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The Resource Page

... creative and practical ideas

Brought to you this month
by Richard Hipps



No 'us' and 'them' in a hospital setting

"I was sick and you looked after me."
—Matthew 25:36

The patient had cancer of the large bowel. After a colostomy the cancer came back. The patient was treated aggressively, and an antibiotic stopped bronchopneumonia. However, the spreading cancer ended liver function and, in spite of innumerable delaying actions, the patient finally died. The patient had been kept alive for 10 months when he otherwise would have died in a matter of days. Was it right or wrong to add 10 months? And, did the treatment add more life or merely prolong the dying process?

Although the medical good of a patient is based on such values as cure, prevention, amelioration, containment of pathology and prolongation of life, these are not the only values to be considered. Deciding what is best for a patient must also include such considerations as self-determination in light of religious belief, quality of life, family needs and economics. Because these considerations are not strictly medical, they call for greater interdisciplinary reflection and participation.

In September 1972, my mother discovered a lump in her left breast during a routine checkup. She was in excellent health at the time — so we thought — and had been water skiing most of the day. Her physician suggested she enter the hospital for a series of tests, which unfortunately ended in a radical mastectomy. The physician's diagnosis was bleak. The cancer had spread to her spine and liver, and he gave her six months to one year to live. She died on June 28, 1973.

Those 10 months between September and June were indeed some of the saddest and most trying of my life. I watched my mother deteriorate and suffer to the point that I prayed for and welcomed her death, which released her from such intense pain.

No one can truly understand the anguish of such an event unless he or she experiences it firsthand. Lack of information, obscurities in prognosis and the inaccessibility of my mother's attending physicians added to our suffering. I had no idea that a DNR (do not resuscitate) order was given by her primary physician the evening before she died. I was with her almost constantly, oblivious to the decision-making going on behind our backs. At the young age of 19 I was learning the hard facts of modern medical care. Later, as a pastor, I relived many of my earlier frustrations in the lives of my parishioners who themselves were "passing through the waters."

In the modern hospital setting the role of religion is far more extensive than has commonly been assumed. Religion is more than a moral and emotional helpmate to scientific medicine. Allied with philosophy, religion offers an over-arching conceptional understanding of the world in which medicine is practiced and supplies a set of explanations for the existence and meaning of illness, of curing and of caring.

When we think of religion in medical settings, we most commonly visualize a staff chaplain or a minister or trained laypersons visiting sick parishioners. In the past, rather than being seen as vital members of the health care team, many religious caregivers (chaplains, pastors, laypersons) were considered outsiders or as conveniences to the patients much like the hospital barber or the owner of the hospital gift shop.

Some physicians still see health care as a "closed shop." In hospital settings the white-coat mystique reminds everyone of a hierarchy of functional importance. And, because of the damaging ineptitude of both clergy and laypersons, some physicians are either reluctant or indifferent in seeking the advice and support of clergy and informed laypersons.

Fortunately, this perceived deficiency is being remedied by sophisticated training programs in ethics and clinical pastoral education. Religious professionals and trained laypersons are losing their sense of inferiority and have begun to assert their right to be considered an important part of the health care team. In the hospital setting, spiritual care is so important that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires hospitals to address the spiritual needs of their patients.

If the ministry of the church is to be relevant, we must educate ourselves and continue to be in touch with the creative edges of the transformations occurring in modern health care. Patients are forced to make difficult decisions: Should I take this experimental treatment for cancer? Should I take my baby off the ventilator? Should I donate my husband's organs? Should I honor my mother's living will?

Persons who face ethical and spiritual dilemmas need a presence that comforts, helps and guides. For this reason, clergy and trained laypersons must come to a working, real-life understanding of both spiritual and ethical principles and then flesh out their role not only with the patient, but also with the family, hospital staff and larger faith community.

Faith concerns are integral to health care, and it is crucial to have both clergy and trained laypersons available for individuals and families facing serious illness, hospitalization and end-of-life issues. Clergy and trained laypersons can help health care professionals see beyond only the medical problems of the patient.

Hospital ministry involves not only ministry to patients, but also to all those who give health care. We must be more than advocates for patients. We must be advocates for physicians, nurses and administrators. In ministering to people, there can be no "us" and "them." **BT**

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