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DEVELOPING A STRATEGY FOR RELATIONAL  
EVANGELISM THROUGH PASTORAL CARE AT  
WESTERN BAPTIST HOSPITAL,  
PADUCAH, KENTUCKY

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A Project  
Presented to  
the Faculty of  
The Southern Baptist Theological Seminary

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Doctor of Ministry

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by  
James Henry Wright  
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**APPROVAL SHEET**

DEVELOPING A STRATEGY FOR RELATIONAL  
EVANGELISM THROUGH PASTORAL CARE AT  
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PADUCAH, KENTUCKY

James Henry Wright

Read and Approved by:

\_\_\_\_\_  
J. D. Payne (Faculty Supervisor)

\_\_\_\_\_  
Adam W. Greenway

Date \_\_\_\_\_

Dedicated to  
the ministers and chaplains of God,  
who share the call to bring the “good news” of Christ  
to those who prepare to face their Maker.

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## PREFACE

While planning, thinking about, and organizing this project, I was not fully prepared for the impact it would have not only on my own life but also on the lives of those who would eventually become a part of the work. I had not realized the needs of the community in the area of communication between the hospital and the local churches. This project has strengthened our hospital's place in the community and even forged a new relationship between the hospital and the local churches and Christian community that had not previously existed. We now have pastors and many lay persons, from several denominations, serving on the pastoral care team. Community support for the disaster counseling program developed through this project is exciting. In addition, the Western Baptist Hospital administration has given full support and financial backing for the continuance of the program. There are, at the time of writing this project, forty trained volunteer chaplains who serve more than 600 hours on a monthly basis and who augment pastoral care services in our hospital. The implementation of this project has made the participating pastors and chaplains of the Paducah area aware of the need for regular communication with community leadership and volunteers and has reinforced our awareness of the need for continual education for the hospital staff and volunteers.

Special thanks are in order for all those who have been involved with this project from beginning to end. Western Baptist Hospital administration has been cooperative and supportive. I could not have even undertaken or accomplished completion of the project without the help, cooperation, and support of our pastoral care staff. They helped to shoulder the workload and offered many valuable suggestions. The churches in the Paducah community have been an asset as well. Their cooperation is



appreciated. The group of people who were part of the “Death and Dying” class provided beneficial and significant pertinent information.

The impact of the project on me personally has been an ongoing realization of how much people want to serve in ministry. To see this develop has proven to encourage and strengthen my own resolve to minister and share the gospel with those who are facing death.

Paducah, Kentucky

James Henry Wright

May 2013

## CHAPTER 1

### INTRODUCTION

#### **Purpose**

This project developed a relational evangelism ministry that enabled ministers and lay people from the local church to become relational evangelists with the sick and infirm in the hospital and the community settings.

#### **Goals**

This project sought to accomplish four goals that served as the criteria for the evaluation of the project. The first goal was to make the Christian religious community aware through local media, mail-outs, word of mouth, and visits to local congregations that the community has a role in the hospital evangelism ministry. Clergy and lay ministers in Paducah, Kentucky, have not typically participated in the hospital ministry. Consequently there was a breakdown in communication between hospital chaplains and local clergy. This goal sought to make it possible for ministers in the area to be on the same page and feel some ownership in the hospital evangelism ministry.

The second goal was to recruit the persons who responded to the recruitment efforts and to enroll them in the training provided as a part of this project. The volunteer chaplains who were already involved in pastoral ministry in local churches were used to assist with the training of others from the community. I also contacted other pastors and lay ministers in the area and gave them an opportunity to participate. They then became a focus group both for this project and for the ongoing ministry in the hospital. In order to better equip the focus group members, I examined the healing ministry of Jesus and discovered what made his healing ministry encounters evangelistic. I also examined the healing ministry of the disciples and the teachings of James for further information and

specific training for the focus group members that was modeled after the biblical ministries. The training involved public and personal ministry to the trainees.

The third goal of this project was to develop an ongoing curriculum to keep newly trained laypersons and chaplains up-to-date in evangelistic ministry methods related to hospital ministry. The trainees needed ongoing training that would enable them to encounter people of various cultures and backgrounds so as to minister to them evangelistically. They also needed a support group and support system to be accountable to the biblical principles of this type of ministry.

The fourth goal was to develop a consultation committee to evaluate the progress of the trained volunteer chaplains. This committee developed and used an evaluation tool to evaluate the progress of the volunteers and the program. This committee and their process kept me accountable to the program as well. The process kept me up to date with the other models of training and new curriculum available.

### **Context**

Paducah, Kentucky, is located at the western edge of the state of Kentucky on the Ohio River, and bisected by Interstate 24, a freeway that traverses the mid-south between Nashville, Tennessee, and St. Louis, Missouri. A patchwork of art, history, and culture, Paducah is the commercial, cultural and medical center for its 30,000 residents and for about 100,000 people in a 45-mile radius.<sup>1</sup> One of Paducah's favorite native sons, Irvin Cobb, aptly described the friendly charm of our city as "an agreeable blend of western kindness and northern enterprise, superimposed on a southern background."<sup>2</sup>

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<sup>1</sup>Dona Rains, presentation to community for Western Baptist Hospital Anniversary Celebration, Spring, 2007; Rains is the Marketing Department Director for the hospital.

<sup>2</sup>Ibid. See also, Jack Sullivan, "Who in the Heck was Irvin S. Cobb?" *Bottles and Extras*, September 2006 [on-line]; accessed 20 September 2012; available from [http://www.fohbc.org/PDF\\_Files/IrvinSCobb\\_JSullivan.pdf](http://www.fohbc.org/PDF_Files/IrvinSCobb_JSullivan.pdf); Internet.

Paducah attracts thousands of international visitors each April at the American Quilter's Society Quilt Show and Contest. Tourism is important year-round in the historic riverfront downtown with Downtown after Dinner, a community street dance featuring various local musical artists, the Dogwood Trail, a neighborhood festival of lit dogwood trees, Summer Festival, a community event, and Barbecue on the River, featuring many local chefs in an outdoor venue near the Ohio River.

Cultural opportunities feature historic and art museums, especially in the Paducah Artist Relocation Program in Lower Town, performances by the Paducah Symphony Orchestra, Market House Theatre, and a variety of national entertainers at the new \$36.4 million Luther F. Carson Four Rivers Performing Arts Center. Outdoorsmen delight in the region's three state parks, two lakes and the 170,000-acre Land Between the Lakes Recreation Area—the cornerstone of a \$600 million tourism industry.<sup>3</sup> Paducah has a healthy business climate with 75 manufacturing companies of various sizes and 25 local businesses employing 100 people or more. Western Baptist Hospital is the largest employer with 1,700 employees.

Two public and two private school systems offer preschool to grade 12 education. Higher education is available at West Kentucky Community and Technical College (featuring the University of Kentucky engineering program and the Challenger Learning Center for grades 3-8). Murray State University is located just 45 miles south and many Paducah residents are fans of the school.

Western Baptist Hospital is a regional medical and referral center, serving about 200,000 patients a year from four states. With more than 1,700 employees and 200 physicians, it offers a full range of services, including cardiac and cancer care, diagnostic imaging, women's and children's services, surgery, emergency treatment, rehabilitation and more. Since its humble beginning in 1953, Western Baptist has grown from 117

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<sup>3</sup>Rains, presentation to community, Spring 2007.

beds to 349 beds on a campus covering eight square blocks. It is part of Baptist Healthcare System, one of the largest not-for-profit healthcare systems in Kentucky.<sup>4</sup>

The mission of Western Baptist Hospital is to continue to lead from a stance of Christian heritage in service and to enhance the health of the people and communities served. The vision of Western Baptist Hospital is to be the healthcare leader in western Kentucky. Western Baptist Hospital lives out its Christ-centered mission and achieves its vision guided by integrity, respect, stewardship, excellence and collaboration.<sup>5</sup> The main campus covers eight square blocks in the heart of Paducah, from 24th to 28th Streets and Broadway to Kentucky Avenue. The hospital and adjacent structures, including three medical office buildings, a freestanding digital imaging center, a day care center and the area's only parking garage, occupy about one million square feet of space valued at more than \$400 million.<sup>6</sup> The hospital also operates a rehabilitation center, two fitness centers and a primary care center off-campus.

Western Baptist Hospital opened its doors on October 21, 1953. It instantly earned respect as one of the most modern hospitals in Kentucky. The \$1.3 million, 117-bed facility boasted four bed patient rooms, an entrance lobby, two operating rooms, a pharmacy and laboratories. Just four and a half hours into its opening day, Western Baptist welcomed its first newborn into the world, William Edward Souders, today a resident of Metropolis, Illinois.

In the years that followed, the hospital experienced its proverbial ups and downs. But by 1973, the hospital solidified its prominence in the community. In two decades, Western Baptist had increased from 117 to 283 beds and had added a new wing on Kentucky Avenue with more than 650 employees staffing the hospital. At this point

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<sup>4</sup>Ibid.

<sup>5</sup>Ibid.

<sup>6</sup>Ibid.

in the hospital's colorful history, Paducah area residents had pledged more than \$1.4 million toward its building fund.

Physicians were recruited from across the state and region. They brought with them experience, knowledge and vision for advancements in areas such as cancer care and cardiology. Groundbreaking accomplishments including the first open-heart surgery in 1985 helped put Western Baptist on the map as a regional medical and referral leader. Characteristic of its past and indicative of its future, Western Baptist is today in a state of advancement. In 1997, the hospital embarked upon a campus development plan with the opening of a new outpatient center, trauma center, surgical services and critical care areas. It also included the construction of the first of three doctors' office buildings.

The next phase of development occurred in 2000 when a second doctors' office building, women's center, and birthing center opened. In 2003, Western Baptist Hospital opened its third doctors' office building, which includes a Center for Digestive Health. Additional campus development included the expansion of a parking structure to accommodate 1,000 vehicles.

More than 60 physicians have located their practices on the Western Baptist campus, resulting in a substantial growth in market share. Not only has the hospital changed in appearance, but it has also made significant investments in leading edge technology. Advances including an all digital diagnostic department, minimally invasive operative procedures, and advanced cardiac and cancer care have further expanded Western Baptist's continuum of healthcare. Programs such as Baptist Health Line, Prime Care, and Baptist Family Fitness further establish the hospital's strong presence in the community. The same mission that brought Western Baptist into existence in 1953 continues to be its guiding principle—to continue its Christian heritage of service and to enhance the health of the people and communities it serves.

The Baptist Heart Center was added in 2007. Since bringing open heart surgery to the region in 1985 and initiating dozens of other "firsts" in cardiac care,

Western Baptist Hospital has become one of the most respected hospitals in the state for its cardiovascular program. Surgeons have performed more than 8,800 open heart procedures, and cardiologists perform more than 2,500 cardiac catheterizations each year.<sup>7</sup> Our chest pain treatment is the only nationally accredited program in the region. To take the commitment to excellence in cardiac care to a new level, Western Baptist hospital opened the \$20 million, 79,000-square foot Baptist Heart Center in 2007. It is adjacent to the emergency department, where many cardiac problems are first diagnosed. A rooftop heliport makes it possible for distant patients to be transported quickly to the Chest Pain Center, when minutes can make a difference. The center houses all non-surgical procedures, including cardiac catheterization labs, echo cardiology, and nuclear cardiology, stress testing, and cardiac rehabilitation. The second level features an auditorium for educational seminars and events.

My desire with this project was to strengthen the Christian ministry and chaplaincy aspects of the hospital. Ministers and lay people living and serving in the Paducah area were given the opportunity to receive training and experience in furthering the spiritual healing process patients needed and often recognized as a patient in the hospital. The Christian community and the hospital were given the opportunity to cooperate together in the pastoral care and the relational evangelism ministry of the hospital.

In 2003, HIPAA (Health Insurance Portability and Accountability Act) was imposed upon all hospitals across the nation. The implementation of HIPAA has caused some problems with ministry in the hospital. Ministers are no longer privileged to receive information about patients like they were before the advent of HIPAA. Hospital employees can now be severely reprimanded and even dismissed for giving information of patients to anyone other than family designated representatives of the patient.

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<sup>7</sup>Rains, presentation to community, Spring, 2007.

Chaplains employed by the hospital and ministers from the community who volunteer for ministerial patient care fall under that same category. Special training is conducted on a regular basis to inform employees, students, and volunteers of the importance of this critical law.

I served as director of the Pastoral Care Department and the clinical pastoral educator for the Pastoral Care Department. My role as part of the management team was to keep the Christian vision statement at the forefront of the hospital staff and community. I approached this responsibility by educating and training employees and community in areas of pastoral ministry in the hospital. The Paducah Christian pastoral community was invited to share in the ministry through serving as volunteer chaplains. Special training was and is required and provided to serve in the hospital in this area of ministry.

### **Rationale**

In James 5:14, James proclaims, “Is anyone 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.”<sup>8</sup> The word “elder” stems from the Greek word *πρεσβύτερος*, which Ralph P. Martin describes as follows:

This suggests that he or she is confined to the sickbed and is too ill to go to the elders. The “elders” (*presbutero* plural in our text, which speak of a delegation of the church representatives) stand for those who hold here a specific office in the early church. The term is never used of a Christian office in the Gospels, where it refers to Jewish elders in the synagogue, but appears as such in Acts ( 11:30; 14:23; 15:2; 16:4; 20:17; 21:28: the last reference is noteworthy, since it shows a scene where “elders” gather around James, who is head of a collegium) and the epistles ( 1 Tim 5:17-19; Tit 1:5; 1 Pet 5:1; 2 John 1; cf. Phil 1:1). Other terms that appear to be synonymous for elder are “overseer” (Acts 20:17, 28) it is evident that the elder’s duties included “overseeing” or “pastoring” the flock. Since “pastors” are never mentioned together in the NT with “elders” it may be that the latter carried out responsibilities, which were similar to those of the present day pastor or minister.<sup>9</sup>

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<sup>8</sup>Unless otherwise noted, all Scripture quotations are from the New International Version, 1984.

<sup>9</sup>Ralph P. Martin, *James*, Word Biblical Commentary, vol. 48 (Waco, TX: Word, 1998), 206-07.



The term “elder” in the New Testament equates to a modern day pastor. Visiting the sick is a part of the typical function of the pastoral ministry. “Elder” has nothing to do with age; while some elders may be advanced in years, the term refers to the spiritual competence of a person. According to this definition of the word, “elder” is one who carries out the pastoral functions of the ministry.

The concept of this project arose from my desire to equip pastors and lay ministers in the ministry-related techniques helpful in visiting the sick, more specifically with the intention of intentional evangelistic encounters during the visitation process. This ministry involved training that was not confrontational but rather relational, including insight into dealing with families that may be involved with the patient. By relational I meant “to establish a rapport with the patient and with the patient’s family.” Hospital administration was skeptical of the visitors that came to preach to patients. The skepticism came from previous experiences when patients had complained about being “preached to” or when a preacher attempted to proselytize a patient of another religious persuasion. There has to be a certain amount of trust within the hospital itself to allow this ministry to take place. The character of the persons in training is important. References from their pastor, bishop, or area missionary helped me to better understand the ministry capabilities, the qualifications, and how these community ministers had presented themselves in the ministry of their church.

Area churches and pastors have been skeptical of the chaplaincy ministry at Western Baptist for several years. One of my purposes in this project was to change the above mentioned feelings and attitude toward the chaplaincy ministry in Western Kentucky. The chaplaincy ministry has not only been a resource for ministers in the community and region for some time in the past, but it also now serves as a pastoral care training class for local colleges, junior colleges, and regional seminaries who have already used the clinical pastoral education program and the volunteer training program

for academic credit to those who choose it for a course elective. I also used this program to train staff from local churches in the regional area.

The Word of God was the main text for the training, using first the model of Jesus in healing and evangelizing. Second Timothy 3:15-16 gives the mandate to place Scripture in the forefront of any biblical training opportunity: “All Scripture is God-breathed and is useful for teaching, rebuking, correcting, and training in righteousness, so that the Man of God may be thoroughly equipped for every good work.” I led the focus group to study the healing ministry of Jesus through the biblical text as well as through Christian authors who had devoted their time to write about and give instruction to pastoral care. We also examined the ministry of the apostle Paul, especially his teachings in the letters of 1 Corinthians, Galatians, Ephesians, Philippians, Colossians, and Thessalonians.

This training ministry was a project that included the church. I intended that the materials I generated as a part of the training and equipping ministry for chaplains in Paducah also be applied as desired by the local church, as my program offered training that many churches and seminaries cannot or did not provide.

### **Definitions and Limitations**

In this project, I used the following definition of pastoral care: “Pastoral care derives from the biblical image of *shepherd* and refers to the solicitous concern expressed within the religious community for persons in trouble or distress.”<sup>10</sup> I used the following definition of evangelism: “Evangelism is a concerted effort to confront the unbeliever with the truth about and claims of Jesus Christ and to challenge him with the view of leading him into repentance toward God and faith in our Lord Jesus Christ and, thus, into fellowship of the church.”<sup>11</sup>

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<sup>10</sup>Rodney J. Hunter, ed., *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon, 1990), 836.

<sup>11</sup>Lewis A. Drummond, *Leading Your Church in Evangelism* (Nashville: Broadman, 1975), 21.

“Family system” is a descriptor of the integral family, including but not limited to immediate family, mother, father, son, daughter, but also extended family, aunts, uncles, cousins, grandparents, and in some cases, those other persons in the life of a patient who may be considered “family” because of close relationships with the patient, though of no direct blood relation.

The limitations of this project are as follows. First, the length of this project was 15 weeks, with the first week used as orientation and the last week used for evaluation of the project. Following the first week was a four-week training class for the focus group, consisting of laying the foundation of the chaplain ministry in pastoral care. This was followed by a nine-week seminar on “Evangelism in a Death and Dying Situation for Patients, Families, and Health Care Staff.” The last week was a time of evaluation by the consultation committee. This ended with an exit interview with the consultation committee and the trainees in the program.

The second limitation is related to who would participate in this pastoral care training. This program of training was offered to those who felt a call to the pastoral care ministry. They could be church staff or lay persons but must have been active in their local churches. Lay persons must have had a written recommendation from their pastor that attested to their active ministry in the church. My desire was and is to train ministers who will use the training to minister in the local church or in the hospital ministry in our area or the area hospital where they live. The senior pastor has a tremendous responsibility to do many ministries in the church. This project sought to enable them to do their pastoral care ministry more effectively and also to add some volunteer staff to their ministry teams.

### **Project Methodology**

The main purpose of this project was to train ministers in the basics of pastoral care in the hospital clinical setting. The first goal of this project was to introduce Paducah, Kentucky, and the surrounding region to the need of pastoral care training. I

used the local media to announce the training opportunity as well as the local churches' newsletters. A printed article contained the long and short-term goals and objectives of the training course and also contained an application for the course.

The second goal of this project was to enlist 6 to 10 people who responded to the training opportunity. The consultation committee served as the interviewers and followed the course of the program. After the acceptance of these ministers into the training, I gave them a questionnaire which helped me to evaluate what they understood about the hospital pastoral care ministry. This gave me a direction of approach in presenting the curriculum.

The third goal was to develop a fourteen-week course that educated and gave practice in the hospital community in the areas of pastoral care to the death and dying patients and family of the patients. My plan was to use several texts as readings for the participants and for the teaching content for the seminars. Elisabeth Kubler Ross' *On Death and Dying* and *On Grief and Grieving* served as my guides to understand stages of grief and dying for patients and families.<sup>12</sup> Robert Coleman's *Master Plan of Evangelism*<sup>13</sup> provided me with insight to evangelistic approaches for dying patients and families, and Michael L. Simpson's book, *Permission Evangelism: When to Talk When To Walk*,<sup>14</sup> will give insight to the right time to share the gospel.

The second week oriented students to the personal care program. The next week dealt with understanding the ministry of death and dying and the ministry of evangelism to the dying and their families.

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<sup>12</sup>Elizabeth Kubler-Ross, *On Death and Dying* (New York: Scribner, 1969); idem, *On Grief and Grieving* (New York: Scribner, 2005).

<sup>13</sup>Robert E. Coleman, *The Master Plan of Evangelism*, rev. ed. (Grand Rapids: Revell, 1993).

<sup>14</sup>Michael L. Simpson, *Permission Evangelism: When to Talk When to Walk*. (Colorado Springs: David C. Cook, 2003).

The fourth goal of this project was to enlist an ongoing consultation committee to evaluate the training program and the progress of the students who take the training. They consisted of local Christian educators, regional pastors, and hospital staff—particularly the hospital education staff. I provided a survey form that evaluated my Christian influence in teaching, educational skills, my organization of the program, and the need to continue the training as a part of the hospital ministry. We met in the midterm of the program and at the end of the program to make this evaluation and present it to senior management of the hospital.

### **Conclusion**

In conclusion, the project to develop a relational evangelism ministry that sought to enable ministers and lay people from the local church to become relational evangelists with the sick and dying in the hospital at both Western Baptist Hospital and in the surrounding region of Paducah, Kentucky was based on a need observed in the community of Paducah. It is driven by my heart to see biblical ministry and evangelism done for those who may, of all people, be closest to that final meeting with the Lord. The program derived its impetus from the Word of God, and specifically from the evangelistic encounters of Jesus and the Apostle Paul.

Chapter 2 examines the biblical exegesis that drove the program. Chapter 3 examines current evangelism practices for the sick and dying, including an overview of family systems and the stages of dying. Chapter 4 presents the project methodology and teaching sessions, and Chapter 5, presents an overview of the project with conclusions and examples of how the future work might be bettered.

## CHAPTER 2

### A BIBLICAL AND THEOLOGICAL MODEL FOR EVANGELISTIC PASTORAL CARE

Chapter 1 set the stage for this project and established the need to develop evangelistic pastoral care in hospital ministries. This chapter will present the biblical and theological rationale for a prayer-based evangelistic ministry. An effective pastoral care ministry requires a solid biblical foundation. God's use of believers in Scripture provides a model for pastoral ministry to the sick and distressed. The biblical evidence suggests that it is God's desire for believers to be equipped for ministry to sick and infirm people and their families.

The Bible shows God's desire for the body of Christ to be involved in going to the sick (Matt 25:36). In both the Scriptures and in the structure of the body of Christ, God gives gifts including faith, prayer, evangelistic encounters, and healing to the members of the body (1 Cor 12:4). Evangelism is a part of pastoral ministry in a hospital setting but evangelistic pastoral care for sick or dying people is accomplished differently than evangelism in other settings of ministry. There is a sense of urgency about life and death decisions that must be tempered by a sense of care and love for an individual in one of the most difficult stages in their life. Scripturally there are models in the Old and New Testament that provide examples for a balanced approach to evangelism and compassionate pastoral care.

In examining evangelism in the context of pastoral care, the authors of the *Complete Book of Christianity* write:

In the Bible, health is first and foremost a divine gift. When sickness occurs, the sick turn to God, the Physician of his people, for healing. God and God alone is the ultimate source of all healing. "I am the Lord, who heals you" (Exod 15:26), says the Lord to Israel. In the New Testament we see that healing is critical and integral

part of Jesus' earthly ministry. It is estimated that one-fifth to one-third of the Gospel record is related to healings. As Matthew says, "Jesus went throughout Galilee, teaching in their synagogue, preaching the good news of the kingdom, and healing every disease and sickness among the people" (Matt 4: 23). And because the biblical view of health is holistic, biblical healing includes the entire person.<sup>1</sup>

Because the Scriptures show compassionate evangelism and prayerful healing efforts for those individuals who are sick or dying, it should be to those Scriptures that one turns for examples of evangelistic pastoral care to the sick and dying.

### **Biblical References of Praying for the Sick**

Healing in Scripture is usually portrayed as a result of God's intervention through prayer. Prayer is the recognition that God is in control of healing. The prayer offered in faith will make the sick person well (Jas 5:14). Scripture is clear and direct about prayer in ministry to the sick, with both Old and New Testaments presenting the need for prayer in the ministry to the sick. The Old Testament linked prayer to health and salvation as it did also with prayer for the restoration and health of the land (2 Chr 7:14). One of the means to accomplish the restoration of health seen in the Old Testament is prayer (c.f., Gen 20:1-18, Num 12:1-15, 1 Sam 1:9-20, 1 Kngs 13:4-6, 2 Kngs 5:1-14, 2 Sam 24:10-25, and others).<sup>2</sup> God does the healing in different ways through the messengers He sends. While the actual words of the healing prayer may not be spoken, the results are healing.

In the New Testament Jesus is vitally concerned with healing physical, mental, and spiritual diseases and commands his followers to do the same. Much of the New Testament practice for healing was modeled on Old Testament examples of prayer and compassionate pastoral ministry. An examination of selected Old Testament texts follows.

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<sup>1</sup>Robert Banks and R. Paul Stevens, *The Complete Book of Christianity* (Downers Grove, IL: InterVarsity, 1997), 479.

<sup>2</sup>A secondary means of healing in the Old Testament was the application of herb, oils, and the cleanliness laws of Moses, i.e., physical means.

## Old Testament Examples

**Health as seen in creation and the image of God.** The Old Testament begins with the creation account. Prior to the account of man's fall into sin, found in Genesis 3, there was no need for healing. God intended for His creation to live in perfect health forever, and the perfection of the created realm and the creatures made to live there speak to God's ultimate desire for His creation. The reality of the fall dictates a need for healing and or pastoral care for the dying.

The biblical creation account implies perfect health from God saying His creation of man was very good (Gen 1:31). Banks and Stevens write,

The Lord God formed the man from the dust of the ground and breathed into his nostrils the breath of life, and the man become a living being.' In creating human beings out of the dust of the earth (material) and breathing into us the breath of life (immaterial), God has explicitly created a psychosomatic unity (*nephesh*)—a living being. . . . Because of this, Old Testament writers do not present health in physical terms, and Jesus did not see his healing role as primarily physical. For both, health relates to the whole person.<sup>3</sup>

Additionally, the creation of man (and woman) in the image of God (Gen 1:26) indicates that we humans were created for health and not for death: "God saw all that he had made, and it was very good. And there was evening, and there was morning—the sixth day" (Gen 1:31). It was the curse of sin in Genesis 3 that ultimately doomed humanity to illness and ultimately death (Gen 3:16-19).

**The role of the body in the Old Testament.** Sickness in the Old Testament, while carried in the flesh, was seen as a spiritual condition of sin. Exodus 23:25 states, "Worship the Lord your God, and his blessing will be on your food and water. I will take away sickness from among you." Banks and Stevens write,

Old Testament anthropology in general reveals a close relationship between the soul and body. The Hebrews regarded the person as a totality: body can be spirit, and spirit can be body. Though they could differentiate between various aspects of a person, the Hebrews believed that human beings operate as integrated, connected and embodied people. Nowhere is this more apparent than in the interchangeable Hebrew terminology for the words heart, breath, soul, flesh, bones and so on. . . .

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<sup>3</sup>Banks and Stevens, *The Complete Book of Christianity*, 482.



Given this, it is understandable that Jewish prayer was expressed through bodily gestures and postures.<sup>4</sup>

Notably, it is in the body that prayer happens whether there is one person praying for another or a person seeking prayer for themselves. Often sickness was an indicator of sin in the body and the restoration of health was a sign of forgiveness. The body and soul were together in the process for seeking healing and restoration.

**Spiritual implications of praying for healing in the Old Testament.** The practice of praying for the sick is found in the Old Testament in the life of Israel, even though expressed in ways other than a strictly personal sense (one person praying over or with another for healing). Genesis 20:17-18 records, “So Abraham prayed to God; and God healed Abimelech, his wife, and his female servants. Then they bore children; for the Lord had closed up all the wombs of the house of Abimelech because of Sarah, Abraham’s wife.” Here, Abraham prayed, asking God to heal Abimelech’s wife and slave girls so they could have children again. God honored the request from Abraham and Abimelech did no harm to Sarah while she was in his custody. Abimelech cares for Sarah and does not harm her while Abraham demonstrates pastoral care to Abimelech in response to Abimelech’s request for the healing of his wife and female servants from barrenness.

Both Abraham and Abimelech were in a position to provide some level of care or pastoral care, and each shared a roll in caring for the other in this event. Clyde T. Francisco writes, “Without a doubt God’s hand was at work here in a strange and mysterious way of preparing Israel for the work of the Righteous Mediator and Perfect Healer who was ultimately to come from the line of Abraham.”<sup>5</sup> God spoke to Abimelech in a dream in Genesis 6 and 7 telling him to restore to Sarah Abraham, and as a bonus, Abimelech and his family would also be restored for heeding God with faithful actions.

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<sup>4</sup>Ibid., 78.

<sup>5</sup>Clyde T. Francisco, *Genesis*, in vol. 1 of *The Broadman Bible Commentary*, rev. ed., ed. Clifton J. Allen (Nashville: Broadman, 1973), 183

Prayer is one of the necessary elements in pastoral care. Another is intentional pointing of people toward God—evangelism. The evangelistic aspect of this encounter could be when, as recorded in Genesis 20:4, Abimelech calls God *Adonai* a Hebrew term for God translated “Lord.”<sup>6</sup> It seems that Abimelech had a new recognition for who God was from the encounter based on the prayer of Abraham.

**Healing broken relationships.** As has been seen several times in the Old Testament, sickness of the body is portrayed as a result of disobedience to God—a spiritual issue with physical manifestations. The healing of the body confirmed the forgiveness of sin, but healing the body is not the entire picture of sickness and healing presented in the Old Testament. There are other places in the Old Testament, which do not point to sin as the reason for sickness, and where praying does not bring immediate healing. God’s relationship with Adam and Eve was broken and they were banished from the garden prepared for them because of their sin and disobedience (Gen 3:22). Prayer did not remedy this situation, and in fact, a “broken relationship with God could rightly be seen in the example of Adam and Eve’s ban from the Garden as a cause for additional pain and suffering.

In other Old Testament passages are found other situations where sickness is not the result of punishment or of having a broken relationship with God (at least in an immediate and direct sense, i.e., God exacting some sort of discipline). For example, the writer of Job records that there was no broken relationship between God and Job. Job was seen as a “righteous man” (Job 1:1). Job was tested through a most remarkable series of health-related experiences that ultimately brought Job and God to an even closer relationship than they had before those painful episodes. The culmination of a book-length epic of sickness, attempted pastoral care of friends, and finally of God’s direct

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<sup>6</sup>James Strong, *The Exhaustive Concordance of the Bible*, rev. ed. (Peabody, MA: Hendrickson, 1986), s.v. “*Adonai*.”

intervention as Job turned his eyes heavenward and prayed. Job prayed not only for his own healing, but for the healing of his misguided friends, as is found at the end of that record: “After Job had prayed for his friends, the Lord made him prosperous again and gave him twice as much as he had before” (Job 42:10).

Sin *can be* an indicator of a broken relationship with God. The story of Job in the Old Testament causes the reader to understand that illness may not always reflect a broken relationship with God. Sickness and disease can overtake even the faithful, and the occurrence of sickness or infirmity in a person does not necessarily reflect a broken relationship with God. Sickness may be used by God as an opportunity to advance spiritual and theological growth in the person, even to the salvation of the soul.

Job learned that man cannot always deduce the reason someone suffers. Moreover, Job realized that his suffering had been used by God to vindicate God’s trust in him over against the accusations of the accuser.<sup>7</sup> Suffering in the events of life, including illness, can bring us to a place where we meet God. Through our crying out, prayers, and the prayers of others on our behalf, our relationship with God becomes stronger and God guides us through the process of suffering.

**Praying for the sick does not always result in healing.** Illness can be a consequence of sin that one has committed. In 2 Samuel 12:1-10, David was confronted and rebuked by Nathan concerning his sin with Bathsheba. After having an affair with Bathsheba, David sent Uriah, Bathsheba’s husband, to fight in the front of the battle and Uriah was killed. Bathsheba became pregnant with David’s child. God struck the child and the child became very ill. In 2 Samuel 12:16-17 David pleaded with God in prayer and fasting to save his and Bathsheba’s dying son. David’s prayer was denied, and his son died. But, even after fervently praying for his son, we see David turning to God with

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<sup>7</sup>Richard D. Paterson and Herman J. Austel, *1-2 Kings*, in vol. 4 of *The Expositor’s Bible Commentary*, ed. Frank E. Gaebelin and J. D. Douglas (Grand Rapids: Zondervan, 1998), 1056.

all of his human strength and devotion after the son dies. Ultimately, we see David coming to realize that God is sovereign and that in coming to a place where trusting God is vital, David is able to say, “But now that he is dead, why should I fast? Can I bring him back again? I will go to him, but he will not return to me” (2 Sam 12:23). We see David moving forward with his life, procreating another child named Solomon, who would go on to usher in a realm of peace in Israel during his days as ruler.

In an attempt to understand all that is in this passage, the implication is that the death of David’s son came about because of David’s disobedience to God. The hopes of David’s prayer were vanquished at the death of the son. Yet, David realized what he had done and why the death had happened. The elders did not understand David’s behavior after the death of the child (2 Sam 12:21). God used this incident in David’s life to bring godly results for the future of David and Israel. Robert D. Bergen writes,

David the man of prayer ‘pleaded with God for the child.’ David’s efforts on behalf of his beloved infant were intense, fueled both by a father’s natural compassion for a sick child and by a profound confidence in God’s mercy. David’s self-denial and self-abasement probably should be interpreted as a demonstration of his remorse for the sins he had committed, carried out in an effort to gain reprieve for his son.<sup>8</sup>

Despite the announcement of the fate of David’s son by the prophet Nathaniel (2 Sam 12:14), David continued to mourn, pray, and fast, crying out to God that his son might be healed. David sets an example in praying for the sick even though the sickness is a result of sin. Prayer is the biblical avenue of hope in situations where change is required. In this instance David was counting on God to spare his son. David’s exhibition of faith and petition to God was seen in his mourning and his intercession to God. While David’s hope was ill founded, he was counting on the open door to God’s grace to be extended to him, saving his son from death. David’s continual emphasis falls

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<sup>8</sup>Robert D. Bergen, *1, 2 Samuel*, The New American Commentary, vol. 7 (Nashville: Broadman & Holman, 1998), 374.

on the sovereignty of God, but we as human beings still dare to hope that God's compassion will gain the upper hand in otherwise impossible situations.<sup>9</sup>

**The conditional aspect of prayer for the sick in the Old Testament.** Second Chronicles 7:14 includes a conditional clause to the prayer for healing the land: "If my people, who are called by my name, will humble themselves and pray and seek my face and turn from their wicked ways, then will I hear from heaven and will forgive their sin and will heal their land." This passage is a response to Solomon's prayer of dedication for the newly constructed Temple.

God is true to his word and his promise. While 2 Chronicles 7:14 talks about the healing of Israel, if and when the nation prays, the passage also provides a great example of how God responds to prayer in general:

He presents a conditional proposition to 'his people.' If they respond with humility and prayer, He will respond with positive healing of their land. . . . God promises to keep his eyes open and His ears attentive to the humble prayers offered by his people. The idiom [his people] means that they belong to Yahweh, hence Yahweh owes the protection.<sup>10</sup>

**The grace aspect of prayer in the Old Testament.** In 1 Kings 17:18-24 the son of a widow at Zarephath became sick and eventually died. The widow, whose name is not mentioned, thought her son's death was a punishment for her sin. She accused Elijah of bringing God's judgment unto her.

Elijah takes the dead boy upstairs to his own private room, where he stretches himself over the body in prayer three times. Normally this would be a violation and of the prohibition of touching a dead body (Num 9:6-7). Elijah ultimately gives a picture of God overshadowing death and bringing life.<sup>11</sup>

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<sup>9</sup>Ibid., 375.

<sup>10</sup>Edward L. Curtis, *A Critical and Exegetical Commentary on the Books of Chronicles 1 & 2*, International Critical Commentary (Edinburgh: T & T Clark, 1910), 350.

<sup>11</sup>August H. Konkel, *1 & 2 Kings*, The NIV Application Commentary (Grand Rapids: Zondervan, 2006), 297.

Peter J. Leithart states, “The widow thinks that her sins are an obstacle to Yahweh. Even sin is not impenetrable barrier, for Yahweh breaks through sin and demonstrates his forgiveness to the widow by raising her son from the dead, by giving new life, in her house.”<sup>12</sup> Sin brings death, but applying God’s grace through prayer brings resurrected life and life more abundantly. Keil, Martin, and Delitzsch make this point: “The mother of the son who, after seeing the result of Elijah’s prayer, recognized Elijah as a man of God and perceived the word of Jehovah in his mouth was truth, by which she confessed *implicit* faith in the God of Israel as the true God.”<sup>13</sup> This Old Testament incident points to the grace side of prayer in our relationship with God. God can move through and in spite of our own personal sin and struggle to provide the grace of forgiveness and healing.

Another potential aspect of 1 Kings 17:18-24 was that God was the instigator of the newfound faith of the widow at Zarephath. The incidents of the arrival of the prophet Elijah and the healing her son were to bring the faith of the widow to a “settled” maturity. Her sin was not the issue but rather a testing of her new found faith in God.<sup>14</sup> The use of this miracle brought a new awareness of faith in God to the widow. The miracle of healing and physical restoration may result in newfound belief in God. Exell and Spence write, “There was a non-conditional situation in Elijah’s prayer. The Lord heard Elijah’s prayer. God healed the son, or in this case, brought him back to life without condition. Elijah could not give life but he could ask God for it.”<sup>15</sup> When we

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<sup>12</sup>Peter J. Leithart, *1 & 2 Kings*, Brazos Theological Commentary on the Bible (Grand Rapids: Brazos, 2006), 128.

<sup>13</sup>Highlights in original text. Franz Delitzsch, James Martin, and Carl Friedrich Keil, *Biblical Commentary on the Old Testament* (Grand Rapids: William B. Eerdmans), 3:240, emphasis in the original.

<sup>14</sup>Joseph Exell and H. D. M. Spence, eds., *Pulpit Commentary* (Grand Rapids: Eerdmans, 1950), 5:409-10.

<sup>15</sup>*Ibid.*, 411.

pray for healing we do not know what the results will be. Often we can have the same experience as Elijah when those we pray for see the moving of God in healing or restoration.

In the examination of selected Old Testament texts demonstrating a perspective on pastoral care and healing in an evangelistic sense, it was discovered that God is central to any process of healing. As the New Testament examination proceeds below, the themes of the Old Testament are continued, with the added influence of the New Covenant and the power of the Holy Spirit operating in believers. Jesus said in John 3:14-15, “Just as Moses lifted up the snake in the desert, so the Son of Man must be lifted up that everyone who believes in Him may have eternal life.”

### **New Testament Examples**

**The body in the New Testament.** Any application of healing begins with the human body. The body is seen as similar in both Old and New Testaments. It is the physical body that suffers the effects of sickness and death, but it is also the spiritual element of that body that cries out for relief. Whether to God or to fellow man, the cries go up for relief and healing.

Those cries are most often in the form of petitions in prayer. The physical expression of knowing and approaching God for petitions is similar in the Old and New Testaments. Lifting hands was encouraged by Paul (1 Tim 2:8). Kneeling was Jesus’ practice when he petitioned his Father in heaven (Matt 26:39; Luke 22:41). The father of the prodigal son danced when his petition was granted and his son returned home (Luke 15:11-31). James makes clear in 5:13 that elders of the church should come and anoint the body with oil for healing.

In that God’s purpose is to bring salvation to the whole person He both heals and saves. The transliterated Greek word for salvation, *sozo*, is sometimes rendered “save” and sometimes “heal.” Indeed, in the story of the faithful centurion in Luke 7, the centurion dispatched his servants to go to Christ and ask him to “heal” (save) his son. Both senses, healing and salvation, show that God is concerned with the physical

dimension of our human existence. Salvation is equated with healing, and indeed can be seen as a form of “perfect healing” in that the saved individual will one day inherit an incorruptible body, never again to be in need of healing (1 Cor 15:42).

The incarnation of Jesus was the physical manifestation of God—God interacting in the physical dimension. The Gospel of John notes, “The Word became flesh and dwelt among us” (John 1:14). God became human and lived among human men and women as a man. Christ was full of life and had all the natural attributes of a man. His bodily form had the limitations of mortal men. His body had the same appetites as all human bodies. He was both God and man and at the appointed time he was the God-sacrifice Isaiah prophesied (Isa 53:5). Jesus was known and is known by the acts he performed with among the people.

Healing was one of the ministries of Jesus. His touch as well as being touched brought healing (Luke 8:46). *The Complete Book of Everyday Christianity* records the physical incarnation and healing ministry of Jesus like this:

The highest affirmation of the physical is in the incarnation of Jesus Christ. As the Gospel of John says, ‘The Word became flesh and dwelt among us’ (John 1:14 RSV). God became a living body and made a home among us: living, breathing, eating, celebrating and mourning with women, men and children. God became known through human flesh, breathing and pulsing with all the limitations and capabilities we have, miracle and mystery twined together. Jesus fulfilled his earthly vocation through his body: walking among the poor, kneeling in prayer, eating with sinners, washing feet, healing the sick. Jesus’ hands became a living extension of the heart of God; his bodily touch was central to loving and transforming people while on earth. Christianity’s regard for the body is stated so well by C. S. Lewis: ‘Christianity is almost the only one of the great religions which thoroughly approves of the body—which believes that matter is good, that God himself once took on a human body, that some kind of body is going to be given to us even in Heaven and is going to be an essential part of our happiness, our beauty, and our energy.’ The centrality of the incarnation and resurrection affirms the body as part of God’s intentional design, not only for our creation but also for our recreation. We are our bodies, and if God can honor the body enough to be revealed through it and to redeem us in flesh, we need to take the body seriously.<sup>16</sup>

There was a shift in the action of the New Testament concerning the sick. In the New Testament, Jesus instructed the disciples to visit the sick. There was an evident

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<sup>16</sup>Banks and Stevens, *The Complete Book of Christianity*, 78.



shift from conditional answer to prayer in the Old Testament to a grace-filled ministry effort where the disciples are to go, taking the ministry to sick people of their day.<sup>17</sup> In Matthew 10:7-8, Jesus tells the disciples to “heal the sick, raise the dead, cleanse those who have leprosy, and drive out demons.” The emphasis of Jesus is on preaching the gospel, but a by-product of that preaching ministry is that the disciples were to be engaged in healing activities while they were going to spread the gospel. This is the introduction of putting feet to the ministry of Jesus. The Great Commission was being born and evidenced through the new ministry given to the disciples.<sup>18</sup> John McArthur calls these the “confirming credentials” of the disciples.<sup>19</sup>

**Visiting and caring for the sick.** In Matthew 25:34-39, Jesus tells the disciples that visiting and caring for the sick mark the lifestyle of a disciple. To the surprise of the servants, Jesus honored the disciples for living out the lifestyle of one of his followers when he reminded them of the good things they had done. The fact that they did not remember what they had done denotes the self-denying, sacrificial service of the servants. Jesus points out that self-sacrificing servanthood in the verses to follow. “For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me” (Matt 25:35). An active servant’s heart is explained in the *Expositor’s Bible Commentary* entry: “Although the New Testament clearly teaches that deeds of kindness

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<sup>17</sup>Ibid., 79.

<sup>18</sup>Robert H. Mounce, *Matthew*, New International Biblical Commentary, vol. 1 (Peabody, MA: Hendrickson, 1985), 236.

<sup>19</sup>John McArthur, *Matthew 8-15*, in *The MacArthur New Testament Commentary* (Chicago: Moody, 1987), 190.

in and of themselves do not secure salvation, it also teaches that when faith is real it must of necessity express itself in a life of concern for others.”<sup>20</sup>

Our motives in this ministry must be pure. If we minister as an act of duty, we will not see godly results (Matt 6:1). If we minister for selfish reasons, we will not have the reward from heaven we might expect. Acts 8 gives us a picture of Simon the sorcerer, who was told he could not be a part of the ministry because his heart was not right with God. His motive was for personal gain. As ministers we must be sure we are serving in the sacrificial example of Christ. Michael L. Simpson’s writes in his book, *Permission Evangelism*, “Pure motives bring joy in ministry.”<sup>21</sup>

**Compassion and prayer in faith for the sick.** In Luke 7:1-10, Jesus responds to one who called on him for healing and reveals his compassion for those who need healing. Revisiting the story of the Roman centurion, Jesus was asked to heal the centurion’s son, and the centurion may have felt unworthy to have Jesus come to his home. In verse 9 the centurion was cited by Jesus as having “faith he had not seen in Israel.” This healing effort by Jesus was in response to the great faith of the Roman centurion.

Jesus was amazed that a Gentile would have the kind of faith that he had not seen in Israel in God’s chosen people who should have known that Jesus, as the Son of God, could heal. Luke’s emphasis on faith implies more than just a person who believed in a person that could heal. The centurion sought out Jesus specifically, and expressed his faith in the healing ability and power of Jesus. It was this faith, demonstrated by actions, that seems to have led the centurion to a conversion into Christianity.<sup>22</sup> The

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<sup>20</sup>Paterson and Austel, *1-2 Kings*, 140.

<sup>21</sup>Michael L. Simpson, *Permission Evangelism* (Colorado Springs: David C. Cook), 2003), 152.

<sup>22</sup>Robert H. Mounce, *Luke*, New International Biblical Commentary, vol. 1 (Peabody, MA: Hendrickson, 1985), 114.

same faith that brought physical healing to the centurion's home also brought spiritual healing to the centurion's soul. Chaplains and ministers should emulate the Centurion.

There were reasons for the centurion asking Jesus not to come to his home. For a Jew to enter a Gentile's home would defile him ceremonially. The centurion knew that the defiled state would occur and did not want to subject Jesus to ritual impurity.<sup>23</sup> This favors the view that "unworthiness" rather than "uncleanness" is the greater issue. No reason is given for this sense of unworthiness in the centurion. The elders had already affirmed that he was worthy, but in his modesty he would not accept his worthiness. The centurion's humility is an example to all who are in the ministry. The fact that he realized Jesus did not have to be present to heal his son was the action that sparked the comment from Jesus about the degree of faith the centurion had. True faith realizes that God can heal apart from rituals, special ointments, touch, or monetary gifts to the healer.

The presence of Jesus makes possible evangelistic and healing ministry encounters for ministers today. This instance in the book of Luke is an example of the compassion Jesus had for those that are sick. The passage is also an example of Jesus' ministry to the dying and their families. Verses 11-17 of Luke 7 gives another example of Jesus' compassion for the dying.

Soon afterward, Jesus went to a town called Nain, and his disciples and a large crowd went along with Him. As he approached the town gate, a dead person was being carried out—the only son of his mother, and she was a widow. When the Lord saw her, his heart went out to her and he said, "don't cry" (Luke 7:11-12)

Jesus was driven by his compassion for the woman's grief. In this account the woman's son is brought back to life. The focus is on the compassion of Jesus, which is an example to ministers as they share message of Christ. The disciples saw first hand the compassion of Jesus. The example of the disciples in calling on Jesus would be an example for ministry to the family of the dying.<sup>24</sup> While ministers today may not raise people from

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<sup>23</sup>Ibid.

<sup>24</sup>Leon Morris, *Luke*, Tyndale New Testament Commentaries, vol. 3 (Carol Stream, IL: Eerdmans, 1982), 138.

the dead, they do minister to the family of the sick, dying, and to the bereaved after a loved one has died. The woman's dire situation caused Jesus to have compassion on her. This compassion, however, was no condescending pity but rather a loving concern.<sup>25</sup>

**Christ's pastoral ministry to the sick.** The New Testament presents several examples, listed below, of evangelistic pastoral care ministry to the sick, including the healing ministry of Jesus and how he instructed and authorized his disciples to do the ministry of healing. The leper in Matthew 8:23; Peter's mother-in-law in Matthew 8:5-10, the woman with the issue of blood in Mark 5:25-34, and the restoration of Malchus's ear in Luke 22:49-51, all fit in the category of healing and pastoral evangelistic ministry.

The ministries of evangelism and healing are pertinent today. They work together to build the kingdom of God. These examples from the work of our Savior show us that we have a responsibility and an authority to perform the ministry of evangelistic pastoral care amongst the people and within the church. The role of the pastoral evangelistic healing minister can be found in the field of work in the church, the hospital, and to the sick in general and all aspects of the evangelistic healing ministry can work to fulfill the Great Commission. As Christ ministered to the sick with the good news of the Gospel through pastoral care, chaplains and ministers too have the mandate to likewise. The healing ministry of Jesus was a visible sign the kingdom of God was drawing near.<sup>26</sup> As ministers and chaplains perform the healing ministry of Jesus, they also declare that the kingdom of God is near.

### **A Model for Praying for the Sick**

In James 5:14, James gives us a model for praying for the sick: "Is any among you sick? He should call for the elders of the church to pray over him and anoint him

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<sup>25</sup>Robert H. Stein, *Luke*, The New American Commentary, vol. 24 (Nashville: Broadman, 1992), 220.

<sup>26</sup>*Ibid.*, 221.

with oil in the name of the Lord.” James teaches that if someone is sick, he should call for the elders of the church to anoint the sick with oil in the name of the Lord. The calling of elders is the first step in the process of praying for the sick.

The Bible spells out five duties and obligations of the elders. They are to help settle disputes within the church, pray for the sick, watch over the church in humility, watch over the spiritual life of the flock, and spend time in prayer and teaching of the word.<sup>27</sup> The spiritual maturity of the elder gave the congregation confidence in their ability to receive answers to their prayers for the sick. Both Old Testament Judaism and New Testament Judaism were governed by elders. Each synagogue, town, and national unit had its elders. Paul appointed elders under the inspiration of the Holy Spirit (Acts 14:23).<sup>28</sup> Paul’s ability to call on the elders so readily would indicate that elders were available and at hand when the time for ministry to the sick was needed in the community.

The elders, persons of spiritual authority within the congregation, could come to the place of the sick, since the manner of sickness could affect the whole fellowship.

The act of going to the sick would show a concern for the physical needs of the sick by the congregation. The movement of the congregation to the sick would demonstrate that sickness is not a cause for exclusion, but an opportunity for concern for physical needs of each member.<sup>29</sup>

It was assumed these men were especially blessed by the Holy Spirit. These men could also pray for the sick person from a remote location, but here James says the sick can call for the elders to come and pray for them.<sup>30</sup>

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<sup>27</sup>Alexander Strauch, *Biblical Eldership: Restoring the Eldership to Its Rightful Place in Church* (Colorado Springs, CO: Lewis and Roth, 1997), 277.

<sup>28</sup>*Ibid.*, 222.

<sup>29</sup>Ralph P. Martin, *James*, Word Biblical Commentary, vol. 48 (Waco, TX: Word, 1998), 206-07.

<sup>30</sup>Kurt A. Richardson, *James*, The New American Commentary, vol. 36 (Nashville: Broadman and Holman, 1997), 231.

Elders were to anoint the sick with oil in the name of the Lord (James 5:14). Oil at times was used as a medicine (Luke 10:34). It was an outward, physically observed sign of the spiritual power of prayer. The application of oil by believing elders corresponds to the prayer for healing as water does to baptismal prayer; the name of the Lord invokes the power and authority of the action.<sup>31</sup>

It is suggested by some religious traditions this anointing was made effectual by the sacraments and rituals provided by priests as a part of their ritualistic function. The word *aleipsantes* (anoint) is not the usual word for sacramental or ritualistic anointing. The word *chrío* is the word for this anointing. . . . Oil was one of the most common uses for healing in biblical times.<sup>32</sup>

Richardson writes,

This anointing was a symbol to the sick for prayer and healing. Elders of the church would be requested by the sick, and they would come to perform the ministry of prayer and healing. The anointing with oil is not merely a kind of home remedy. As it is applied, the name of the Lord Jesus is to be invoked.<sup>33</sup>

Burdick suggests, “Olive oil, according to the Old Testament and Jewish understanding, was prized for its nurturing of human well-being and for its healing properties.”<sup>34</sup>

Jesus and the disciples used oil in their healing of the sick when combined with the preaching of repentance in Mark 6:12-14. The use of oil combined with the prayer for the sick was a tool for healing. In the case recorded in Mark, the anointing was done as an act of faith. The act of anointing is done in faith by the authority of Christ, where the power of healing may come in obedience to the word of God.

James 5:15 shows the necessity of the faith on the part of the sick for the healing to take place. James says the prayer of faith will save the sick. The plea from the

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<sup>31</sup>R. V. G. Tasker, *The General Epistle of James*, Tyndale New Testament Commentaries (Carol Stream, IL: Tyndale, 1983), 129.

<sup>32</sup>Peter H. Davids, *James*, New International Biblical Commentary (Peabody, MA: Hendrickson, 1983), 123.

<sup>33</sup>Richardson, *James*, 233.

<sup>34</sup>Donald W. Burdick, *James*, in vol. 12 of *The Expositor's Bible Commentary*, ed. Frank E. Gaebelein (Grand Rapids: Zondervan, 1998), 204.

sick united with the authority of the elders was the effective prayer for healing of the sick. The word for healing here, translated “make well,” is the same word used for “save.” Although there is anointing with oil and laying on of hands, it is the power of God that has the healing properties that those who are sick call for. The fact the passage states that the prayer of faith shall save the sick does not make it different from any other kind of prayer. The prayer of the elders does not imply with certainty that only if there is a sufficient degree of faith, will God answer prayer. An example of the inability of the sick person to do much by way of their own healing is found in James 5, as explained by Richardson, “The transliterated Greek word used here [in James 5:15] for sick is *ton kammonta*, and this is the only place it is used in the New Testament. It is the present participle of a verb whose primary meaning is to ‘grow weary’ with the secondary sense of growing weary by reason of sickness.”<sup>35</sup> The promise of God, and the ministry of the elders as found in James, is that God will raise up the sick person. Tasker explains further the actual role of God versus the prayers of the elders:

The lord will raise him up. In Greek it is clearly physical healing, not just spiritual preparation for death, that James is concerned with, and it is the Lord’s action that does the healing, not the oil, the hands, or the power of the elders. The Lord remains sovereign: God answers prayer; he is not compelled by prayer.<sup>36</sup>

### **Biblical Hope for the Dying**

The Old Testament speaks of the certainty of death for everyone. In Genesis 2:16, God told Adam he could eat of the fruit of any tree in the Garden of Eden except for the tree of knowledge of good and evil. If he ate the fruit of that tree, he would surely die. Genesis 2:16 is the first reference to death in the Old Testament. The first actual human death is recorded in Genesis 4:8. This instance of death occurred as a response to sibling rivalry between Cain and Abel.

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<sup>35</sup>Richardson, *James*, 232-33.

<sup>36</sup>Tasker, *The General Epistle of James*, 133.

In 2 Samuel 14:14, the wise woman of Tekoa tells King David: “Like water spilled on the ground, which cannot be recovered, so we must die.” In the words given to the woman of Tekoa from Joab, this statement was used to say that everyone must die at sometime or another. From Genesis to this time death is with us and is seen as natural.

Job writes in 30:23 that he realizes death is a certainty: “I know you will bring me down to death, to the place appointed for all the living.” He was sure of death but also realized the place he would be after his death. Job’s confrontation with death was a time in Job’s sufferings when he addressed God concerning what he described in earlier verses as abuse. Job had come to a place in his life where he began to dialogue with God about the pain and suffering he was going through. In all this he realized that “it is appointed unto man once to die (cf., Heb. 9:7)”<sup>37</sup> Robert Alden notes,

At this point Job is certain that God would let him die. Job’s prayer ends on a depressing note. Job feels as if God is not responding to him, and non-response is the greater pain of his condition. As Job begins to understand God’s purpose and reason, he describes death as the “land of the living.”<sup>38</sup>

In 1 Kings 17:21 Elijah prays for the soul of the boy return within his body. He did not pray that the body would come back to life. While resurrection and resuscitation are not the same they do provide some insight into the Old Testament’s view of afterlife. There is support for the existence of *nephesh* after death apart from the body. This passage brings hope for life after death in the Old Testament. After his faith-filled prayer, Elijah gave the living son back to his mother.

### **New Testament Hope for the Dying**

The New Testament, like the Old Testament, speaks of the certainty of death for everyone. An added dimension of the New Testament is that it is written on the

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<sup>37</sup>Everett F. Harrison, *Romans*, in vol. 10 of *The Expositor’s Bible Commentary*, ed. Frank E. Gaebelin (Grand Rapids: Zondervan, 1998), 61.

<sup>38</sup>Robert L. Alden, *Job*, The New American Commentary, vol. 11 (Nashville: Broadman, 1994), 295



premise that people who trust Christ will never die. Though there is a distinction made between physical death and spiritual death, the coming of Jesus and the New Testament or the New Covenant gives us the true understanding of life after death, and with that new meaning, a reassurance that those “in Christ” will not perish eternally, though their physical bodies die on earth (Matt 18:14; Luke 21:18).

Romans 5:12 gives us a clear statement about death for every person:

“Therefore, just as sin entered the world through one man, and death through sin, and in this way death came to all men, because all sinned.” This passage of Paul clarifies the Old Testament teaching of how death entered into the world (cf., Gen. 2:16-17; 3:1-24).

The disobedience of Adam and Eve in the Garden of Eden brought sin into the world when they ate from the tree God had specifically told them not to eat. Romans 5:14 states that sin entered into the world and brought death as the result. Mounce states, “In verse 12 Paul pictures sin and death as entering the whole world through one man, with the result that death permeated the whole of mankind.”<sup>39</sup> Verse 12 in the passage states that every human being will die and gives the reason for death entering into human life; the reason is sin which is disobedience to God.

It was to Adam that God gave the responsibility for the care of the garden, and with that, oversight of the forbidden tree. Mounce shares, “Satan made his appeal through Eve, but Adam rightfully bears the responsibility since he was God’s appointed representative of the race.”<sup>40</sup> Rebellion against God cost humanity the ability to live forever and it is not until our original state is restored by Jesus that we will re-inherit life without end.

Hebrews 9:27 gives another statement about the certainty of death for everyone. Already cited above in the thought of Job, verse 27 states, “And it is appointed

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<sup>39</sup>Robert H. Mounce, *Romans*, The New American Commentary, vol. 27 (Nashville: Broadman & Holman, 1995), 140.

<sup>40</sup>Leon Morris, *Hebrew-Revelation*, in vol. 12 of *The Expositor’s Bible Commentary*, ed. Frank E. Gaebelein (Grand Rapids: Zondervan, 1981), 93

for men to die once, but after this the judgment.” Men are destined to die once. Dying is not something within their control. Donald Guthrie makes clear, “A condition of life here on earth is that it ends in death.”<sup>41</sup> Death in itself is unavoidable. God appointed men to die once. No one can escape from this experience. Harrison notes, “The difference between Christ's death and all others is that his was voluntary whereas for all others it is appointed; stored up for them.”<sup>42</sup> We will die, and we should prepare ourselves for that eventuality.

Beyond death, however, is the hope of eternal life. The security of eternal life comes from receiving the provision of life after death provided by the sacrifice of Jesus Christ. John 6:27 states, “Strive for the food which endures to everlasting life, which the Son of man will give you, because the Father has set his seal on Him” (NKJV). The seal of eternal life comes from receiving Jesus Christ as personal savior. Then the believer can secure the hope of eternal life. John 10:28 also gives the assurance of eternal life. Tenney remarks, “The ‘sheep’ are guaranteed eternal life and permanent protection; all the resources of God are committed to their preservation. Eternal life is given to them, not earned by them, and they themselves are given to Christ by the Father.”<sup>43</sup> Verse 28 gives the eternal promise, “No one can snatch them out of my hand.”

Hebrews 10:36 gives us the promise that belongs to the Christian who perseveres to the end, “You need to persevere so that when you have done the will of God, you will receive what he has promised.” To be and remain in the Son (and the Father) is life. The gift from God is eternal life.<sup>44</sup> Norman Hilyer writes,

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<sup>41</sup>Donald Guthrie, *Hebrews*, Tyndale New Testament Commentaries (Grand Rapids: Eerdmans, 1983), 199.

<sup>42</sup>Harrison, *Romans*, 61.

<sup>43</sup>Merrill C. Tenney, *John and Acts*, in vol. 9 of *The Expositor's Bible Commentary*, ed. Frank E. Gaebelein (Grand Rapids: Zondervan, 1981), 112.

<sup>44</sup>Thomas F. Johnson, *1, 2, and 3 John*, New International Biblical Commentary, vol. 17 (Peabody, MA: Hendrickson, 1993), 60.

All God's gifts to the believer are due to the divine Mercy, a note struck in the opening prayer of the book of Jude. God has committed the final judgment to the Lord Jesus Christ, and it is he who will bring you to eternal life, for that life is his gift.<sup>45</sup>

### **Conclusion**

Ministers and chaplains are called to pray to God to intercede for those to whom they minister. Especially important is the intercessory prayer on behalf of the sick and dying. The minister or chaplain can approach the throne of God with boldness in their intercessory prayer for others, especially now since the sacrifice of Jesus Christ the Savior. As the faith of ministers and chaplains increases, their understanding of this passage of Scripture may be shown more clearly: "Let us then approach the throne of grace with confidence, so that we may receive mercy and find grace to help us in our time of need" (Heb 4:16).

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<sup>45</sup>Norman Hilyer, *1 and 2 Peter, Jude*, New International Biblical Commentary, vol. 16 (Peabody MA: Hendrickson, 1992), 264.

CHAPTER 3  
PASTORAL CARE AND EVANGELISM  
IN DYING SITUATIONS

The ministry of evangelism to dying persons is a crucial ministry, considering the stage to which the dying person has come. From the dying patient's point of view, the opportunity to speak to someone evangelistically about death and dying may be the last chance he or she has to secure hope in heaven before his or her impending death. For the individual ministering to the patient, there is a feeling of responsibility to lead the person to an understanding of the need to accept the promise of hope God has provided for us in life after death. In the hospital setting with patients, there are certain principles the caregiver should follow in ministering to the dying.

Many hospital administrations have instituted policies to protect patient rights and to insure that no patient feels as if he or she is being persuaded or proselytized toward belief in any certain religious dogma against their will. These administrators feel that there is a need to protect a patient's right to freedom of religious expression, especially at a time when a patient may be facing imminent death when he or she might be vulnerable to suggestive thoughts. The pastoral caregiver must be sensitive to both the patient's feelings of nearing the end of life and the mandates of the hospital administration designed to protect patient rights.

**Understanding the Issues of Dying**

The news of imminent death brings a shock to both patient and family; the news of losing a loved one usually comes from a family physician after every effort to preserve life by that physician and other specialists has been made. In the hospital setting there are options the actively dying patient may have to consider when preparing for the

issues of dying he or she will face. Palliative care is a major program that assists the dying patient and their family find comfort, counseling, and consultation in this end of life time. Physicians, nurses, social workers, palliative care specialists, and chaplains play a role in the end of life care for the patient. This team is trained and specializes in the issues the dying patient and their family will face. In order to better understand the way family interacts, especially in evangelistic endeavors during the potential death of an individual under hospital care, an investigation of the role of family systems is in order.

Michael E. Kerr and Murray Bowen state that family systems are developed by a particular pattern or patterns of emotional functioning learned in the family system. The tendency to stereotype patterns and emotions of behavior by culture should be avoided.<sup>1</sup> In the hospital setting it may be difficult to understand the family system based on the culture of the family. It is important to walk with the family and discover and encourage their emotional process as you stand alongside the patient and family. Understanding the cultural background of a family is a part of that process. Derald Wing and David Sue describe three cultural barriers to counseling different cultures. The first consideration is the sociopolitical and biological culture of the patient. The second consideration is that language barriers can be a disadvantage in communicating with patients. A third consideration is that culturally-bound issues play a big part in communication with patients.<sup>2</sup>

Men and women can approach the news of imminent death in different ways. Most of the early research into the response to dying issues was done from a male perspective. Denial was one of the major aspects discovered. Denial comes as the person who is dying considers who they will leave behind. Denial may be especially true

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<sup>1</sup>Michael E. Kerr and Murray Bowen, *Family Evaluation* (New York: W. W. Norton, 1998), 163.

<sup>2</sup>Derald Wing Sue and David Sue, *Counseling the Culturally Diverse* (New York: John Wiley & Sons, 2008), 135-36.

with fathers who will leave children behind. It is important to understand the impact of family systems in the grieving process.

### **Grief Issues of Dying In Patients and Families of Dying Patients**

As a person comes to the place in his or her life when he or she knows death is very near, their perspective about life can go in several different ways. Elisabeth Kubler-Ross describes five stages persons may go through when faced with mortality. These five stages are denial, anger, bargaining, depression, and acceptance.<sup>3</sup>

Denial as explained by Kubler-Ross is the first way of accepting the loss. George W. Bowman III writes, “Denial is a common emotional response to the primal drive to live.”<sup>4</sup> Dying patients sometimes may deny the news of death when approached. This denial may fly in the face of facts to the contrary.

Anger is the second stage of grief as explained by Ross in both dying patient and family of the dying patient. Patient feelings of anger have a wide range of sources. The dying patient is often angry with him or herself, with the circumstances of death, and even with God at this point.<sup>5</sup> The anger of the family of the patient is apt to surface “when the family feels safe enough to survive whatever comes.”<sup>6</sup> Anger is necessary for acceptance with the patient and the family in the process of grieving. Anger can go on for a long time. It will surface toward self, medical doctors, counselors, and God.<sup>7</sup> Anger means the patient and families are processing their feelings. Guilt may arise during this

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<sup>3</sup>Elisabeth Kubler-Ross and David Kessler, *On Grief and Grieving* (New York: Scribner, 2005), 7.

<sup>4</sup>George W. Bowman III, *Dying, Grieving, Faith, and Family* (Binghamton, NY: Haworth, 1998), 48.

<sup>5</sup>Elisabeth Kubler-Ross, *On Death and Dying* (New York: Scribner, 1969), 83.

<sup>6</sup>Kubler-Ross and Kessler, *On Grief and Grieving*, 11.

<sup>7</sup>*Ibid.*, 13.

time which is explained by Kubler-Ross as anger turned inward.

Bargaining is the third stage according to Kubler-Ross and usually begins with begging God for healing. Both patient and family plead and bargain. They begin to look at the circumstances leading to this time and think that if they had only done things differently the result might now be different. Bowman writes, “Guilt is a bargaining companion.”<sup>8</sup> When the patient dies, the family begins to think about what they could have done differently that might have saved their loved one. Bowman says bargaining is the second stage with the dying patient. In this desperate stage the patient tries to do what he or she can to extend life. Non-religious people sometimes began to bargain in religious terms.<sup>9</sup>

The fourth of Kubler-Ross’s stages is depression. There are two different types of depression, one is open and expected. This depression is a normal stage of grieving. For the patient it is often the beginning stage of acceptance of dying. Often at this stage of dying, loved ones and family tend to encourage patients with the hope of the brighter things in life. Often this encouragement is done to meet a family member’s own needs and with those needs the inability to tolerate their own loss rather than as a means to encourage the one who is dying. Depression can, however, be used as a tool to move patients to acceptance. When the depression stage is used by the chaplain or palliative care professional to prepare for the loss of things people love and miss, patients should not necessarily be encouraged to look at the bright side of life. The patient may be beginning to contemplate his or her own death, which is a necessary step in the process of preparation.

A second type of depression is more silent than the first. The patient needs more physical touch for comfort and less verbal dialogue. Kubler-Ross suggests, “It is

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<sup>8</sup>Ibid., 17.

<sup>9</sup>Bowman, *Dying, Grieving, Faith, and Family*, 58.

the discrepancy between the patient's wish and the readiness and the acceptance of those in his environment which causes the greatest grief and turmoil in our patients."<sup>10</sup> Hospital chaplains are a good resource for patients and families in these kinds of situations. The time any chaplain or minister has in a patient's room is not long, sometimes as short as fifteen minutes. It is difficult to build relationships in the short amount of time spent with a patient. Because of the condition of the patient, it can open the door to talk about spiritual feelings and needs of the patient and the family. Adequate training is needed to be available to patients and families in these situations. A significant part of the training is to know when to refer the patient for the next step of their process.

The fifth stage according to Kubler-Ross is acceptance. Not all patients come to a place where they can accept that death is inevitable, however, most eventually do. Coming to acceptance should not be mistaken for a happy stage in the stages of death and dying. The feeling level of the patient during this stage is almost non-existent.<sup>11</sup> During this stage, the family usually needs more support than the patient. The patient usually wants to be left alone and to not hear about things happening in the outside world. They need silence, and visitors may need to sit and hold his or her hand in silence.

There are a few patients who will fight to the end. These patients find it almost impossible to make it to the stage of acceptance. When they finally give up to death, they have little energy left and are exhausted from non-acceptance. Family, and sometimes hospital staff, can contribute to this because they encourage the patient to keep on fighting. Family and staff can often encourage a patient so much he or she feels as if it is cowardly to accept the stage of death he or she is in at the present. The disconnect between the reality of the situation and the hopes of the family or patient can make the

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<sup>10</sup>Kubler-Ross, *On Death and Dying*, 98.

<sup>11</sup>*Ibid.*, 124.



acceptance stage of dying harder for the patient to accept. He or she wants to be all they can be for the family who cannot accept the stage of the patient. At times a family may leave the patient on life support for weeks because of the unified family message to the patient to stay strong, even long after any real hope for life is past. For the patient's loved ones and family, acceptance of the fact that one of their own is dying can leave them with a range of feelings from withdrawal from life to wondering if there is any reason to go on with their own life. Depression is an appropriate and normal response.<sup>12</sup> If grief is a process of healing, then depression is one of the necessary steps in the process.

There is no set pattern for the five stages, and people will not always go through all of the stages. Not everyone goes through all of them, and there is no prescribed order. Since the explanation of these stages could easily be misunderstood, they are not always a tool that compartmentalizes the stages of dying so that grief could be placed in packages and dissolved. They are given as a reference to enable persons and their families going through death an understanding of the process of emotions in loss of life of a loved one. Wayne Oates calls this emotional outpouring "anticipatory grief," a state of being where all hope of continuing life is gone and the loss becomes real in the process.<sup>13</sup> In the hospital setting there is a realization that physical conditions can be serious. Finding oneself in the hospital in today's world means the discovery that one is sick otherwise the admittance procedure would not be completed. The anxiety, and, in some cases, the grief process begin when the patient is told that he or she has to be admitted to the hospital. At this point the anticipatory grief begins. When the diagnosis is favorable, the anxiety is lessened. There is, however, always a certain amount of anxiety when a person is admitted as a patient in a hospital.

The stages of dying are helpful in understanding the grief issues of patients. It

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<sup>12</sup>Kubler-Ross and Kessler, *On Grief and Grieving*, 21.

<sup>13</sup>Wayne Oates, *Your Particular Grief* (Philadelphia: Westminster, 1981), 28.

is helpful to know the family and the patients share the same stages of grief. The outcomes are different because the loss is different.

### **Death and Dying Issues from a Terminal Disease**

The issues that arise when a person is told he or she is terminally ill vary from social, personal, relational, and spiritual aspects. Social issues range from the way that the dying person appears physically to the person's peers (often in physical disarray), to how those peers or family members will be perceived after the loss of an integral family member, to loss of the patient's self-dignity, to being a burden to others. The current health care crisis has caused many people to be financially drained while paying for their healthcare. The financial aspect of death is a social issue in that it is a financial drain to the patient and family. Being terminally ill in American society is a reminder that the ill person is a drain to society. The message can be for the elderly to limit their use of resources to make way for the young and vigorous in the society.<sup>14</sup>

Some people begin to lose a feeling of dignity when they are terminally ill. The person may not be able to dress themselves. Their physical faculties may be disintegrating, leaving others to do private physical tasks for them. The person's sense of self worth may deteriorate when they can no longer fill the roles and responsibilities of a spouse, children, co-worker, and friends.<sup>15</sup> At this point Hospice may be called in to give the patient comfort measures only as treatment of their disease. The patient loses more sense of worth as the quality of life declines. If the patient is in the hospital, he or she is in foreign territory which feels uncomfortable and invasive.

The spiritual needs of the terminally ill patient are evident in the dying process. The patient's spiritual needs are hope and security in the life after death. Larry Platt and

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<sup>14</sup>Ira Byock, *Dying Well* (New York: Berkley, 1997), 242.

<sup>15</sup>*Ibid.*, 85.

Roger Branch suggest, “The process of death and dying offers an opportunity for true Christian caring by which we forge a very personal bond among God, ourselves, and the dying patient.”<sup>16</sup> Oftentimes the minister stands in the gap with the patient, the family, and the hospital care givers. The chaplain is a resource during this time to communicate with the family what is taking place with the medical professionals, the patient and the family.

### **Death and Dying Issues from an Accidental or Unexpected Death**

With an accidental or unexpected death in the hospital setting, a chaplain may go to the emergency department to be with the patient and family. In cases of sudden or unexpected death, the ministry is primarily with the family. Information can be gathered from the desk clerk in the emergency department, if there is time. In some cases there is no time to talk with anyone but the family of the patient. There is a range of emotions that take place in just a few moments. All of the emotions connected to shock can come all at once. Shock includes alarm, disbelief, and panic.<sup>17</sup>

When all these feelings come at once, there can be sudden physical and emotional reactions. Some family members can even have periods of fainting and become unconscious. The unreality of the loss is a major factor in the process. The family members cannot believe what has happened to their loved one. There is a sense of unreality or a feeling like it is a bad dream.<sup>18</sup> Guilt is another feeling family members often experience. Reviewing the time previous to the incident, the family members wonder what they could have done differently to prevent the death. There can be a need to blame someone for the sudden death. This can be turned inwardly or outwardly to someone else close to the situation.

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<sup>16</sup>Larry A. Platt and Roger G. Branch, *Resources for Ministry in Death and Dying* (Nashville: Broadman, 1998), 141.

<sup>17</sup>Oates, *Your Particular Grief*, 46-47.

<sup>18</sup>J. William Wooden, *Grief Counseling and Grief Therapy* (New York: Springer, 2002), 125.

Legal involvement when someone dies can lengthen the grieving process, especially if there is suspected foul play in the death. Some people find closure when the legal process ends and the people involved are justly punished for the crime that resulted in the death of their loved one.<sup>19</sup> The counselor should realize in helping the family that the desire for retribution may be defense against reality and the pain of death.<sup>20</sup> A final feature can be helplessness. Edward Rynearson states, “This type of death is an assault on our sense of power and orderliness.”<sup>21</sup> There seems to be no answers to the tragedy, and, in the quest for reasons why, many times there are none. The minister can be a source of comfort as the family tries to understand why this event took place. Some people begin to have a need to understand. It is a journey for them, and the chaplain can walk alongside the family even though there seems to be no answers to their questions.

### **Cooperation with Hospital Staff**

Communication with hospital staff in the death and dying event of patients is a major comfort to the family. The interaction with chaplains and staff is a benefit to the patient and his or her family in that most settings the chaplain has the freedom to talk with the hospital staff and convey messages to the family during the crisis. They can act as a liaison between the family and staff and bring helpful, sometimes comforting, information to the family as they wait to hear the news, good or bad, from the doctor. Platt and Branch give a diagram of the minister’s arena of interaction with dying patient that includes interaction with hospital staff in the process.<sup>22</sup>

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<sup>19</sup>Ibid., 126.

<sup>20</sup>Edward K. Rynearson, *Violent Death: Resilience and Intervention Beyond the Crisis* (New York: Taylor and Francis Group, 2006), 49.

<sup>21</sup>Ibid., 126.

<sup>22</sup>Platt and Branch, *Resources for Ministry in Death and Dying*, 140-41.

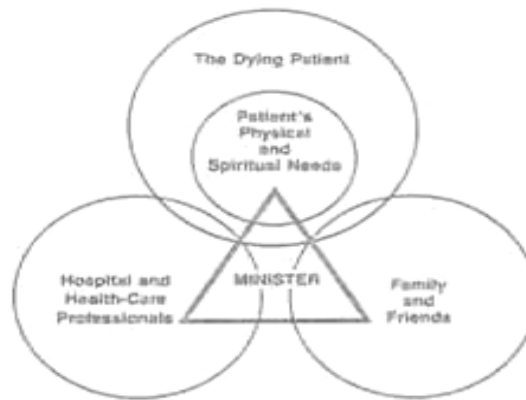


Figure 1. Minister's Arena of Interaction with Dying Patient

A positive relationship with hospital professionals takes time and more effort on the part of the chaplain than the hospital health care professionals. This positive relationship pays off with valuable benefits in the process of doing pastoral care in the hospital. The nursing staff is much more ready to accept chaplains as part of the team than the physician staff. Nurses will welcome chaplains when they realize the chaplain cares for their patients as much as they do. Physicians and administrative staff are fully aware of their status and authority and may be reluctant to share their information which is basic to their power.<sup>23</sup> Chaplains can cultivate a working relationship with healthcare professionals when the need arises for their integration of pastoral care and the medical practice. Trust is the key element in the process. If there has been an inappropriate response from a chaplain, there is a break in trust and that may take a long time to repair.<sup>24</sup> A specialized chaplain can engender trust with physician and nurses if they are caring and sincere in their ministry in the hospital.<sup>25</sup>

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<sup>23</sup>Toni J. Sullivan, *Collaboration: A Health Care Imperative* (New York: McGraw Hill, 1998), 501.

<sup>24</sup>Larry VandaCreek and Laurel Arthur-Burton, "The Chaplain-Physician Relationship," *Journal of Healthcare Chaplains* 3, no. 2; 1991: 5-18.

<sup>25</sup>Elisabeth Kubler-Ross, *Death: The Final Stage of Growth* (New, York: Touchstone, 1975), 85.

## **Guidelines for Evangelism of the Patient and Family: When to Listen, When to Speak**

We began with a brief definition of evangelism. “Evangelism is a concerted effort to confront the unbeliever with the truth about and claims of Jesus Christ and to challenge him with the view of leading him into repentance toward God and faith in our Lord Jesus Christ and, thus, into fellowship of the church.”<sup>26</sup> According to Michael L. Simpson in *Permission Evangelism*, the world’s definition of evangelism is *militant zeal*.<sup>27</sup> Simpson’s definition is certainly not God’s definition of evangelism. The author goes on to say that “God intended our zeal for reaching others to be born out of our personal experience with him, filling us with such great peace of the Holy Spirit that we must often respond to questions concerning our evidence of hope.”<sup>28</sup> Earlier in this chapter several dynamics a patient and family encounter when given the news of imminent death were discussed and those dynamics play into the role of the evangelist. Understanding these dynamics can give the minister or chaplain insight into the patient’s experiential encounter. The patient is in a strange place. He or she is wearing strange, sometimes revealing, clothing. Their privacy is invaded constantly by doctors, nurses, and hospital staff. He or she is not in the comfort of their own world, and, on top of the issues so described, they receive devastating news concerning their end of life dilemma. The following excerpt from *The Journal of Advanced Nursing* discusses some reactions to the anxiety patients experience while in the hospital. C. M. Shuldham writes, “Discriminate analysis suggested that six characteristics adequately discriminate anxious subjects, sweating, faintness, tendency to blame others, continual review of things in their mind, focus on self, and a lack of self confidence.”<sup>29</sup>

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<sup>26</sup>Lewis A. Drummond, *Leading Your Church in Evangelism* (Nashville: Broadman, 1975), 21.

<sup>27</sup>Michael L. Simpson, *Permission Evangelism: When to Talk When to Listen* (Colorado Springs, CO: David C. Cook, 2003), 24.

<sup>28</sup>*Ibid.*, 24.

<sup>29</sup>C. M. Shuldham, “Assessment of Anxiety In Hospital Patients,” *Journal of Advanced Nursing* 22, no. 1, (July 1995): 87-93.

Several techniques are often attempted by the minister or chaplain to manage the anxiety of the patient. The best efforts of the ministers often go without success, and the patient experiences fears and frustrations. Evangelism at this point can be misinterpreted and even appear abusive, especially to a non-Christian. Both Christian and non-Christian alike have to have trust in the person addressing them concerning the salvation of their soul. Trust is the important element in this kind of evangelism.

Trust is built through a series of permissions; it can be a quick process or a lengthy process. The length of time it takes to be able to talk with patients about evangelism depends on the relationship the chaplain has with the family members of a dying patient. Patients need to know that the minister or chaplain honors their choices at their level of willingness to engage or they can feel pressured and threatened and trust will be broken.<sup>30</sup>

### **Sharing Scripture Passages**

The minister plays a significant role at the time of the death with the dying patient and the family. The time when the minister speaks of death is a time when certain things are said that comfort and bring peace. The minister's presence at this time in someone's life can have a variety of responses from both the patient and the family. The religious background of the family plays an important role in the kind of ritual ministry expected during this time of grieving. This depends on the religious tradition of the family. Edgar Jackson in *Grief and Religion* explains:

Mourning is modern psychological understanding verifying the value of religious rites, rituals, and practices, which, and through anthropological studies have found, were long and practiced in fortifying the individual against stress of grief and during the work of mourning.<sup>31</sup>

To the Christian Scripture is particularly important during the time of grief and

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<sup>30</sup>Simpson, *Permission Evangelism*, 89.

<sup>31</sup>Edgar Jackson, "Grief and Religion," in *The Meaning of Death*, ed. Herman Feifel (New York: McGraw-Hill, 1959), 219.

loss. The minister uses the Scripture as a source of comfort, confirmation, and hope. Scripture for the Christian pastor is the major resource during this time of pastoral care. Prescriptive use of the Scripture means the pastor uses the Scripture that is prescribed to the situation.<sup>32</sup> The use of Scripture is a valuable tool, and it is necessary to use it appropriately. Ministers should be trained in this part of the ministry to be effective with the sensitive needs of the dying patient and his or her family.

Scripture should be used sparingly. The minister does not need to show his or her expertise in quoting verse after verse in the midst of the distress of the family. Brief portions of Scripture passages may work well, allowing the family to experience the compassion of the minister. Using the Scripture in its context is also important. Quoting Scripture about things that are not related to the grief of loved ones can be perceived as insensitive. Scripture needs to be used verbally. Sometime the long read passage of Scripture can take away from the moment of ministry. Pastors learn by experience as well as through their relationship with the family as how to effectively minister, using the Scripture in the grief process. Scripture can be used with persons who are religious and non religious. When these times come in a person's life comfort of Scripture can be a help.<sup>33</sup>

The use of Scripture is a way to remind people who are grieving and suffering loss of the presence of God. It is important to note that Scripture does not have to be read every time. Being sensitive to the needs of the grieving patient and family will give insight to the minister to best meet the needs of the grieving, whether it is Scripture reading, being there representing God to them, or praying.

### **The Use of Prayer with the Patient and Family**

Prayer is a source of comfort to the dying patient and the family. Prayer can

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<sup>32</sup>Bowman, *Dying, Grieving, Faith, and Family*, 108-09.

<sup>33</sup>*Ibid.*, 109.



bring a calming effect to a tense situation with the dying patient and the family. Patients will often ask for prayer, and sometimes they will ask often in the course of the visit.

Some will not ask for prayer. In *The Caregiver Journal* the following was stated:

The clinical training movement correctly saw that prayer was too often being imposed upon sick people by the clergy and therefore regularly interfered with, rather than promoted, the pastoral care relationship. It was being used as a crutch to fill in or close a visit when the chaplain had nothing else to say. Unfortunately, rather than finding ways to integrate prayer, it was too often abandoned as a pastoral care tool.<sup>34</sup>

Prayer should never be substituted for the need to be present and listen to a patient and their family in a death and dying crisis. Prayer is of great significance in this time of ministry. How to use prayer makes a difference in this ministry setting. Prayer can help in the spiritual assessment with the people present in the crisis. The chaplain can ask what the family wants to specifically pray for in this time of loss and/or grief. The response can allow the chaplain to understand where the family might be in the process. Physical needs may be obvious. Asking about prayer can give the chaplain insight to the spiritual needs of the patient and family.

During these times in patients' lives, they often need to confess a certain sin in their lives. The prayer is directed to hearing the confession and guiding the patient in a confessional prayer. In some traditions a priest can offer a sacrifice or a sacrament for the forgiveness of sin, but the biblical New Testament position stipulates that Christ is the once and for all sacrifice, sufficient, and the source of all hope (Rom 6:10; Heb 9:26-28, 10:10).

Prayers during this time of ministry do not need to heighten guilt or cause more anxiety to the patient and the family. It does not need to be a sermon to the family and the patient. It is a conversation with God that the family can enter in and feel the presence of God during this crisis in their lives. The length of the prayer should be determined by the spirit of the patient and family. The need may be to encourage the family in their walk of faith through this time. The prayer may be a celebration of the life

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<sup>34</sup>Bruce Evanson, et al, "Prayer and Pastoral Care," *The Caregiver Journal* 10, no. 3, 1993: 40.

of the patient and their expected reward when they pass from life to death.

When the chaplain prays, he or she needs to be realistic concerning the condition of the patient. If all the resources have been used in bringing recovery to the patient and it is obvious the patient's condition will be terminal, the prayer does not need to claim healing for the patient. This kind of prayer can cause doubt in the minds of the patient and family and can make the loss of a loved one question the reason the loved one died instead of being completely healed.<sup>35</sup>

The chaplain who is sensitive to the prayer needs of the patient can be more effective in this ministry of grief and loss. Prayer is the avenue for the chaplain to join with the family and be present with God. God becomes real for the patient and family, and the comfort of the Holy Spirit is present in the room.

### **Hospital Ministry to Dying Patients and Families in Community Disasters**

The Red Cross defines a disaster as “an event of such destructive magnitude and force as to dislocate, injure or kill people, separate family members, and damage and destroy homes.”<sup>36</sup> Disasters are commonly defined by two categories: caused by natural or human agencies; accidental or intentional.<sup>37</sup> Hospital chaplains are often the front line counselors when community disasters happen. When there is only one chaplain, the task quickly becomes overwhelming and almost impossible. Having a core chaplain group available within the community is an effective way to meet the sudden support needs for community disasters.

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<sup>35</sup>Bowman, *Dying, Grieving, Faith, and Family*, 112.

<sup>36</sup>American Red Cross, “Definition of Disaster, <http://www.redcross.org> (accessed 2 July 2011).

<sup>37</sup>Stephen B. Roberts and Willard W. C. Ashley Sr., *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy* (Woodstock, VT: Skylight Paths, 2008), xvi.

According to the Center for Disease Control 92.3 percent of all hospitals have revised their emergency plans since September 11, 2001. The Joint Commission accreditation requires each hospital to follow 13 standard steps in planning its emergency preparedness program.<sup>38</sup> The disaster plan for chaplains at Western Baptist Hospital will be identified in the next chapter. Chaplains play an important role in the event of a community disaster. The number of chaplain staff in most hospitals is not nearly what is needed in a community disaster. It is important to train local pastors and lay people to address the needs of the people during the trauma.

After a disaster, people are extremely vulnerable and fragile. They are easily taken advantage of in many ways, including spiritually. They are lonely, afraid, scared, often homeless, and hopeless. Understanding the needs of these patients may seem obvious; however, every person is different and deals with these situations in a variety of ways. Learning to listen and be present with these patients and their families is necessary. The ministry of presence is very important even though it can be uncomfortable for the minister. The minister wants to be there for the family and be supportive, but oftentimes feels as if he or she is just in the way of all the events taking place. At times the minister feels awkward and outside of the turmoil surrounding him or her. Sometimes the only thing the minister has to offer is their presence.<sup>39</sup>

Grief that comes with sudden loss is different from grieving the loss of a loved one who has died over a period of time. This grief is sudden in its onset. It takes people by total surprise, and dealing with it causes various kinds of reactions. The first feeling of traumatic grief that comes is shock. There are physical dimensions that come with the shock. There are feelings of alarm, disbelief, and panic. These cause physical reactions

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<sup>38</sup>Greg C Beatty, "Developing a Hospital Emergency Preparedness Program," *Management and Compliance Series*, vol. 2 (Chicago: American Hospital Association, 1987).

<sup>39</sup>Henry J. M. Nouwen, *The Wounded Healer* (New York: Doubleday, 1979), 87-88.

with the body and can even need the attention of a physician if they are severe.<sup>40</sup> Some of the reactions are trembling or shaking, sweating, breathing deeply, laughing, crying, stomach rumbling, feeling of warmth, and goose bumps.<sup>41</sup>

### **Short Term Effects of Death in Community Disasters**

The *Southern Baptist Relief Chaplains Training Manual* states, “The growing awareness of spiritual needs in crisis has begun to formalize the response of disaster relief agencies.”<sup>42</sup> The actual time a disaster can occur can be seconds or minutes and depending on the disaster and the warnings involved, the reactions to the actual event can range from shock to confusion to disbelief. Meyers and Wee, in *Disaster Mental Health Services* write, “In disasters of discreet and rather sudden impact, people may experience intense fear but rarely panic.”<sup>43</sup> A warning may have been issued, and people can have a sense of some preparation. When it is sudden without warning, the family is devastated, and the chaplain is a front line resource. It may seem as if the stages of grief from Kubler-Ross happen all at once. Everything a trained chaplain knows can be used; however, it often seems as if nothing is working. Emotions are at their peak, and there may be no way to calm the emotions.

### **Long Term Effects of Death in Community Disasters**

When the hospital chaplain is present with the family after a community

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<sup>40</sup>Oates, *Your Particular Grief*, 47.

<sup>41</sup>Melinda Smith and Jeanne Segal, “Healing Emotional and Psychological Trauma, Symptoms, Treatment, and Recovery,” <http://www.helpguide.org> (accessed August 11, 2011).

<sup>42</sup>*The Southern Baptist Relief Chaplains Training Manual* (Alpharetta, GA: North American Mission Board, Southern Baptist Convention, 2007), 2.

<sup>43</sup>D. Meyers and D. Wee, *Disaster Mental Health Services: A Primer for Practitioners*, Routledge Psychological Stress Series (New York: Brunner-Routledge, 2005), 77-78.

disaster, there are usually some follow-up issues in which the chaplain may be involved. The chaplain has been there with a family during a devastating time and has become a significant part of the recovery process for the family. The family will often call the chaplain for consultation after the event for counsel. Usually there are only a few calls because the other support systems are more available to the family. Chaplains are trained to understand they are not long term counselors for families in crises. In an article from the *Psychosomatic Medicine Journal of Behavioral Medicine*, it is stated,

The long-term sequelae have been studied less extensively. However, reports do suggest that: 1) there may be a latency period or, delayed onset of some symptoms, 2) that some symptoms may wax and wane, 3) and that significant psychiatric symptomatology may remain for as long as 14 years.<sup>44</sup>

This information is helpful for chaplains to understand the grief cycle and future care for people who come to them. Oftentimes people do not consult with a chaplain after long periods of time because it can bring back memories they do not want to consider.

### **Developing Support and Support Groups for Families**

Support groups for families in the hospital are a common practice. One such group is a support group for cancer survivor patients that meets monthly. They discuss their struggles and their celebrations of dealing with cancer and its survival. Further groups include an Alcoholic Anonymous group that meets weekly and an Al-Anon group which meets bi-weekly, both as support for the families of those individuals involved with alcoholism, a post-heart surgery group that meets quarterly to discuss the stress feelings of heart surgery and the recuperation time, and an additional group started because of the findings of this project; a support group for families losing their children by suicide that began the first week of February, 2011.

Other support groups have been and will be established as needed. These

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<sup>44</sup>Susan Bland, et al, "Long Term Effects of Natural Disasters," *Psychosomatic Medicine* 58 (1996):18-24. "Sequelae" is a technical term used to describe the pathological response long-term, from disease, trauma, etc.

groups are time-specific and meet for a certain group of people and then disperse when the group feels the need to meet is finished. The Pastoral Care Department at Western Baptist has a marriage and family therapist as a contract counselor who practices in the hospital. There are several support groups in the community that are utilized by chaplains when this kind of tragedy takes place because of the limited time of the pastoral care staff.

Developing a support group in the hospital setting is strenuous work. There are many issues to consider. The new privacy laws are very clear about keeping confidential records of all meetings on the hospital campus. The Risk Management Department has to review all the purpose statements and contracts for the group to meet. The members of the groups have to sign a confidentiality statement if they attend the meetings. Finally use of the facility meeting place has to be approved by the legal department and the senior management team for the event to take place. All these steps and procedures can make it difficult to establish a support group in the hospital. It is worth the work to have a place where people can come, receive and give support.

### **Conclusion**

Ultimately, the issue of death and dying in the patient and patient's family is a difficult and often confusing time. The confusion and difficulties surrounding this last-of-life event can be greatly eased by the skilled pastoral counselor who both understands the precepts behind death and dying as well as the hope that is in the gospel of Jesus Christ. Empathy for the patient and the patient's family can go a long way toward a successful ministry that serves both the hospital setting as well as the patients who reside therein. Knowing the steps in the death sequence, as well as some of the guilt and associations with those steps can help the pastoral counselor into an evangelistic presentation that brings hope while steering clear of the laws that protect the rights of the patient during that time of stress and difficulty by offering hope and counsel in keeping with established guidelines that serve both the Lord and the hospital facility.

CHAPTER 4  
METHODOLOGY USED AND TRAINING SEMINAR  
IN TRAINING VOLUNTEER CHAPLAINS FOR  
RELATIONAL EVANGELISM

**Introduction**

In the previous chapters there was an examination of the biblical understanding and psychological dimensions of pastoral care to patients and families in dying situations. This chapter presents the implementation of the ministry project that was conducted at Western Baptist Hospital in Paducah, Kentucky. I was motivated to begin this project because of my desire to train local chaplains to develop a strategy for relational evangelism through pastoral care at Western Baptist Hospital, Paducah, Kentucky.

The project lasted fourteen weeks and consisted of twelve weeks of training for the local lay people, ministers, and Western Baptist staff chaplains. The training was conducted in four sections. The first section was a three hour meeting where the recruits met with the consultation committee and me to complete the pre-seminar survey and get acquainted. The second section meeting was for the group to discuss the survey with those who attended the seminar. The third section consists of the 12-week training portion of the seminar for the recruits who were the volunteer chaplains at Western Baptist Hospital. The last section of the seminar consists of a project and teacher evaluation and a graduation ceremony for the volunteer chaplains.

In order to conduct the project at Western Baptist Hospital I had to seek permission from proper administration officials who oversee the facility. Since we already have a volunteer program in the hospital, the senior management group gave permission to establish and pilot the program. A Professional Advisory Committee was formed to oversee the implementation of the project. The committee was made up of the

vice president of nursing, vice president of medical staff, three staff chaplains, administrative assistant of pastoral care, nursing directors from three departments, two local pastors, the director of hospital education, the hospital librarian, and the privacy officer of the hospital. In a scheduled meeting, I shared with the committee my proposed project. As we discussed the details of the project, I explained that the staff chaplains at the Center could benefit from some additional training with regard to counseling terminally ill patients. At the end of our meeting, we were granted permission to conduct my project within the hospital facility.

Once the proper authorities had provided permission, I requested approval from the education department to use the regular training room for volunteers and chaplain interns for twelve consecutive weeks to conduct the training. The purpose of making the reservations was to ensure that the focus group would have a secured space to meet during the seminar each week. The process for reserving the room required that I go through the hospital Education Department and provide the dates and times for the project training sessions. Within one day of making my reservations, I received confirmation from the Education Department that the requested space was available. The Education department scheduled a room located in the Education Department, for Monday mornings from 9:00 am until 10:30 am. We were now ready to begin the training program.

## **Training Program**

### **Session 1: Orientation to the Hospital Setting**

Once I had received approval to conduct the project and had been assigned a designated space to meet with the group, I invited the group of eleven chaplains to join the Professional Advisory Committee and me for the orientation meeting. At the meeting there was a time of fellowship and sharing of various ministry experiences that had occurred within the hospital. Then I requested that the group consider signing up for my ten-week seminar and presented them with an outline of the topics (see appendix 4) that



would be covered along with the dates, time, and location of the event.

I also informed the group that during this ten week period they would be required to come one day per week to apply the material that had been presented in the seminar and to complete a verbatim of a patient encounter and consult with the pastoral care staff concerning the encounter. After explaining what my project entailed, I gave each chaplain an application form that offered the opportunity to sign up for the seminar. At the end of the meeting all eleven chaplains returned the forms. In order to protect confidentiality, the individuals who participated in the project will be referred to as chaplains 1, 2, 3, etc.

During the first meeting the consultation committee gave the group a packet that contained a pre-seminar questionnaire (see appendix 1) and a pre-seminar survey (see appendix 2). The pre-seminar questionnaire was also used post-seminar to gauge response to the teachings of the seminar. Confidentiality statements (see appendix 3) were signed by the chaplains to assure strict confidentiality for the group during and after the training. I requested they complete and return both forms to me within a week. The pre-seminar questionnaire requested some basic information such as name, age, highest level of education completed, when they became a Christian, and their experience with regard to counseling people with a terminal illness. The pre-seminar survey asked the candidates to rate their knowledge and skill level in giving evangelistic pastoral care to terminally ill patients. Once the chaplains returned the pre-seminar questionnaire, the survey and the confidentiality statement the twelve-week training program commenced.

### **Session 2: Orientation to the Pastoral Care Department**

Session 2 was designed with two goals. The first goal was to enable the group to get acquainted with each other by sharing a short story about themselves, their place of ministry, and what they hoped to get out of the training seminar. This time of sharing proved to be an emotional time for the group. They shared stories about walking through

a time of death with their own families and loved ones. Each one had a story to share and offered support to each other for their loss. It was a time of ministry to each other and a good formation-experience for the group.

The second goal was to orient the chaplains to the Pastoral Care Department. The policies for the Pastoral Care Department were distributed and explained. A part of orientation is to talk with the class about getting permission from the patients to share their faith. Because of the nature of the training, the examination of hospital policies was mentioned in this session and will be further discussed in the next session. Hospitals require different approaches in sharing religious faith. There are privacy laws that must be observed with patients. Also, patients are in a very vulnerable position while in the hospital and may not want to talk to anyone who is a stranger to them.

During this session the chaplains were given a syllabus that explained each week of training. Each week's training was described in the syllabus so the chaplains could be prepared with reading assignments and be ready to discuss them in class. There was also a brief discussion concerning each chaplain's understanding of the biblical context of sharing their faith in a relational way, rather than an emotionally contentious way with patients in the hospital.

Finally, in this session the eleven chaplains were told they would be studying the principles of evangelistic pastoral care with the dying patients and the patients' families. We ended the session with a season of prayer for all the participants, the staff, and the families of those whose lives would be touched by the participation in this training opportunity.

### **Session 3: Training for Evangelistic Pastoral Care Begins**

Session 3 was designed to teach the chaplains how to have a biblical understanding of the principles of pastoral care and evangelism with dying patients. It was also a time to emphasize the need to be sensitive to the needs of the patients when

doing an evangelistic visit. It is important in the hospital to be invited to share the plan of salvation rather than imposing it on the patient. Michael L. Simpson gives a good example of how to initiate a spiritual conversation by using “trigger phrases” to get a spiritual conversation started: “Trigger phrases pull a superficial conversation into a personal direction, but without force, so the other person isn’t made to feel uncomfortable.”<sup>1</sup>

During the session, the students were reminded of several essential facts concerning biblical reasons for evangelism and how it was to be done in the hospital with patients and families. The desired outcome is to give patients an opportunity to hear about and receive the gift of salvation at their own request. We introduced the policy for sharing Christ in the hospital with patients, and it will be expounded upon later in this chapter. The chaplains understood there is a different way to share with patients in the hospital than with people in other places in their ministry.

#### **Session 4: Understanding the Stages of Dying**

In a hospital setting, patients experience multiple emotions and grief stages when they hear they are terminal. The dying patient and his or her family begin to directly experience the emotional process involved in the stages of dying instead of merely understanding that there are stages in the process. This session was designed to teach the stages a person can encounter when they receive the news that their life is coming to an end. The time of dying is a difficult time for the patient as well as the patient’s family. Chaplains may encounter difficulties ministering to a family during this time. In order to equip chaplains to be prepared to counsel and remain present with terminally ill patients who are suffering, I taught the Elisabeth Kubler-Ross book, *On Death and Dying*, so the chaplains would have a reference for some of the things the

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<sup>1</sup>Michael L. Simpson, *Permission Evangelism: When to Talk When to Walk* (Colorado Springs: David C. Cook, 2003), 98.

patients were experiencing and also equip them to understand their own feelings in the process.<sup>2</sup>

Another source for learning was George Bowman's book, *Dying, Grieving, Faith, and Family*, which give a pastoral care approach to death and dying.<sup>3</sup> This book presented ethnic-related issues in death and dying that were particularly helpful in the Western Baptist culture with the African American population. Two of the volunteers in this group were African-American which proved to be helpful with the understanding of cultural issues of dying. It was important to the program to give training for various cultures in understanding the stages of dying. We discussed how these cultures manage stress in preparing for the news that a loved one is dying.

As the session concluded, the group was presented with the following question; "How do you pray for a person who, according to the physician, is terminally ill and does not have long to live?" We discussed two biblical examples where people who were prayed for and were healed. Genesis 20:17-18 records, "So Abraham prayed to God; and God healed Abimelech, his wife, and his female servants. Then they bore children; for the Lord had closed up all the wombs of the house of Abimelech because of Sarah, Abraham's wife." In Luke 7:1-10, Jesus responds to one who called on him for healing and reveals his compassion for those who need healing. In verse 9 the Centurion was cited by Jesus as having "faith he had not seen in Israel." This healing effort by Jesus was in response to the great faith of the Roman Centurion.

Using an Old Testament and a New Testament example helped to see how God works in the healing process throughout the Scriptures. I chose the New Testament example purposely to show how our faith is an instrument in the healing process. I then used an example where God did not respond to a request for healing. In 2 Samuel 12:16-

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<sup>2</sup>Elizabeth Kubler-Ross, *On Death and Dying* (New York: Scribner, 1969).

<sup>3</sup>George W. Bowman III, *Dying, Grieving, Faith, and Family* (Binghamton, NY: Haworth, 1998), 23.

17 David pleaded with God in prayer and fasting to save his and Bathsheba's dying son. David's prayer was denied, and his son died. We talked about the reason surrounding the denied request and the possibility of sin that had caused the situation to materialize as it did. Some of the chaplains gave an example of how they felt their requests were denied. The feelings that were discussed were about the sadness, the anger, and the hard feelings they felt toward God during that time. The positive side of this is that they all found the situations in their lives had served to increase their faith in God after a time of healing and reflection. I reminded them that the same thing happened to David. That led to a discussion of the Apostle Paul who requested the "thorn in the flesh" be removed and his request was denied (2 Cor 12:7-10).

The chaplains then asked how they should respond to patients when asked to pray for their healing. In the Paducah culture there is a strong emphasis on prayer. Almost every patient will request the chaplain to pray for them when they visit. The chaplains were taught to pray petitioning God for the patient. They understood that every prayer would not be answered, but that they would pray for God's will to be done.

At the conclusion of this session we were able to discuss our own feelings of the news of the death of a family member or friend. The meeting became emotional for all of us, and we saw the compassion we felt in being ministers at this time in the lives of our patients and parishioners. I read Psalm 23, and we had prayed together.

### **Session 5: Grief Issues with the Death and Dying**

In session 4 we discussed the issues of grief that come to the patient and the family during the time of terminal illness. I began the session by asking them to write down an instance where they had lost a loved one and to consider their own grief process. The assigned reading for this session was *On Grief and Grieving*, by Elisabeth Kubler-

Ross and David Kessler.<sup>4</sup> In reading the text, the chaplains discovered that the stages of grief, according to the text, were the same as the stages of death. The overview of the stages of grief seemed to be helpful in their own experiences of grieving. They were able to recall feelings and emotions during their times of loss. This overview of the stages of grief, again, was an emotional time in the training for all the chaplains. Three of the chaplains shared a story of loss with the group. One of the chaplains shared about the loss of a child. Even though the loss had been some time in the past, the chaplain was able to talk about how this study was helpful for her to understand the grief process and how it was still a process she was experiencing.

Two of the chaplains talked about the illness of their spouses and how they were in a grieving process for their loved ones who had chronic illnesses. They talked about their anticipatory grief. Another assigned text was Wayne Oates' book *Your Particular Grief*. In this text, anticipatory grief was explained as, "the severe time-limiting of life by such a disease commits your loved one and you to a long but nevertheless patterned process of grief."<sup>5</sup> With both chaplains there was a real feeling of anticipatory grief for their loved ones who had been told they were terminal. The process of daily caring and watching their spouses brought grieving emotions for them.

These two events opened the door for the chaplains to discuss their understanding of how patients and their families experience grief in death and dying situations. We shifted to the experience of the patient and their family and how these stages were like the stages of dying. We talked about the grief-work cycle of bereavement. This grief-cycle for the loved ones is explained in *Death and Ministry*, by J. Donald Bane,

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<sup>4</sup>Elizabeth Kubler-Ross and David Kessler, *On Grief and Grieving* (New York: Scribner, 2005).

<sup>5</sup>Wayne Oates, *Your Particular Grief* (Philadelphia: Westminster, 1981), 23.

Austin H. Kutscher, Robert E. Neal, and Robert B. Reeves, Jr.<sup>6</sup> The grief cycle can be explained in two steps. The first step is the realization the loved one is gone. The second step is when the mourner gradually begins to form ties with the living and with the things of life. There are new adjustments to their environment and the life tasks they face.

The remainder of this session consisted of orienting the group to the areas of the hospital where grief ministry might possibly take place. Each member of the group was one of our volunteer chaplains and was familiar with the hospital setting. The purpose of the tour was to give the group a feel for the areas where they would be called upon to minister to patients and families who would experience grief in their hospital experience. The tour consisted of the Emergency Department waiting room, the critical care unit waiting rooms, and the surgery waiting rooms to discuss patients who received news of death and dying patients from emergency situations. We then visited the units themselves to talk about how we minister to patients who are in the units and have been given the news of their impending demise.

We then visited patients in the Oncology unit and the medical-surgical units to make ourselves aware of areas where we would be apt to talk with patients and families who have received the news of eminent death. We then saw two patients, who were on ventilators, whose families had made each of them a DNR. The DNR means to “do not resuscitate” in case the heart stops beating and the patient stops breathing. The families of these patients were planning on removing the ventilator the next morning. We talked about what it was like to visit a patient on life support and how the patient may be able to hear conversations from the chaplain and the family. Prayer and reading Scripture is important to these patients during this stage of their lives. The chaplains were taught to take families to the waiting rooms to discuss issues about grief for their loved ones unless the family knew the patient would want to hear the discussion. Most importantly,

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<sup>6</sup>J. Donald Bane, et al, *Death and Ministry, Pastoral Care of the Dying and Bereaved* (New York: Seabury, 1975), 110-11.

chaplains must knock on the door before they enter a patient's room and obey any sign that is on the door.

Chaplains at Western Baptist can go at any time to minister to patients. The chaplains were taught to be respectful of other health care providers in the process of their visit. They were taught to respond to the pager they would be wearing when they were on call and how they would be a welcomed part of the healthcare team in these kinds of situations. After the tour the chaplains were told there would be more touring of other areas in the hospital in the next session. We had prayer and were dismissed.

### **Session 6: Principles for Pastoral Care with the Dying**

One of the single most important things a chaplain can do while ministering to a dying patient is to help them maintain their dignity in the dying process. This is not only the responsibility of the chaplain; however, the chaplain can have a role in this area. The chaplains were trained to understand the personal losses the patient experiences. They may not be able to dress themselves or control bodily functions. The patients may be dependent on family and total strangers for daily care and daily functions. They can begin to lose parts of their identity and their feeling of self-worth because of the restrictions placed upon them because of their situation. *Dying Well*, by Ira Bylock, was the text for this section of training.<sup>7</sup> In chapter 5 he talks about the dilemma a patient faces in this process of dying. Chaplains need to help these patients find self-worth, self-esteem and dignity as they discuss their lives and the contributions they have made to their families and to society. The patient's memory is a good tool to use in the stage for affirmation of life with the patient. Chaplains were told this is a time-consuming process in their ministry, and it is important to stay with the patient as long as they are needed.

During this session we discussed some of the tools the hospital provides in

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<sup>7</sup>Ira Bylock, *Dying Well* (New York: Berkley, 1998), 86.



helping people make decisions for this time in their lives. The Advanced Directive is one of the tools we use in assisting people to make their own decisions in the last stages of their own lives. This group has been taught to administer Advanced Directives to patients as part of their training as a volunteer chaplain. This part of the session was a discussion as to how we can use the Advanced Directive to minister to patients and to let patients know how they can minister to their families in the event they come to the end stages of life. The chaplains understood that patients do not have to be in the stages of death to have an Advanced Directive. In fact, the patient needs to be coherent and able to make the decisions concerning their end of life wishes. It is preferable to make those decisions before being faced with a terminal diagnosis.

Palliative care is another tool the chaplains have to minister to dying patients and their families. While this is a new ministry of our hospital, the chaplains are involved in the ministry and are part of the palliative care team. The process was explained to the chaplains and how they are involved in it and how they are an important part of this discussion with the patient and family.

As discussed in the last session, we finished the tour of the hospital. We toured 4B which is the unit where our heart patients come before surgery. After a time in the Intensive Care unit, they return to this floor to prepare for discharge. Each student is given the opportunity to view heart surgery or any other surgery if they choose to as part of their training. It is not mandatory.

We then went back to the classroom where they were instructed on the process of receiving the department computer referrals and the daily patient admission list. These are the tools used by the medical staff to inform the chaplains of the need for a pastoral care visit. They were instructed on how to log their visits. It could be a routine visit from the daily patient admission list. It could be a referral from the medical staff. They were trained to log the visits in the respective file for good record keeping. They were then instructed on how to develop relationships with the medical staff. A chaplain's main

role is to minister to patients. In Western Kentucky Baptist hospital, chaplains have a role in supporting our medical staff. We offer seminars and in-services on compassion fatigue, emotional intelligence, group dynamics, conflict resolution, and hospital mission emphases. The hospital's mission statement is, "The mission of Western Baptist Hospital is to exemplify our Christian heritage of providing quality healthcare services by enhancing the health of the people and communities we serve."

The Pastoral Care Department is invited to hospital departmental meetings and managerial meetings to offer prayer at the beginning of most meetings. Chaplains are trained to encourage staff with the mission statement in their conversations with them. Chaplains are encouraged to develop professional relationships with medical staff, especially the physicians. I taught the chaplains the best way to have a good rapport with the medical staff is to give good pastoral care to their patients.

### **Session 7: Guidelines for Evangelism of the Patient and Family**

This session is very critical to the project. The purpose of the chapter is to train chaplains how to have an evangelistic visit with patients in the hospital. Several issues need to be taken into consideration when the opportunity for evangelism surfaces in the patient's room. Privacy laws have changed the way hospital visits can be done in the hospital. The evangelistic visit can only be made at the request of the patient. If in the conversation during the pastoral care visit, the subject of the gospel is approached and the patient invites the chaplain to share the gospel, then the chaplain is free to share his or her faith with the patient.

The following are some preliminary issues about evangelistic visits we use as a policy. First, the chaplain should make it his or her practice to live out his or her faith and to make that faith an intrinsic part of who they are during the time of sharing so that the sharing of faith will seem the most natural thing possible in the mind of the patient.

Second, the chaplain should understand that even seemingly simple things can be profound. Attentively listening when the patient speaks can exemplify of the care of the chaplain and in turn his or her concern and faith. People want to be heard. No matter how insignificant something may seem, God can use it to bring about His purposes.

Third, the chaplain should always be reminded to “let your light shine.” One should always pray before visiting patients in the hospital, praying not only that the Holy Spirit will guide the chaplain in what to say and do, but also that He will help one to reflect His character in the chaplain’s life. The chaplain should ask God to help them to be conscientious in making the fruit of the Spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control, an ingrained part of their daily life.

Fourth, the chaplain should always treat patients with consideration. We are often reminded of the statement that people do not really care how much one knows until they know how much one cares. Just treating patients with common courtesies can go a long way in showing them that the minister of the gospel cares.

Fifth, one should never force discussions about faith. Doing so does more harm than good. Keep in mind that mentioning faith is only appropriate when it arises naturally out of the chaplain’s conversations, when it naturally fits into the topic of a conversation, or when someone asks the chaplain about their faith.

Sixth, the minister should remember that only God can do what God alone can do. The chaplain should not try to take on the burden of convicting people of spiritual truths, rather the chaplain must remember that only the Holy Spirit can transform someone’s heart. Instead, one should seek simply to show others how God has made a difference in their life and how He can make a difference in the life of the patient or their family as well.

Seventh, the chaplain should use “faith flags.” When natural opportunities arise “faith flags”—brief statements that identify one as someone who is serious about his or her faith involving briefly mentioning prayer, the Bible, or God—as they naturally

relate to a particular topic can be shared by the one doing the ministry. The minister should be sure not to mention a particular church or denomination, as that might raise a barrier for the person listening.

Eighth, the minister should share “faith stories.” When a patient expresses a need in their life and the chaplain senses a natural opportunity, they should ask if they can share a story from you’re his or her life that tells how God helped them with a similar need. One can also share about any other way God has worked in his or her life at a specific time in a specific way, as long as it relates well to the patient’s situation. In the stories, use conversational language, avoid preachy language, avoid using too many specific details (so people can more easily relate to what is said), include human interest or a humorous touch, use word pictures, illustrate the basics of the gospel, and explain how God meets deepest inner needs. Keep the stories simple, short, and specific. One should not make the stories so much about themselves that that patient loses the main point, which should be an illustration of how God has worked in the life of the chaplain and how He blessed others in their time of need.

Ninth, the chaplain ought not overload people. They should stop discussing faith when they sense a patient isn’t interested in continuing the conversation. Tenth, the chaplain should avoid Christian jargon. One should keep in mind that many people are biblically illiterate, therefore the chaplain should use words that a non-Christian can relate to and understand. Eleventh, one should not discount the beliefs or experiences of others; show respect for them. The minister should respectfully ask the patient to evaluate how their current belief system is working in their life. And the twelfth most important thing for the chaplain to remember is to pray! One should pray that God help one as chaplain to share his or her faith effectively, pray for other people's needs, and pray with others as well; knowing that the prayers of the chaplain have great power because of the God to whom they are prayed.

I then taught the section in Mark McCloskey’s book about “process

evangelism.”<sup>8</sup> We discussed the moral and ethical issues in sharing faith with unbelievers, particularly with hospital patients and families. The problem with process evangelism is that there is not a lot of time to build a relationship with a patient while in the hospital. The students were aware of the short stays in the hospital and the lack of time to build a relationship that can foster an evangelistic opportunity. It is possible to accomplish, but there are skills to be learned in the process. Michael Simpson’s book *Permission Evangelism: When to Talk, When to Listen* gives good principles as to when to share and when not to share.<sup>9</sup> The chaplains were taught to use their previously learned listening skills and look for the opportunities to share. The above polices were emphasized again.

I informed the chaplains that patients are in a vulnerable position in the hospital. I reiterated some of the circumstances in session six about the feelings of being a patient. These feelings often increase the sense of vulnerability to the decisions of doctors, specialists, and nurses in the patient. I then taught the chaplains to be relational in each visit and avoid asking questions of the patient. A patient answers questions repeatedly in the hospital setting. It is refreshing for someone to enter the room without asking more questions. Teaching the trainees how to deal one-on-one with dying patients was one of the most difficult aspects of the training for chaplains to understand.

Using an example of a verbatim where the chaplain asked no questions during the visit and yet had a successful evangelistic conversation, was a helpful tool to assure them the evangelistic encounter could be done. The verbatim was three pages long, and by the end of it, the patient had asked the chaplain to pray with them to accept Jesus as their personal Savior. I was clear with the chaplains that this was not the norm but rather

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<sup>8</sup>Mark McCloskey, *Tell it Well, Tell it Often* (San Bernardino, CA: Here’s Life, 1951), 70-71.

<sup>9</sup>Michael L. Simpson, *Permission Evangelism, When to Talk When to Listen* (Colorado Springs: David C. Cook, 2003).

the exception. They would have chances to share their faith, and they could cultivate relationships, even in a short time. Being in tune to the Holy Spirit is as important in this process as it is with other evangelistic opportunities.

### **Session 8: Death and Dying Issues in a Terminal Disease**

This session began with the chaplains talking about their personal experiences with their own families who had received news of an impending death. It was an emotional time of sharing how they had struggled in their experiences. Some shared of situations they were going through in the here and now with their loved ones. This set the tone for the discussion and the openness to learn how to minister to those going through similar experiences.

Some of the issues surrounding the stages of death and dying in this section were discussed before in previous sessions. The instruction disseminated during this session, however, was to be a more intense understanding of what patients and families experience when they receive news that they or their loved one has a terminal illness. One of the resources in our hospital is a newly developed Palliative Care Department. This pastoral care department was developed for the purpose of ministering to patients who receive news they are terminal. The palliative care director presented an hour long power point presentation for the chaplains during this session. They were informed of the issues such as the importance of communicating, honestly and pastorally, the information concerning their future. Honest disclosure about their situation is an important step to enable them to begin the acceptance process. It was also discussed that this was not easy for all patients and families. They were taught the importance of being sensitive to the needs of the patient and family, helping them to set goals, aiding them to see what life can be in these last stages, and encouraging them to have hope because of what life had meant to them before the news of the terminal status.

The director discussed the need for pastoral care in this process and how

chaplains play an important role with terminal patients. Prayer, daily visits, counseling, communicating, bereavement processes are all helpful for the patient and their family. The chaplains were taught how they can assist the staff in support for their loss of a patient. Nurses often do not have time to grieve when they lose a patient. The chaplains were taught that listening to staff and giving them a chance to debrief about the loss was a helpful tool.

Chaplains were assigned to read a section in Elisabeth Kubler-Ross's book *Death the Final Stage of Growth*, "Living until Death: A Program of Service and Research for the Terminally Ill."<sup>10</sup> We discussed the main issues of death from the study. They learned about the emotional adjustments, anxieties, and struggles of the sudden life changes. From this section they learned how they could assist patients and families with making choices about living wills, advanced directives, power of attorney documents, and encouragement of communicating with families their wishes in this stage of their lives. We closed the session with a moment of silent prayer and reflection on our own experiences.

### **Session 9: Death and Dying Issues in Accidental and Sudden Death**

In this session the chaplains were taught the issues people face when death is unexpected. In the hospital there are a significant number of deaths that come from motor vehicles accidents, gun shots, and accidents of various kinds. This session began with a return visit to the Emergency Department so the chaplains could understand the process a patient goes through when they come to the hospital in this situation. Even though some patients are not breathing when they arrive at the hospital, the triage of the Emergency Department may determine there is hope in trying to resuscitate the patient. Chaplains learned their role in working with staff, families and authorities. They learned that the coroner may be involved in the situation in order to be sure of the circumstances of the death.

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<sup>10</sup>Elisabeth Kubler-Ross, *Death: The Final Stage of Growth* (New York: Touchstone, 1975), 75-86.

The chaplains toured the family waiting room and were taught the liaison procedure with the families and the staff for keeping the families informed. The chaplain is allowed to be in the room as an observer only to keep the family aware of the process. They were taught to assist the physician when the news of death is to be shared with the family. In our hospital the chaplains do not give the family the information of the death. They are with the physician when they share with the family. The physician will usually dismiss themselves and leave the chaplain to minister to the family. The technical things can be discussed about calling the funeral home etc. Chaplains were taught to stay and listen as long as the family wants to talk.

Chaplains understood it was their responsibility to take the family into to see their loved one after the proper preparations were made for the family to view. They were taught that every family is different, and it is impossible to prepare them for the various responses they would likely encounter. After the tour we returned to the training room for discussion and instruction. They talked about their own experiences with their families and how different it is from the other side of the Emergency Department. This opened the door for further training.

Using Wayne Oates' book *Your Particular Grief*, the chaplains were taught the grief issues involved when there is a sudden death, and the shock issues families of the deceased often encounter. There can be physical issues when sudden loss is experienced. People are encouraged to see a physician when this happens. The shock issues are alarm, disbelief, and panic. I encouraged them to look back on their own experiences and see how they moved through these stages. We discussed how different people can be helpful during these times of sudden grief. Friends, work associates, and clergy were listed among the top supporters.

Numbing is another emotion people often experience in these kinds of losses. Chaplains were taught these were reactions that could come at the time of the incident



and also be experienced later as the grief process continues. This kind of grief can be extended for weeks, months, and even years.

The chaplains were taught that they would be significant in the process at the hospital but that may be the end of their ministry with these people. People seldom contact chaplains after the incident where they were of assistance in their loss. Most of these chaplains were pastors and understood the role they played as a chaplain. The training involves the pastor of the family and chaplains are taught to assist the pastor in their ministry. We do not discourage contact with chaplains after the experience with the family, even though that can happen.

The chaplains were asked to talk about the evening's experiences and to express any concerns about their ability to serve in sudden death situations. It was stressed to the chaplains they would not be asked to serve in this situation if they felt uncomfortable. We dismissed with prayer.

### **Session 10: Short-term Effects of Death in a Community Disaster**

The previous session was purposely set to prepare for session 10. The Paducah community and these chaplains were no strangers to community disasters. On Monday December 1, 1997, a fourteen-year-old boy opened fire on a group of students who were praying in the school hallway at Heath High School in Paducah, Kentucky. This incident has been discussed by these chaplains many times before. Paducah is close to several chemical plants and a uranium processing plant. This potential for a new community disaster is always on the minds of persons who serve the region in ministry. This session was designed to understand what their role would be if another disastrous community event were to take place.

The chaplains were taught the procedures for their arrival and placement in the hospital in the event they were called in for a disaster. Their ID badges were given in the earlier sessions, and they were told they would not be permitted in the hospital if they

were not wearing their badges. Chaplains are assigned places to be in the event this takes place. The staging for some future disaster event is a pre-planned strategy that puts chaplains in strategic places to assist families, staff, and physicians with the event. After a time of questions, the trauma training began.

For this training we used the First Responder Chaplains training course; a course prepared by the same training organization used when the Twin Towers were attacked in New York.<sup>11</sup> First Responders are particularly good at training chaplains for disasters. I used their *Level I: Awareness* training for this section. We discussed the roles and responsibilities of the chaplains in these events. The topics discussed were as follows:

1. Chaplain's spiritual preparation when called to the event.
2. The place the chaplain enters the hospital.
3. Finding the team leader for specific instructions.
4. Assigning an assistant to keep times and records.
5. Moving the people to the designated place for counsel.
6. Using listening skills with the group and individuals.
7. How to function in group activity.
8. Greif and loss expectations with the group and how that affects the group experience.
9. Death Notification to the individuals in the group.
10. Suicide assessment and survivor care with the group.

This session proved to be one of the longest sessions due to the information and questions asked by the chaplains. There was a time of sharing at the end of the session because everyone in the group knew someone or were friends with someone who went through the Heath High School incident. There was an expression of gratitude for

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<sup>11</sup>First Responder Chaplain Ministries, *First Responder Chaplains Training Course : Level I: Awareness* (Taylor, MI, N.D.).

this training and a feeling that the chaplains needed to invite fellow ministers and lay people for a session of this training.

### **Session 11: Short-term Effects of Death in a Community Disaster**

People who experience severe trauma and loss of life with the sights, sounds, and even the smells of the trauma often experience on-going issues. The chaplains were taught about PTSD, post traumatic stress disorder. PTSD is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma. The symptoms for PTSD may include re-experiencing the original traumas through flashbacks or nightmares, avoidance of stimuli associated with trauma, and increased mental arousal such as difficulty falling or staying asleep, anger, and hyper-vigilance among other symptoms.<sup>12</sup> The reason for discussing this syndrome in the session was to inform the chaplains of the latent effects of trauma in the event they would have a patient who was suffering with PTSD.

Twice since the Heath High School shooting, the person who committed the shooting has come up for parole. This early release parole scenario has caused a resurgence of recalling the incident in the community, and PTSD has been one of the issues found after the rekindled interest, especially for the family and friends of the victims. Chaplains should be prepared to deal with disorders common in the public arena like PTSD.

The rest of this session consisted of discussion with the chaplains about their assignment of completing a verbatim of a pastoral encounter in the hospital. These were discussed individually with the group. I reminded the trainees that the post- seminar questionnaire (see appendix 1) was to be turned in this week for evaluation of the seminar the following week. They were given the particulars of the graduation banquet which would be in two weeks. After prayer, we dismissed.

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<sup>12</sup>“Posttraumatic Stress Disorder,”<http://www.psyweb.com/Mdisord/AnxietyDis/posttraumatic.jsp>, (accessed 11 June 2012).

## CHAPTER 5

### PROJECT EVALUATION

#### **Introduction**

This project and its resultant work had a major influence in the way I present the plan of salvation to all people, not just those that have come to the place of considering end of life issues. The project work also had a major impact on the chaplain volunteers and Western Baptist Hospital staff who participated in the studies implemented by this project, and who have felt and continue to feel the benefits of this project. Another benefit of the project were the awareness in hospital staff of the need for pastoral care coverage and for the volunteer chaplain staff being efficient in sharing the plan of salvation with patients in a non-threatening way at the patient's request. This project has increased the appreciation for chaplaincy in the hospital staff and physicians who call on the Pastoral Care Department on a regular basis. From the beginning of this project until its completion, hospital staff referrals of chaplains to patients in need have increased from two to three per day to an average of twenty-five per day. Pastoral Care is called to all emergencies day and night. The budget for the Pastoral Care Department has increased to meet the ministry needs of the program. A further blessing to me is the request from five other hospitals to present similar chaplaincy training to their pastoral care staff.

The impact of this project has been significant. As a working chaplain I have often conversed with hospital patients concerning their spiritual life. Through the insights gained in this project, I have gained a new understanding of the patient's and family's disposition when they are faced with decisions of death and dying that have helped me and others in sharing the gospel. I have learned that an evangelistic approach

can be very pastoral and rewarding if presented in a careful and respectful manner. I have increased invitations to speak the gospel to patients and also have assisted other chaplains in speaking to their patients' spiritual condition and the need for salvation. I have grown in my ability to be more relational with patients and staff alike in the chaplaincy ministry field. This project gave me the insights required to be able to train ministry volunteers in relational evangelism and hospital protocol that has proven fruitful in their parish ministries as well as in the hospital setting.

The volunteers who participated in the project developed skills helpful in understanding their own lives and the ministry situations they potentially face, where illness or death may occur in their own families. This informed understanding gave them a new sense of how they can use their lives and testimonies to encourage others to be open to hearing and receiving counseling for support. And, if opportunity arises, they can be an agent of salvation, capable of understanding the ways that the gospel can be shared in a pastoral medical setting. In addition to this training, the participants in this project were also given a new way to celebrate life by understanding the stages of death and the grieving process patients and families experience when end of life comes. The training and experience they gained from this project have been added to their own parish ministries.

The comments expressed in appendix 5 indicate volunteer chaplains' responses to the received training. They have continued, since the training, to become a part of the Pastoral Care Volunteer team and have made themselves available for hospital chaplaincy on a regular basis, thus increasing the number of qualified chaplains at Western Baptist Hospital. The Pastoral Care Department has organized and maintained quarterly meetings for training and competency check lists for continuing education in the ministry of chaplaincy and evangelism.

An additional benefit beyond Western Baptist Hospital to the community of Paducah, Kentucky, was the training of other community volunteers for a potential community disaster ministry based on the materials presented in this project. Western

Baptist Hospital approved the training, and provided funding as a support to the community at large. The hospital administration agreed that this ministry program was needed and welcomed the additional training and volunteer staff that was provided as a product of this project's coursework. Meetings with hospital security and the Patient Safety Committee were scheduled to coordinate the community disaster training. Aspects of the training provided for this project were used to further the reach into a guide for the chaplains to use in the event a community disaster takes place. One of the objectives of this guide was that it could instruct volunteer chaplains in the techniques useful to disaster ministry without the need for a skilled instructor to be present. The guide was then used to train chaplains in triage to assess the needs of the people coming into the hospital who are concerned about their loved ones. The community plan outlined the logistics of sectioning the hospital building to meet the various needs of victims and family members in the event of a community emergency. Further, each designated triage area was located in a specific location of the hospital with each having a trained chaplain in place to meet whatever needs the family may have during an emergency scenario. The community guide is intended to assist local chaplains and volunteer ministers who may be required in the future to use their knowledge and skills learned during training in disaster ministry from the course of study developed in this project and it has already proven a valuable resource for the hospital and community.

Since the beginning of my ministry, I have had a desire to talk with every person with whom I came in contact about his or her spiritual life and eternal destiny. I had good success in speaking to a wide audience concerning the gospel while in my parish ministry except when it came to ministry in the hospital setting. There was seemingly a barrier in place for me when speaking about salvation to those who were in the last stages of life. It seemed to be a good time to talk about eternity but I did not feel comfortable in the conversation. I felt that a patient who faced immanent death was in a vulnerable position and that any decision that might potentially be made by he or she

regarding their spiritual condition might not be an authentic decision. The potential existed that the ones facing imminent death were merely grasping at some thread of hope instead of truly coming to know Christ and the realization of that potential often hindered my efforts to share the gospel. This project gave me tremendous insight to the feelings and the pain of someone who is faced with end of life decisions. It has deepened my understanding of what it means to walk alongside people during this time in their lives. I no longer feel hindered and now share the gospel frequently with those who face imminent death. Moreover, I have discovered that there is joy in ministry as lives are impacted by the gospel of Christ.

Before beginning this project, I had not investigated the topic of healing and praying for the sick in Scripture as I did while writing chapter 2 of this project. The exegetical work in the Scriptures proved to be both a humbling and motivating experience as I looked at both the Old Testament and the New Testament examples of prayer for the sick. During my ministry prior to the project I prayed for people to be healed when in the hospital or if sick while at home. The theological understanding of the purpose for and the results of prayer for the sick from Scripture gave me a biblical understanding of God's intent for our prayers for the sick as well as a solid doctrine to teach to the chaplains involved with this project. As my understanding grew, so did my confidence to teach others as well as actually praying for and with those persons who were sick or imminent of death in my pastoral care ministry at Western Baptist Hospital.

The discipline and the work involved in planning and teaching the project were taxing, physically and mentally. Watching the trainees become emotionally involved as we went through each phase of the training was rewarding and relieved some of the burdens involved in the preparation time as I began to realize this project was more than a course they were taking; it was a training the selected volunteer ministers for a future in ministry. The trainees came to understand how they could use their own lives in ministry to help people suffering from end of life issues and intense grief. I truly believe that the

training that resulted from the implementation of this project benefited me more than anyone else who was involved, and yet I am grateful that the ministry to the immanently dying is expanded in the community. My hope is that the program of training and the guide produced to assist new trainees in community emergency preparedness ministry will serve as tools for ministry in the years to come and in many places like Western Baptist Hospital.

### **Evaluation of the Project's Purpose and Goals**

The purpose of this project was to develop a relational evangelism ministry that would enable chaplains, pastoral ministers, and lay people from the local church to become relational evangelists with the sick and infirm in the hospital and the community. As the project progressed, there were several other considerations that entered the process. The discussions became very personal and emotional with the participants as individual stories of ministry to the infirm and dying became known. All of the chaplains were moved and touched with emotional responses that drove their further participation in the training process. Their conversations during training sessions on how this training had deepened their sense of their own family needs and the grief issues they were facing in their own lives from the loss of loved ones were an important part of the classroom experience. Personal involvement and investment of the chaplains in the training program and later ministry work with actual patients developed as a result of the discussions note above, all of which added richness to the total experience.

From the exegetical details in chapter 2 of this project, the chaplains involved in training understood the theological implications of prayer and gospel encounters for the sick and dying. This theological understanding was an important part of learning, by invitation, to share their faith with those who are at the point of death and need to either affirm or find faith. Theological reflection from the chaplains was an unexpected rich experience in the group meetings. As they shared their personal experiences and patient-visit experiences they aligned those times with Scripture, connecting the experience with



their theology. This project gave pastors and lay-people a place to practice continuing education in ministry.

### **Goals of the Project**

The first goal was to make the religious community aware, through local media, mail outs, word of mouth, and visits to the local congregations, that the community plays a role in the local hospital evangelism ministry. I contacted the local newspaper to advertise the program and newspaper instead published a story about the training program that brought a lot of local publicity for us. Paducah area pastors had expressed to me the feeling of alienation from the hospital when it came to being invited to do ministry in that setting. Now, as a result of the training program, many local pastors felt that they finally had access to the local hospital and the caregiving aspects of that hospital. As a result of the publicity, other local pastors (in addition to the ones selected for the project) asked for training in pastoral care for the sick and dying for their own congregations.

The shooting at Heath High School in Paducah, Kentucky, raised a lot of questions for pastors and lay leaders for doing hospital ministry during a crisis.<sup>1</sup> I was invited by seven different Paducah area pastors to speak as a guest in their churches in order to explain the training. I visited eight other area churches during their midweek church services to give information about the program. The response was great. The volunteers for the first group of trainees came from the churches where I spoke. Since then word of the program was shared amongst the local pastors and as a result we have people of several denominations who are in-process of training to be volunteer chaplains and thirty-seven volunteer chaplains who have been trained since the program began. These local pastors and other lay ministers have learned to share their faith in a relational, non-invasive way as they were trained in this project. Several of the pastors have

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<sup>1</sup>“Featured Articles: Heath High School,” *Chicago Tribune*, <http://articles.chicagotribune.com/keyword/heath-high-school>, (accessed 12 July 2012).

reported the evangelistic ministry in their congregations has grown by using the relational approach to evangelism. This goal was accomplished in the project.

The second goal was to recruit people who respond to the announcements and to enroll them in the training provided. As the project developed the implementation of this goal began immediately. Recruitment seemed to be the easiest part of the project. I discovered that people in this culture really want to minister and learn pastoral care skills. One of the significant things I learned is that the number of bi-vocational pastors is more than the number of “full time” pastors. The consensus of the bi-vocational pastors is that they are full-time but have to work another job to support their families. Two of the larger churches sent their support staff for the training. The training was mandatory to receive an ID badge from the hospital that made the volunteers’ presence in the medical units official, if they wished to continue in the hospital ministry. Seventy-eight percent of those who went through the training remained as hospital volunteer chaplains. The others used the training in their own parish settings to develop relational evangelism in their church ministry.

The study on the healing ministry of Jesus was a theological wake up call for the trainees in relational evangelism. The pastoral role of evangelism became clear to the pastors in the training. Understanding Jesus’ approach to healing gave insight to the relational dynamic of Jesus in the process of his healing ministry. The prayer model of healing and the process of anointing from the book of James was a favorite topic for discussion. Several of the pastors were concerned about the anointing process and how their churches would respond to this action within a congregational meeting. This goal of the project was (and at the conclusion of this project is) an ongoing process for the trainees. We have stimulated conversations with local pastors as a result of this program of training as they have participated with the hospital program for chaplains to discuss their approach to healing ministry in their local churches.

The third goal of this project was to develop an ongoing curriculum that would be taught in training sessions to keep newly trained laypersons and chaplains updated in evangelistic ministry methods of hospital ministry similar to those taught in this project. The biblical study for this ongoing training consisted of chapter 2 of this project. The first training session of the project moved to the ministry model of caring for dying and grieving patients and their families. Each person was assigned to read the biblical material for class discussion. The curriculum on death and dying gave the chaplains a focus for ministry with patients and family members who were at the end of life. The attendees became personally involved by sharing their own stories of grief and loss.

Using Elisabeth Kubler-Ross' books on death and dying and grief was, and will be, continued use for the ongoing classes. The evangelistic approach is different with these patient and family members. I discovered there are several curriculums and articles available for discussion in this area. The hospital administration approved a budget that enables us to do quarterly training with the volunteers to maintain their skills. The trainees are offered articles and text books for training.

We now have (at the conclusion of this project) a staff chaplain and a volunteer administrative assistant who devote much time to managing the schedule of the trainees as well as doing yearly evaluations. The same evaluation we used for staff chaplains was also used for volunteer chaplains with a few modifications. The evaluation process is also required for the Joint Commission inspection process for chaplains working with the hospital. Anyone who does the work of a chaplain in the hospital setting must have the chaplain training and maintain competencies.

The quarterly in-service meetings provide support for the team of thirty-seven volunteer chaplains. The director has developed a community of servants who call each other regularly and meet outside the meetings. One of the rewards for service was a free meal in the hospital cafeteria when visiting pastors and chaplains are on duty. The volunteers often meet to share a meal with each other. They email and have phone

conversations to keep the staff and the volunteer staff informed of the needs of each other as well as patients.

The fourth and final goal was to develop a consultation committee to evaluate the progress of the trained volunteer chaplains. This committee will develop and use an evaluation tool to monitor the progress of the volunteers and the program. The ongoing program will be called "Clinical Pastoral Training." This committee and their process will keep me accountable to the program as well. The process will keep me up to date with the other models of training and new curriculum available. This committee of fifteen people consists of nursing staff, social work staff, pastoral care staff, administration staff, two local pastors, and two members of the community who are volunteer chaplains. They meet once a quarter to discuss the curriculum, look at evaluations, and make recommendations for the ministry.

### **Project Methodology**

The outcome of this project is discussed previously in this chapter. This project has become a ministry at Western Baptist Hospital and several other hospitals in the region. There are a few things I would like to point out with which I feel very satisfied. There were also some things that I believe were limitations of the project. I will discuss the strengths and limitations of this project.

### **Strengths**

One of the several strengths was the pastoral presence that now exists in our hospital. The recognition of pastoral care is in the forefront of the operations of the hospital. We are an integral part of the functioning and decision-making process in the workings and administration of the hospital. The staff and the volunteers serve on several committees that meet regularly to discuss the hospital's functioning and operations. The ethics committee, the executive quality council, the research oversight committee, management team, and the medical executive committee are just a few of the

committees in which we participate. Local pastors who felt alienated from the ministry of the hospital are now visiting on a regular basis. They have access to their own locked lounge with a list of names of their parishioners to make it easy for them to know who of their parish is in the hospital. There is less competition with some of the pastors as they have developed a community of caring in the hospital.

Another strength is that the Pastoral Care unit at Western Baptist Hospital has become a pastoral care training center for training for pastors and laypeople in the community of Paducah. The Pastoral Care unit staff now has pastors and laypeople who do not want to be on the volunteer chaplain's team but who do take advantage of the training offered by the Center.

A further strength that I am very pleased to see is the confidence of the trainees that have worked with the Pastoral Care center and who are now involved in sharing their faith with people in the hospital and outside the hospital. Pastors report how the training detailed in this project has given them insight to the spiritual needs of their parishioners and a relational method to share the gospel with them. There are several reports of salvation experiences from these pastors and also reports of effective ministry to the dying patients and their families both from the hospital and the parishes where these pastors serve. While other aspects of needed ministry surfaced during this project, seeing local community pastors trained and engaged in sharing the gospel in the community was one of the main goals of the project.

### **Limitations**

One of the limitations that hindered the overall effectiveness of this project is the amount of time I took to complete the project. There were several family interruptions and occupational interruptions that led to the lack of continuity in the training process. I started the training over on one occasion because I saw the lack of continuity in the training process. I am thankful for the outcome; however, my fear is that continued prolonging of the project ultimately contributed to a drop in the number of participants.

Another limitation was the resources available to discuss the topic of sharing faith with dying patients. At best, I had to, on occasion, adapt material written from perspectives found in other faiths, or perhaps of no faith, in order to craft a project about the sharing of faith in the situations that have been detailed in this project. The shift to understanding the spiritual needs of dying patients from a Christian perspective rather than a secular perspective was one I had not expected but the exercise was ultimately helpful. Coming to an understanding of the needs of sick and dying patients, even from a perspective based in secular psychology, gave me an open door to further instruct the trainees in to show compassion and care from their own experience of grief and loss. My hope is this limitation will be addressed in our Convention and especially in the chaplaincy department of the North American Mission Board of the Southern Baptist Convention.

Another limitation was found in how one effectively deals with some of the more difficult cases during the death and dying process. As an example, one of the trainees asked a question about ministering to patients who were on ventilators and other life sustaining measures. There is some written material that delves a bit into how much a patient in this condition can understand; however, that research is not truly adequate to really know how to minister to these patients, especially regarding issues of salvation. What is not known is the state of mental cognition and whether the words shared during these times of extreme need is sufficient for a true salvation experience in the soul of the dying one. During discussions in the training seminars, we arrived at the concept of using what we could to impact the soul of the one with whom we may not be able to converse normally. We agreed that using singing in the room, the reading of Scripture, and certainly praying out loud were all helpful, but that it just seemed that there was a lack of truly one-on-one effective ministry in these situations. Understanding the difficult issues found in counseling the dying was a major limitation in this project and a perceived deficiency among the trainees and the pastoral care staff. Those who we jointly

perceived most in need of the gospel as they faced imminent death were the least likely persons we were able to reach because of their incommunicative status.

The limitation of time was also a factor in this training. Pastors and laypeople are very busy in their parish ministries, with their families, and occupations. Their ministry is a sacrifice even though all said it was also very rewarding. The amount of time trainees had to serve in order to maintain their competencies is set forth in the policy from the hospital. Some of the trainees had to take time off from serving with the team for a time, or even permanently, because of the aforementioned time limitations. The hospital policy on time spent in service as a function of credentialing potential chaplains is a big source of this limitation. The requirements are such that some cannot be at the hospital as much as hospital policy requires.

A final limitation was the amount of time I had to be involved with the training process. While this project opened the door for the presence of pastoral care in every department of Western Baptist Hospital, my time was taken in management meetings, which left me without the time I would like to have spent in training the chaplain team. The staff chaplain and the volunteer administrative assistant who were in charge of the chaplain ministry were tremendous assets to the program, but even with their aid I had difficulty in scheduling adequate time. Actual job requirements caused me to miss some aspects of the ministry training, something I yet regret.

### **Post-Evaluation of the Project**

The post-project evaluation was designed with the pre-project training as a follow up tool to give insight to the trainees as to their experience during the course of the project. The post-project evaluation proved a helpful tool in looking at changes that I made during the training emphasis of this project as an ongoing ministry of chaplaincy at Western Baptist Hospital. There were several good responses from the participants that gave the Pastoral Response Department valuable tools to adapt the program to meet the needs of the future trainees.

I realized that the participants were more accustomed to instructional training than interactive, didactic training. Once they came to understand the didactic training and became involved in the dialogue style of learning they participated without reservation. I saw a difference in their interactions with me when they reported for chaplaincy work. The receptors of the project material were more conversational than they were before the training.

I gave the project participants several sources to read including the books detailed in chapter 3 of this project. Some trainees expressed that there was too much reading and not enough dialogue about the reading. I have always made the text books available in the pastoral care library at Western Baptist Hospital and welcomed the trainees to pursue further reading and dialog after the end of the program. Some of the pastors and participants purchased the required program books for their own library. They found the information very helpful in their parish ministry as well as their hospital ministry.

The one area I saw needing change was the case conference discussion that ensued after any session with a patient. I was expecting discussions concerning the clinical aspects of pastoral care but instead, the post-session discussions became sessions about the instances and examples that the project participants had experienced in earlier attempts at pastoral care. I have since learned while dealing with other groups that came after the initial project focus group to keep the training focus on the case at hand instead of a debriefing session for past events. The new insights trainees gained once we made clear the expectations for their training ultimately proved more valuable to them than rehashing prior experiences. What group participants discovered was that their experiences on the inside edge of pastoral care in all situations gave them a new perspective of ministry that strengthened their own faith and resolve to share the gospel no matter the situation they found themselves in. Sharing their faith with patients was the most ultimately the most valuable tool they received according to testimonials after the training sessions were complete. Knowing when and how to share their faith was a big hit in the



experience. Several training group members have since shared that the valuable experience gained from being forced to deal with the here and now in patient care had given them more understanding in their parish ministry to guide them and their people in sharing their faith with others no matter the situation.

Continuing their hospital ministry is at the top of the list of desired ministry activities for most of the participants once the training was completed, even though that expectation was not required for the purposes of training. The Pastoral Care Center has seen and increase to forty-one trained chaplains who now have a consistent ministry at the hospital. Some continue to serve on two or three days a week in the program.

### **What I Would Do Differently**

The first thing I would do differently should an attempt be made to re-do this project is make the sacrifice to finish this project in a timely manner. Doing so would have been helpful for both me and the hospital where I serve. The training and the actual project completion would have been improved if they were both done in a consistent manner and with better continuity. I would also spend more time with senior management of the hospital to inform them of the benefits of the program instead of just doing the program and letting them see the progress and benefit on their own.

Furthermore, I would look for additional related material to use as text books for the class and also incorporate articles and Internet for more resources. I have already stated the need for additional references to help with training for gospel counseling with persons nearing death. In that light, I have begun to write some articles that may serve as resources on the subject of sharing faith with the dying patient and their families in the hopes that publication may further the knowledge base in the field.

### **Theological Reflection**

As I looked back at the many scenarios I faced daily at the hospital I was confronted with the fact that this ministry exists because of man's fall in the Garden of

Eden. My explanation for all the problems and struggles people have are due to sin in the world. While serving in the pastorate the sin of humankind and the resultant curse on this world was the standard explanation I gave to people when they encountered suffering. Early in my tenure with the hospital chaplaincy ministry I realized that I needed to find ways to talk with people about their situations without being blunt or seeming to be uncaring. I do know that we are all born in sin since Adam's fall in the garden, and we live in the consequences of our sin. The Bible makes that very clear. However, when I compare what the Bible says concerning sin to the passage in Matthew 5:45b that says, "For he makes his sun to rise on the evil and on the good, and sends rain on the just and on the unjust," the question I live with is, "Who is just and who is unjust?" Suffering is a part of this world. There are no people who are perfectly righteous in the world. God caused his own just son to suffer because of sin. We are called to suffer for Christ's sake. All of this causes me to wrestle with the question "why?" Yet, seeing someone suffer due to illness, and even to the point of death, gives me some understanding of the heart of God, for when he saw man suffering in sin he offered a solution to the suffering, eternal life through the suffering and death of his son who substituted himself for us.

The second chapter of this project details a God who has compassion on suffering as found in both the Old and New Testaments. This discovery became a major source of the teaching experience for the project and also for the reality of the responsibility of a compassionate ministry that God has given us for suffering people in the world. We can provide hope for the future, spiritual relief during the trials of suffering, and comfort in the heart of the one suffering. We can work with a care-giving team in a hospital setting and be an important part in the process of assisting those who may be dying to face that death with the peace of God that passes all understanding through the life-giving gospel of the Lord Jesus Christ. We can be respected in the caring community by physicians, specialists, and caregivers as we share with them the God who

lives inside us and who gives us hope for eternity and we can be the presence of God to those who are preparing to meet him face to face.

The psychological and sociological training in the project enables pastoral caregivers to interact with other caregivers and become a part of the interdisciplinary team in the care-giving process. Not understanding each other's disciplines can cause a disconnect in communication and the need for specialized care for patients and their families. But that training is not the last word for pastoral chaplains. Rather, the implications of God's interaction with the dying and that he understands suffering because he sent his own son to suffer all help to lift us to a higher place in times of suffering that transcend psychological and sociological training, as valuable as they both are. The training that came about as a result of the theological investigation in this project gave a feeling of appreciation rather than apprehension within the care team for patients.

Pastoral Care is an intricate part of the team present in the hospital setting during the end days of life for many patients and is now accepted at Western Baptist Hospital by nursing, physician staff, and administration alike. God was (and is) represented in the process. Caring comes from the compassion and grace that God displayed in each of the team members who were part of the program and who served after the program ended. I do yet see that sin in the world causes suffering in many ways, however, the presence of Holy God in the midst of suffering and that God understands suffering because he sent his son to suffer shows the compassion of God and the desire of God to have everyone who believes to have eternal life because of that very same suffering son.

My own spiritual feelings about my life and the limits of my own health became a reality to me during the completion of this project. I have seen how healthy people can come to a place of suffering, even to death, overnight. In this world we are subject to the conditions of the world brought about by sin. My own inner conviction

that God is a compassionate God, even as I witness the suffering of people, is ever with me. I continue to work through personal struggles as I continue my journey of Christianity and servanthood of the Lord Jesus Christ, but those struggles are born in hope that the God who knows, loves, cares, and provides is ever with me, and I am able to share with those who need that divine providence as needed because of the overflow in my own life.

### **Conclusion**

The experiences I gained in the process of this project are many and continue to surface as I continue my ministry. I became more compassionate with those who are suffering. I became aware of my own counter-transferences in the process of ministry that has at times hindered my ability to stay in the room, both physically and emotionally, with a suffering patient. I have recaptured the feeling that the urgency of sharing faith with others is the reason God has left us here on this earth, often in difficult situations, to minister to people. Relational evangelism has become the main process of my desire to see the lost come to know Christ as a personal Saviour. People do not care how much you know until they know how much you care. What a valuable lesson to learn, and what a valuable way to teach that same lesson to others; Jesus loves you and understands suffering!

The pastoral community needs encouragement and training. This project opened the door to many people who wanted to have a better understanding of the theological concepts of ministry to the dying patient and family member. Some of the people who sought the training had little access to training opportunities apart from the program developed in this project. The appreciation for this program from local churches, hospital administration, and nursing staff continued to exceed my expectations. The commitment of the people in Paducah, Kentucky far exceeded my expectations. I continued to see the progress of this project as it became an ongoing ministry of care and training at Western Baptist Hospital, hospitals in our region, and other states. This

program has been presented and used as a model in five other hospital settings at the date of the conclusion of this project.

My prayer is that I and others among the pastoral staff at Western Baptist Hospital will continue to provide this program of evangelistic and pastoral care to people and in places where there are those who are interested in learning and growing with us in the value of sharing our faith with the people in this world who are loved by God. The sacrificial example of God's love for us remains the source of our ministry and commitment to service. For his glory we serve and because he suffered, we live!

APPENDIX 1

PRE- AND POST-SEMINAR QUESTIONNAIRE

1. Please write your full name: \_\_\_\_\_
2. Circle the number of years since you came to faith in Jesus Christ.  
0-5 years      6-10 years      11-15 years      16-20 years      Over 20 years
3. Education  
Graduate level \_\_\_\_\_  
\_\_\_\_ Bachelor's degree  
\_\_\_\_ Associate's degree  
\_\_\_\_ Some college or technical school  
\_\_\_\_ Finished high school  
\_\_\_\_ Last year of high school completed
4. How much training should volunteer chaplains be required to take?  
6 months      1 year      ongoing training      no training
5. Should volunteer ministers who participate in the hospital pastoral care ministry be held accountable to the same standards as the paid staff chaplains? \_\_\_\_\_

Using the following scale write the number that corresponds in response to the following statement.

- 
- |                   |          |           |       |                |
|-------------------|----------|-----------|-------|----------------|
| 1                 | 2        | 3         | 4     | 5              |
| Strongly Disagree | Disagree | Uncertain | Agree | Strongly Agree |
- 
- \_\_\_\_ 1. I believe God calls Christians to be ministers of evangelism to dying people.
  - \_\_\_\_ 2. I believe the ministry of Jesus recorded in God's Word is the main resource for preparation for evangelism to dying people.
  - \_\_\_\_ 3. Evangelism is a part of pastoral care ministry to dying people.

- \_\_\_ 4. I am completely comfortable ministering to people who are dying.5. I am familiar with the stages of dying.
- \_\_\_ 6. It would be improper to evangelize the family of a dying patient.
- \_\_\_ 7. Every patient should be confronted with the plan of salvation.
- \_\_\_ 8. Chaplains should bring up the topic of death only after the patient has done so.
- \_\_\_ 9. Only patient's physicians should discuss dying with patients.
- \_\_\_ 10. Patients with long-term illnesses are easier to talk with about salvation.
- \_\_\_ 11. Families who experience sudden and expected death find hope in pastoral care ministry.
- \_\_\_ 12. Pastors and chaplains are needed when community disasters happen.
- \_\_\_ 13. Pastors already have training for pastoral care issues in community disasters.
- \_\_\_ 14. God has provided, for Christian ministers, seminaries to be trained in pastoral care ministry to dying people.
- \_\_\_ 15. Pastoral care ministry training for dying people is lacking in many of our churches.
- \_\_\_ 16. Hospitals are in need of pastoral care ministry to dying people.
- \_\_\_ 17. Most dying people being treated in hospitals are already Christians.
- \_\_\_ 18. Hospital chaplains are people who do pastoral care with dying patients in the hospital.
- \_\_\_ 19. Hospitals welcome volunteer pastoral care ministers.
- \_\_\_ 20. You do not need specific training to do pastoral care in the hospital to dying people.
- \_\_\_ 21. I believe pastoral care ministers should include training to do pastoral care ministry to dying people.
- \_\_\_ 22. Hospitals are good places to train ministers to do pastoral care to people who are dying.
- \_\_\_ 23. Volunteer ministers who participate in the hospital pastoral care ministry should be held accountable to the same standards as the paid staff chaplains.

APPENDIX 2

PRE-SEMINAR SURVEY AND APPLICATION

Name: \_\_\_\_\_

Circle the number of years since you came to faith in Jesus Christ.

0-5 years

6-10 years

11-15 years

16-20 years

Over 20 years

Education:

Graduate level \_\_\_\_\_

\_\_\_ Bachelor's degree

\_\_\_ Associate's degree

\_\_\_ Some college or technical school

\_\_\_ Finished high school

Last year of high school completed \_\_\_\_\_

1. What is your understanding of the pastoral care ministry to dying people?
2. How is pastoral care ministry different to dying patients than other pastoral care ministry?
3. How is pastoral care ministry different to families of dying patients?
4. Describe your calling to the pastoral care ministry in the hospital setting, especially to people who are dying.
5. Describe the kind of preparation you feel like you need to do pastoral care to dying people.



## APPENDIX 3

### AGREEMENT TO PARTICIPATE

The research in which you are about to participate is designed to evaluate the level of understanding of pastoral care evangelism you have as we begin our classes. This research is being conducted by James H. Wright for his Doctor of Ministry project addressing the training of pastoral care volunteers in the ministry of evangelism to dying patients and their families. In this research, you will answer basic questions about your salvation experience, call to the ministry of pastoral care, and your understanding of evangelism ministry to dying patients and their families. Any information you provide will be held in strictly confidential, and at no time will your name be reported, or your name identified with your responses. Participation in this study is totally voluntary and you are free to withdraw from the study at any time.

## APPENDIX 4

### OUTLINE OF TEACHING SESSIONS

1. Week one: Orientation to hospital setting
2. Week two: Orientation to Pastoral Care Department
3. Week three: Preparing the volunteers for the training and securing the consultation committee. The consultation committee distributes the survey questionnaire to the participants.
4. Week four: Understanding the stages of dying
5. Week five: Grief issues with death and dying
6. Week six: Principles for pastoral care with dying
7. Week seven: Guidelines for evangelism of the patient and family
8. Week eight: Death and dying issues from a terminal disease
9. Week nine: Death and dying issues from accidental and sudden death
10. Week ten: Short-term effects of death in a community disaster
11. Week eleven: Long-term effects of death in a community disaster
12. Week twelve: Post-seminar questionnaire and trainees evaluation and comments

APPENDIX 5  
APPLICATION RESULTS

2. Circle the number of years since you came to faith in Jesus Christ.

0-5 years      6-10 years      11-15 years      16-20 years      Over 20 years

*100%*

3. Education

Graduate level 46% *Graduate/Masters*

18% Bachelor's degree

27% Associate's degree

\_\_\_\_\_ Some college or technical school

\_\_\_\_\_ Finished high school

.09% Last year of high school completed

1. What is your understanding of the pastoral care ministry to dying people?

*All applicants: "Believe God calls Christians to minister to dying people in the areas of presence, comforting, allowing them to express their fears, etc.*

*"Pastoral care may be just sitting by the bedside and having a normal conversation."*

2. How is pastoral care ministry different to dying patients than other pastoral care ministry?

*"More emphasis on support and listening than on teaching and preaching."*

*"There may be more urgency to deal with matters of an eternal nature."*

3. How is pastoral care ministry different to families of dying patients?

*"Often families of dying patients are more receptive to pastoral care at this time."*

*"Good pastoral care at this time can be beneficial in helping families with grieving."*

4. Describe your calling to the pastoral care ministry in the hospital setting, especially to people who are dying.

*“I feel called to demonstrate God’s love through love, listening, support, patience & compassion.”*

*“My father died with lung cancer. Some of the unresolved issues I faced afterward may have benefitted from good pastoral care in my many hospital visits with him.”*

5. Describe the kind of preparation you feel like you need to do pastoral care to dying people.

*“CPE to understand myself and be better prepared to instruct and understand others.”*

*“A general understanding of the stages of death is beneficial.”*

APPENDIX 6

PRE- AND POST-SEMINAR  
QUESTIONNAIRE RESULTS

2. Circle the number of years since you came to faith in Jesus Christ.

0-5 years      6-10 years      11-15 years      16-20 years      Over 20  
years  
  
*100%*

3. Education

Graduate level *46% Graduate/Masters*

*18%* Bachelor's degree

*27%* Associate's degree

\_\_\_\_ Some college or technical school

\_\_\_\_ Finished high school

*.09%* Last year of high school completed

4. How much training should volunteer chaplains be required to take?

6 months      1 year      ongoing training      no training  
  
*100%*

5. Should volunteer ministers who participate in the hospital pastoral care ministry be held accountable to the same standards as the paid staff chaplains? \_\_\_\_\_

*YES – 82%      NO – 18%*

Using the following scale write the number that corresponds in response to the following statement.

---

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

- \_\_\_\_ 1. I believe God calls Christians to be ministers of evangelism to dying people.  
*64% Agree 18% Strongly Agree .09% Uncertain .09% Strongly Disagree*
- \_\_\_\_ 2. I believe the ministry of Jesus recorded in God's Word is the main resource for preparation for evangelism to dying people.  
*55% Agree 36% Strongly Agree .09% Disagree*
- \_\_\_\_ 3. Evangelism is a part of pastoral care ministry to dying people.  
*55% Agree 27% Strongly Agree .09% Disagree .09% Uncertain*
- \_\_\_\_ 4. I am completely comfortable ministering to people who are dying.5. I am familiar with the stages of dying.  
*46% Agree 36% Disagree 18% Strongly Agree*
- \_\_\_\_ 5. I am familiar with the stages of dying.\_\_\_\_  
*55% Agree 27% Strongly Agree 18% Uncertain*
- \_\_\_\_ 6. It would be improper to evangelize the family of a dying patient.  
*73% Disagree .09% Agree .09% Strongly Agree .09%Uncertain*
- \_\_\_\_ 7. Every patient should be confronted with the plan of salvation.  
*46% Disagree 18% Agree .09% Strongly Agree 18% Uncertain*
- \_\_\_\_ 8. Chaplains should bring up the topic of death only after the patient has done so.  
*64% Disagree 18%Agree 18 Uncertain*
- \_\_\_\_ 9. Only patient's physicians should discuss dying with patients.  
*46%Disagree 36%Strongly Disagree 18% Agree*
- \_\_\_\_ 10. Patients with long-term illnesses are easier to talk with about salvation.  
*46% Disagree 18%Strongly Disagree .09% Agree 36% Uncertain*
- \_\_\_\_ 11. Families who experience sudden and expected death find hope in pastoral care ministry.  
*82% Agree 18% Strongly Agree*
- \_\_\_\_ 12. Pastors and chaplains are needed when community disasters happen.  
*64% Strongly Agree 36% Agree*

- \_\_\_ 13. Pastors already have training for pastoral care issues in community disasters.
- 46% Disagree 27% Strongly Disagree 27% Uncertain*
- \_\_\_ 14. God has provided, for Christian ministers, seminaries to be trained in pastoral care ministry to dying people.
- 27% Agree .09% Strongly Agree .09% Strongly Disagree 36% Uncertain*
- \_\_\_ 15. Pastoral care ministry training for dying people is lacking in many of our churches.
- 55% Strongly Agree 36% Agree .09% Disagree*
- \_\_\_ 16. Hospitals are in need of pastoral care ministry to dying people.
- 55% Agree 45% Strongly Agree*
- \_\_\_ 17. Most dying people being treated in hospitals are already Christians.
- 46% Disagree 27% Strongly Disagree 18% Uncertain*
- \_\_\_ 18. Hospital chaplains are people who do pastoral care with dying patients in the hospital.
- 64% Agree 18% Strongly Agree 18% Uncertain*
- \_\_\_ 19. Hospitals welcome volunteer pastoral care ministers.
- 46% Agree 18% Disagree 36% Uncertain*
- \_\_\_ 20. You do not need specific training to do pastoral care in the hospital to dying people.
- 46% Disagree .09% Strongly Disagree .09% Strongly Agree*
- \_\_\_ 21. I believe pastoral care ministers should include training to do pastoral care ministry to dying people.
- 54% Strongly Agree 46% Agree*
- \_\_\_ 22. Hospitals are good places to train ministers to do pastoral care to people who are dying.
- 54% Agree 46% Strongly Agree*
- \_\_\_ 23. Volunteer ministers who participate in the hospital pastoral care ministry should be held accountable to the same standards as the paid staff chaplains.
- 36% Strongly Agree 36% Agree 18% Disagree .09% Uncertain*

## Final Evaluation of Training

(Please write a brief explanation of the following questions)

1. Was the atmosphere of the training center conducive to pastoral care learning?

*All Answers were Affirmative*

*Comments: "It was set up to be able to share & discuss, like an encounter group." "Yes, except for the table-less environment. I prefer a table." "With open discussion, things were always upbeat."*

2. Was the instructor adequately prepared to do the training?

*All Answers were Affirmative*

*Comments: "He provided materials for study, recommended books and guided discussion." "Instructor is very knowledgeable & experienced in subject matter." "Very – His experience is always an added bonus to his teaching." "Very much so!"*

3. Were the textbook(s) valuable for the learning experience?

*All Answers were Affirmative*

*Comments: "Well chosen & appropriate." "Information shared from texts was valuable." "This instructor always makes textbooks available for checking out in addition to giving where they made be purchased and the price."*

4. Were the case conferences good learning resources for pastoral care?

*All Answers were Affirmative*

*Comments: "The sharing of experiences was very helpful." "They proved to be very helpful resources" "I am impressed with how much more I learned about pastoral care."*

5. Do you feel more equipped to do pastoral care to dying people than before the training?

*All Answers were Affirmative*

*Comments: "I learned some insights that were new to me and will be helpful." "Just talking about the topic helped me as a pastoral care giver to understand the process more." "I have a deeper understanding of the grieving process." "Has been a great encouragement to my ministry."*

6. Will you become a part of the pastoral care team now that you have been trained?

*All Answers were Affirmative*

7. Would you recommend this training to your friends and colleagues?

*All Answers were Affirmative*



8. Would you recommend this training to your pastor and pastoral staff at your local church?

*All Answers were Affirmative*

*Comments: "The insights would be valuable for local pastors and their staffs."*

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## ABSTRACT

### DEVELOPING A STRATEGY FOR RELATIONAL EVANGELISM THROUGH PASTORAL CARE AT WESTERN BAPTIST HOSPITAL, PADUCAH, KENTUCKY

James Henry Wright, D.Min.  
The Southern Baptist Theological Seminary, 2013  
Faculty Supervisor: Dr. J. D. Payne

Chapter 1 introduces the project, states its purpose, and defines the project's specific goals. Attention was given to explaining the parameters in which the project was conducted, outlining the community that impacted the study, and establishing the project's rationale. A closing section deals with definitions and delimitations, concluding with brief initial observations regarding the project's enduring value.

Chapter 2 outlines the biblical and theological basis for ministry to the sick and dying as established from selected references from the Old and the New Testaments. This section provides an overview of the imperative for Christian believers to be personally involved in sharing the gospel of Jesus with persons who are at the end days of life and also with their families. The chapter concludes by establishing the importance of God's calling in the lives of pastoral ministers and chaplains to preach the gospel in the context of the sick and dying.

Chapter 3 provides a study of important sociological and psychological aspects of ministry to the terminally ill patient. The first section outlines the issues surround the act of dying including stages of grief. The second section of the chapter outlines the ways that chaplains and ministers reach out to the patient and his or her family. The conclusion of this chapter explains a specific strategy sharing the gospel to the dying.

Chapter 4 details the development and implementation of the project from its

inception through its culmination. In the first section an explanation of the preliminary assessment necessary for the establishment of the project is provided. In second section, the attention is given to the development of specific training sessions for training local area pastors and chaplains in ministry to the terminally ill. The final section is a record of the manner in which the project was implemented in the community. A measure of performance is provided by testing instruments implemented in two classroom sessions.

Chapter 5 begins with an evaluation of the project's impact as evidenced by the testing instruments. Second, the strengths and weaknesses, both inherent in the project are outlined. The conclusion brings to light the impact of this project on my own life and what I believe can be its eternal impact in the lives of ministers of the gospel who are passionate about ministry to the sick and dying.

## VITA

James Henry Wright

### EDUCATIONAL

Diploma, Marion Senior High School, Marion, Illinois  
Diploma, John A. Logan Junior College, 1977  
B.S., Southern Illinois University, 1979  
M.Div., The Southern Baptist Theological Seminary, 1988

### MINISTERIAL

Pastor, First Baptist Church, Energy, Illinois, 1976-  
Pastor, First Baptist Church, Hurst, Illinois, 1974-1976  
Pastor, Hafer Baptist Church, Carterville, Illinois, 1971-1974  
Chaplain, Veteran's Administration Hospital, Marion, Illinois, 1996-1998  
Director of Pastoral Care, Western Baptist Hospital, Paducah, Kentucky, 2002-  
Senior Pastor, Gospel Mission Worship Center, Paducah, Kentucky, 2011-

### ORGANIZATIONAL

Association of Professional Chaplains