider la personne malade à accueillir sa démarche spirituelle.
• Accéder de ne pas avoir de prise sur le handicap.
• Provoquer à l'autre d'entrer dans un processus de développement et de connaissance spirituelle dans la mesure du possible et avec l'accord de la personne.
• S'ouvrir à l'autre, quelles que soient ses croyances et/ou sa situation religieuse.
• Être à l'écoute sans "imposer plus que donner".
• Demander s'il lui est de la personne qui.
• Exprimer ses débats, à rester l'anonyme en elle.
• Mettre la personne malade en résonance avec elle-même, avec les autres et peut-être avec Dieu.
• Se soustraire, lire la Parole de Dieu et prier avec elle.

La Souffrance Spirituelle

• La souffrance spirituelle, passée sous silence dans les textes de loi à la différence des besoins spirituels, qu'est-elle ? Quelle forme prend-elle ? Comment la définir ?
• Quelle place pour la souffrance spirituelle par rapport à la souffrance physique, psychique, morale, religieuse et sociale ?

La Souffrance Spirituelle

• Comment accompagner la souffrance spirituelle ? Auprès où aller ? Quelles attitudes : miroir, neutralité, transparence ? Quelle présence ?
• Existe-t-il un risque pour l'accompagnant de susciter la souffrance spirituelle chez la personne accompagnée ? Pose sa différence, est-ce créateur de souffrance spirituelle ?
Accompagnement Spirituel

• Selon William Barry et William Connolly, l'accompagnement spirituel est « une aide donnée par un chrétien pour lui permettre d'être attentif à la communication personnelle que Dieu a avec lui, de répondre à ce Dieu qui communique ave lui personnellement, de progresser dans l'intimité avec Lui, et de vivre pleinement les conséquences de cette relations.

• Ce qui est recommandé c'est d'accompagner la personne et de laisser Dieu agir directement. C'est la personne elle-même qui fait les exercices. C'est elle qui prend ses responsabilités. C'est en même temps un exercice de liberté, une liberté de part et d'autres.

• L'accompagnement spirituel part du réel, c'est-à-dire du réel de la personne qui désire une aide dans ce domaine. C'est dans le vécu, ici et maintenant que le Seigneur rejoint. C'est dans ce vécu que la personne accompagnée et l'accompagnateur sont invités à discerner les mouvements des esprits, dans les moments de crise et de difficultés, comme dans les moments forts de joie et de consolations. C'est toute l'histoire de la personne humaine qui est prise en compte en tant qu'être somatique, psychique et spirituel.

• D'après Bernard Carrière, « la personne qui accepte d'en accompagner une autre dans son cheminement doit avoir conscience qu'elle s'inscrit dans un type de relation d'aide où elle aura à donner la priorité à l'expérience de Dieu que vit la personne accompagnée et cette expérience survivra le plus souvent dans la prière. »

• L'intention première est toujours le bien de l'autre, ce qui inclut appelé la santé de l'âme. A travers une conversation spirituelle peut se produire une véritable rencontre avec le Créateur. Cette rencontre peut pousser la personne rencontrée à faire une démarche de foi plus approfondie et personnelle. L'accompagnateur est donc invité à s'engager dans la qualité de ses conversations afin de permettre à Dieu d'agir directement dans les personnes. Il s'agira concrètement de savoir nos humbles, nos doctrines, nos animations des groupes de l'école du sabbat, nos conseils pastoraux etc...

• Germán Arias note que « convertir » et « se convertir » sont de la même racine étymologique.

• « C'est sortir de l'enfernement de notre propre cloître intérieur et de ses mécanismes de défense pour nous convertir en serviteurs de l'autre, avec l'arme la plus humaine, la plus subtile, la plus immédiate et universelle, la plus lumineuse et acérée, la plus manifeste de notre propre maturité et la plus désirable de s'approprier d'elle : la parole. »
Comprendre le monde du malade

- Dans le cas de la maladie grave physique ou mentale, on peut réellement parler d’une rupture dans la vie du patient. Il y a un « avant » la maladie et un « après ». Le patient se sent fiché, traîné, par son corps ou son esprit. Il découvre, peut-être, une vulnérabilité, une fragilité, face à laquelle il se sent impuissant et démun, souvent il ne se reconnaît plus. Il vit une rupture d’identité. Il vit également une rupture de son histoire – ses objectifs, son idéal, ses projets, sont bouleversés par l’arrivée de la maladie. Celui-ci interroge les rôles que le patient remplit, en temps normal, dans la société (travail, parent, ...) et provoque une incertitude quant à son avenir.

Questionnement du sens:

- « Pourquoi moi ?
- « Est-ce une punition ?
- « Que va-t-il m’arriver ?
- « Comment vais-je pouvoir payer ces factures ?
- « Vais-je perdre ma place dans mon travail, ma famille, auprès de ma femme, mes enfants ?
- « Qu’est-ce que je vais (encore) ?
- « Où est Dieu ? Qu’en est-il de Dieu ?

Le malade est, ne fasse que par son hospitalisation, isolé du reste du monde. Il est coupé des relations qu’il entretenait habituellement et vit des moments d’angoisse, de remise en question, de questionnement du sens :

- Le patient qui est touché, dans son être et pas seulement dans son corps, va tenter de combattre sa détresse par un comportement instinctif, inconscient, par ce qu’on appelle les mécanismes de défense. Ceux-ci lui sont, à ce moment, nécessaires pour vivre ce qu’il a à vivre, par exemple :

- L’annulation (dissoudre la réalité insupportable pour mieux la nier, on pourrait croire que le patient n’a pas été informé)
- La dénégation (par exemple : « une sorte de cancer »)
- La maîtrise (rationnalisation / rites obsessionnels)
- La régression
- La projection agressive (animosité)
- La sublimation (par exemple créer une association d’extraïde)

- Les malades ne sont pas les seuls à avoir leurs mécanismes de défense. Les soignants, mais aussi les familles, vont, eux aussi, devoir se défendre du trop-plein de tensions émotionnelles en mettant en place leur propre mécanisme de défenses.
Mechanisme de Défenses

- le mensonge
- la banalisation
- la fausse réassurance
- la démission
- la fuite en avant (toujours balancer d'un coup)
- l'identification projective (se substituer au malade : je sais ce qu'il lui faut car il est comme moi ; toute puissance)

Les Besoins du Malade

Définition de Virginia Henderson (1969), retenue par les formations aux métiers du soin depuis plus de 20 ans :
- le besoin d'être reconnu comme une personne
- le besoin de reître sa vie, de lui trouver un sens
- le besoin de se libérer de la culpabilité et même de se réconcilier
- le besoin de placer sa vie dans un au-delà de soi-même
- le désir de continuité.

BESOIN SPIRITUEL

- Toute personne, quelles que soient sa religion et ses croyances, cherchant un sens à sa vie, à sa maladie, à sa souffrance, à sa mort appréhendée, est invitée à se faire connaître auprès de notre service.
- Les patients en fin de vie ont des besoins spirituels qui s’inscrivent au delà des autres besoins somatiques, psychologiques, religieux et sociaux. Ils comprennent fondamentalement un besoin de sens de la vie et de la mort, un besoin de pardon et d’espoir.

Le Besoin du Recherche Spirituelle

- Le besoin de recherche spirituelle (recherche d’un sens, de valeurs, de transcendance, …) au sens large a toujours existé, de tous temps, dans toutes les cultures, de façon manifeste ou latente, chez l’homme. C’est une donnée anthropologique de base. Ce besoin est accru dans les moments de “fragilités” tels le deuil, la maladie, la perte de quelqu’un ou une chose…

L’Accompagnateur Spirituel

- L’accompagnateur est en présence d’un mystère qui le dépasse. Le feu qui brûle n’a pas été allumé par lui, il est appelé à une infinie délicatesse.
- Le rôle de l’accompagnateur est un très beau rôle. Il fait appel à une très grande gratuité, c’est-à-dire à un grand sens de la grâce, et à une belle qualité de présence.

- L’accompagnement ne consiste pas à enseigner. En effet il s’agit d’accompagner une vie de foi qui grandit dans une histoire.
- Voir documents titre : “Visiter et se laisser Visiter”
• Accompagner quelqu’un c'est lui donner la parole pour qu’il puisse relire son histoire, les événements de sa vie, dans ses propres mots.

• Beaucoup de personnes, même assez éloignées de l'Eglise ou de la foi, se posent pleins de questions (pourquoi ?, pourquoi moi ?, est-ce une punition ?, ... et Dieu ?) à l'annonce d'une maladie grave, à la suite d'un accident, au moment d'un deuil.

La visite des membres de l'Eglise dans une institution hospitalière

• Savoir accueillir le malade croyant.

• Puis attentivement écouter lorsque les patients vous demandent de vous adresser à eux.

• Lorsque le malade dirige la conversation.

• Écrire le témoignage aussi aux parents de cette recherche.

• Ne pas être le malade croyant si il ou elle lutte avec sa vie spirituelle.

• Ne pas poser des questions absurdes (Dieu, l'âme, les péchés, ...)

• Ne pas parler de la santé de la personne (pouvoir, forces, ...)

• Ne pas les encourager à se poser des questions spirituelles.

• Ne pas parler de la santé de la personne (pouvoir, forces, ...)

• Réaliser que les questions spirituelles sont des questions spirituelles.

• Il n'y a pas de questions spirituelles à poser.

• Il n'est pas question de changer les croyances de qui que ce soit mais de les accompagner au degré où la personne le demande. Notre priorité est de « suivre » et donc dans le concret il faut toujours rechercher ce que le patient attend de nous (et pas seulement une fois, car cela évolue !). Il faut surtout respecter les confidences personnelles.

La visite du malade non-croyant dans une institution hospitalière

« Un patient doit pouvoir, dans la mesure du possible, suivre les préceptes de sa religion (recueillement, présence d'un ministre du culte de sa religion, nourriture, liberté d'action et d'expression,...) » (Circulaire 1400/00 n° 3350-57 du 02.02.09 (l'œuvré dans les états de santé)
Le but de la visite est de répondre aux besoins spirituels des patients : ou résidents que vous visiterez et non pas ses voisins ou autres

• Le directeur de l'Eglise local doit respecter les croyances

• Les convictions et émotions des personnes curatives (...). Il y a de la visite médicale de la religion, nourriture, liberté d'action et d'expression, rires funéraires...

• Toutefois, l'expression des convictions religieuses ne doit pas porter atteinte ni au fonctionnement du service, ni à la qualité des soins, ni aux règles d'hygiène, ni à la tranquillité des autres personnes hospitalisées et de leurs proches.

• Tout proclamatif est interdit, qu'il soit le fait d'une personne hospitalisée, d'un visiteur, d'un membre du personnel ou d'un bénévole. »

3/23/2014
• donner une information ponctuelle ;
• évaluer de faire une étude biblique ;
• évaluer de donner des sacrements (eucharistie, sacrement de réconciliation, onction des malades, ...);
• être témoin du vécu (révélée, émotion, difficultés, ...) et du questionnement éthique, spirituel et religieux.
Certaines personnes font toute une recherche de foi, se posent de grandes questions : Quel sens a ou a eu ma vie ? Quelles sont mes priorités ? Qu’en est-il de l’éthique ? Qu’est qui possible ? Et après la mort... ?
• Gérer des chemins de foi très différents à l’intérieur d’une même famille.

La visite du malade non-croyant
• ne pas s’ingérer dans les domaines médical, paramédical, administratif ;
• ne pas faire de prosélytisme ;
• cultiver l’écoute et le non-jugement ;
• prendre en charge à son tour le relevé du répondant (relevé à distance) ;
• chacun s’engage au minimum pour un an.

Difference entre un aumônier et un visiteur bénévole de l’Église Locale

• Voir les documents.

Job reçoit une visite
• Analyse de la visite rendue à Job
• Evaluation des réponses de ses amis
• Points Negatifs
• Points Positifs

L’Aumônier/ère
• lidée est évidente etc.
• Le seul pour le chef
cette période, bénéficiante au moment de la mort.
eucharistie... donnée à de grands pratiquants tout à fait consensuelles.
• Valoriser la souffrance
• Visite les soignants et se mettre au service des malades pour une action humaniste et spirituelle.

Le leader de l’Eglise Locale
• Visite bénévole (Volontaire)
• Lui uniquement pour visiter ses membres de son église.
• Valider la souffrance
• Rendre une visite régulière.

• L’offre d’un accompagnement spirituel se base sur une écoute active et ouverte afin de permettre à la personne souffrante de s’exprimer le plus librement.
PRACTICUM

- Retrouvons dans la salle de la Sante a l'Eglise pour les role-play avec:
  - A. Dr. Cherez-Chris Rei
  - B. Donaharo Clermon, Nurse

Formation d'une Équipe bénévole

- Pour combler les besoins grandissants des malades et des aînés de notre milieu, nous formons présentement une équipe de 10 personnes pour recevoir la formation de base de 6 heures et des visites auprès de ceux qui sont malades.

What is a Verbatim?

- The verbatim is an attempt to report as accurately as possible the dialogue that takes place between the chaplain and one or more individuals with whom he/she is engaged in ministry situations. Leave a three-inch margin for supervisory comments.

Visit Background

- Patient
- Plans & Expectations
- Contexts of the Visit/Observations

The Verbatim: Visit Background

- The Patient
  Summarize what factual information/significant data you have learned about the person before this visit, if the patient is Adventist, state what church he/she is from; if patient is not Adventist, state the referral sources (family, friend, colleague, co-worker, neighbor etc.).
Visit Background: Plans/Expectations

- Plans and Expectations for the visit
  Reflect on what you were feeling and thinking about yourself, your plans and expectations about the visit. Note what you wanted to listen for and what you did not wish to do.

Visit Transcript

- The pastoral role usually prevents taking notes during the conversation, but immediately afterward a stream of key words may be jotted down. Then, at the first opportunity, typewrite key excerpts from the visit as much as is applicable to your purposes as a verbatim. Enter only direct quotations. In parentheses record pauses, interruptions, tones of voice, non-verbal communication and your internal feelings. Prayers should be recorded in full. Reserve all interpretations for the evaluation, keeping the verbatim part of the report without commentary.
- Start each speech as a separate paragraph, indicating who is speaking with a pseudonym or initial. Number as follows (in this example, V for visitor and P for patient):

Visit Transcript Example

- Visiting Non-Adventists:
  V: Hello
  P: Who are you?
  V: I'm ... I was referred/told by ... to come to visit you
  P: I am ...

- Visiting church members:
  V: Hello Sr./Bro.
  P: Hi Sr./Bro., how are you?
  V: I'm fine and you?
  P: I am ...

Assessment and Reflection

- The Patient
- The Relationship
- The Visitor
- Theological/Spiritual Reflection

Assessment & Reflection: Patient

- The Patient
  Reflect on the physical, emotional, psychosocial, cultural, ethnic and spiritual issues or concerns evident in the patient and experience. What was the patient's initial concern? What is your spiritual assessment? What feelings were present?
Assessment & Reflection: Relationship

- The relationship
  Analyze what took place. Address what you perceived to be the interpersonal dynamics and relational processes present. Identify the level of rapport, attitude toward the visit, feelings (both yours and those of the patient/resident), etc.

Assessment & Reflection: Visitor

- The Visitor
  Evaluate how you feel about your responses. Critique your pastoral work, both positively and in terms of areas of growth and development. Be specific! How well did you do? What did you miss? What would you do differently? Include your feelings and insights gained. Relate your self-critique about the visit.

Assessment & Reflection: Spiritual Care planning

- Spiritual care planning
  What goals, plans, strategies, and issues would you determine to be appropriate for continued spiritual care ministry?

Assessment & Reflection: Theological Reflection

- Theological reflection
  Reflect theologically on the visit. What theological dynamics, religious issues, faith-realities, spiritual concerns, etc. emerge for you in this experience? How does the experience confront or affirm your theology?

Assessment & Reflection: Write-up

- Write-up
  Reflect on why you elected to write-up this visit and/or present the case to the spiritual support group.

Examples of Biblical Peer Critiques

- Peer David: To set better boundaries with patients and peers and supervisors.
- Peer Jesus: To deal with perfectionism and learn to fail.
- Peer Moses: To state ideas about leadership more clearly.
- Peer Mohammed: To discover an alternate way to deal with thieves.
- Peer Luther: To get out of your head and into your heart more in ministering to patients.
- Peer Calvin: To become less legalistic and more gracious in dealing with patients.
- Peer Prophet Miller: To pay more attention to math, particularly End of World calculations.
Spiritual Support Group

- Odny Ulysse..............Sr. Josephine Dalencourt
- Arnel Dubois..............Sr. Sherline Maurisaint
- Luckner Poitevien........Sr. Lucie Saintilaire
- Virgo Beluzaire............Sr. Sallida D. Gracien
- Baltazar Floresta...........Sr. Primose Pelicer
Anxiety, Depression and Stress Management
By
Dr. Cheres Chris-Roi

A word about anxiety and depression in those you are visiting. To foster communication, it is extremely useful to recognize any emotional issues common to people experiencing illness or disability:

**Anxiety** is often the inevitable result of the uncertainties of illness and hospitalization. The loss of control over one’s life may often bring feelings of self-doubt and helplessness.

**Depression** can be a normal and limited emotional response to a current illness; or even a physiological reaction to the stress, depletion, or “chemical imbalance” caused by the illness. Often people respond to the opportunity to express his/her thoughts and feelings. It is not necessary or helpful to reassure the patient too quickly or unrealistically. If the patient speaks of feeling depressed, it can be useful to listen and get him/her to focus from generalized malaise to identifying his/her worst worry.

It is more helpful for the visitor to remember that often just listening to the patient’s fears and frustrations, anger and bitterness, can, by itself, aid in the healing process. By allowing the patient to vent negative feelings and doubts, and then reflecting them back in a thoughtful and friendly manner may help put these feelings in perspective.

Building trust with someone you’ve just met sometimes takes time, and not everyone will choose to open up personal discussion initially, if at all. If you want to build trust it is important to be consistent, keep promises, be discrete and emphasize the confidential nature of all interactions that take place in a visit. To maintain engagement, you might bring along some cards, or a book to read from, and be prepared to talk about general subjects of interest. Possible topics for discussion: current events, community developments, art and music, jokes, movies. Things you could bring: crossword puzzles, checkers, scrabble, interesting photos. Try going for a walk with person in a wheelchair for a change of scenery.

Engage in reminiscing

“People say 40 years ago were better times: What do you think?” Reminiscing can be a useful part of a visit — especially when visiting the homebound/elderly/nursing homes.

**What reminiscing can do for us:**

1. Learn from the past — thinking about how things were and what we were like reminds us of life lessons.

2. Feel better — laughing about how we managed without money or convenience and thinking about positive things makes us feel better.
3. Positive aging — exercising our minds keeps us active and alert mentally even when our bodies slow down physically.

4. Have fun comparing neighborhoods, lifestyles — comparing neighborhoods reminds us that we have a lot in common. Sharing brings closeness.

**On Boundaries:**

“When we have good intentions and are clear that what we are doing has merit, then when we set boundaries we need not be apologetic, and there is no shame in that for ourselves or for the other. Healthy boundaries are established when the attributes of lovingkindness and strength are in balance...” —Rabbi Uzi Weingarten, “Communicating with Compassion” 2003

Signs you may be too involved

1. You are distracted at home and find yourself frequently wanting to talk about the person you are visiting. You are unable to get the patient off your mind.

2. You are overwhelmed by your own feelings of fear, anger and helplessness.

3. You find yourself saying “that could be me.”

Factors influencing burn-out

1. Lack of boundaries of what you/your group can and can not do.

2. Unrealistic expectations, spreading yourself too thin or wanting to ‘fix’ people’s problems.

3. Identifying too closely with a patient’s experience, reminding you of yourself or a loved one who suffered.

Saying “NO”

It is especially hard to say NO to two groups of people: people for whom we feel sorry and people for whom we care. Remember your role, your intentions and your limits. But when asked to do something that you do not feel comfortable doing, it can still be hard to decline.

*Be as brief as possible:*

Simply state a legitimate reason for your refusal, “I really don’t have the time,” and avoid elaborate explanations, justifications, and “lies” (e.g. “I can’t because my mother is coming in from out of town” or “My child is ill”).

*Actually say the word “No” when declining:*

The word “no” has more power and is less ambiguous than, “Well, I just don’t think so” or “We’ll see” or “I can’t just now.” You might need to say “NO” several times before the person hears you.
Stress Management Tips

1. Nurture yourself. List 5 things that you enjoy doing. Choose something that inspires or sustains (e.g. exercise, buy flowers, take a relaxing bath, nap, see a movie, listen to music, gardening).

2. Utilize deep breathing and relaxation exercises.

3. Journaling. Write out your thoughts. Be spontaneous. You can record what is stressing you or whatever surfaces as you put pen to paper.

You may start informally, cultivating opportunities to be mindful and diligent with those in your circle of family, friends, and neighbors. Visiting can be as easy as picking up a telephone and calling a homebound senior or knocking on a neighbor’s door offering to shop.

I’m not sure what to say when I visit someone?

The purpose of visiting the sick is to let the person know that they are remembered. We do this with our presence — by showing up! Whether it is a face-to-face.

What if the person does not want a visit?

There are two parts to a successful visit: The visitor’s positive intention to be present with the visited, and the visited’s willingness to be visited. Asking someone if they would like a visit is especially meaningful. Firstly, it restores control to the visited. Secondly, the ‘mere’ asking conveys respect and dignity to the visited. This can help to counterbalance feelings of dependency and feeling a lack of control. It is better for the visited to have the option to refuse, which puts the power in their hands. If the person does not want a visit, you can try again later.
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