San Francisco Theological Seminary

Grounded, Governed and Graced:
Foundational Practices for Hospital Visitation Volunteers Serving with the United Church of Canada

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by

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Dedication

To Joan Simmins, my beloved wife.

Joy of my life, full oft for loving you.
I bless my lot, that was so lucky placed.
—Edmund Spenser

Acknowledgements

I am the first student to complete a San Francisco Theological Seminary (SFTS) Doctor of Ministry (D.Min.) dissertation project without setting foot on either the Redlands or the Marin County campuses. I entered the SFTS D.Min. program in January 2021, when pandemic restrictions prevented in-person teaching and international travel. Although I missed keenly being on campus, I acknowledge gratefully that I have been supported and encouraged during my graduate studies. I became part of a community of fellow learners passionately committed to projects relevant to their congregants and to the wider communities in which we live, work, worship, and pray.

My advisor, Charlene Jin Lee, describes herself as a practical theologian whose work occupies a "middle space between reflection and action." While encouraging me to strive for excellence and clarity in the dissertation project, Charlene awakened my awareness of the ways in which my project occupies a space between reflection and action. It was my good fortune to be associated with a mentor who encouraged me to seek joy in the journey. As Charlene wrote in one blog entry, "I pray we will find joy in the journey. And invite one another along our way. Morning by morning, day by day. Amen."[1] I share and celebrate this perspective on life.

Navigating the SFTS system from afar was not easy. Teresa Chávez-Sauceda, SFTS D.Min. Program Director, generously provided me with framing concepts, administrative information, and personal support. I wish her well in her retirement. Ruth West, Associate Dean Graduate School of Theology, provided timely reminders about

[1] Charlene Jin Lee, "There Is a Joy in the Journey," Charlene Jin Lee, May 17, 2020, https://www.charlenejinlee.com/post/there-is-a-joy-in-the-journey.

administrative matters. She also provided worship leadership during the summer program. Steve Moore generously provided time and expertise with respect to the University of Redlands Institutional Review Board.

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As I undertook research for the program, I was welcomed by colleagues in ecumenical circles to participate in their hospital orientation programs. In the fall of 2020, Pastor Mark Lobitz, Director of Pastoral Care for Lutheran Hospital Ministries, Southern Alberta, invited me to participate in the course that he facilitated. Pastor Mark, a wise and empathetic leader, left me with an indelible memory of Jesus the storyteller as

a key to listening in hospital ministry. I felt privileged to be among the last cohort of a program that he had facilitated many times before.

Heartfelt thanks are due the Rev. Tracey Stagg, Diocesan Pastoral Care Coordinator for the Anglican Diocese of Calgary, who warmly encouraged me to participate in the pastoral care course that she facilitated in the spring of 2021. Taking that program confirmed in my heart that developing a hospital ministry orientation program would be a worthwhile doctoral topic.

I also benefitted from the gentle wisdom and seemingly infinite experience of Deacon Michael Soentgerath, ordained a Roman Catholic Deacon in 1983 and subsequently serving for many years at the Catholic Pastoral Centre heading the departments of Religious Education and the Health Care Apostolate for the diocese. I note with admiration that Deacon Michael is leading a Pastoral Care Training Program in the spring of 2023. Bravo, Michael, and thanks to you, to Mark, and to Tracey for helping me understand how other denominations practice hospital visitation.

David Pike, a long-time friend who developed a teaching and learning center at our local technical college, shared freely about the principles and practices of enhancing adult learning.

Finally, and by no means least, I would like to thank the congregation and staff of St. Andrew's Presbyterian Church in Calgary, where I have served as the Interim Pastoral Care Minister since January 2020. Ministry colleagues Jean Morris, Tim Archibald, and Peter Coutts actively supported my goal to enter the D.Min. program and cheered on as I made progress. So did congregation members. Staff members Deb Dorcas, Dolly Forcade and Evan Mounce have been wonderful and supportive friends and colleagues. It has

been an honor and a privilege to worship and work with these faithful people and to drink with them from the living waters of faith.

Thank you all.

Please note: Unless otherwise noted, Scripture references come from the New Revised Standard Version Updated Edition.

ABSTRACT

Grounded, Governed and Graced: Foundational Practices for Hospital Visitation Volunteers Serving with the United Church of Canada

Geoffrey Simmins

Three questions undergird the structure of this dissertation project, which has as its goal to develop a facilitation program for religious community hospital volunteers. How can we equip hospital volunteers so that they feel confident and ready to undertake their roles? How do we make information provided to them not only palatable but memorable, so that it can continue to inform and inspire the volunteers? How can adult learning theory and practices be employed to heighten a sense of empowerment and inspiration in the volunteer's ongoing work, so that the materials and techniques become a dynamic tool that can be applied in many different circumstances?

The dissertation adds new elements to an existing literature on training and sustaining hospital visitation volunteers by organizing a facilitation program with a three-part structure—Grounded, Governed and Graced, described here as the Three-G model. These consist of being Grounded in self-knowledge and an awareness of the Holy; Governed by church and hospital regulations; and Graced by the reciprocal gifts of visiting. The Three-G model informs engagements with case-studies focusing on role-playing and practices of extemporaneous prayer and enable volunteers to gain fluency and confidence for diverse visitation scenarios. Despite the project's focus on the United Church of Canada, its outlook is ecumenical.

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Charlene Jin Lee, Ph.D., Advisor Date

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PART I: CONTEXT

INTRODUCTION

"Listen to your life. See it for the fathomless mystery it is. In the boredom and pain of it, no less than in the excitement and gladness: touch, taste, smell your way to the holy and hidden heart of it, because in the last analysis all moments are key moments, and life itself is grace."

—Frederick Buechner, *Listening to Your Life*

"Tell me, what is it you plan to do with your one wild and precious life?"

—Mary Oliver, excerpt from "The Summer Day"

Mary Oliver asks us what we intend to do with our "wild and precious" lives. This dissertation project suggests that service to others as hospital volunteers can provide a meaningful way of doing something special with at least part of our precious life. In doing so, we might be able to experience what Buechner writes about, experiencing each part of our lives as "key moments," while understanding that "life itself is grace."

The dissertation is guided and inspired by Scripture's invitation to be formed and reformed in the image of God, so that the Kingdom of God comes closer. As Rowan Williams, former archbishop of Canterbury, writes in *Holy Living*: "Our Christian practice is fundamentally about nothing else than the re-creation in us of the divine image: Christ being shaped in human lives." Rather than concentrating on the limitations

and failings of social structures or of the Church or other institutions, we need, Williams says, "to get on with the real work of opening the way for God's transforming presence."[2]

Faith-community volunteers are called by their faith to exert just such a transforming presence. As Diana Garland et al. observe in "Social Work with Religious Volunteers: Activating and Sustaining Community Involvement," "Faith motivates volunteers to serve, and serving, in turn, may deepen and transform the volunteer's faith, leading to a greater commitment to service, compassion for those who suffer in unjust social systems, and the potential for more radical engagement in the community."[3]

If faith can motivate volunteers to serve, then perhaps the principal problem how to devise a facilitation program for hospital volunteers that will help them understand their role within a complex social setting, and to understand themselves better so that they can practice self-care so that they can continue to give of themselves and feel fulfilled and renewed through their faithful giving.

Visitors also need to understand that individuals in hospital find themselves uprooted and distanced from their frames of reference and comfort. Hospitals are often places of spiritual ennui and disappointment. Hospitals are characterized by complex and interlocking social networks that often leave the patient at the periphery of power. Hospitals are almost always places where interruptions are the norm. Volunteers need to be aware of at least some of these interlocking social structures, and the ways that hospital norms dictate any social interactions. This knowledge is helpful and necessary.

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[2] Rowan Williams, *Holy Living: The Christian Tradition for Today* (London: Bloomsbury Continuum, 2017), 127.

[3] Diana R. Garland, Dennis M. Myers, and Terry A. Wolfer, "Social Work with Religious Volunteers: Activating and Sustaining Community Involvement," *Social Work* 53, no. 3 (2008): 256, http://www.jstor.org/stable/23721724.

Gaining it can make hospital visiting more congenial and more effective. Volunteer visitors need to be acquainted with some of the complexities of the hospital system. It is also imperative that potential visitors understand themselves. When they do so, significant potential benefits are available to both themselves and to patients.

A well-prepared hospital visitation volunteer can make a positive impact in the hospital setting, both to staff and to patients. A recent Australian study has shown that the benefit of volunteers for patients are so significant that they ought to be deemed as essential, not optional.[4] Volunteers also help effect positive change within a system.[5]

In pre-modern days, it was relatively straightforward to visit the sick in hospital, one expression of caring for the "least of these brothers and sisters of mine" (Mt. 25:40). This is no longer the case. Hospitals have become complex institutions where interlocking professional values and standards make it challenging for volunteers to know what to expect and how to function to their best abilities.

Visiting: Key Concepts Derived from Social Science Literature

Potential visitors wonder about how to begin a visit. Research shows that the best way to do so is simply to begin a conversation.[6] What really matters, these studies show, is that visitors express empathy and validate the feelings of others. In social science

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[4] Heather Tan et al., "'Essential Not Optional': Spiritual Care in Australia during a Pandemic," *The Journal of Pastoral Care & Counseling* 75, no. 1_suppl (2021): 41–45, https://doi.org/10.1177/1542305020985071.

[5] Gemma Louch et al., "'Change Is What Can Actually Make the Tough Times Better': A Patient-Centred Patient Safety Intervention Delivered in Collaboration with Hospital Volunteers," *Health Expectations* 22, no. 1 (2019): 102–13, https://doi.org/10.1111/hex.12835.

[6] Melinda Wenner Moyer, "The Best Way to Comfort Someone When They're Sad," *The New York Times*, December 23, 2022, sec. Well, https://www.nytimes.com/2022/12/23/well/mind/sad-emotional-comfort-support.html.

terms, “how people help regulate each other’s emotions [is] a process called social emotion regulation.”[7] Phrases such as “I understand why you feel that way” or “That sounds very hard” seem to be both comforting and well-received. Validating a person’s emotions can be done without necessarily endorsing or agreeing with the person. (This might be important if the person broaches a moral or ethical issue with which the visitor might differ.) These insights are reinforced from data derived from studies with consumers, which show that validating their experiences, rather than asking them to rationalize them or downplay them, is especially important.[8] One technique called “temporaral distancing” might be employed, with some caution. This phrase is a way of helping people reframe a given situation so that some improvements in their situation might take place over time. Although it is not clear exactly why, people in the study program seemed to prefer this “temporal distancing” approach to other strategies such as attempting to make them feel more optimistic (employing “glass half-full” phrasing, for example).

Research has shown that visiting is good for the visitor, and it is well received by the person visiting. People truly appreciate it when others reach out to them and show that they care for others. James A. Dungan et al. have shown that potential visitors may inaccurately predict how positive an impact they will have just by caring enough to visit.[9]

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[7] Razia S. Sahi et al., “One Size Does Not Fit All: Decomposing the Implementation and Differential Benefits of Social Emotion Regulation Strategies.,” *Emotion*, 20221208, https://doi.org/10.1037/emo0001194.

[8] Laura M. Little et al., “More Than Happy to Help? Customer-Focused Emotion Management Strategies,” *Personnel Psychology* 66, no. 1 (2013): 261–86, https://doi.org/10.1111/peps.12010.

[9] James A. Dungan, David M. Munguia Gomez, and Nicholas Epley, “Too Reluctant to Reach Out: Receiving Social Support Is More Positive Than Expressers Expect,” *Psychological Science* 33, no. 8 (August 2022): 1300–1312, https://doi.org/10.1177/09567976221082942.

Their article's premises are worth citing in their entirety, because they reinforce that it is not only important for visitors to believe in what they do, but for them to realize that the effects of their visits are more positive than they might realize. As Dungan et al. observe,

> People rely on support from others to manage adversity. Although people may want to support those in need, they may be somewhat hesitant to express it. We document a psychological barrier impeding people from expressing support that they might otherwise be willing to offer. Specifically, our research indicates that people's interest in expressing support is guided by expectations of the recipient's response but that these expectations are overly pessimistic. People who sent supportive messages to someone they knew and who expressed support to a stranger face to face underestimated how positively their support was received. Our research also indicates that expressers focus relatively more on their competency in providing support rather than fully appreciating the warmth and compassion that expressing support conveys to recipients, providing one possible explanation for their overly pessimistic expectations. Underestimating the positive impact of expressing support could lead people to miss opportunities to help others more often in daily life.[10]

The Three-G Model Explained

The facilitation program is organized into three broad thematic subject-areas that might be likened to the three legs of a stool: Grounded; Governed; and Graced. I call this the Three-G model. To be grounded is to explore spiritual practices and theological concepts so that volunteers will find themselves with a solid basis from which to practice. Being governed recognizes the reality that hospitals, as well as religious denominations, have complex rules regarding how and when individuals can offer spiritual support to individuals in hospitals. Another aspect of being governed is to learn to recognize the limitations of a volunteer's role within the system. To be graced means that the program

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[10] Dungan, Munguia Gomez, and Epley, 1301.

has a reciprocal basis that confers a blessing upon both the caregiver and the care-recipient. The gift of time, for example, enables the visitor providing a ministry of presence to provide space and place so that patients can voice stories that need to be told.

The program is designed to enable volunteers to hone their empathetic listening skills as a means of supporting the patient and their family and friends, as well as the professional team(s). A key part of the training will be to help equip volunteers with the skills to know when and how to delegate and refer to more specialized members of the health-care team when faced with specialized medical and/or psycho-social problems.

Volunteers are provided with tools to help recognize their own limitations within the system. The facilitation program emphasizes the significance of a volunteer's unique and valuable service, which include being an unhurried presence in a setting where everyone else has too many demands on their time: a ministry of presence. A volunteer in a hospital setting offers the gift of their presence, without promising to cure or ameliorate a person's condition.[11] Volunteers offer the gift of *time*, and *radical availability*.

Equipping visitors adequately is important so that they can fulfill their role faithfully and with benefit to those in hospital. This project sets as its goal the creation of an ecumenical facilitation program that can be used by different denominations and tailored for their contexts.

Why Visit?

The website of the United Methodists provides an excellent theological explanation as to why Christians visit. We do so because this is one form of the service to

[11] Neil Holm, "Toward a Theology of the Ministry of Presence in Chaplaincy," *Journal of Christian Education* os-52, no. 1 (May 1, 2009): 7–22, https://doi.org/10.1177/002196570905200103.

others that Jesus commanded us to do. We visit others, and bring them comfort, because "we long to participate in God's work in the world. We pray, worship, and offer well wishes. We also serve, lend a hand, and meet a need. Through our service, we often find healing for ourselves as the Holy Spirit moves in and through us."[12]

The program is informed by the Biblical injunctions to visit the sick while also being responsive and attentive to the contemporary social issues and concerns of a large, professionalized health-care institution. "I was sick and you took care of me" (Mt 25:36) is the key biblical passage that has motived religious community volunteers to visit hospital patients. Throughout both testaments, the Bible reminds us strongly about the importance of extending loving care to all persons. Our rich scriptural heritage speaks eloquently and powerfully about how important it is to care for one another and support each other throughout our lives. The Bible also contains many helpful reminders to persevere, which is helpful for anyone who is engaged with caring for others.

For Christians, the resurrected Jesus stands at the heart our teachings about care and compassion. Jesus tells us, "I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another" (John 13:34-35).

Challenges and potential benefits

The principal problem, or academic and practical challenge, identified in this dissertation proposal is how to prepare Christians who wish to become religious

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[12] "'You Did It for Me': Serving Others," The United Methodist Church, accessed January 23, 2023, https://www.umc.org/en/content/you-did-it-for-me-serving-others-in-times-of-tragedy.

community visitors so that they feel that they can fulfill Jesus' injunction to visit the sick while also understanding their social role within a modern hospital. The dissertation responds to this pressing social need from a faith-based perspective. As explained below in the section on theological perspectives, and to cite a phrase from John Swinton, my goal with this program is to "create creative cultures of care." That is, I do not wish simply to impart information and facts and "how-to's" but rather to inculcate values that encourage individuals to explore their own gifts and vulnerabilities, to serve as agents of a transformational process for both the individual RCV as well as the patient receiving care and, within circumscribed parameters, the hospital system itself. The academic problem will be addressed by focusing on four interlocking but separate learning outcomes:

1. Encouraging visitors to prepare themselves by learning more about themselves, their gifts, and their vulnerabilities.
2. Helping visitors to identify sources of spiritual strength and sustenance, through regular spiritual disciplines and practices.
3. Equipping visitors to understand and chart their location and role within a complex social setting, understanding issues of vulnerabilities and power, including demarcating clear limits for the volunteer's appropriate responsibilities, so that the volunteers will know when and how to delegate and refer to trained clergy or specialized members of the health-care team when faced with circumstances requiring medical and/or psycho-social attention.
4. Fostering and encouraging practices that will help religious community visitors be able to keep on offering their gifts without burnout.

A Personal Checklist Manifesto. Developing a list of best practices can be very good practice in a variety of settings. In *The Checklist Manifesto: How to Get Things Right* Atul Gawande argues that the more complex a series of choices are, the more important it is to develop a clear, concise checklist.[13] Pilots have used these checklists for a long time: if they don't follow a repeated sequence to get the plane safely off the ground (and back onto it), a lot of things can go very wrong, very quickly. Gawande provides compelling evidence that healthcare practitioners achieve better health outcomes if they use lists like pilots. Surgical outcomes are better (and there are fewer embarrassing errors); practitioners know each time how they are to proceed; outcomes can be predicted and measured. To be effective, such lists must remain simple and straightforward. Otherwise, people simply cannot process or effectively manage their choices. A must lead to B, which must lead to C, and so on. Volunteers in hospitals can use such a checklist manifesto to protect against feeling overwhelmed, and to claim ownership over their practice. If we reduce the overall program to the three categories listed above—the Three-Gs of Grounded, Governed, and Graced—then it can be useful on an ongoing basis.

The Three-G Model is particularly compatible and appropriate for adult learners. Each person is encouraged to develop a set of questions that they find important to address, both before and after the visit. If the volunteer writes down (or dictates to themselves for later review) the main desired outcomes for a visit, and the main potential stumbling blocks or challenges, then reviews them deliberately afterwards, then the

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[13] Atul Gawande, *The Checklist Manifesto: How to Get Things Right*, 1st edition (New York: Picador, 2011).

proposed learning program will accord with what Gawande argued for—namely, that a checklist be succinct enough to be easy to apply, and easy to review. One way of doing this is to develop a parking lot prayer.

A Parking Lot Prayer. Imagine a hospital volunteer arriving at a site. They will not know what awaits them inside. How can they prepare themselves so that they will be functioning as their best selves once inside the hospital? They need to ground themselves for what might lie ahead. One good way of grounding themselves is to take a couple of minutes in a "parking lot prayer." The prayer is a way to remind the volunteer to slow down and invite the Holy into conversation with the visits to come. Starting with prayer will remind that they are not alone, and what they do is for God and with God's help. Thinking of Gawande's stated goal to reduce elements to their essentials will help the prayer be concise and focused.

The Three-G Model Applied. After prayer, the visitor might review what they have learned from the facilitation program—and apply it to their role each time they undertake a volunteer shift. In that the program is designed in three parts: grounded, governed, and graced, the volunteer might ask herself: In what I am grounded *this* day? This would provide them with an opportunity to review some of the sources of strength and comfort that they possess.

The visitation volunteers might ask themselves, how am I governed today? Such a question will help remind them of their responsibilities and their role within two larger organizations—the church and the hospital. They can remind themselves of the importance of record-keeping, of confidentiality, and of being careful about health-care

protocols and personal protection, for their sake, for the patient and the patient's family or visitors, and for the staff.

Finally, people might ask, in what ways might I be graced today? This last question must be framed in the conditional or future tense—because much of the grace will be experienced in the encounter with a patient. Asking themselves these three questions, after taking the time to pray, will help the volunteers prepare themselves. I imagine that each time they do this, they will ask the questions somewhat differently, in part due to their own mood and available energies, and in part due to experiences gained from other visits. The preparatory prayer, and the review of the three categories, will encourage an ever-changing process that will help the volunteer become more aware and more open to insight about what they are learning about themselves and about their encounter with other people. If grounded in such a deliberate and repetitive way, the visit will surely have a better likelihood of mutually beneficial exchange.

The process of review would continue after the visitor's shift. Volunteer are invited to engage with the same three questions after the visit. They can ask themselves, for example, whether they felt adequately grounded, whether they understood (and accepted) the specific ways in which they were governed. And finally, the volunteer could reflect on the third question, namely, in which ways was I graced (and I which ways was I an agent of grace to others?). Taking time for a second parking lot prayer to review the three components of the training will help them become *conscious and aware of their roles and awakened to the potential for meaningful impact with others*.

Post-Visit Review. These three questions are so straightforward, and conceptually linked, that a person could easily review them silently in their minds. Yet it

will be helpful if visitors can engage with the same process in a post-visit review. Learnings can be measured; roadblocks or challenges if some become evident, can be identified, and addressed. To do this, perhaps the potential volunteer might bring with them a small notebook or utilize the dictation feature on a phone. In either case, the volunteer would find it valuable to reflect deliberately on how they have felt grounded, governed, or graced during their visit.

If visitors have *not* felt grounded or graced during in their visit—or if they have only felt governed—this will also be a valuable insight. Reflecting on what went well, and what might have gone better, will help volunteers identify what has differed from previous visits. Doing so over many visits will help them identify trends. Are they always somewhat uncomfortable with certain kinds of individuals, or with certain categories of illnesses? Do they avoid talking about issues that patients have raised as concerns? Do volunteers know when they are getting in over their heads, and when they ought to refer patients to specialized members of the health-care team? Do volunteers understand their own limits and boundaries, and know when it's okay to say that they are not ready to talk about something? Or do volunteers find themselves glibly avoiding any spiritual questions, and instead focus on easy topics such as sports or the weather?

Volunteers can apply what they have learned in such a way that they deepen their understanding of themselves and of their role. Undertaking conscious review of each visit might be described as dialogical if defined as in conversation with oneself. The prayer and reviews of the three categories, both before and after the visit, will provide a way of keeping the theoretical work grounded and in conversation with practice. In this way,

their embodied engagement and commitment can become richer and more fulfilling over time.

Case-Studies. The facilitation program employed case-study scenarios to help potential visitors identify how certain techniques have consistently been shown to result in positive outcomes. The program will also acquaint volunteers with knowledge and practice of spontaneous prayer, active listening skills, a ministry of presence, and practices of spiritual nourishment and self-care.[14] Pastoral care theory, particularly the writings of Carrie Doehring, will be utilized to help acquaint the religious community visitor with different tools and perspectives to call upon during their visits.[15] Program participants will engage these essential components as a means of supporting the patient and their family and friends, as well as the professional health-care team(s). By means of the checklist and the parking lot prayer, visitors are empowered and prepared for their role.

To sum up the approach taken in the dissertation project:

1. There are both **limits and possibilities** to the hospital visitor's role. Visitors can be guided and positively influenced by both.

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[14]Ana Manzano et al., "Active Listening by Hospital Chaplaincy Volunteers: Benefits, Challenges and Good Practice," *Health and Social Care Chaplaincy* 3, no. 2 (May 9, 2015): 201–21, https://doi.org/10.1558/hscc.v3i2.26065; Robert Mundle, *How to Be an Even Better Listener: A Practical Guide for Hospice and Palliative Care Volunteers* (London and Philadelphia: Jessica Kingsley, 2019); Sara Webb Phillips, *Just in Time! Pastoral Prayers for the Hospital Visit* (Abingdon Press, 2010); Mikal Keefer, *Care & Visitation Ministry Volunteer Handbook: Equipping You to Serve* (Colorado Springs: Churchleaders Press, 2020).

[15] Carrie Doehring, "The Practice of Relational-Ethical Pastoral Care: An Intercultural Approach," in *Navigating Religious Difference in Spiritual Care and Counseling*, ed. Jill L. Snodgrass, vol. 2, Essays in Honor of Kathleen J. Greider (Claremont Press, 2019), 45–70, https://doi.org/10.2307/j.ctvwrm4c3.7; Carrie Doehring, *Practice of Pastoral Care, Revised and Expanded Edition* (Louisville, Kentucky: Westminster John Knox Press, 2015).

2. Adult learners **learn by doing**. By engaging with case-study visiting scenarios, sharing perspectives in discussions, and practicing spontaneous prayer, visitors can gain both fluency and confidence in their role. These practices remind us that volunteers often must think on their feet and are asked to pray.
3. Visitors are asked to commit to **ongoing practice** to derive meaning and inspiration from the learning examples. The "parking lot" prayer puts all these points into practice.

The facilitation program employs case-study scenarios to help potential visitors identify how certain techniques have consistently been shown to result in positive outcomes. The program will also acquaint volunteers with knowledge and practice of spontaneous prayer, active listening skills, a ministry of presence, and practices of spiritual nourishment and self-care.[16] Pastoral care theory, particularly the writings of Carrie Doehring, will be utilized to help acquaint the religious community visitor with different tools and perspectives to call upon during their visits.[17] Program participants will engage these essential components as a means of supporting the patient and their family and friends, as well as the professional health-care team(s). Religious volunteers have the potential to make a profound effect on the wellbeing of the hospital community. Religious volunteers are called by their faith to make a positive difference in the contexts where they live and work. Faith and social service interlock in profound ways.

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[16] Manzano et al., "Active Listening by Hospital Chaplaincy Volunteers"; Mundle, *How to Be an Even Better Listener: A Practical Guide for Hospice and Palliative Care Volunteers*; Phillips, *Just in Time! Pastoral Prayers for the Hospital Visit*.

[17] Doehring, "The Practice of Relational-Ethical Pastoral Care"; Doehring, *Practice of Pastoral Care, Revised and Expanded Edition*.

One of the strongest and timely reasons for developing a visitors' program for hospitals is because of the increasing number of people who have experienced negative experiences because of the pandemic. Isolation is not the same thing as being alone. A recent article, for example, reminds us of the how much people are negatively impacted because of social isolation and feeling unsupported. The authors write, "While isolation or being alone sometimes contributes to a sense of loneliness, some people experience loneliness despite having close connections with friends and/or family. Loneliness has been found to impact both physical and mental health. Longitudinal studies have found loneliness to predict future depression, paranoia, and social anxiety; only the latter of these in turn predicted subsequent loneliness, demonstrating that loneliness is a definitive precursor or contributor to mental health symptoms." Such were some of the motivating factors and general guiding principles that have influenced this dissertation project.

Chapter 1. Social Context

Hospitals are among our largest and most complex public institutions. Yet their functions and purposes often remain opaque to those who do not work there professionally. Within this complex, multi-site institutional framework, hospital volunteers find themselves sandwiched between two distinct, highly professionalized groups—the health-care professionals (HCPs), with their many different disciplines, and the increasingly specialized realm of the Spiritual Health Practitioner (SHP), the term used in AHS hospitals to describe a chaplain. From a social analysis perspective, patients are the individuals with the least amount of power within a hospital setting. Volunteers share with patients a sharply limited amount of power in hospitals. The volunteer operates in a space that is in between—between the ill and the well; between the nursing and medical staff and patient; and between those with professional standing and those who have no standing. Volunteers share a place of the least amount of power in the whole system. Learning to navigate effectively so that that limited power, but limitless influence, is used to best effect, is the goal and hoped-for outcome of this dissertation project.

The social analysis component of the dissertation project enables me to help volunteers understand both the limitations as well as the possibilities within their role. The writings of Maria Cimperman and Elizabeth Liebert provide an understanding of the

challenges associated with providing faith perspectives within a complex institutional framework such as a hospital.[18]

During a summer 2021 class taught by Elizabeth Liebert on Theology, Culture and Mission, classmate Jodi Bushdiecker remarked during her presentation: "Both personal and social transformation are needed in the practice of culturally appropriate and spiritually sensitive care." This comment frames what I hope might be possible in this hospital visitors' program: personal transformation that contributes gradually towards social transformation. My underlying attitude might be described as "radical availability," a phrase that Maria Cimperman memorably employs in her book *Social Analysis for the 21st Century*.[19] I hope that my analysis will help me live according to the traditions of Christian spirituality, which Cimperman, quoting Richard Gula, defines in this way: "a way of discipleship under the power of the Holy Spirit working in and through the community of believers to bring about a world marked by justice and peace."[20] A necessary part of this task is to broaden our own awareness, of race, class, disability, gender; to investigate how these come to play; to think structurally and theologically, and to think of discernment.

Pastoral Spiral in Theory and Practice. In *The Art of Theological Reflection*, Killen and De Beer develop a platform based on theological reflection (they don't talk

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[18] Maria Cimperman, *Social Analysis for the 21st Century* (Maryknoll, New York: Orbis Books, 2015); Elizabeth Liebert, *The Soul of Discernment: A Spiritual Practice for Communities and Institutions* (Westminster John Knox Press, 2015).

[19] Cimperman, *Social Analysis for the 21st Century*, 133.

[20] Cimperman, 132.

much about social analysis).[21] They write that we can come to wisdom as a cyclic movement in five parts. According to their methodology, the person practicing theological reflection engages with the following steps: First, the person enters an experience; then they encounter feelings; they allow images to arise from the feelings; they invite images that may spark new insight; and insight may (if the person is ready and willing) lead to action.

Branson and Martinez argue that theory and practice are related.[22] To undertake a process of analysis, one must first name and describe the situation, then analyze it. Next comes a process of study and reflecting on scripture (this is another way of saying, "theological reflection": their evangelical background is revealed because of their emphasis on scripture). Then one recalls and discusses stories from experience, before finally (and collaboratively) discerning and shaping a new praxis. The pastoral circle never repeats, although it does cycle. When the reflection goes through these four steps, it does not conclude.

The Pastoral Circle/Pastoral Cycle (Fig. 1) has a circular structure. It can be entered anywhere: the motion is continuous, experience, analysis, prayer and theological reflection, pastoral action. When we write "analysis," these can be theological as well as social. Focused prayer is necessary, asking for the action of the Holy Spirit as you move towards a decision; pastoral action comes out of it.

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[21] Patricia O'Connell Killen and John De Beer, *The Art of Theological Reflection* (New York: Crossroad, 2018).

[22] Mark Branson and Juan F. Martinez, *Churches, Cultures and Leadership: A Practical Theology of Congregations and Ethnicities* (IVP Academic, 2011).

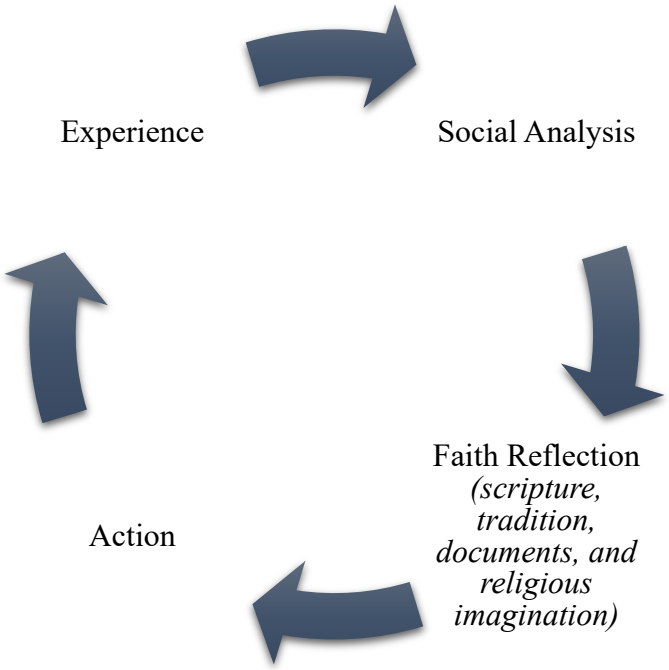

Fig. 1. Faith Reflection, part of the pastoral spiral. Diagram adapted from Cimperman, *Social Analysis for the 21st Century,* p. 126.

The pastoral spiral model is dynamic. That is, an experience can be followed by social analysis, then by theological analysis, and finally by action. At any point in time the person undertaking the process can begin the process again, until insight and action become clear—or until inaction becomes a conscious and necessary choice. Looking at experience, social analysis, faith reflection (or theological reflection) can lead to an appropriate action. "Action" can be understood widely, for example, sociological, economic, political, and so on. An action can take us around the spiral back once again to experience.

Cimperman recognizes how entrenched some social systems appear to be yet writes, "The *capacity for transformation* is already with creation as the cosmos constantly changes. We are constantly changing, growing, and adapting as we encounter

each interaction. This is part of our experience each day. Being intentional about the changes we seek is part of living in hope. We have particular hopes, and thus our imagination makes much more possible. Just as creation changes, so do the systems that people create change."[23]

Prayer can be an effective component of efforts to undertake analysis that leads to change. This can take place while attempting to find "truth, freedom, justice, love and beauty," which, as Lee E. Snook remarks, are the "secular forms that the Holy Spirit takes in the world."[24] As Liebert writes, "However complex or straightforward your social analysis may be, its ultimate purpose is to see the new underlying structure waiting to come into being."[25] Further to this: "Once you sense this vision, the 'stuckness' that sometimes dogs this step of the Social Discernment Cycle dissolves. In its place arises a sense of a right action. The context for sensing this new vision comes in the next step, theological reflection and prayer."[26]

In my preliminary analyses of this social setting, I turned to Killen and De Beer, particularly the section on "Theology as a Form of Human Reflection."[27] The section on correlation— "building a context in which conversation between our experience and the wisdom of our religious heritage can take place" (64-5) led to helpful insights. The authors speak of a person's uncomfortable experience in a homeless shelter. That person

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[23] Cimperman, *Social Analysis for the 21st Century*, 22.

[24] Liebert, *The Soul of Discernment: A Spiritual Practice for Communities and Institutions*, 95.

[25] Liebert, 96.

[26] Liebert, 97.

[27] Killen and De Beer, *The Art of Theological Reflection*, 65–69.

imagined the discomfort as being like having a steel rod across her shoulders. Killen and De Beer invite the reader to consider this image (or a similar one) in ways that relate to Christian themes of creation, sin, grace, and salvation. They transpose those words into more neutral ones: existence; negative; life-affirming; and "what might make it better?" (65). In a table, the authors sum up these points writing: "When we encounter our experience, we encounter our feelings. When we pay attention to those feelings, images arise. Considering and questioning those images may spark insight. Insight leads, if we are ready and willing to action."[28]

Selecting the Structure. These remarks lead me back to "Looking at the Current Situation," as described in *Soul of Discernment.*[29] Several salient questions to consider are found there. My social analysis leads me to conclude that I need to concentrate on the volunteers themselves. I can work directly with these people. There is both freedom and responsibility when doing so.

"It is God who Transforms." Maria Cimperman offers this observation in *Social Analysis for the Twenty-First Century*, writing, "…as disciples, we are called to participate in the transformation of systems, but it must be with an awareness that change of heart or metanoia is God's doing. It is God who transforms."[30] This statement colors my approach to the development of this Dissertation Project: I can develop muscles and become stronger and more practiced. There are limits. God lifts us above our own personal limits and transforms our spirits in ways we cannot alone.

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[28] Killen and De Beer, 74.

[29] Liebert, *The Soul of Discernment: A Spiritual Practice for Communities and Institutions*, 68.
[30] Cimperman, *Social Analysis for the 21st Century*, 51.

Yet transformation can and does take place. "Away of discipleship under the power of the Holy Spirit working in and through the community of believers to bring about a world marked by justice and peace," Cimperman, quoting Richard Gula, writes.[31]

A key challenge is to describe and understand the social role of the volunteers within a complex and highly professionalized setting—the HCPs on one hand, and the Spiritual Health Practitioners (SHPs, as we call them in our jurisdiction). A key component of the program will be to equip volunteers to know when and how to refer patients' concerns, either regarding health-care issues or spiritual concerns, or both, to specialists within the hospital. Social analysis will also include a discussion of aging and prevailing social assumptions regarding the older person, as regards the definitions of personhood, informed by the writings of John Swinton, particularly in connection with aging populations.

A Missional Perspective of Pastoral Care. Rick Rouse, in *Beyond Church Walls: Cultivating a Culture of Care*, argues that a twenty-first century church needs to understand pastoral care and mission as inseparable. He writes: "Pastoral care has been traditionally understood as pastoral acts administered to individuals or small groups—usually within congregations or church-related institutions—by an ordained or lay religious practitioner. As congregations in the twenty-first century begin to reclaim the missional nature of the church, this view must be broadened to also include care and concern for the needs of the larger community. A missional perspective does not diminish or abandon the fine traditions of pastoral care but engages them within this wider perspective. A missional perspective believes that good pastoral care leads to mission and

[31] Cimperman, 132.

that mission is undergirded by good pastoral care. A missional perspective of pastoral care embraces the notion that all of God's people—not just trained professionals—are called to partner in God's healing and redemption of the world. A missional perspective sees pastoral care and mission as inseparable."[32]

Expanding on why he believes that engaging in missional activities is an essential way of following Jesus, Rouse writes: "There are two bodies of water in Israel. One is the Dead Sea, so called because there is no outlet for the water it receives. It only takes, so cannot sustain life. The other is the Sea of Galilee, teeming with life and emptying into the Jordan River and giving nourishment to the land. As a church we are to exemplify the latter. Jesus calls us to give ourselves away in love for the sake of the world."[33]

Ministry Context. Since September 2020, I have served as the Hospital Ministries Coordinator for the United Church of Canada in the Chinook Winds Region, in southern Alberta, Canada. The regional office has commissioned a facilitation program for visitors to acute-care hospitals in the southern Alberta region. Timing was negatively impacted by the pandemic. During July 2022, in-person visiting resumed, albeit haltingly. The timing is now right to develop and assess a facilitation program so that well-trained volunteers can feel well equipped when they return to visit hospital patients.

The project is limited geographically and denominationally. As an ordained minister in the United Church of Canada working for the Chinook Winds Regional

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[32] Rick Rouse, *Beyond Church Walls: Cultivating a Culture of Care* (1517 Media, 2016), xxiv, https://doi.org/10.2307/j.ctt19qgfkq.

[33] Rouse, xxiii.

Council, I report to the Pastoral Relations Minister in the Chinook Winds Region, who has actively supported this initiative.

All volunteers are adults, who will visit adult patients in hospitals. Children and adolescents fall beyond the scope of this project. Each religious community volunteer is an adult member who is active in a specific faith community—in our case, as an active adult member or adherent of a congregation of the United Church of Canada. To be approved as hospital volunteers, volunteers pursue two independent but related tracks. They are vetted and trained by a person conferred that authority by their own religious community. (Volunteer Services has delegated the rights and responsibilities to train interested potential volunteers to each religious community organization of any recognized faith group.) Potential volunteers need to complete a Spiritual Care/Volunteer Resources orientation and education. Once they have completed this dual orientation, Spiritual Care Services accepts them (and has supervision over them) as religious community visitors (RCVs). RCVs must adhere to established policies and rules as provided by Volunteer Resources and Spiritual Care Services, which include signing a confidentiality agreement, recording hours, wearing a lanyard, identifying themselves by the acronym NOD (Name, Occupation, Duty). They also must restrict their visits to "members of the religious community they are mandated by that community to visit and provide services to."[34]

Grace can be experienced and shared even in painful places such as hospitals. Equipping religious community visitors so that they can identify and be sustained by their

[34] "Religious Community Visitor Application," n.d.

own sources of grace and share and be open to the grace expressed in and among others, is what beckons me and compels me to undertake this work.

Social Context

Acute-care hospitals in Southern Alberta are administered by the publicly funded Alberta Health Services (AHS), "part of Canada's first and largest provincewide, fully integrated health system, responsible for delivering health services to more than 4.4 million people living in Alberta, as well as to some residents of Saskatchewan, B.C., and the Northwest Territories. AHS has more than 108,600 direct AHS employees …[and] AHS is also supported by approximately 12,200 volunteers and more than 10,900 physicians practicing in Alberta, approximately 9,000 of whom are members of the AHS medical staff (including active, temporary and community appointments)."[35]

Some readers might wonder whether these volunteers limit their visitations to fellow Christian church members, or be expected, as a professional chaplain would be, to work as an Interfaith spiritual care provider. The answer is that within the Alberta Health Services hospital system, all Religious Community Volunteers (this is the term that the AHS employs) are prohibited from visiting patients from another denomination or another religious group. This is one of the conditions of their role as religious community visitors. To quote from one of those stated conditions, "The Volunteer will restrict his/her visiting to members of the religious community they are mandated by that community to visit and provide services to. Proselytizing in not permitted." Therefore, the RCV is not

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[35] Alberta Health Services, "About AHS," Alberta Health Services, accessed January 25, 2023, https://www.albertahealthservices.ca/about/about.aspx.

permitted to visit patients who have not self-identified as members of their specific faith community.[36]

In the AHS system, when a patient is admitted to hospital, they are asked whether they would like a visitor from their specific faith community. If they say yes, then their names are entered onto a database accessible only by Spiritual Health Practitioners (SHPs), by religious leaders of a specific community (e.g., an imam, a rabbi, a priest, a minister, etc.), or by religious community volunteers. In practice, SHPs generate the lists for the volunteers. SHPs, who are paid professionals, can and do visit anyone on a given ward, or indeed anyone in the hospital, including other staff. A religious community leader can visit anyone who is a member of a specific faith community. But religious community leaders often don't have time to do this. This is where religious community volunteers come in. After volunteers have signed a confidentiality agreement, they are provided with lists of those individuals within their specific faith community who are currently in the hospital. Thus, United Church volunteers are only provided access to the patients who have given their permission to be included in the United Church's database. Similarly, Lutherans, Roman Catholics, and Latter-Day Saints (to name but a few of many denominations) only visit their own members. All volunteers from faith groups access their lists the same way.

The system works reasonably well and minimizes confusion and misunderstandings. If for example, another patient in a unit who was from another denomination asked one of our RCVs for a visit whiles s/he was in the unit, the correct response would be to ask them if they wanted a visitor from their faith community to

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[36] "Religious Community Visitor Application."

come see them, a religious leader if one was available, or else a chaplain/SHP. Then an RCV would follow up with Spiritual Care and/or Volunteer Services.

The weak link in the existing system is not so much the structure but rather the paucity of available volunteers. On any given day, there might be 15-20 United Church of Canada members in each of our acute-care hospitals. Most of them are not receiving visits. That is the reason that we want to train more of them so that they can provide this ministry of care—within the specific parameters described above.

Consultations and Collaborations. The dissertation has been undertaken in close collaboration with AHS employees, both from volunteer services as well as from Spiritual Care. I consult with Alberta Health Services regarding rules and expectations for volunteers Religious Community Volunteers (RCVs). I developed handouts that provide RCVs with the norms and expectations of their role and sent these to the AHS teams for their input and comments. I worked with Religious Community Visitor coordinators from other denominations, including the Roman Catholic, Lutheran, and Anglican (Episcopalian) traditions. Reinforce concept of a "parking lot prayer" as a means of reinforcing the learnings from the orientation and keeping it relevant to each visit.

What the visitor can control during a visit. The volunteer, despite a prevailing lack of status within the system, can exert a surprising amount of control, if visitors make a regular practice of inviting self-awareness and consider the limits and possibilities of their role. All this should take place before the visit, and, if possible, afterwards.

Individuals do have a good deal of control over their visits, particularly their interactions with others. Visitors can do this by using all the tools at our disposal. Visitors

think of the ways in which they are grounded, governed, and graced in any given situation. They can make a checklist of what tools they want to be particularly aware of, using Gawande's Checklist Manifesto as a guideline. Volunteer visitors can engage in a prayerful and focused pre-visit "Parking lot prayer" (repeated before each room or encounter, and preferably afterwards, too). They can think carefully about how to begin and end the visit, trying to avoid surprises or inattentive moments.

During the visit, visitors are best advised to focus on one fundamental approach, such as attentive listening, as our means of attending to the person they are visiting. They adopt an attentive attitude to signs and signals from medical staff and patient (including family and friends). They encourage people to voice their story, or at least the aspects of their story that need to be expressed in this moment and encounter. They pay attention to their own body-language, clothing, and personal grooming options (such as unscented toiletries).

What cannot be controlled during a visit. It is equally important to reflect on the things and qualities that visitors cannot control. For example, people cannot control the social and structural context in which they visit. They cannot control the physical setting of the visit (although in some cases, they can creatively find ways of making a setting more congenial). They cannot control their role within the medical team (although they can control how they are perceived, i.e., as a helpful ally or as a distraction or worse). They cannot control, nor should we every wish to control, a patient's inner dialogue and reality, which will remain forever distant to them.

The social benefits that accrue from visiting are also relevant. "Religious/spiritual wellbeing is related to better health," observe two authors in a study about the benefits of

spiritual visiting.[37] The social and spiritual benefits of volunteers for patients are so significant that they ought to be deemed as essential, not optional, according to a recent Australian study. [38] Studies also have shown the value that volunteers bring to the culture of care in hospital systems.[39]

Self-care is challenging for both professionals and volunteers working in fields where they offer care and attention to others. Is self-care a social or a theological issue? Perhaps both. It is located here, under social perspectives, although it can easily be argued that a person must recognize themselves as having a self that is worthy of self-care, and thus it is a theological concern. (Self-care is also returned to as an ongoing concern in the chapter on Next Steps.) Leanna K. Fuller provides statistics showing that those in the caring and ministerial professions have significantly poorer health profiles than the public. Arguing against "contemporary critiques of self-care, which describe it as potentially self-indulgent and theologically problematic," she maintains that "such critiques are based on a highly individualistic understanding of "self" that is inattentive to social location and that obscures the relationship between self and community."[40] A key goal of this program is to help potential volunteers become aware that it is essential to practice self-care in ministry and dedicated volunteer work.

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[37] Marcelo Saad and Roberta de Medeiros, "Programs of Religious/Spiritual Support in Hospitals—Five 'Whies' and Five 'Hows,'" *Philosophy, Ethics, and Humanities in Medicine* 11 (December 2016), https://doi.org/10.1186/s13010-016-0039-z.

[38] Tan et al., "'Essential Not Optional.'"

[39] Louch et al., "'Change Is What Can Actually Make the Tough Times Better.'"

[40] Leanna K. Fuller, "In Defense of Self-Care," *Journal of Pastoral Theology* 28, no. 1 (January 2, 2018): 5, https://doi.org/10.1080/10649867.2018.1459106.

Comparative Denominational Perspectives

Each Christian denomination will have reasons for encouraging volunteers to visit patients in hospitals. In the case of Roman Catholic, Lutheran, and Episcopalian faith traditions, providing sacraments is of crucial importance. As noted in the Catechism of the Catholic Church, "'Seated at the right hand of the Father' and pouring out the Holy Spirit on his Body which is the Church, Christ now acts through the sacraments he instituted to communicate his grace. The sacraments are perceptible signs (words and actions) accessible to our human nature. By the action of Christ and the power of the Holy Spirit they make present efficaciously the grace that they signify."[41] The provision of these sacraments provides comfort to patients.

Reform traditions also celebrate the sacrament of Holy Communion and provide it in hospitals when requested. It is becoming more common for some practitioners to provide anointing, thus reclaiming ancient rites that predate any church divisions. The pandemic, however, made it less feasible for visitors, whether ordained or lay, to offer Communion or anointing.

The United Church of Christ (UCC) positions itself differently, as part of a broader goal to encourage what they term Health and Wholeness Advocacy. The UCC understands this mission as an example of the *diakonia*, or service to others, that we find explained and practiced in the early church. As they write, "Our UCC mission in health and human service belongs to all who have been called by God in Christ. Where the Church is, there is the mission. Where the Church is, there are those

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[41] "Catechism of the Catholic Church - Paragraph # 1084," accessed January 25, 2023, http://www.scborromeo.org/ccc/para/1084.htm.

who have been called to live "for the sake of the other." Where the Church is, there are those engaged in "*diakonia*"—the ministry of healing, service, care, compassion and hospitality—the love and grace of God made visible in our mission in health and human service."[42]

The United Church of Canada, the denomination in which I am ordained, is in full communion with the United Church of Christ and shares with it the same general understanding that service to others, including volunteering in hospitals, is a biblical injunction to be treasured and followed. Still, it does seem somewhat unusual that the United Church of Canada (UCC) developed in 2020 a new position for a Hospital Ministry Coordinator. The reasons for this appear to be in response to the dedicated work of one dedicated volunteer, Wilma Clark, who led the hospital ministry as a lay person for many years. I was one of the clergy members who was willing to come into the hospitals. In 2020 I was recruited for the new position.

One of my goals in this role is to position it within the broader context of The United Church of Canada as it seeks to define its role in 21st-century Canada and sees its ministry as applying within a much wider range of settings than a church. The UCC's 43rd General Council in October 2021 adopted a new vision reflecting what the church aspires to be over a 5- to 10-year span. The gist of the new vision is as follows: "Called by God, as disciples of Jesus, The United Church of Canada seeks to be a bold, connected, evolving church of diverse, courageous, hope-filled communities united in

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[42] "Health and Wholeness Advocacy," *United Church of Christ* (blog), accessed January 25, 2023, https://www.ucc.org/what-we-do/justice-local-church-ministries/justice/health-and-wholeness-advocacy-ministries/.

deep spirituality, inspiring worship, and daring justice."[43] Living purposefully into this vision anticipates becoming what Dr. Martin Luther King, Jr. and others called the "Beloved Community," the ever inbreaking, ever transforming, ever reconciling realm of God, realized in our time. The call is to three powerful frames: Deep Spirituality; Bold Discipleship; and Daring Justice. To what extent this new position can be understood as an attempt to extend this call and vision to the wider secular world to hospitals remains to be determined as to whether the position can be maintained and perhaps expanded in areas. The dissertation project envisages a time in which well-equipped visitors will provide a comforting presence in hospitals, counting themselves as valued members of an interdisciplinary team. To achieve this goal, some realistic analysis of social settings of hospitals, and the ability of individuals to affect change within such a system, is now in order.

[43] "Call and Vision Opening Prayer," accessed January 30, 2023, https://united-church.ca/prayers/call-and-vision-opening-prayer. See also https://united-church.ca/sites/default/files/2022-06/strategic-plan-overview.pdf

Chapter 2. THEOLOGICAL REFLECTION

In what theological soil is this dissertation rooted? It is rooted in a vision of wholeness and healing. A theology of wholeness sees all human beings as possessing qualities that are beautiful yet mysterious. Each person Spirit-filled, touched by God's grace. People are also inherently mysterious; we can never fully know them or their inner thoughts, dreams, fears, and hopes. In response to beauty and mystery of other human beings, we are called to care for others, to love them as God loved them.

Pope Francis has offered cogent, persuasive, and powerful words on this subject. During his Mass of Inauguration, on 19 March 2013, Pope Francis spoke eloquently about how we need to serve others, emulating the model of Joseph as protector.[44] Pope Francis called on those gathered in St. Peter's Square, and all those listening and reading in the wider world, to emulate Joseph and to think of Joseph's tenderness and caring. He said, "Caring, protecting, demands goodness, it calls for a certain tenderness. In the Gospels, Saint Joseph appears as a strong and courageous man, a working man, yet in his heart we see great tenderness, which is not the virtue of the weak but rather a sign of strength of spirit and a capacity for concern, for compassion, for genuine openness to others, for love. We must not be afraid of goodness, of tenderness!... [A]mid so much darkness, we need to see the light of hope and to be men and women who bring hope to others. To protect creation, to protect every man and every woman, to look upon them with tenderness and love, is to open a horizon of hope; it is to let a shaft of light break

[44] "Pope Francis' Inaugural Mass," March 19, 2013, https://www.vatican.va/content/francesco/en/homilies/2013/documents/papa-francesco_20130319_omelia-inizio-pontificato.html.

through the heavy clouds; it is to bring the warmth of hope! For believers, for us Christians, like Abraham, like Saint Joseph, the hope that we bring is set against the horizon of God, which has opened up before us in Christ. It is a hope built on the rock which is God."[45]

Such compelling words, resonant with hope and imbued with faith, remind us that Christians are called to advance an alternative vision to an obdurate world—the vision of the Kingdom of God, grounded in the person and teachings of Christ. When we advance this vision of the Kingdom faithfully and wholeheartedly, we are "Attending to Vision," to borrow a chapter title that Leach and Paterson employ in their book *Pastoral Supervision*.[46] They quote a powerful excerpt from former archbishop of Canterbury Rowan Williams' 2002 book, *Open to Judgement.* Williams writes, "Are you looking *into* your vision? Are you letting yourself be shaped and changed by what you see? I'm asking, in fact, about the precise degree to which your vision is for you what you live by from day to day, a matter of life and death, sense and nonsense. Are you attending to your vision?" [47] This key question will help guide volunteers and encourage them to become more aware both of their own core values and of the values and practices of the society in which they work.

While some gestures and attitudes can enhance this process, others can inhibit it. Edward Farley developed two contrasting terms as a way of summarizing the main components of this challenge. He terms them "structures of idolatry" and "structures of

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[45] "Pope Francis' Inaugural Mass."

[46] Jane Leach and Michael Paterson, *Pastoral Supervision: A Handbook: Second Edition* (London: SCM Press, 2015), 7–34.

[47] Leach and Paterson, 12.

redemption."[48] By means of the former term, Farley draws awareness to "the ways the priorities and values of institutions or societies can centre on money, productivity or status and draw individuals away from the priorities of the kingdom and the valuing of all human beings as those made in the image of God."[49] In contrast, the biblically inspired term "structures of redemption" refers in Farley's lexicon not just to the salvific work of Jesus Christ but also to "the ways institutions and societies can put the well-being of all creation and all God's creatures at the heart of their policies and priorities."[50]

The Goals and Practices of Theological Reflection. Wilson and Waggoner's *A Guide to Theological Reflection* provides helpful suggestions about the importance of theological reflection, as well as acquainting the reader with tools to practice theological reflection.[51] Volunteers will be encouraged to undertake this practice of self-reflection, particularly what the authors term "the reflection loop" encompassing theological reflection encourages people to reflect critically and to be to be more effective in ministry.

Since the mid-1970s, theological reflection has been a critical component of theological curricula of Association of Theological Schools (ATS) members.[52] A guiding scripture in this regard might be "Reflect on what I am saying, for the Lord will give you insight into all this" (2 Tim. 2:7 NIV). Wilson and Waggoner's *A Guide to Theological*

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[48] Leach and Paterson, 267.

[49] Leach and Paterson, 267.

[50] Leach and Paterson, 267.

[51] Jim Wilson and Earl Waggoner, *A Guide to Theological Reflection: A Fresh Approach for Practical Ministry Courses and Theological Field Education* (Grand Rapids, Michigan: Zondervan Academic, 2020).

[52] Wilson and Waggoner, 17.

Reflection provides helpful suggestions about the importance of theological reflection, as well as acquainting the reader with tools to practice theological reflection.[53] The authors define theological reflection as "identifying how our beliefs, thoughts and feelings influence our actions, aligning them to our best understanding of God's truth, and exploring possibilities for future ministry responses."

The authors suggest that "the reflection loop" encompassing theological reflection encourages people to reflect critically and to be to be more effective in ministry. Reflection needs to be more than spontaneous responses to one's actions and words; it needs to comprise other helpful sources of inspiration and teaching, including biblical, theological, and theoretical insights. "Reflection influences future actions," the authors write. Reflection also has the potential to change the minister (or in this case, the volunteer); practiced conscientiously, "it transforms us, helping us become the kind of people God wants us to be." This process invites people into a process of "enacting the learning." A reflective practice, as Leach and Paterson observe in *Pastoral Supervision*, means that those who practice a discipline are encouraged to foster both reflexive and reflective capacities.[54]

What is "the heart of the matter," as Killen and de Beer aptly put it?[55] As Wilson and Waggoner observe, a "critical and foundational assessment of the situation requires honest, thorough, and focused thought."[56] They also encourage people to "explore God's

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[53] Wilson and Waggoner, *A Guide to Theological Reflection,* 23-27.

[54] Leach and Paterson, *Pastoral Supervision*, 265.

[55] Killen and De Beer, *The Art of Theological Reflection*, 61.

[56] *A Guide to Theological Reflection*, 29.

activities around [them]," and particularly encourage a practice of journal-writing to achieve this goal.[57]

Similarly, Leach and Paterson, in their book *Pastoral Supervision,* strive "to place spiritual values at the heart of supervision for people with no explicit faith allegiance," while aiming "to foster professional actions that are aligned with personal beliefs and actions."[58] This could be an effective tool to help people ask questions that foster an awareness of social structures and how these can affect a person's interactions. Values-based Reflective Practice asks five questions of every situation brought to supervision, questions that can be remembered by the mnemonic pattern with the unintuitive acronym "NAVVY":[59]

1	N	Whose **needs** were met by doing what was done? Whose **needs** were left unmet?
2	A	What does the situation say about our **abilities** or capabilities? Competence, physical and human resources, training, etc.?
3	V	Who had a **voice** in the situation? Who was silent or silenced?
4	V	What was **valued** in the situation? What was **undervalued** or **overvalued**?
5	Y	What does the situation say about **you**? **You** the practitioner, **you** the team, **you** the organization?

[57] Wilson and Waggoner, 77–97.

[58] Leach and Paterson, *Pastoral Supervision*, 275–76.

[59] Leach and Paterson, 276.

Leach and Paterson's book *Pastoral Supervision* is structured in a way that helps readers become aware of wider contexts and group dynamics. They argue that in a context where effective supervision is taking place, there will be "lively dialogue" between past, present, and future. They suggest that this working process can be committed to memory by means of the acronym MAP, which is:

M	Motivation
A	Actual practice
P	Potential practice

As Leach and Paterson write, using MAP "helps practitioners connect the 'why' of personal vocation with the 'what of everyday activity."[60]

"Attending to Vision" is fittingly, the first chapter in Leach and Paterson's book. The remaining nine chapters in their book address a wide range of thematic topics, each of them prefaced by the phrase, "Attending to." These comprise attending to; process; the present; there and then; here and now; the body; the story; context; group matters; and endings. Each of these chapters provides wise counsel and informative exercises to readers. Most of them, however, would be more applicable in a formal supervisory relationship than to volunteers.

One chapter, however, offers much to potential volunteers, in that it awakens in them an awareness of their embodied selves. This is the chapter entitled "Attending to the Body." They refer to three key concepts related to the body: embodiment; projection; and

[60] Leach and Paterson, 13.

role. Embodiment, as the authors write, reminds us that "bodies matter. Being human is not a question of being a mind in a machine, but of becoming some*body* who is in concrete relation to other bodies. The doctrines of creation and of incarnation are doctrines of embodiment. Matter is created good yet suffers; bodies are redeemed through the suffering body of Christ; the bodily resurrection we proclaim in the creed is a matter not only of symbol but of substance."[61] This comment serves as a helpful theological reminder of why we value the body.

To apply these insights further, the authors invite people to become more aware of their own embodied selves, by using tools derived from drama-therapy practice. Volunteers might become more aware of their bodies as think about how they might be projecting feelings and memories from another context into the current one. Role-playing is also a specifically embodied practice. The authors discuss techniques such as doubling, mirroring, and role-reversal. Each of these could be a valuable exercise to introduce to volunteers. [62]

Spirituality and Aging

In 2019, I heard John Swinton, a theologian, and a former nurse, speak at a conference on Spirituality and Aging, held in Canberra, Australia. I attended the conference while serving as a minister in a Methodist-Presbyterian church in New Zealand. I was also considering undertaking D.Min. studies. Swinton spoke on the topic of "Reimagining Personhood: Dementia, Culture and Citizenship." His abstract stated:

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[61] Leach and Paterson, 145.

[62] Leach and Paterson, 152.

"This presentation will explore citizenship as an aspect of personhood with a particular focus on spirituality and the creation of creative cultures of care."[63] I experienced him to be a compelling speaker whose soft-spoken manner and precise Scots diction belied an adamantine passion for social justice and equality for all people.

I experienced a dithyrambic, fierce joy in listening to him speak about how personhood is inviolable, no matter what happens to our physical and cognitive abilities. Later, I researched Swinton's writings and career, and realized that he is a most unusual person. Now serving as a Professor in Practical Theology and Pastoral Care at the University of Aberdeen, Scotland, United Kingdom, before becoming a professor in theology, he worked for sixteen years as a psychiatric nurse. He has championed the cause of those who live with physical and intellectual challenges. His book *Dementia: Living in the Memories of God* won the Archbishop of Canterbury's Ramsey Prize for excellence in theological writing in 2016.

In addition to presenting the view that people can never lose their "citizenship" in the Kingdom of God—Swinton's presentation quoted "our citizenship is in heaven" (Phil 3:20)—something about what Swinton said about fostering "creative cultures of care" resonated deep within me. When several years later I had identified a potential D.Min. topic to design a visitor's program for hospital volunteers, I remembered Swinton's

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[63] John Swinton, "Disability, Vocation, and Prophetic Witness," *Theology Today* 77, no. 2 (July 2020): 186–97, https://doi.org/10.1177/0040573620920667; John Swinton, *Dementia: Living in the Memories of God* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2012); Swinton, "Disability, Vocation, and Prophetic Witness"; John Swinton and Stephen Pattison, "Moving beyond Clarity: Towards a Thin, Vague, and Useful Understanding of Spirituality in Nursing Care," *Nursing Philosophy* 11, no. 4 (2010): 226–37, https://doi.org/10.1111/j.1466-769X.2010.00450.x; Simon Dein, John Swinton, and Syed Qamar Abbas, "Theodicy and End-of-Life Care," *Journal of Social Work in End-of-Life & Palliative Care* 9, no. 2–3 (April 1, 2013): 191–208, https://doi.org/10.1080/15524256.2013.794056.

example and arguments about creating creative cultures of care. This, I realized, is what I hoped to do.

In addition to presenting the view that people can never lose their "citizenship" in the Kingdom of God—Swinton's presentation quoted "our citizenship is in heaven" (Phil 3:20)—something about what Swinton said about fostering "creative cultures of care" resonated deep within me. Swinton's example and arguments about creating creative cultures of care can help inform what we do.

While no data exist on the typical age of hospital patients who United Church visitors visit, many of them will be agèd or elderly. When someone like Swinton writes about how agèd persons still have spiritual value, this is valuable to note.

A Catechesis on Aging (Pope Francis)

Pope Francis has also offered some powerful and persuasive theological arguments about the spiritual value of the elderly. In a homily offered in February 2022, Pope Francis wrote, "Increased longevity has led to growing numbers of elderly persons in our midst, and thus a need to reflect anew on the relationship between the generations. Our throwaway society often exalts youthfulness and even dismisses the elderly as an unwanted burden. It is important, then, to consider and value the spiritual fruitfulness that this time of life can bring to the elderly themselves, as well as the gifts that they can offer to the communities of which they are an integral part. In this sense, we need to rediscover the "covenant" that unites the generations in looking to the future of our human family. The prophet Joel speaks of a time when 'the elderly shall dream dreams and the young see visions' (Joel 2:28). In these days of pandemic, we have come to see once more how

important it is to offer our young people wise guidance, hope and enthusiasm as they look to the future. As we begin these reflections, let us ask the Holy Spirit to help us understand and appreciate the great contribution that the elderly can make to a just and fraternal society."[64]

Other helpful guides to working with the agèd have been developed in other countries. For example, Australia has developed National Guidelines for Spiritual Care in Aged Care. These guidelines are based on an approach that recognizes that spiritual care is an essential component of graceful aging.[65]As they put it on their website: "Resourcing, and engaging with, community and residential aged care services to ensure meaning, purpose and connectedness are part of every ageing journey." The National Guidelines articulates five domains of spiritual care, with ten outcomes and actions listed for each:

1. Organisational leadership and alignment
2. Relationships and connectedness
3. Identifying and meeting spiritual choices, preferences and needs
4. Ethical context of spiritual care
5. Enabling spiritual expression.[66]

Together, Swinton, Pope Francis, and the Australian National Guidelines for Spiritual Care in Aged Care provide helpful and clear comments about the inviolable

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[64] "General Audience of 23 February 2022 - Catechesis on Old Age: 1. The Grace of Time and the Bond between Age and Life | Francis," accessed January 25, 2023, https://www.vatican.va/content/francesco/en/audiences/2022/documents/20220223-udienza-generale.html.

[65] "Meaningful Ageing - Social, Emotional and Spiritual Support Resources and Advocacy," accessed January 23, 2023, https://meaningfulageing.org.au/.

[66] Meaningful Ageing Australia, *National Guidelines for Spiritual Care in Aged Care* (Parkville, Australia: Meaningful Ageing Australia, 2016).

spiritual value of the agèd. These writings are helpful for potential volunteers to be aware of, so that they don't buy into the pervasive cultural view that the agèd person is inherently diminished in value and spiritual worth.

An inclusive theology propounds a view of humankind as powerfully and mystically interconnected. Karen Medland, the Pastoral Relations Minister in Chinook Winds, offered as the punchline of a story that she shared with a group of us gathered at a regional denominational meeting during the spring of 2022, "Our job is to walk each other home in the pilgrimage of life."

This remark provided a satisfying conclusion to a riveting story she told about a tragedy averted while she was visiting the Holy Island of Iona. Several people had gone for a hike and were stranded on high rocks by an incoming tide. The time of their expected arrival home came and went…yet they did not return. Foreboding among the islanders was inevitable: the sea is sometimes benign, often cruel. Silently, the islanders walked to the harbor and waited for news. They stood in a silent, prayerful vigil.

Thankfully, a passing boat managed to rescue the errant hikers. They all safely returned to Iona. Those silent folk gathered on the dock blessed those returning with their prayerful presence. As Karen remarked to our own group later, "When we meet on this journey as people of faith our work is to walk for a time with each other, to welcome the companionship, support each other in that time and place. I see the people of Christ as soul-bread for each other, in that what we should be offering is something to sustain each other, feed each other, and nurture the whole people of Christ. And that nurturing and sustaining comes in many ways, and we may not even know we are doing it. So, when I told the story of the boat arriving back from our extended adventure seeing the

community gathered on the dock felt like we were being welcomed home by the body of Christ, that then accompanied us back to the Abbey, and sat and ate with us, nurturing body and soul in one action."[67]

This story helps frame the theological underpinnings of the facilitation program. We are all the body of Christ. We are responsible to one another, and we are responsible for sharing Good News that Christ is with us, always, including our hospitals. We are *soul-bread to for each other.*

Another way of framing the theological understandings of this Dissertation Project is to refer to what Daniel S. Schipani has called "The four-dimensional framework of spiritual care." He derives this from James E. Loder's *The Transforming Moment*.[68] For Loder, the four dimensions of human existence are the self, the lived world, the Void, and the Holy. The "Void" is the third of the fundamental four dimensions of human existence: human existence is destined to annihilation and the ultimate absence of being. The many faces of the Void include existential loneliness, despair, and death. The "Holy" constitutes the fourth dimension of human existence which has, by the power of the Spirit of God, the capacity to transform the other three dimensions (80–91).[69]

In this schema, the Holy is presented in the same way as what Karen Medland termed "soul-bread"—as "abundant life, wholeness, communion, meaning, hopefulness,

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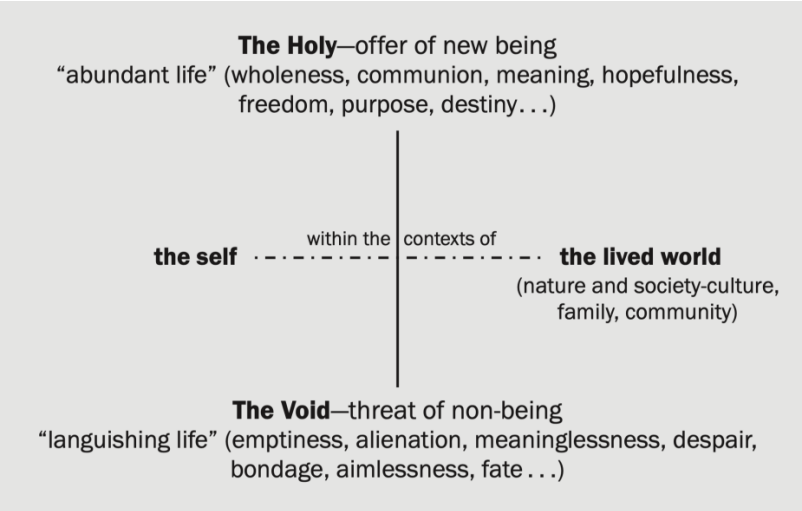
[67] Personal communication to the author, May 2022.
[68] James E. Loder, *The Transforming Moment*, 2nd ed. (Colorado Springs: Helmers & Howard, 1989), 69.

[69] Applying this guideline in counseling practice and reflection is discussed in Daniel S. Schipani, *The Way of Wisdom in Pastoral Counseling* (Elkhart: Institute of Mennonite Studies, 2003), 11–36.

freedom, purpose, and destiny." (See immediately below for a visual schema of this construct.)



Kenosis: Self-Giving for the Sake of the World

Kenosis, or self-emptying, provides an additional theological perspective focusing on humility and acceptance of one's limitations within contexts where power to effect change may be limited. *Kenosis* can be understood as transformational, as God-filling, as self-denying through self-emptying, an opening up with a degree of vulnerability and transformation—but without connotations of self-annihilation and absolute self-abnegation.[70]

Jesus brings hospitality and comfort (Luke 24:13-35)— "Come, have breakfast" (John 21:1-14)—yet empties himself so that he can serve others (Philippians 2:7).

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[70] Travis Ryan Pickell, "Gentle Space-Making: Christian Silent Prayer, Mindfulness, and Kenotic Identity Formation," *Studies in Christian Ethics* 32, no. 1 (February 1, 2019): 66–77, https://doi.org/10.1177/0953946818808142; Sarah Coakley, "Kenōsis and Subversion: On the Repression of 'Vulnerability' in Christian Feminist Writing," in *Powers and Submissions Spirituality, Philosophy and Gender* (Oxford, UK: John Wiley & Sons, Ltd, 2002), 3–39, https://doi.org/10.1002/9780470693407.ch1; Sarah Coakley, *Powers and Submissions: Spirituality, Philosophy, and Gender* (Oxford: Blackwell, 2002).

Kenosis is perhaps the most fruitful theological framework to guide the volunteer's understanding of their gifts in service to another individual. If kenosis means self-emptying, does that mean (as one standard source puts it) that we should emulate "God's humility exhibited in the incarnation as a call for Christians to be similarly subservient to others?"[71]

There are other and perhaps more fruitful ways of understanding this term, ways that open us up to transformation without self-abnegation. Travis Pickell explores the nuances of this approach, observing that "The Christian notion of *kenosis* follows a pattern of death and resurrection, whereby the one who loses her (old) life does so in the faith that God will raise her to new life. *Kenosis*, as [Sarah] Coakley repeatedly urges, is not to be equated in Christian theological terms with the obliteration or annihilation of the subject, but rather with its existing in a special form of vulnerable self-giving which *echoes and invites God's own special form of vulnerable self-giving*." (Emphasis added).[72]

Pickell's reference here to Sarah Coakley, a well-known feminist scholar and systematic theologian, is significant. Pickell observes that "According to Coakley, these practices enact a 'spiritual extension of Christic kenosis' because the one who thus prays must refuse from the outset a grasping, controlling mentality. This 'involves an ascetical commitment of some subtlety, a regular and willed practice of ceding and responding to the divine'.21 Coakley calls this 'gentle space-making'. [73] This form of 'self-emptying' is

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[71] I quote Wikipedia here to demonstrate one common understanding of kenosis.

[72] Pickell, "Gentle Space-Making," 77, note 48.

[73] Coakley, *Powers and Submissions: Spirituality, Philosophy, and Gender*, 35.

not simply an abnegation of the self, but rather, 'the place of the self's transformation and expansion into God.'"[74]

For some theologians, however, the term *kenosis* has become problematic for several reasons, including the idea that it is incompatible with feminist values. Can the term be reimagined or recontextualized? According to Pickell, there may indeed be creative and authentic way of ensuring that the term retains its power and relevance. As Pickell suggests, quoting Coakley, "The adjective 'gentle' is key, for the encounter which takes place here is 'not an invitation to be battered; nor is its silence a silencing …God … neither shouts nor forces, let alone "obliterates."' Coakley's treatment of silent prayer in Powers and Submissions comprises an extended refutation of important critiques of feminist theologians like Daphne Hampson who suggests, at least 'for women, the theme of self-emptying and self-abnegation is far from helpful as a [spiritual] paradigm' (cited by Pickell, n. 22).[75]

Coakley has written an article exploring these ideas in detail.[76] For Coakley, the word "gentle" frames her insights about kenosis being something one can invite without being invaded and annihilated. She ends her article with what she terms "a suggestion for 'right' *kenosis* founded on an analysis of the activity of Christian silent prayer (or 'contemplation'), an activity characterized by a rather special form of 'vulnerability' or 'self-effacement.'" [77] *Kenosis* can be understood as transformational, as God-filling, as

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[74] Coakley, 36.

[75] Margaret Daphne Hampson, *Theology and Feminism* (Oxford: Blackwell, 1990), 155.

[76] Coakley, "Kenōsis and Subversion."

[77] Coakley, 5.

self-denying through self-emptying. This is the spirit in which I see and understand the term: as an opening up with a degree of vulnerability and transformation—but without connotations of self-annihilation and absolute self-abnegation.

Branson and Martinez invite us into an even wider understanding of faith-based change, writing, "God wants shalom to be known across cultural boundaries. The eschatological images of the book of Revelation reinforce this trajectory: "There was a great multitude that no one could count, from every nation, from all tribes and peoples and languages, standing before the throne and before the Lamb" (Rev 7:9). Does this help us know the shape of any gathering called "church"? What did Jesus envision when he taught the disciples to pray, 'Your kingdom come. Your will be done on earth as it is in heaven' (Mt 6:10)? [78]

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[78] Branson and Martinez, *Churches, Cultures and Leadership,* Kindle locations 338-341.

PART II: OUTCOME: DESIGNING AND ASSESSING THE PROGRAM

Chapter 3. THE "THREE-G" MODEL: GROUNDED, GOVERNED, GRACED

The Impact of the Covid-19 Pandemic

Before discussing the development of the program, it is important to discuss the pandemic, which affected every aspect of how the program was designed and implemented.

As the lights dimmed at the beginning of Calgary Opera's fall 2022 production of Carmen, a hush came over the audience. The overture was accompanied by scrims on which were projected massive reproductions of prints from Francisco Goya's *Disasters of War/Los desastres de la guerra* (1810-1820). These prints adumbrated the director's approach to the opera, which emphasized the theme of violence against women. Goya's prints provided an ominous foreshadowing to the sad fate of Carmen herself.

These horrific prints from the *Disasters of War*, unpublished during Goya's lifetime, testify to Goya's disgust with humanity's inhumanity. The title of Print 45 in the series perhaps says it all: *Yo lo vi/I saw this*. Prints such as this, which depict things that no one should ever have to see or experience, occupy a completely different conceptual universe from Goya's bucolic early cartoons produced for tapestries installed in the royal palaces of San Lorenzo de El Escorial and El Pardo between 1775 and 1791. Those earlier works, peopled with doll-like figures set in bucolic landscapes that seem to exude

the cloying scent of lilacs, contrast with the terrible images from the *Disasters of War*—lolling, sprawling, dehumanized objects that exude the stench of death. Human beings who once lived, and loved, have been transformed into something less than they were—and far less than they might have become.

Such thoughts roiled in my mind as I tried to enjoy Carmen. With the familiar story of the opera unfolding before me, a B-roll of images from the pandemic unrolled in my imagination—images just as horrible as the prints from the *Disasters of War*. *Yo lo vi/I saw this*: crowded hospital corridors with gurneys filled and weeping friends and family standing beside them. Health-care workers, eyes dark with fatigue, trying hard to maintain some sense of equilibrium—or just to remain on their feet. Unforgettable, searing images from the media—makeshift morgues; pleading people; screens separating loved ones from one another even at the time of death. *Yo lo vi/I saw this.*

This dissertation project has been strongly affected by the pandemic. I took up my role in the newly created position during in the second half of 2020. I watched and worried as the hospitals began to close their doors to family and to visitors. The forced interlude enabled me to read and to frame the project. Overall, however, the pandemic revealed how provisional and how fragile some of the expected norms that we benefited from before were eroded, or simply abrogated. This text is written in the late fall of 2022, when the privilege and challenge of offering some hospital visiting has resumed. But I cannot help but look uneasily over my shoulder, wondering what might lie ahead. The hospital doors were shut to visitors without warning. Will it happen again?

During the height of the pandemic, I scrolled several times a day to the online Johns Hopkins University & Medicine Coronavirus Resource Center.[79] I stopped visiting this site, and reduced my media consumption more generally, because the news was unfailingly bad. The numbers of those affected became so vast and overwhelming that I could no longer hold them in my head. As someone who values precision and facts, I was distressed that as soon as I had some milestone number in mind, the pandemic would simply blast past whatever milestone had been achieved, making a mockery of statistical probity.

At the end of December 2022, I visited the Johns Hopkins site again. Doing so still felt remarkably like standing on the edge of an abyss. By whatever criterion one measures such things, what we read there are astonishing statistics. One hundred million cases in the USA and more than one million deaths. Some 655,000,000 cases world-wide, with nearly 6.6 million deaths. In Canada, nearly 4.5 million cases and close to 50,000 deaths. And so on, even in those remote Pacific islands where the pandemic took its time arriving, then reveled in its hegemony once it had done so. A worldwide pandemic, epidemic, and scourge, unleashed the hounds of Hell, causing personal suffering and awakening hostility, suspicion, and claims of conspiratorial complicity.

I mourn the loss of life. I grieve the loss of civility and trust. I feel deeply bereft that people suffered alone. I feel saddened that I have not been able to help more than I have. On the scrim on which are traced my own feelings, I project all these images of grief, loss, and shortcomings like the Goya images of war.

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[79] "COVID-19 Map," Johns Hopkins Coronavirus Resource Center, accessed December 16, 2022, https://coronavirus.jhu.edu/map.html.

If we saw all these things, either directly because family members or friends were affected by the pandemic, or indirectly through the ubiquitous images from social media and conventional public-information resources, then what could, or can we do with them? Does faith help in any way?

Faith can help us survive experiences that which would otherwise crush us. I thought of this recently when I picked up after a long day *A Crazy, Holy Grace: The Healing Power of Pain and Memory*, a book that compiles and reprints some of the late Frederick Buechner's writings.[80] As a young boy Buechner experienced his father's death by suicide. The details are etched in his mind: on a Saturday in the late fall—his father drifting to his destiny, passing by the door of the bedroom Buechner shared with his brother without saying anything to his sons—the young boys cheerfully played roulette. Buechner's childhood ended that same day.

Coming to grips with that early trauma underlies Buechner's later attempts to explore whether grace can be found amid grief. In *A Crazy, Holy Grace*, he speaks of the "Gates of Pain." He names some of the different ways that people typically respond to grief in their lives. Some people respond to grief by shutting it away, as he did. Others might become trapped by their pain (and are thus stopped in their tracks). Some people use grief as a defining hallmark of who they are. Buechner provides the example of Mrs. Gummidge in Dicken's *David Copperfield*, who mopes about while describing herself as a "lone lorn [i.e., forlorn] creetur." This caricatural person is amusing on one hand, yet it is not at all humorous that Mrs. Gummidge essentially defines herself by her grief.

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[80] Frederick Buechner, *A Crazy, Holy Grace: The Healing Power of Pain and Memory* (Zondervan, 2017).

Other people make a joke out of grief and hide the pain behind the joke, no matter how inappropriate or brittle the "joke" might seem. Still others engage with the game of competitive pain: "pain becomes a kind of accomplishment."[81]

In contrast to those ineffectual yet common strategies to insulate oneself from the effects of pain, Buechner invites us to stop fighting our grief, or avoiding it. He invites us instead to look to how pain can be surrounded by something omnipresent, which is the love of God. He observes that even though pain may be a universal component of the human condition, we are provided with means of moving through and past grief. In his typically clear and direct way, he writes:

> Simply put, suffering is universal. Pain is what it's all about. Life is terminal. We all end up in death or losing everything we have and are and loved. And I think that when Jesus looked out at the world of young people and old people, lucky people, unlucky people, black people, white people, poor people, rich people, and said, "Come unto me all ye that labour and are heavy laden and I will give you rest," he was saying some of the same thing. No matter who you are, how lucky or unlucky, or richer poor, or this or that, part of what it means to be a human being in this world is to labour and be heavy laden to be in need of whatever he means by rest.[82]

Buechner offers a suggestion about how we respond to pain that I found surprising but apt—that we should become "good stewards" of our pain. Referencing the Parable of the Talents, Buechner observes that the person who chooses to hide his pain—as indeed, he had tried to do—was not going to get past his own fear, not unless he recognizes that God "does not sow, but [God] expects that out of whatever the world in its madness does to us, we will somehow reap a harvest. [God] does not sow, but [God]

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[81] Buechner, 16–20.

[82] Buechner, 17.

expects that out of whatever the world in its madness does to us, we will somehow reap a harvest."[83] In contrast, the others who judged that trading their talents was "worth taking the risk, even if you live your life and it doesn't turn out the way you want. There is forgiveness There is compassion. There is mercy in God. And therefore, you dare take your chances and do what you can with the hand that life, or God, has dealt you. He concludes that those who risked and tried to make the best of what they could "were not life-buriers like that first fellow, they were life-traders."[84]

Failing to take up the offer of using one's talents as a good steward can lead to tragic outcomes, in Buechner's view. As he writes, "Faith is the assurance that the best and holiest dream is true after all. Faith in *something*—if only in the proposition that life is better than death—is what makes our journeys through time bearable. When faith ends, the journey ends—either in a death like my father's or in the living death of those who believe themselves to be without hope."[85] I recognize that not all would share such a view, but for me at least, I found it comforting both generally and more specifically as I tried to persist in a faithful way following the devastation wrought by the pandemic.

As it happened, the day after reading Buechner's remarks about grief, I had tea with a mother who had once experienced the death of her daughter, only a few days old. Marked and changed forever by that experience, just as Buechner had been marked and changed by his father's death, this mother spoke to me about the peace and acceptance she now feels. She and I talked about how God now seemed to be nudging and calling her

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[83] Buechner, 24.

[84] Buechner, 26.

[85] Buechner, 52.

towards a ministry of presence either in hospices or hospitals. Perhaps this is how God works in the world: by nudging and calling us, then by having that call affirmed by those who share some understanding of the same journey.

Do those who have faith make sense of the pandemic any better than those who do not? Perhaps. Perhaps not. Faith helps many people, including me, transmute the seemingly unbearable pain of an experience into that which can be lived with, perhaps even learned from. During the pilot project, as I relate later in the discussion related to that, I mention my sister, Karin, who died from a heroin overdose when we were both teenagers. Just as Buechner did, I placed her death in some sort of underground vault, sealed off in such a way that it could never hurt me again. What I hadn't reckoned on was that meditating on her death could heal me and call me into ministry. Healing and wholeness are miraculously possible, even if at first, we feel as shattered as Humpty Dumpty after his fall from the wall.

Another recent book provides quite different insights to those provided by Buechner about how faith-perspectives can be brought to bear during a situation such as a pandemic. In 2020, the first year of the pandemic, Walter Brueggemann published *Virus as a Summons to Faith*.[86] I ordered the book immediately and read it eagerly, looking for some solace amid what I was experiencing as cascading grief. Nahum Ward-Lev's foreword provided me with some comfort by reminding me that "the devastation caused by the Covid-19 virus is the same summons that all prophets hear in the mist of calamity: the call into right relationship with Living Presence; a call into deeper, more caring, and

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[86] Walter Brueggemann, *Virus as a Summons to Faith: Biblical Reflections in a Time of Loss, Grief, and Uncertainty* (Eugene, Oregon: Cascade Books, 2020).

mutually beneficial relationship with all that is."[87] Brueggemann brilliantly traces the ways in which biblical texts can provide insight into how human societies have lived through terrible times. I did not find the book as viscerally powerful as Buechner's discussions about how to be a good steward of grief, but I admired how Brueggemann can mine the Bible to provide helpful comments about how earlier people have found God's presence and support in their reading of the Bible.

I resonated particularly with comments Brueggemann offers regarding Isaiah 43:18-19, God's New Thing. Brueggemann reads this text as a reminder that we cannot find security through technological prowess, personal or collective wealth, or our overweening ambition to control outcomes, and thus the world. "We are pressed back to basics!" he writes," and observes: "As God often does, in hidden ways God may be amid this crisis to do the hard work of checking arrogance and curbing hubris. Amid the virus, we now face an alert about the indifferent, exploitative world of global self-sufficiency we have been making and that some of us mightily enjoy."[88] Yet I read that book entirely in my head, whereas Buechner's book touched me in my very core—a quite different experience. Brueggemann's insights about the biblical understanding of hope amid suffering, are a worthy complement to Buechner's book about how grief-work can be framed in a Christian way. Both books make it possible to drink from the cauldron of grief that the pandemic forced us to consume.

Scholars from the social sciences provide different, complementary insights. Trying to measure the effects of the pandemic, these scholars have generated statistics

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[87] Brueggemann, viii.

[88] Brueggemann, 57.

and measured trends and portends, while also inviting participation from those directly involved. I take comfort and inspiration from the ingenuity and creativity of such articles, from their scientific basis, and from the courage of those who shared their insights and their feelings with scholars. Something good will come out of this sharing and caring and quantitively measuring the effects of the pandemic. Of this I am convinced.

For example, scholarly literature has now traced some of the effects of the pandemic on patients as well as health-care professionals. In one insightful article, a multi-national team posted to an international group of chaplains three qualitative questions regarding COVID-19: "What was the most important aspect of spiritual care that was lost during the pandemic? What was new to you during this pandemic? What are the new ways of delivering spiritual care you have experienced? Of these new experiences, what do you think was the most effective?"[89] More than 1650 chaplains from many countries answered the questions, making the article rich in content and wide in scope. The authors summarized their goals in the following way: "When people experience loss, chaplains give them space to talk about it. Therefore, it seemed appropriate in the worldwide survey on Covid-19 to ask chaplains what their losses were. What did they see disappear from their pre-pandemic chaplaincy? For some chaplains everything was lost. They were made redundant or sat at home. For others nothing was lost. On the contrary, they gained visibility and assignments. Most chaplains though found themselves in between these extremes. The responses to the question what most

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[89] Anne Vandenhoeck et al., "'The Most Effective Experience Was a Flexible and Creative Attitude'—Reflections on Those Aspects of Spiritual Care That Were Lost, Gained, or Deemed Ineffective during the Pandemic," *Journal of Pastoral Care & Counseling* 75, no. 1_suppl (April 1, 2021): 17–23, https://doi.org/10.1177/1542305020987991.

important aspects of spiritual care were lost, can be divided into different categories: loss of physical presence or support and touch, of shared group and community moments, of not being able to work as we should as health care professionals, of a feeling of safety, of working with volunteers, of a backup theology."[90]

Poignantly, "the most referred to injury was seeing suffering and not being able to support."[91] A number of chaplains pointed to their own gifts and skills not being called on; they felt "the loss of being present and of touch." Some reported loneliness and feeling unsafe. Some felt that their theology was inadequate to help them navigate through the stormy seas; for example, as the authors report, one chaplain "described the tension between a God of proximity and the lived reality in hospital rooms."[92] Other chaplains reported missing volunteers to support them; often, these volunteers were among the groups identified as most at-risk.

Responding to the question of what had been most effective in terms of new procedures developed during the pandemic, chaplains provided widely varying answers. As the authors relate, "Responses ranged from the enthusiastic 'All have been effective' to the dispirited 'All of them felt failures.' However, given the focus of the question, the majority of the 1126 responses described those experiences that were effective. Chaplains have always responded to the needs before them as they arise. It is work that is unpredictable and requires a high capacity for paying attention, assessing, planning, and preparing. It is not surprising that this need for situational flexibility was highlighted

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[90] Vandenhoeck et al., 18.

[91] Vandenhoeck et al., 19.

[92] Vandenhoeck et al., 19.

during the pandemic. 'The most effective experience was a flexible and creative attitude.'"[93] While concluding that "What seems to be most hurtful though was the loss of being able to give quality spiritual care to those who needed it most," the article observed that flexibility, resiliency, and adaptability had helped many chaplains adapt to the unprecedented upheaval in their work setting.[94]

Another scholarly article reported the outcome of having asked a group of 21 American chaplains to keep a journal from March to June 2020.[95] A poignant insight that chaplains widely shared was that their known world and ways of working and communicating with care-receivers and their families were upended with no warning. As the authors write, "Chaplains operate in the world of chaplaincy, with associated cultural norms, language, practices, behaviors, tools, and set of competencies required. When the pandemic hit in March 2020…with no warning, family visitation in hospitals was eliminated or limited. Personal protective equipment (PPE) was limited, resulting in chaplains helping to con-serve PPE by not entering rooms with patients who had or were suspected of having COVID-19. This new world was constantly changing as new information was given, procedures shifted, and COVID-19 patient numbers rose."[96]

Chaplains also reported feeling upset about debates they had little ways of contributing to, such as those regarding who was an "essential" health-care worker.

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[93] Vandenhoeck et al., 20.

[94] Vandenhoeck et al., 21.

[95] Cate Michelle Desjardins et al., "American Health Care Chaplains' Narrative Experiences Serving during the COVID-19 Pandemic: A Phenomenological Hermeneutical Study," *Journal of Health Care Chaplaincy* 0, no. 0 (July 12, 2022): 5, https://doi.org/10.1080/08854726.2022.2087964.

[96] Desjardins et al., 5.

Sometimes, chaplains were considered essential; other times they were not. As the authors reported, that a "chaplain felt anger over how chaplains debated over who was essential and that the concept appeared to incite competition and martyrdom: '*Angry at what feels like competition to see who is more essential, who can martyr themselves more. Angry that this is what is celebrated and rewarded*.'"[97]

Providing comforting rituals, particularly at or near the end of life, also became difficult for chaplains. Some chaplains developed innovative strategies such as providing "a folded paper tent on which is printed a prayer of spiritual communion (when Eucharist is not available), the Apostolic Blessing of Pope Francis regarding the Anointing of the Sick, the Lord's Prayer, Psalm 23, a prayer to The Holy One, and a message from the spiritual care team."[98] But all this took place against a troubling background that included racism against some chaplains, and saw some of them report feeling unsupported in their general work.

The authors' conclusions are worth citing in full; they testify to the devastating the effects of the pandemic on these chaplains. As the authors write:

> The stories chaplains shared in their journals during the COVID-19 pandemic were powerful. Many were moving, shocking, and awe-inspiring. What is evidenced strongly in the data is not only profound suffering, but extraordinary resilience in the face of many mounting and shifting challenges. The chaplain journalers struggled at times to know how best to serve amid shifting policies, unclear messages from leadership, and radical changes in modes of practice—but every chaplain who submitted a journal did continue serving. Almost every chaplain in this study wrote of the shift to providing greater staff care and working intensely with family members who were kept out of the hospital due to the pan-demic. Amid their own profound grief and worry, again and again

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[97] Desjardins et al., 8.

[98] Desjardins et al., 9.

> chaplains recounted stories of creativity, teamwork, and drawing from a strong well of spirituality and strength to not only continue serving but, for many, to do so with profound depth. This did, how-ever, leave many of the chaplains exhausted, and a significant lingering question this research raises relates to how the profession of chaplaincy will respond to the exhaustion and trauma chaplains experienced during the COVID-19 pandemic.[99]

Care for the caregivers is also a critically important issue, as at least two authors have argued. Those who provide spiritual care might be likened to Henri Nouwen's famous "wounded healer" paradigm, argues one author.[100] Related to this line of reasoning, self-care should be treated as essential, not just as an aspirational goal to which one pays lip-service, another author observes.[101]

Bereavement during the pandemic was brutally interrupted, as was clearly documented in popular media. Scholarly articles are now emerging that trace the horrific impact of the pandemic on bereavement. A statistically significant article based on UK data with the self-evident title, "It was Brutal. Still Is," traces the responses of nearly 500 participants.[102] The article showed just how quickly, and tumultuously faithfully nurtured spiritual nurture practices fell into disarray. As I read this article, I experienced emotions ranging from anger to despair, yet I am grateful for the authors' powerful testimony to the neglect and disorder among hospitals. And although the data are from the U.K., what we

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[99] Desjardins et al., 15.

[100] Philip Joseph D Sarmiento, "Wounded Healers: A Call for Spiritual Care towards Healthcare Professionals in Time of COVID-19 Pandemic," *Journal of Public Health* 43, no. 2 (June 7, 2021): e273–74, https://doi.org/10.1093/pubmed/fdaa232.

[101] Fuller, "In Defense of Self-Care."

[102] Anna Torrens-Burton et al., "'It Was Brutal. It Still Is': A Qualitative Analysis of the Challenges of Bereavement during the COVID-19 Pandemic Reported in Two National Surveys," *Palliative Care* 16 (2022): 1–17.

read resonates with what we heard (and sometimes experienced) in North American hospitals. One quote from the authors will scarcely do justice to this powerful article, but that is what I will provide now:

> Negative emotions such as anger at being unable to visit, at the care that their loved ones received or treatment decisions that were made, further affected relatives' ability to process and reconcile their feelings surrounding the death. Having unanswered questions or doubts over how or why they died, and feelings that the deaths may have been avoided by the earlier introduction of infection control measures or, for non-COVID deaths, continued access to treatment, compounded this anger and upset.[103]

A Canadian study asked participants about their experiences of loneliness and the pandemic, using data compiled from 3,012 English-speaking Canadian adults aged 18+ years who completed a web-based survey in one of three waves between May 8 and June 23, 2020.[104] I found it fascinating and counter-intuitive to me at least that younger people were more at risk of experiencing loneliness during the pandemic than were older people. The authors speculate about why this might be the case, observing, "The higher rate of loneliness among younger adults may be due to a reduction in social interactions during shelter-in-place orders. There are age differences in how satisfaction is derived from social relationships; where young adults value the size of their social networks and quantity of interactions, older adults value the quality of their social networks and interactions."[105]

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[103] Torrens-Burton et al., 16.

[104] Christine M. Wickens et al., "Loneliness in the COVID-19 Pandemic: Associations with Age, Gender and Their Interaction," *Journal of Psychiatric Research* 136 (April 1, 2021): 103–8, https://doi.org/10.1016/j.jpsychires.2021.01.047.

[105] Wickens et al., 106.

Other articles surveyed healthcare professionals about their level of stress, about compassion satisfaction and fatigue, using the PROQOL protocol.[106] Many healthcare professionals maintained a high level of compassion satisfaction, yet also named grief as a significant additional stressor in their jobs. As the authors note, "Respondents' answers about additional stressors conveyed a high level of distress in some instances, and an overall theme of grief, that cut across all five reported themes. Participants articulated that they were grieving the loss of 'important things that were planned', grieving the inability to see a new grandchild or be with a sick relative, grieving the inability to grieve death of loved ones and patients, and grieving the obstacles to and an overall loss of 'normalcy'."[107]

Storm Swain, who serves as The Frederick Houk Borsch Associate Professor of Anglican Studies, Pastoral Care and Theology, United Lutheran Seminary, Gettysburg and Philadelphia, bridges the two worlds of theology and social sciences, thus providing the single most helpful and far-ranging article about the pandemic's effects on health-care professionals that I located.[108] In my reading of the literature, Swain's article about disaster-informed care provides of the most cogent, structurally analytical, and helpful framing of how chaplaincy can be practiced in traumatic disaster settings.

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[106] Meagan Dwyer et al., "Burnout and Compassion Satisfaction: Survey Findings of Healthcare Employee Wellness During COVID-19 Pandemic Using ProQOL," *Kansas Journal of Medicine* 14, no. 2 (May 21, 2021): 121–27, https://doi.org/10.17161/kjm.vol1415171.

[107] Dwyer et al., 124.

[108] Storm Swain, "'We Are All Disaster Chaplains Now': Pastoral Accountability and Planning Care in Pandemic Reality," *Journal of Pastoral Theology* 32, no. 1 (January 2, 2022): 83–88, https://doi.org/10.1080/10649867.2022.2028056.

Swain's article provides both a scientific as well as a pastoral formation perspective on the pandemic. Recognizing the pandemic as the traumatic experience it was, Swain argues that insights can be gained for many spiritual health care providers by considering some of the known insights garnered from trauma-informed care and disaster chaplaincy. Swain also provides one of the most helpful and optimistic descriptions of the chaplain working as a well-regarded, indeed essential, member of a wider healthcare team. (Other articles, by contrast, reported a widespread sense of disconnection among chaplains as regards their sense of place within a team.) In a traumatic situation, one's options are reduced to a binary formula: either to keep on going or to stop. Keeping on going requires a kind of inner resiliency that one seasoned chaplain referred to as "spiritual duct tape," in which the chaplain's role is essential because it provides solace to those who are doing other work on the ground (or in the wards); "You are here to support, to uplift, to bless bodies, to be a symbol, to be a presence in whatever way they need you to be."[109] The goal of the chaplain in such a setting, the authors argue convincingly, is to provide both a temporal as well as a spiritual presence. Their own words express this eloquently:

> Disaster chaplains are there to support the temporal mission of disaster response and recovery, working to care for those impacted, and support recovery workers to achieve a common mission. We need to keep that big picture, as well as the personal interaction in mind. Secondly, we are accountable also to the spiritual realities of symbolizing the presence and care of the divine, in ways that go beyond our personal presence, and the particularities of the disaster. The nature of disaster chaplaincy, with high and sometimes unabated levels of emotional arousal, often working with a community we may not know, in a chain-of command where we are not the ones in charge, working with those traumatized, or in potentially traumatizing conditions ourselves, in a role that speaks to meaning and

[109] Swain, 84.

> hope in a way that other recovery workers are not called to account for, means that we need to also be accountable for caring for ourselves as a priority. Such self-care enables us to continue to care for others in the long moments, days, weeks, and months of disaster response.[110]

Swain, a long-time professor of pastoral formation, has developed a five-dimensional rubric that she calls CAIRA; this stands for Pastoral Collegiality, Authority, Identity, Responsibility, and Accountability.[111] Of these, the final point, accountability, seems most germane to determining roles and responsibilities during the pandemic. For Swain, accountability entails more than simply responding to "simplistic moralism through idealized cognitive assent to codes of ethics and practice, and standards of care;" accountability needs to be understood instead as "an embodied owning of an ethical sensibility that affirms boundaries and foregrounds safety for the care of both self and others."[112]

To help students of pastoral formation develop these skills, Storm assigns Carrie Doehring's Plan of Care model from *The Practice of Pastoral Care: A Postmodern Approach*.[113] Storm cites Doehring's Plan of Care to help those who provide care to move beyond the bread-and-butter compassionate response of many caregivers to recognize the times and contexts in which a more demanding and systemic response is appropriate. Swain argues that chaplaincy (and by extrapolation, volunteering to support chaplaincy), is most effective when it is structured in terms of "compassion and assertion [that] are both required to build a systemic accountability that focuses on the good of the

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[110] Swain, 84.

[111] Swain, 84.

[112] Swain, 84.

[113] Doehring, *Practice of Pastoral Care, Revised and Expanded Edition*.

whole."[114] Such a systemic accountability is possible only when the person involved in offering care goes beyond "what William H. Willimon calls, 'the ethics of nice,' [when] ministers [or other care-providers] always being nice, good and helpful ... to a structural ethical accountability that cares for all in the structures."[115]

I have not located articles that document the effects of the pandemic on hospital volunteers. I did locate one article, however, drawing from Australian data, that discussed the presence of volunteers as part of a spiritual care team that they deemed "essential" during the pandemic.[116] In the view of the authors, increased professionalization of spiritual care, along with improved standards of supervision and reporting, were more desirable than focusing on encouraging volunteers or staff paid for by faith groups. In fairness to these authors, it is only right to cite their reservations about volunteers, at least in terms of providing long-term, sustainable spiritual care. They write,

> Together the quantitative and qualitative data paint a picture of the mixed models of spiritual care provision across participating sites. With all volunteers stood down the question of sustainability of a model based on a volunteer workforce must be raised. There is a need for a greater investment in a professional spiritual care workforce or the models will not move from a reliance on volunteers and chaplains paid by faith traditions. There is a need for further research to confirm whether professionally trained, supervised and certified practitioners make a difference to the quality of spiritual care for patients and staff and to the professional credibility of the practitioners within their institutions.[117]

I can relate from personal experience, as well as having received anecdotal reports, that being a hospital volunteer during Covid was both confusing and troubling.

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[114] Swain, "'We Are All Disaster Chaplains Now,'" 86.

[115] Swain, 86.

[116] Tan et al., "'Essential Not Optional.'"

[117] Tan et al., 44.

The pandemic inhibited the development of the hospital visitation ministry in many ways. To name only two obvious ones, hospitals in our region prohibited or sharply curtailed volunteer visiting for nearly two and a half years, from March 2020 to July 2022. For another, many among the cohort of existing volunteers as well as those who were potentially interested became legitimately concerned about their own health, and thus either stepped away from the practice or simply did not step forward to offer their gifts and skills. Even after July 2022, the readmission of volunteers has been halting and sometimes stalled if a renewed outbreak took place. The ministry has simply not developed as quickly as I would like to see, or in ways that support the health-care professionals, SHPs, and patients adequately.

Although my lanyard clearly shows "volunteer" on it, I was frequently waved through screening stations. I was told several times, "Oh, you are staff." I corrected the gatekeepers several times, without effect. I eventually decided that it was appropriate for me to continue to go into the wards. During the entire time of the pandemic, I was able to visit in the hospitals. Yet other volunteers were not able to visit. I have no idea why this was the case. I simply learned not to ask too many questions. I exercised some volunteers' version of the Hippocratic oath: I checked in at the screening stations ("go ahead, you are staff!"), then at the nursing station, treating staff respectfully, politely and in a friendly manner. I donned and doffed appropriately whatever Personal Protective Equipment (PPE) I was asked to, according to the level of outbreak or the then-current regulations. (I sometimes visited Covid-active wards and patients.) As a result, I found that my presence was welcomed and accepted, both by patients and health-care professionals.

Still, it was both confusing and disquieting that what I heard and read about the restricted entrance to the hospitals, and what I experienced as a visitor, were so very different. It crossed my mind that a smiling, silver-haired white man can move in and around many different places without being asked many questions. Would that have been the case for someone else? I hope so but can only testify based on my own experience. Overall, confusion and disquiet were the hallmarks of my pandemic experience.

I also name my discomfort at wearing the PPE and the ubiquitous masks, even though I recognized that both were essential for safeguarding the staff, patients, and me. I later read about some health-care professionals who wore what they call a "Visual NOD"—a large photo of themselves on a button, which showed their face without a mask. They could then state their NOD—Name, Occupation, and Duty—and the patient could see their face. My ID card does have a photo of me on it, but it is about one inch high—not convenient for a patient to see or for me to show without leaning inappropriately into the patients' space.

Speaking of the patients' space, I also felt concerned at how crowed and cluttered many of the wards were. This was no one's fault, but it did add to my anxiety on some occasions, as I tried to step around things without knocking them over. Once, a well-meaning nurse invited me to fetch a chair from a nearby corridor. When I tried to, I found that it weighed close to 40 pounds. I lugged it into the room, scraping it across the floor, trying not to catch it on any essential lines or tubes. All this made grace in the moment elusive if not impossible to experience.

Despite all these challenges, both petty and profound, I frequently experienced grace in encounters with ordinary people, who demonstrate extraordinary courage and

grace not only in their response to the pandemic but in their way of responding to grief, loss, and pain in their own lives. The pandemic seems to have brought out both the worst and the best in many people. Perhaps Buechner's remarks on the ubiquity of suffering are accurate. If this is the case, I hope that his remarks about the possibility of finding solace after grieving are equally true.

With all this context regarding the pandemic providing a backdrop for the project, I will now discuss the design and development of the program according to the Three-G model.

Grounded by Self-Knowledge

How well do we know ourselves? How well do we know the places of tenderness as well as strength? Visitors need to ground themselves in three different ways: in self-awareness and self-knowledge; in spiritual practices; and in an awareness of historical precedents and key writings on the subject. The goals and benefits are immense, as are the potential pitfalls.

If our goal as hospital visitors is to engage in spiritual conversations, offering a non-anxious, non-judgmental, empathetic, and compassionate presence, what could possibly go wrong? The answer is—much can go wrong. If we don't know ourselves, we risk not knowing our own trigger points, our vulnerable places, and the ways that we are perhaps ineffective in a conversation or interaction. For this reason, the facilitation program encourages people to engage in some reflection on who they are, and how they come to be interested in hospital ministry.

People rarely come through life unscathed, or unscarred. I was an enthusiastic but untrained teenage woodworker. Once, attempting to make a woodblock print, I held a block of wood with my left hand and a V-shaped gouge with my right. The gouge slipped and I dug a deep furrow in the fleshy part of my left hand. My hand still bears the faded scar that resulted from that mishap. But the scar only describes me; it does not define me. This simple truth about our own painful places is an important one to communicate to others.

When looking at the profiles of those who offer themselves as volunteers for hospital visiting, it seems fair to observe that most of them have experienced similarly scarring events in their lives, whether these scars are visible, as mine is, or are invisible yet still palpable, as for example from the scars of damaging or abusive relationships. Chronic illness can also leave deep and invisible scars on one's psyche (and sometimes the physical body). Invisible yet traceable scars are left after caring for someone close to us who has had such life experiences. Coming through such experiences seems to draw at least some people to wish to offer a healing and gentle presence to others who are experiencing pain and suffering. I salute these impulses, yet I also believe that it is essential for those who wish to be part of the healing ministries to examine why and how these painful experiences have marked them—and whether they are sufficiently moved through them to be effective in offering a presence to others.

The single best advice I ever received about pastoral care was summed up in a single sentence: "Pay attention to what you are paying attention to." This cryptic-sounding sentence opens vast doors of perception. Each of us will find ourselves reacting to conversational gambits and to underlying body language and posture. What are we

averse to? What are we attracted to? What do we find off-putting, frightening, repellant, or arousing? We owe it to ourselves to learn more about ourselves, to watch ourselves in action and to reflect later about how and what we have seen, heard, and offered to others.

With that premise set out, it is also fair and important to note that there are limits to what people will learn in this program. SHPs and other professionals in the caring ministries engage with deep reflective practice through their Clinical Pastoral Education. Volunteers, by contrast, who are drawn by their own internal calling to offer their gifts in this way, receive much less intensive education. The orientation program such as the one I have developed will only get them started on a process of self-study and self-knowledge. With this important caveat about educational differences recognized, I nonetheless believe that effective preparation can be offered to hospital volunteers by inviting them to become more aware of who they are and how they respond to others. If they are interested in more education, they will at least have received some grounding in the caring ministries that will prepare them for more intensive study.

If hospital volunteers assiduously practice the Parking Lot Prayer, I suggest, they will ground themselves effectively and become more aware of how they are interacting with others. This is even more important if a person practices the prayer afterwards, as a process of self-reflection and consideration. Something like, “Lord, open my heart and my mind to what I have seen and heard in this conversation with (name)” would do just fine as a starting point. Our goal is to pay attention to patterns, to our repeated behaviours in each situation.

It has taken me many years to realize my own points of vulnerability and tenderness, which have mostly to do with growing up in a house with an alcoholic father

and a sister who became a heroin addict (and eventually died from an overdose). My main points of vulnerability are, unsurprisingly, about prevarication, addiction, violence, and raised voices. It has taken me decades to move into a place of relative peace about those formative influences on me, and to stand rather than to flee. Even now, when I hear raised voices, I feel my heart start to pound in my chest. I have learned techniques such as mindful breathing that will help me calm during such circumstances. Perhaps I was drawn to practice Christian meditation because silence can be healing and redemptive, and because not all situations benefit from analysis or efforts to impose one's will. I have become a much happier and grounded individual, one who can sit with others calmly and with peace. My father was able to enjoy a happy and sober second part of his life, which was blessed with two more children and a sustained search for grace. My mother's courage and determination to raise four children on her own, and my father's eventual search for redemption, are foundational underlying experiences that have influenced me and my ministry in pastoral care.

I still experience underlying areas of vulnerability. For example, growing up in an unstable household led me to overdo "performance" as a compensating strategy. I embraced academics as a panacea for disorder. I willed my world into order. Even now I can experience performance anxiety. I felt this quite recently, for instance, during a visit with a person in an Intensive Care Unit. I dragged a heavy chair so I could sit beside the person. Then I realized that he was far too ill for that to be helpful for him. My conversational gambits were hurried and ineffective; I felt painfully inadequate. I started to feel near panic as I sat there with him. My closing prayer was stiff and forced. My Parking Lot Prayer afterwards took some time, as I tried to focus on how I had done my

best under the circumstances, and that tomorrow would be another day. I mention these personal anecdotes not to focus unduly on myself, but to make the point that each of us has work to do if we are to be effective practitioners of the caring ministries.

Self-Knowledge Tools and Insights

All self-awareness tools need to be approached with a degree of caution; they are not infallible recipes for self-knowledge, nor after taking one should the results of the test be brandished as explanations for one's own or another person's perceived behaviours or personality. With that said, I have found that participants found value in looking at themselves through the eyes of some of the most familiar tools. These include the Myers-Briggs Type Indicator® (MBTI®), a personality inventory designed to make the theory of psychological types described by C. G. Jung understandable and useful in people's lives. As we read on one website, "The essence of the theory is that much seemingly random variation in the behavior is quite orderly and consistent, being due to basic differences in the ways individuals prefer to use their perception and judgment. Perception involves all the ways of becoming aware of things, people, happenings, or ideas. Judgment involves all the ways of coming to conclusions about what has been perceived. If people differ systematically in what they perceive and in how they reach conclusions, then it is only reasonable for them to differ correspondingly in their interests, reactions, values, motivations, and skills."[118]

[118] "The Myers & Briggs Foundation - MBTI® Basics," accessed January 25, 2023, https://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/home.htm?bhcp=1.

Another valuable and popular self-awareness tool is the Enneagram, with its nine basic personality types (Peacemaker, Reformer, Helper, Achiever, Individualist, Investigator, Loyalist, Enthusiast, and Challenger) grouped under three organizing principles, or rubrics—stillness, silence, and solitude. Like all self-awareness tools, this should be used carefully; not every description of a person applies completely to each of us. Many churches offer extensive programs based on the Enneagram, so there is no lack of opportunity to become aware of its tenets. Both free and paid versions are available. I prefer the one with a cost to it; there is more to it.[119] It was the best $12 I have ever spent.

The Junto Institute Building Blocks of Emotional Intelligence and the Emotion Wheel provide another helpful tool for self-awareness.[120] The Junto Institute descriptors are particularly helpful to help encourage our awareness as social beings in relationship with others, and with systems that are larger than ourselves as individuals. Self-awareness, self-management, social awareness, and relationship management are the rubrics that describe the building blocks. The Emotion Wheel consists of a colorful wheel with descriptors of emotions on them invite us to consider how we are feeling in each situation. As the website relates, "The Junto Emotion Wheel is a tool that helps you build self-awareness and empathy for others. As depicted in our Building Blocks of Emotionally Intelligent Leadership, self-awareness is the foundation: the ability to recognize your own emotions and mood, your thoughts about them, and how those

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[119] "Enneagram," accessed January 25, 2023, https://tests.enneagraminstitute.com/.

[120] "Emotion Wheel – The Junto Institute," accessed January 25, 2023, https://www.thejuntoinstitute.com/emotion-wheels/.

thoughts are connected with your behavior."[121] I encourage people in the program to become acquainted with the Junto Institute. Depending on the person's proclivities, some might find it useful to have the Building Blocks or Emotion Wheel accessible on their phone. In that way, after a visit, they might glance at the phone and ask themselves, "OK, what am I feeling *right now*?" Simply posing that question provides an open door to the wisdom and self-awareness.

Paul Gilbert's Three Circles of Emotional Regulation provide another way of becoming familiar with one's own proclivities and preferences. Gilbert helps people learn something about the ways that the body's emotional regulatory systems work. In 2009, Gilbert described how people are motivated and to some extent controlled by three different circles of emotional regulation.[122] These consist of the Drive System (which enables us to set and achieve goals and tasks); the Soothing System (which slows us down, encourages us to rest, and to find safety); and the Threat System (which has as its goal to manage threats, and to seek safety as appropriate). Gilbert has made these precepts widely known, not only from his publications but also from his website, The Compassionate Mind.[123] One of its central precepts is that many people are living in a state of unbalance, wherein both their drive and threat systems are hyper-activated, whereas their soothing system is underdeveloped.[124]

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[121] "Emotion Wheel – The Junto Institute."

[122] Paul Gilbert, *The Compassionate Mind: A New Approach to Life's Challenges* (Oakland, Calif: New Harbinger Publications, 2010).

[123] "Compassionate Mind," accessed January 2, 2023, https://www.compassionatemind.co.uk/.
[124] Ruth Buczynski, "Applying the 3 Circles Model of Emotion to Help Clients Heal Shame," *NICABM* (blog), October 28, 2019, https://www.nicabm.com/3circles/.

Grounded by Spiritual Practices

The facilitation program actively encourages participants to learn about spiritual practices that focus on peace and the presence of God, drawing from both monastic and lay practitioners in the contemplative Christian tradition. Theological perspectives from within these traditions—which Wendy Farley has written about in a recent book—focus on the many practitioners who have taught that God is never distant from God's created world.[125] The contemplative traditions, as practiced by contemporary Benedictines and Cistercian communities, and intended for broader public practice, provide a framework for the underlying theological perspectives that I bring to this project. My meditation practice stems from the tradition of John Main, OSB (1926-1982), a Benedictine monk, which has strongly influenced me, particularly through the practice of Christian Meditation.[126] This tradition is still practiced and led by his associate, Laurence Freeman, OSB.[127] The World Community of Christian Meditation is a vital study center located in France but with a worldwide audience.[128]

Some authors have popularized teachings from the Christian contemplative tradition and made them attractive and relevant to a wider audience. Such books would

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[125] Wendy Farley, *Beguiled by Beauty: Cultivating a Life of Contemplation and Compassion*, 1st edition (Louisville, Kentucky: WJK Books, 2020).

[126] Main, "Introduction to Christian Meditation"; John Main, *Christian Meditation: The Gethsemani Talks* (S.l., 1989); Main, *The Way of Unknowing: Expanding Spiritual Horizons through Meditation. Introduction by Laurence Freeman*.

[127] Main, "Introduction to Christian Meditation"; Laurence Freeman, *John Main: By Those Who Knew Him*, ed. Paul T. Harris (Meditatio, 2014); Laurence Freeman, ed., *John Main Essential Writings*, Modern Spiritual Masters Series (Maryknoll, N.Y: Orbis Books, 2002); Main, *The Way of Unknowing: Expanding Spiritual Horizons through Meditation. Introduction by Laurence Freeman*.

[128] "WCCM | The World Community for Christian Meditation," accessed January 30, 2023, https://wccm.org/.

be helpful to encourage people to learn how others throughout history, and up to now, have grounded themselves in the Holy. One example is *Everyday Contemplative*, a book by L. Roger Owens, professor of Christian spirituality and ministry at Pittsburgh Theological Seminary. His book is directed to all those who seek God yet haven not developed a spiritual practices that allow them to approach their search methodically.[129] Stating explicitly that his book is not a how-to book to achieve "contemplative bliss," Owens argues instead that the book provides "an invitation to approach prayer and life differently, with a posture of receptivity that allows you to become ever more open, available, and responsive to the recreating work of God's Spirit in your life and in the world."[130] Owens is a pleasant companion on the road.

I found much to take away from his seven clearly developed chapters, in which he discusses the themes of longing, attention, patience, playfulness, vulnerability, nonjudgment, and freedom. Owens refers to the "Word of the Lord, spoken in silence, spoken in love," and writes that in seeking this word, this way, "I write as a companion on the way, as one who has smelled the possibility of living open to God and has followed the scent far enough to be able to describe the smell. But I also know there is a meal waiting, and I realize what I'm really doing is writing my way to the banquet table where God longs to break bread with us, to share this life with us, and to be our most intimate companion."[131]

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[129] L. Roger Owens, *Everyday Contemplative: The Way of Prayerful Living* (Nashville, TN: Upper Room Books, 2021).

[130] Owens, 15.

[131] Owens, 20–21.

Owens helpfully reminds readers that spiritual development is neither linear nor something that can be judged as either a success, or as a failure. Yet we do judge, he observes in "Saying Goodbye to Goldilocks: Nonjudgment."[132] We judge others; we judge ourselves; we judge our circumstances. In a passage that I found both moving and compelling, Owens writes, "If God makes Godself known to us through the people we encounter, God also allows the circumstances of our lives to become sacraments of Divine Presence, mercy and grace."[133] The insights in this book are conveyed with a touch that is light and graceful; I would find it useful to help potential hospital visitors become acquainted not only with the practices of contemplative prayer, but to be reminded, gently and kindly, that God is served poorly if we are always looking to judge ourselves, our prayer-life, or other people.

A.J. Sherrill is another pastor and spiritual formation teacher who has written convincingly about contemplative prayer and why and how it encourages us to draw closer to the Holy. *Being with God*, a 2021 book, has an intriguing subtitle: *The Absurdity, Necessity and Neurobiology of Contemplative Prayer.*[134] In a section of his book devoted to Neurobiology, Sherrill writes, "We are not a brain and then a body. We are holistic beings, integrated at every level. To love God with all our minds is to seek integration of every system of our being."[135] To those who might argue that change is not

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[132] Owens, 117–32.

[133] Owens, 123.

[134] A. J. Sherrill, *Being with God: The Absurdity, Necessity, and Neurology of Contemplative Prayer* (Grand Rapids, Michigan: Brazos Press, 2021).

[135] Sherrill, 112.

possible for people, that we are in effect "hardwired from birth or due to social forces beyond our control," he argues instead that "Christian belief is that change is possible."[136]

In related discussions of breath, stress, and of the effects of prayer on our brain-patterns, Sherrill paints an attractive vision of a person gradually being awakened to Godself around and in that person. In a section of the book headed "Holy Listening," Sherrill writes, "Contemplative prayer helps us train our brains not to overreact, as much of society is accustomed doing. In this form of prayer, we practice each day what it means to go slow, take time, and pray through life circumstances before reacting. Over time, being with God cultivates patience and compassion. Further, it permits the Holy Spirit groaning within us [Romans 8:26] to be involved in our daily decisions. Contemplative prayer isn't merely a good idea; it's essential to navigating life well."[137]

Both these books strongly remind me that insights about self-discovery when seeking the divine are recurrent in spiritual formation books. David G. Benner's *The Gift of Being Yourself* came to mind.[138] I used this book in a Lenten study a few years ago. In a way like what both Sherrill and Owens write about, a contemplative practice enables the person to grown closer to Godself. Benner writes, "God first loved us into existence. Our true self-in-Christ is the only true self that will support authenticity. It and it alone provides an identity that is eternal."[139]

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[136] Sherrill, 112–13.

[137] Sherrill, 132–33.

[138] David G. Benner, *The Gift of Being Yourself: The Sacred Call to Self-Discovery* (Downers Grove, Illinois: Formatio, 2015).

[139] Benner, 17.

These three books, along with the many writings by John Main and Laurence Freeman, help a person ground themselves in a sense of the Holy, and to gain a sense of confidence and optimism about their lives and about the ways that they offer their gifts to others. My belief is that books such as these are the most helpful for potential hospital volunteers. They share an outlook that a person can be changed by the Spirit and can draw closer to God in so doing. As argued elsewhere, hope is an essential component to this volunteer ministry; books such as these foster hope. They are also accessible and clearly written for non-specialists.

Why stop at hope? What about going past hope to find better mental health and eventually even the possibility of wisdom? A contemplative spiritual practice holds out the prospect of wisdom to any person. Lisa Miller, a professor of clinical psychology and the founder and director of the Spirituality Mind Body Institute, discusses in a recent book the strong scientific links between better mental health and those who have an active spiritual life.[140] Relating in a compellingly animated style the results of comparing MRIs between individuals who professed a strong spirituality, and those who did not, she writes, "The finding was so stunning, it stopped my breath. The high-spiritual brain was healthier and more robust than the low-spiritual brain. And the high-spiritual brain was thicker and stronger in *exactly the same regions* that weaken and wither in depressed brains."[141]

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[140] Lisa Miller, *The Awakened Brain: The New Science of Spirituality and Our Quest for an Inspired Life* (New York: Random House, 2021).

[141] Miller, 7.

This book serves as a meditation on awakening. This theme is given palpable presence by the interweaving of stories about Miller's three children. I read the book and felt deeply moved by it. While it might well be that the insights contained in Miller's book lie beyond both my ability to convey to hospital volunteers, and perhaps also my own ability to live into its precepts, I nonetheless found its contents to be stimulating, personal, and inspiring. Miller invites the reader to journey into a greater awareness of awakened attention, awakened connection, and awakened heart.[142] In essence, these are the component legs along journey to self-discovery that I am referring to as being grounded in the Holy.

Grounded by History and Scholarship

The goal of this dissertation project is to create a program relevant for contemporary hospital visitors. Providing a selective overview of certain historical precedents for historical visiting nonetheless provides a helpful context for how understandings of the visitor's role have shifted over time. As a means of demonstrating some of the historical understandings of the role of hospital visiting up until the beginning of the 20th century, I would like to highlight one painting, one historical book, and one scholarly book about hospitals.

Historical examples of hospital visiting. In 1443, Nicolas Rolin (Chancellor to the Duke of Burgundy, Philippe le Bon) and his wife Guigone de Salins commissioned a hospital for the sick, disabled, and destitute in Beaune, France, then the capital of the Duchy of Burgundy. They commissioned Rogier van Der Weyden, perhaps the greatest

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[142] Miller, 174.

painter of his time, to undertake a monumental polyptych painting, the *Altar of the Last Judgment*, also known as the *Beaune Polyptych.* The painting was completed in 1434. Both the painting and the hospital were extraordinary statements of their age. Thanks to the visionary patrons' links to the region's wineries, the hospital functioned well for hundreds of years, and now is the centrepiece of a remarkable museum, part of the collection of the Hôtel-Dieu de Beaune (Museum).[143]

During the Middle Ages, Christians were accustomed to thinking of the Last Judgment; cathedrals often featured carvings on their main entrances that showed both the elect and the damned. As the Beaune Polyptych demonstrates through its painterly preaching, those who entered the hospital did not generally expect to leave it alive. They were grateful for being cared for and given food and a roof over their heads. Preparing for eventual judgment was more important than the mundane concerns of their earthly existence. I am not able to state with confidence whether visitors were normally permitted into the Hôtel-Dieu de Beaune. Even if visitors were permitted, there can be little doubt that their role was secondary to the larger work of preparing for death and judgment.

A different role for visitors is demonstrated in a 18th-century book on hospital visiting. Its long title packs all its main points in the first part of the title: *The sick man visited: and furnish'd with instructions, meditations, and prayers, for putting him in mind of his change, for Supporting him under his Distemper, and for Preparing him for, and*

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[143] "Rogier van Der Weyden, Last Judgment, 1443-51, Oil on Panel, 215 x 560 Cm (Musée de l'Hôtel Dieu, … – Gloria.Tv," accessed January 30, 2023, https://gloria.tv/post/6V4VmU3qwcTV4zayD3HWKp38E#55.

carrying him through, his Last Conflict with Death. By Nathanael Spinckes, A. M. Late Prebendary of Sarum, &c. The fourth edition corrected.[144] (The first edition was published in 1712.) The clergyman author, Rev. Nathaniel Spinckes (1652-1727), was a voluminous writer whose prose today exceeds most people's patience to persevere through even one of his books.

As in the case of the Beaune Altarpiece, the goal of Spinckes's book was to lead the sick towards a state of penitence and contrition. Note a different connotation here: The role of the professionalized clergyman is coalescing. The hospital patient is regarded as someone who will be visited as a Christian duty. Spinckes is there not so much as to console as to admonish, helping people prepare for divine judgment. Would those patients who knew that the windy, prolix Rev. Spinckes was about to visit have tried to hide under the covers or feigned sleep? We will never know. But his book does provide interesting evidence of how visitors were, in a sense, infiltrating the hospital and becoming part of its décor and daily patterns.

The Industrial Revolution brought with it not only highly concentrated wealth but also waves of contagion due to insanitary living conditions in overcrowded, ill-planned cities. Hospitals needed to develop more specific rules to keep patients and visitors from making each other sick, or from bringing in or taking out contagious illnesses. Although theories of contagion were yet poorly understood, hospital administrators understood that contagious patients needed to be kept apart from other people. Wards and separate areas

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[144] Nathaniel Spinckes, *The Sick Man Visited : And Furnished with Instructions, Meditations, and Prayers, for Putting Him in Mind of His Change; for Supporting Him under His Distemper; and for Preparing Him for, and Carrying Him through, His Last Conflict with Death* (London : Printed for J. Rivington, 1744), http://archive.org/details/sickmanvisitedfu00spin.

designated for the care of specific illnesses developed. Into this already complex and often poorly managed setting, new categories of visitors emerged. These were often people from the middle-to-upper classes, such as educated women of means who provided both material as well as spiritual succor.

The complex social and cultural practices associated with hospital and asylum visiting are the main foci of *Permeable* Walls, a book edited by Graham Mooney and Jonathan Reinarz.[145] This book shows how visitors might be loosely categorized into four different groups, i.e., "patient visitors, including family and friends; public visitors, such as entertainers, tourists and clergy who have no direct formal ties with the institution or the patients; house visitors involved with the management and government of the hospital; and official visitors, who have inspectorial responsibilities."[146]

Framing the issues both poetically and effectively, a reviewer of the book summarized its overall thesis in the following way:

> Most of our experiences of the hospital world come from visiting friends or relatives; not so 'patient visitors'…we awkwardly enter the alien sick world, breathe its disinfected air, perch uncomfortably on the edge of its universe of medicalized order and control over bodies too sick to retain their own, and leave sooner rather than later, grateful that we still can. However, as the very title of this excellent and timely collection reminds us, so many other (overlapping) types of visitors have crossed this line—most similarly historiographically invisible—that the boundaries between the realms of sickness and health seem porous and fluid. In fact, from c. 1750 until c. 1920s (arguably longer) the busy social relations between the outside community and the hospital reflected and shaped both the nature of society and of the institution. The articles here first cover charitable institutions: general, then specialist children's hospitals. The emphasis then changes to state provision: infectious disease, and mental hospitals.

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[145] Graham Mooney and Jonathan Reinarz, *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam: Brill Rodopi, 2009).

[146] Mooney and Reinarz, 7.

> All hospitals emerge as inextricably connected to their communities and wider societies in so many ways, sometimes to the point of co-constitutiveness. Visiting emerges as about governance, citizenship, and the nature of civil society; as such it partakes in, and contributes to, the same changes that that society goes through in the changing mixed economy of health care.[147]

In another review of *Permeable Walls*, Anne Borsay observes that the book highlights the period's fluid social roles and responsibilities, summarizing this by observing that "in the American mission hospitals of China, established from the mid-1830s, families and friends were welcomed just for entertainment but as 'companions, advocates, intermediaries or nurses.'[148] Borsay continues: "Elsewhere, however, visitors were viewed as in need of reformation, with mid-Victorian isolation hospitals instructing them on how to limit the spread of infection. But more often, outsiders were agents for reform. At the eighteenth-century London Lock Hospital, clerical visitation was thus applied to the rehabilitation of venereal patients, while at the Great Ormond Street Children's Hospital—also in London—women, though excluded from the management board, were 'welcomed on the wards as agents of maternal socialization, bringing the breath of the well-ordered and comfortable Christian home to the working-class patients.'"[149] Although Borsay found the book's categorization of visitors to be somewhat unconvincing and the book somewhat uneven, she nonetheless agreed that

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[147] Andrew J. Hull, "Permeable Walls: Historical Perspectives on Hospital Visiting," *Medical History (Pre-2012)* 54, no. 4 (October 2010): 562–63, http://www.proquest.com/docview/762237417/citation/8F8544FB7FE64BE7PQ/1.

[148] *Permeable Walls*, 65.

[149] Anne Borsay, review of *Review of Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting. The Wellcome Series in the History of Medicine*, by Graham Mooney and Jonathan Reinarz, *Bulletin of the History of Medicine* 84, no. 3 (2010): 91, http://www.jstor.org/stable/44448977.

"other chapters confirm the porous nature of institution."[150] Borsay also points out that the book addresses large and important themes, specifically, "Walls shows that hospital and asylum visiting raises key issues for historians: family and community, class and gender, professionalization, social control, the state, and imperialism."[151]

Borsay's comments underline just how fluid the roles of volunteers were during much of the nineteenth century—yet again and again we witness efforts to isolate patients, to control visitors, to institute both norms and rules. In a sense, much of what this book covers, despite its early chronological focus, anticipates similar concerns that became evident during the pandemic. I refer to this book therefore to demonstrate that hospital visitors have sometimes been welcomed and courted, and other times shunned and prevented to enter.

Social control based on a fear of contagion is a recurrent theme in hospitals. This view has a direct bearing on how or whether visitors are welcomed. Thus, while visitors might think of themselves as engaging in specifically one-to-one personal contact, their interactions must be understood in the wider context of the hospital being a complex social institution. It is sobering to realize that many of the same issues addressed during the nineteenth century have arisen again, and still defy a satisfactory resolution.

Three Valuable Books on Hospital Visitation

Three books contributed in important but quite different ways to my understanding of the role of the hospital visitor, and the goals that she or he might set

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[150] Borsay, 521.

[151] Borsay, 522.

while visiting. They rose like cream to the top of my list of preferred books about volunteers in hospitals. I characterize them as eminently practical, grounded in Christ, and charmingly original.

Under the rubric of eminently practical is Sue Wintz's *Chaplaincy Care: Volunteer Training Manual, 2nd edition.*[152] Wintz understands the social role of the volunteer; she understands the essential skills that are necessary for hospital volunteers to succeed in their work; she understands the importance of listening skills and building a rapport with the patient. Her book remains a touchpoint in my understanding of the skills and techniques that a well-trained hospital volunteer will be able to bring to bear. In ten chapters, Wintz covers an impressive amount of ground, from discussing the function and the role of chaplaincy departments to care for the dying and for those who are grieving. She invites the potential volunteer to compare definitions of spirituality and religion, and to define spiritual wellness and spiritual distress. A chaplaincy care volunteer, Wintz writes, "is a specially selected and trained individual who has the maturity and experience to be a caring listener to a terminally ill person or family member."[153] She also offers what I found to be an inspiring summary of the four overarching functions of such volunteers. These four functions, she writes, are to sustain, to guide, to heal, and to reconcile.[154] Perhaps Wintz's most important contribution is to situate volunteers as a complementary yet also supporting role to the professional chaplains on site. Again and

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[152] Sue Wintz, *Chaplaincy Care: Volunteer Training Manual. Caring for the Human Spirit*, 2nd ed. (New York, New York: Healthcarechaplaincy.org: HealthCare Chaplaincy Network, 2017).

[153] Wintz, 5.

[154] Wintz, 5.

again, she describes scenarios where the volunteer will need to step back and ask the professionals to take charge.

Wintz effectively and succinctly identified the vulnerability of the patient in a health-care facility, many of whom, she writes, will be experiencing loss of identity, loss of control, loss of personal interaction, loss of independence, and, resulting from all these experiences, experiencing emotional instability.[155]

In her discussion on listening, Wintz observes that "when a person really listens to another, more than the ears are involved; a person's heart must be engaged too.[156] To listen is to open oneself up to another person and take his or her pain, troubles or bewilderments into one's senses. Many genuinely compassionate people make poor listeners. They are so anxious to correct the problems that are causing pain that they begin to break in with 'advice and solutions' before they have heard the whole story."[157]

Before discussing the necessary skills that facilitate effective listening practice, Wintz addresses what she terms "Attending Skills." These non-verbal skills demonstrate that a person is "giving one's intentional physical and psychological attention to another person in a communication situation. Effective attending conveys nonverbally that the volunteer is interested and is paying careful attention to the other person."[158] Having established the central importance of Attending Skills, Wintz goes on to discuss Active Listening, Building Rapport, and Responding. She also offers some tips on what to do

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[155] Wintz, 20.

[156] Wintz, 24–30.

[157] Wintz, 24.

[158] Wintz, 24.

and what not to do when attending a patient.[159] As a teaching tool developed for work with the HealthCare Chaplaincy Network™, Wintz's book situates volunteers, as I do, between the professionally trained spiritual health practitioners and the hospital's professional medical staff. There is a strong need for the volunteers, who can complement the efforts of the Spiritual Health Practitioners, who are often asked to see more people than they can manage. I would have no hesitation in recommending this book as a key supporting resource. I work in a different social context, however, and needed to develop a program tailored for the Canadian hospital setting. I also wished to develop a separate technique and practice, one ultimately expressed through the Three-G model and the parking lot prayer.

Basil Pennington's *The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry*, provides an entirely different perspective from Wintz's practical, socially grounded book.[160] Pennington's book is grounded in Christ, as known, and experienced through the western monastic traditions. This book focuses on the need for the visitor to have an active spiritual practice to enable them to function well within a hospital setting. Basil Pennington (1931–2005), a member of the Order of Cistercians of the Strict Observance (O.C.S.O.), generally known as Trappists, used his vocation as a monk and priest to promote to American and international audiences the practices and principles of Centering Prayer. As is well known, Centering Prayer is rooted in the

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[159] Wintz, 24–30.

[160] Robert John Pennington aka M. Basil, *The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry* (New York, NY: The Haworth Pastoral Press, 2007).

teachings of monastics such as John Cassian (circa 360-435). Main and Freeman share with Pennington a strong interest in the prayer tradition taught by Cassian.

Bernard McGinn, in his introduction to the essential writings of the Christian tradition, provides a helpful context for Cassian's writings.[161] The Conferences (written circa 426-29) consist of twenty-four recollections of conversations with leading fathers concerning their views on the interior spiritual practices of monastic life. The Institutes focus more on the community life of monastics. Cassian's writings, particularly regarding the purpose and practice of prayer, remain relevant to all devout Christians seeking to deepen their own prayer practice. Pennington's book is immersed in the monastic worldview of contemplative prayer.

In his perceptive introduction to Pennington's *The Christ Chaplain*, Clarence Liu reveals how Pennington struggled to do ministry and yet also confront and acknowledge his own limitations, and from this struggle Pennington "discovered a place within that was transformative and life-giving."[162] Liu continues: "The Christ Chaplain is written for hospital chaplains who find themselves at the limits of what they can do and endure in living out their calling. Fr. Basil invites us to enter the Christian mystical tradition via *lectio* and centring prayer. It is a path of learning receptivity and *emptying*, that we may rest in the Source at the heart of our being and show others the way there too."[163]

Wintz and Pennington both strive to ground the chaplain (or volunteer) in a way that they feel adequately equipped for their role. Wintz comes from a tradition of social

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[161] Bernard McGinn, *The Essential Writings of Christian Mysticism* (New York: Modern Library, 2006), 88–96.

[162] Pennington, *The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry*, xiv.

[163] Pennington, xiv.

science and psychology, and Pennington from a tradition of mystical, contemplative Christian prayer. Pennington goes so far as to say that *Christ Chaplain* "is essentially a book about prayer."[164] So rather than focusing on *technique* per se—Active Listening, to name but the most obvious—Pennington uses this book to invite readers, as Chapter 2 is headed, "To Know Him: Acquiring the Mind of Christ." To reveal God, Pennington writes, we use tools that are shared by Christians and Jews—to know God through deep and intimate connection to and engagement with scriptures. Later, he uses the classic monastic characterizations of the progressive revelation of the study of scripture, namely, *lectio, meditato, oratio,* and *contemplatio.*[165]

The fourth chapter, titled "The Ministry of Presence," reveals Pennington's approach most fully. Pennington argues that a life rooted in the living soil of the gospel will enable the hospital chaplain to feel compassion—and that in doing so, we will link ourselves with the God of compassion. "Our God not only feels for us," he writes, "God feels with us." [166] In pain or grief, "we come as Christ—as a Christ Chaplain—only if we come with compassion."[167] He writes limpidly about why this goal is both worthwhile yet also elusive:

> This is not easy. For we are not only called upon to be there in sorrow and pain but also in joy and wonderment—when an operation has been a success, then one is released, when parents rejoice in new life. These could be moments of significant ministry, seemingly not so much needed but perhaps more far reaching in their effect it is certainly one of the great challenges of our ministry to be able to move from several to joy to sorrow

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[164] Pennington, 7.

[165] Pennington, 22.

[166] Pennington, 31.

[167] Pennington, 32.

> again it can also be a great challenge to move from the profound to the trivial and to be able to truly be with even the trivial when it is called for. Behind them all as a person, a person loved beyond anything we can imagine by a God who is love. And that is of that love that we as Christ are to be sacraments. How few really know God's love is a gentle, tender, carrying love, eager to be with us in our joys as well as our sorrows. As Christ chaplains we are to make that love experientially present.[168]

This passage reveals such a depth of spiritual presence and grounding that it almost feels as though one should remove one's sandals in the presence of a writer who could be so deeply grounded in the mystical traditions of Christian practice. The Spirit radiates from this writing and reveals a deep wisdom that can inspire as well as teach. Facing the sadness and tragic losses that are part of the cadences of hospital rhythms, a spiritual practice that proclaims hope and light during despair and darkness is our only possible sustaining tool.

Robert Mundle's *How to be An Even Better Listener* is quite different from either Wintz's practical, A-Z guidebook, or from Pennington's Christocentric paean to an ongoing spiritual practice grounded in centering prayer. Yet Mundle offers a quite different perspective from either of these books that is equally valuable in several ways.[169]

Mundle's book is primarily devoted to helping those who work in hospices and palliative care centers to become more effective listeners. What makes for a good volunteer? Stephen Claxton-Oldfield poses this question in his foreword to Mundle's

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[168] Pennington, 32.

[169] Mundle, *How to Be an Even Better Listener: A Practical Guide for Hospice and Palliative Care Volunteers*.

book, then answers it with, "to be a good listener."[170] The essence of a good listener might be defined as "the drive or need to make a difference, a gentle heart, a listening ear, basic kindness, a healthy attitude of death and dying, and an understanding of what the patient and family are facing."[171] Mundle devotes his book to exploring how to enhance such innate gifts and personality traits can be complemented by lovingly and gently applied skills.

Three characteristics in Mundle's book stand out. For one, he used judicious stories from his own life to make broader points about becoming a good listener. Some of these stories were not easy or comfortable ones, such as when Mundle once asked his father to listen to something about Mundle's life. His father flatly refused. "I can't handle it," he told his son.[172] Mundle didn't just leave the story awkwardly hanging there, however; he drew an important point from it. As he writes,

> Different experiences—good and bad—of having other people listen to me have inspired and shaped my way of listening to others in my role as a hospital chaplain. First, I learned how to ask open-ended questions and then to wait patiently for the answers to unfold in stories. Second, I learned how to use body language and nonverbal communication, such as making appropriate eye contact. And third, I worked on developing my emotional capacity for listening, and continue to do so. Finally, I am still learning how to attend to my own needs for self-care, especially when I feel that listening to sad stories is starting to weigh me down. goodbye middle I hope you have a good rest of the day.[173]

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[170] Mundle, 9.

[171] Mundle, 9.

[172] Mundle, 18.

[173] Mundle, 18.

Mundle's writing is especially clear and helpful here, both empathetic and encouraging. He does not get lost in the thickets of too many words or too many concepts. If you wish to become a good listener, you must practice.

Second, Mundle discusses in quite creative ways how the skills of listening might be likened to quite disparate activities—like reading a novel closely; like dancing with a partner; and like jazz improvisation.[174] I read this chapter with delight. Listening like responding to a dance partner! Listening like jazz improv! Both these similes open the door to understanding listening as a subtle, contextual action, one that is unique to each person and each visit. Mundle points to an important insight covered in more specialized literature, namely, the importance of trusting one's intuition.

The third special quality in Mundle's book, related to the second one about improvisation, is that way Mundle writes with deep insight about how the engaged listener can respond to cues. The listener sits in still attentive regard and picks up on subtle cues. "I am always drawn to stores or phrases that repeat," Mundle writes. "I hear them as a subtle dangling way to get my attention, an invitation that the person can tuck away again safely if I fail to pick up on the cue."[175]

This book calls attention to the goals and importance of listening as a spiritual act and gift. As the French spiritual writer Simone Weil once wrote to the poet Joë Bousquet, "Attention is the rarest and purest form of generosity."[176] Benedictine monk and

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[174] Mundle, 40–57.

[175] Mundle, 29.

[176] In the original French, the statement reads : "*L'attention est la forme la plus rare et la plus pure de la générosité*." Weil made this remark in an April 13, 1942, letter to poet Joë Bousquet, published in *Correspondance* (Lausanne: Éditions l'Age d'Homme, 1982), p. 18, as cited at https://en.wikiquote.org/wiki/Simone_Weil

meditation teacher Laurence Freeman offered a similar comment during a series of meditation talks entitled *Attention and Love*: "To pay attention is to love. To love is to pay attention."[177]

Other Insights from Scholarly Writings

Mundle's book provides a solid bridge from which one can discuss more specialized articles on listening skills. A wide literature addresses the goals and practice of professional hospital chaplaincy, or spiritual health care practitioners.[178]

The Professional Quality of Life (ProQOL) health measure tool is intended for "any helper," including volunteers.[179] It provides people with a tool that helps them assess their own levels of stress and challenges honestly and confidentially. ProQOL helps a person measure how they assess qualities such as compassion satisfaction, perceived support, burnout (BO), secondary trauma stress (STS), compassion fatigue (CF), and moral distress. As a writer on website describing ProQOL observes, "Understanding the positive and negative aspects of helping those who experience trauma and suffering can improve your ability to help them and your ability to keep your own

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[177] Laurence Freeman, *Attention and Love*, Meditatio Talk Series (Singapore: Medio Media, 2021), 26.
[178] Rev. Gloriajean Jonathan Pye, Peter Sedgwick, and Andrew Todd, ed., "Critical Care: Delivering Spiritual Care in Healthcare Contexts," *Journal of Disability & Religion* 21, no. 3 (July 3, 2017): 339–41, https://doi.org/10.1080/23312521.2017.1350070; Jonathan H. Pye, P. H. Sedgwick, and Andrew Todd, *Critical Care: Delivering Spiritual Care in Healthcare Contexts* (London: Jessica Kingsley Publishers, 2015); Alistair E. McGrath, "Christianity," in *Oxford Textbook of Spirituality in Healthcare*, Oxford Textbooks in Public Health (Oxford ; Oxford University Press, 2012), 25–31; Barbara Pesut et al., "Hospitable Hospitals in a Diverse Society: From Chaplains to Spiritual Care Providers," *Journal of Religion and Health* 51, no. 3 (September 2012): 825–36, https://doi.org/10.1007/s10943-010-9392-1; Keefer, *Care & Visitation Ministry Volunteer Handbook: Equipping You to Serve*.

[179] ProQOL, "ProQOL Health Measure," ProQOL, accessed January 30, 2023, https://proqol.org/proqol-health-measure.

balance…. As a health worker working in difficult humanitarian or pandemic situations, you have direct contact with the lives of your patients and beneficiaries. As you may have found, your compassion for those you help can affect you in positive and negative ways."[180]

Becoming aware of such knowledge about oneself by using the ProQOL tool might even be more valuable than learning about one's inherent preferences and learning styles. As Caitlyn McClure observed in a 2021 dissertation, citing an article by Avieli et al., becoming aware of these measures, especially secondary trauma stress (STS), burnout (BO), and compassion fatigue (CF), can have a direct bearing on how a person feels about their work—and whether they can continue to perform it without burnout or cynicism. As McClure remarks, "underprepared workers struggle more than well-trained professionals in the face of similar stressors. The study found that volunteers completing the same responsibilities as their professionally trained peers were more likely to have lower ethical behaviors and subsequently higher STS, BO, and CF."[181] Yet as much as ProQOL can be a helpful tool to enhance self-knowledge, it is probably better suited for a seasoned volunteer than one just beginning. For this reason, I will return to the ProQOL tool in a later chapter, when I describe possible next steps for the program.

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[180] ProQOL.

[181] Caitlyn C. McClure, "Using the ProQOL to Understand the Impact of Work Stress on Helping Professionals and Emerging Professionals," *ProQuest Dissertations and Theses* (D.S.W., United States -- Illinois, Aurora University, 2021), http://www.proquest.com/publiccontent/docview/2637973774/abstract/30E1904E815F4578PQ/1; Hila Avieli, Sarah Ben-David, and Inna Levy, "Predicting Professional Quality of Life among Professional and Volunteer Caregivers.," *Psychological Trauma: Theory, Research, Practice, and Policy* 8, no. 1 (2016): 80–87, https://doi.org/10.1037/tra0000066.

Specialized literature drawn from the caring professions provides insights into different foci that are helpful to know about. Back in 1975, Gerald Egan developed an aid for teaching and learning about nonverbal communication that he described by the acronym SOLER.[182] This stands for "Sit squarely," "Open Posture," "Lean Towards the Other," "Eye Contact," and "Relax." The last admonition to relax might be seen as unintentionally amusing; it might not always be easy to do, especially when keeping track of the other instructions.

In 2011, Thomas Stickley proposed replacing this SOLER approach with a new one, which he described by the acronym SURETY. As Stickley writes, "Acronyms (mnemonics) are useful ways to help memorise related points and are widely used as teaching aids. In that sense, SOLER has probably become fixed in the minds of generations of nurses and counsellors. I have therefore maintained the idea of using an acronym (SURETY) to help facilitate the creating of a practical therapeutic space. The content of the model is not dissimilar to SOLER but allows for cultural variations and the appropriate use of touch. The model can be summarized as follows:

S: Sit at an angle to the client

U: Uncross legs and arms

R: Relax

E: Eye contact

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[182] Gerard Egan, 1990, *The Skilled Helper: A Systematic Approach to Effective Helping*. 4th ed. Pacific Grove California: Brooks/Cole Pub.

T: Touch

Y: Your intuition.[183]

Paying attention to one's posture and one's body language is obviously an important consideration for any visitor. There would seem though to be a risk of becoming formulaic; astute patients might soon pick up on the "schooled" approach. Mundle's more intuitive and spontaneous approach allows cues to speak through carefully maintained and vigilant silence. Yet Stickley differs from Egan in one crucial way: Stickley shares with Mundle the view that intuition is important and needs to be trusted; a formula is only as good as the way it is being implemented and received. Stickley writes, "The final point with non-verbal communication is the need for nurses to trust their intuition; and this vital component is what differentiates the SURETY model from SOLER."[184]

Two additional trends in recent literature seem important to discuss. One is related to the discussion of how to ameliorate traumatic experiences undergone during one's work. How issues such as loneliness and trauma affect the wellbeing and outlook of hospital patients needs to be recognized as part of the social setting. Literature exists on both loneliness and trauma.[185]

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[183] Theodore Stickley, "From Soler to Surety for Effective Non-Verbal Communication," *Nurse Education in Practice* 11, no. 6 (November 2011): 397, https://doi.org/10.1016/j.nepr.2011.03.021.

[184] Stickley, 398.

[185] Wickens et al., "Loneliness in the COVID-19 Pandemic"; Laura van Dernoot Lipsky and Connie Burk, *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, Illustrated edition (San Francisco, CA: Berrett-Koehler Publishers, 2009).

Nursing professionals have developed a practice called Code Lavender that can help people debrief after having experienced an unsettling or upsetting experience.[186] Ideally, this debriefing takes place just after a critical incident has taken place; it can also be useful when later reflecting on an incident that we have experienced as traumatic.[187] In best practice, there would not only be a team with which one could debrief a challenging incident, but also safe places, respite rooms, that might "include diffusers, light dimmers, hospital blankets, a massage chair, pillows and a sound machine."[188]

Well-trained nurses can help patients experience different levels of comfort, from the physical to the psychospiritual. This insight is as old as nursing itself. As Miki Goodwin et al. observe in an article discussing holistic comfort, "Since Florence Nightingale first opened a window in a sick room to admit air and light, nursing has been described as both a science and an art."[189] As these authors observe, "Holism in nursing is often conceptualized as caring for body, mind, and spirit interacting within an environment."[190] One of the key contributors to this way of practicing nursing is to become aware of the person's inner self, hence the term holistic applied here. And while the literature is directed principally at healthcare professionals (HCPs), some of the

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[186] Anne Manton, "Emergency Nurses and Code Lavender," *Journal of Emergency Nursing* 44, no. 4 (July 1, 2018): 321, https://doi.org/10.1016/j.jen.2018.05.003; Debra Garnita Orton, "Team Lavender Supports Healthcare Workers: 'Our Spiritual, Emotional and Mental Health Matters,'" *Journal of Pastoral Care & Counseling*, June 17, 2022, 15423050221106424, https://doi.org/10.1177/15423050221106423.

[187] Lipsky and Burk, *Trauma Stewardship*.

[188] Debbie Gregory, "Code Lavender: Designing Healthcare Spaces to Enhance Caregiver Wellness," *HERD: Health Environments Research & Design Journal* 14, no. 2 (April 1, 2021): 13, https://doi.org/10.1177/1937586721993785.

[189] Miki Goodwin, India Sener, and Susan H. Steiner, "A Novel Theory for Nursing Education: Holistic Comfort," *Journal of Holistic Nursing* 25, no. 4 (December 1, 2007): 278, https://doi.org/10.1177/0898010107306199.

[190] Goodwin, Sener, and Steiner, 279.

insights offered in these professional writings can be gleaned by volunteers in their own practice.

As Goodwin et al. observe, one of the most significant contributors to the concept of holism in nursing stems from the nurse and educator Katherine Kolbaca, who developed what she terms as a "comfort theory" to help support both patients and physicians. Kolbaca's theory is based on an ascending hierarchy of support, from relief, ease, to transcendence—especially the aspect that addresses what Kolbaca designated as "transcendence."

Both patients and physicians need support, as is demonstrated in a recent article analyzing how the Kolbaca schema could be applied during the pandemic, using as its example a physician's tragic death by suicide during the pandemic. [191]A brief excerpt from this article demonstrates some of the promising potential for applying Kolbaca's theory:

> A dying patient diagnosed with COVID-19 can attain physical relief when the nurse takes vitals, offers fluids, and monitors electrolytes. Providing dry, warm blankets to replace wet and soiled ones can provide physical relief. Turning and repositioning the patient can assist in physical ease. Moisturizing a dry mouth or dabbing the patient's lips with a cotton swab dipped in water or sucrose fluid can enhance all 3 concepts of relief, ease, and transcendence. Providing periods of undisturbed rest can aid in environmental relief and psychospiritual transcendence. Frequent contact with family and friends in-person (e.g., 1-hour hospital visitor policy) or via video chat (e.g., FaceTime) can increase sociocultural ease and transcendence. The patient can experience environmental relief and ease by dimming the lights as well as psychospiritual relief by minimizing external stimuli to prevent anxiety. Nurses can always provide emotional support which can help facilitate sociocultural relief. Playing instrumentals including harp, cello, or sax, a music genre or song request

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[191] Timothea Vo, "A Practical Guide for Frontline Workers During COVID-19: Kolcaba's Comfort Theory," *Journal of Patient Experience* 7, no. 5 (October 1, 2020): 635–39, https://doi.org/10.1177/2374373520968392.

> can increase the person's overall comfort. This list is far from exhaustive.[192]

Visitors might take comfort in realizing that their presence can contribute to this holistic comfort that Kolbaca has written about.

Volunteers can creatively apply some of these techniques in their own practice. The Kolbaca schema, for example, suggests that relief, ease, and transcendence can be experienced in each of four different four contexts: physical, psychospiritual, environmental, and sociocultural. [193] In practical senses, the nurse or healthcare professional would be able to respond to each of the four contexts (physical, psychospiritual, environmental, and sociocultural). The visitor, by contrast, would in most contexts be able to respond to only two of these—the psychospiritual, and the sociocultural. (Visitors would be able to refer the patient's concerns about the other two categories to healthcare professionals.) The visitor might experience the patient, for example, as exhibiting "Anxiety, fear, frustration, anger, and depression," or some other combination of similar emotions. Applying the Kolbaca taxonomic structure would entail first seeking to provide relief in response to these emotions. Ease and transcendence would be those moments of grace when the patient experienced a sudden lightening of emotions. Sociocultural factors might be expressed when a patient shares feeling uncomfortable with how they are treated, whether this is due to gender, sexual orientation, language barriers, or to a perceived combination of traits traceable to education, age, and so on. The visitor's goal in such a case would be to listen, and this

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[192] Vo, 636.

[193] Goodwin, Sener, and Steiner, "A Novel Theory for Nursing Education," 280.

would provide the first stage of relief. Ease in this context might also take place, but rarely transcendence.

The following descriptions are quoted directly from Kolbaca and DiMarco's article exploring how this theory could be applied in a pediatric context. (Despite the pediatric context, the general insights seem generally applicable to many patient/caregiver interactions.)

Type of Comfort. Relief describes the state of having a specific comfort need met. Ease describes a state of calm or contentment. Transcendence describes the state in which one can rise above problems or pain.

Context in which Comfort Occurs. Physical comfort pertains to bodily sensations and homeostatic mechanisms. Psychospiritual comfort pertains to internal awareness of self, including esteem, concept, sexuality, meaning in one's life, and one's relationship to a higher order or being. Environmental comfort pertains to the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc.). And finally, sociocultural comfort pertains to interpersonal, family, and societal relationships (finances, teaching, health care personnel, etc.), also to family traditions, rituals, and religious practices."[194]

Applying these concepts, if a patient were experiencing anxiety about surgery, or about test procedure results, they might experience relief if they were encouraged to speak about their concerns. They might feel some easing of their anxiety if they felt that they had been listened to. Would transcendence ever be experienced? It's hard to say, but

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[194] Katharine Kolcaba and Marguerite A. DiMarco, "Comfort Theory and Its Application to Pediatric Nursing," *Pediatric Nursing* 31, no. 3 (June 2005): 3.

it might occur if the person felt a sense of peace and comfort as the result of a prayer or a blessing.

In terms of sociocultural factors, these could be of many different types, as mentioned above. To turn to an example that Kolbaca and DiMarco raise, a patient might be experiencing discomfort as the result of being separated from familiar traditions and culturally sensitive care. They might also be feeling anxious and unsettled if their familiar family members were not present. Language barriers, if present, would surely exacerbate these factors. In this case, the patient would most likely experience relief, ease, and transcendence if the familiar comforts of home—and the people of home—were present. The visitor could still provide relief and ease if they listened empathetically and carefully and tried to encourage the patient to focus on the likelihood of being reunited with familiar people and practices.

Blessings. Visitors can freely offer blessings; this act can be deeply meaningful to those who are blessed. Atkinson's research on blessing, for example, demonstrates that visitors might adopt a practice of blessing those they visit. As Atkinson writes, citing David Spangler's 2001 book *Blessing*, "The art of blessing becomes a mode of service, a spiritual practice, and a participation in what the Western mystical alchemical tradition termed the Great Work."[195] Offering a blessing is a powerful gesture.[196] To offer a blessing can be motivated by kindness, yet as Atkinson observes it is far more than this: "the distinction between an act of kindness and offering a blessing may be the depth of

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[195] Atkinson cites David Spangler, *Blessing: The Art and the Practice* (New York: Riverhead Books, 2001), 68.

[196] Carolyn Fisher Atkinson, "Blessing: A Practice of Presence, Intentionality, and Appreciation," *Journal of Holistic Nursing* 38, no. 1 (March 1, 2020): 159, https://doi.org/10.1177/0898010119882860.

sharing of spirit. As a form of communion, the act of blessing carries a reciprocity and cannot come from a superficial or judgmental place. When 'blessing' becomes a synonym for anything that makes us happy or prosperous, no matter how trivial, it undermines its ability to vitalize a spiritual power within us. In addition, it fails to appreciate that not all blessings come from pleasant circumstances."[197] It is entirely within the visitor's purview to adapt such a practice of blessing during their visiting. To offer a blessing, of course, would be done only after asking the patient if they would like this ritual act shared with them. Provided that this permission was granted, the reciprocity of the gesture might lead to surprisingly powerful experiences for both the person offering the blessing and the person receiving it. To do so might contribute to enhancing what Goodwin et al. write has "the potential to affect patient care and outcomes, as well as benefit 'institutions where a culture of comfort is valued.'"[198]

Blessings might also be offered by the nursing practitioners themselves. In some settings, specifically Muslim nurses in Kuwait, nurses have adapted a practice of blessing for their patients, based on the concept that "study participants saw no separation between care for physical needs and care for spiritual needs."[199]

Other specialized articles can help the visitor respond effectively with those who are experiencing cognitive decline.[200] Other literature describes the value of pastoral care

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[197] Atkinson, 159–60.
[198] Goodwin, Sener, and Steiner, "A Novel Theory for Nursing Education," 281; Kolcaba and DiMarco, "Comfort Theory and Its Application to Pediatric Nursing," 187.

[199] Atkinson, "Blessing," 158.

[200] Sophie Sapergia, "Dementia Care in Residential Settings," no. November (2017), https://www.albertahealthservices.ca/assets/info/seniors/if-sen-dementia-care-in-residential-settings.pdf; Swinton, *Dementia: Living in the Memories of God*; Swinton and Pattison, "Moving beyond Clarity: Towards a Thin, Vague, and Useful Understanding of Spirituality in Nursing Care."

visits while also discussing the spiritual benefits to the person visited.[201] Volunteers also provide to the system economic benefits because they provide their services free of charge and can devote longer visits than paid-accountable staff.

Considering the ways in which volunteers are retained is important, in that training is not the only or even most important part of the process that ensures happy and committed volunteers.[202] And while hospital volunteers will not normally work directly with patients with diagnosed mental health concerns, trauma and mental health issues affect a wide range of patients in hospital.[203] In sum, volunteers can bring about significant benefits to patients. An Australian study has shown that the benefit of volunteers for patients are so significant that they ought to be, in the views of the Australian study's author, deemed as essential, not optional.[204] Volunteers also help effect positive change within a system.[205]

The FICA Tool. Some knowledge of the FICA Spiritual History Tool (FICA), developed by Puchalski and Romer sometimes used by medical professionals to gauge the patient's degree of understanding of their own spiritual needs and practices, can also

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[201] Daniel E. Hall, "We Can Do Better: Why Pastoral Care Visitation to Hospitals Is Essential, Especially in Times of Crisis," *Journal of Religion and Health*, July 30, 2020, 1–5, https://doi.org/10.1007/s10943-020-01072-x.

[202] Femida Handy and Narasimhan Srinivasan, *Valuing Volunteers: An Economic Evaluation of the Net Benefits of Hospital Volunteers*, *Nonprofit and Voluntary Sector Quarterly*, vol. 33, 1, 2004, https://doi.org/10.1177/0899764003260961.

[203] Tiburtius Koslander, António Barbosa da Silva, and Asa Roxberg, *Existential and Spiritual Needs in Mental Health Care: An Ethical and Holistic Perspective.*, *Journal of Holistic Nursing: Official Journal of the American Holistic Nurses' Association*, vol. 27, 1, 2009, https://doi.org/10.1177/0898010108323302.

[204] Tan et al., "'Essential Not Optional.'"

[205] Louch et al., "'Change Is What Can Actually Make the Tough Times Better.'"

be beneficial for volunteers.[206] FICA© is an acronym that can help any person who is part of a health-care team to develop a spiritual history with a patient. The acronym relates to these concepts:

F	Faith, Beliefs, or Values
I	Importance or Influence
C	Community
A	Address (i.e., how would the patient like his/her/their concerns addressed).

An article assessing how much healthcare professionals (HCPs) found the FICA tool to be valuable. Its authors observe that "Spirituality, broadly defined as that which gives meaning and purpose to a person's life and connectedness to the significant or sacred, often becomes a central issue for patients. Growing evidence demonstrates that spirituality is important in-patient care. Yet healthcare professionals (HCPs) do not always feel prepared to engage with patients about spiritual issues." [207] With some conscious adaptation, these questions might be useful for volunteers. For example, although the FICA tool asks just whether people feel spiritual or religious, the visitor could adapt the question to ask them how their spiritual beliefs or values help them cope with what they are experiencing. They could also ask them whether these beliefs are

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[206] Christina M. Puchalski et al., "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (June 2014): 642–56, https://doi.org/10.1089/jpm.2014.9427; Michael J. Balboni, Christina M. Puchalski, and John R. Peteet, "The Relationship between Medicine, Spirituality and Religion: Three Models for Integration," *Journal of Religion and Health* 53, no. 5 (October 2014): 1586–98, https://doi.org/10.1007/s10943-014-9901-8.

[207] Suzette Brémault-Phillips et al., "Integrating Spirituality as a Key Component of Patient Care," *Religions* 6, no. 2 (2015): 477, https://doi.org/10.3390/rel6020476.

providing comfort in this situation. It also might come up that the person's specific beliefs might influence their healthcare decisions. And rather than just asking whether a person is a member of a spiritual or religious community (we would know that because they would have indicated this upon admission to the hospital), the visitor might ask the patient how being a member of a spiritual community is of support to the patient and how. We might have to be prepared to hear that perhaps the community has *not* been a support, and to know how to proceed if this is what we hear from the patient. We could also ask them how, as a religious community visitor, we can address any of the issues or concerns or hopes that the patient has mentioned.

The potential for rich interactions is well worth the somewhat stilted beginnings that the FICA tool seems to connote. Conversations could occur along many different lines. The authors identify all these potential subject areas as possibly being raised as a result of using the FICA tool: a "need for empowerment, courage, hope, meaning in suffering; grieving, anxiety, lament or protest over loss; a sense of being overwhelmed by suffering and uncertain about their ability to endure; difficulty expressing feelings about the situation; expressing guilt, concerns, grief and/or difficulty reflecting on joys, hopes and values; concerns regarding how significant others are coping with illness, loss/changes; coming to acceptance of illness and mortality; fear of dying; abandonment by God; and others Religious/spiritual struggles."[208]

[208] Brémault-Phillips et al., 484, Table 4.

RCOPE tool. The RCOPE tool is another tool that measures how well and how widely patients use religious coping strategies in response to an illness or another challenge.[209]

In an article remarkable for its recommendation for direct, hands-on involvement with patients, Yi-jung Liu discusses care dimensions, goals, and methods of practice.[210] Although much of what this author recommends might more readily fall under the purview of an SHP or perhaps a family member, the article is useful because it points to a wide range of options that the visitor might call upon. A real relationship is what is implied here, not merely a quick prayer. Physical care, psychological care and emotional support, and social relationships maintenance constitutes their own care dimensions, as does religious and spiritual care. The author presents a rich panoply of options under the care dimension of religious and spiritual care, many of them involving direct participation from the visitor. Visitors are encouraged to help patients recognize their own value, while helping them to resolve any feelings of guilt and strengthening their motivation and courage to live. The author also recommends that visitors discuss with patients the meaning and value of living, aging, sickness, death, misfortune, and happiness. The article also recommends that visitors encourage patients to review their life journeys, and to share poetry, and to share worship with the person. It's a remarkable article and one that might be read with benefit if a visitor ever felt that they were running out of ideas as to how to engage spiritually with a patient.

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[209] Kenneth Pargament, Margaret Feuille, and Donna Burdzy, "The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping," *Religions* 2, no. 1 (February 22, 2011): 51–76, https://doi.org/10.3390/rel2010051.

[210] Yi-jung Liu, "A Proposal for a Spiritual Care Assessment Toolkit for Religious Volunteers and Volunteer Service Users," *Journal of Religion and Health* 53, no. 5 (2014): 1414–26, http://www.jstor.org/stable/24485218.

Nonetheless, although religious community visitors in the AHS system are not permitted to offer physical care to patients, Liu's article is useful because it points to a wide range of techniques that the visitor might call upon. A real relationship is what is implied here, not merely a quick prayer. Even if visitors cannot provide physical care, they can provide psychological care and emotional support; social relationships maintenance constitutes their own care dimensions, as does religious and spiritual care.

Visitors are encouraged to help patients recognize their own value, while helping them to resolve feelings of guilt while strengthening their motivation and courage to live. The author also recommends that visitors discuss with patients the meaning and value of living, aging, sickness, death, misfortune, and happiness. The article also recommends that visitors encourage patients to review their life journeys, and to share poetry, and to share worship with the person. It's a remarkable article and one that might be read with benefit if a visitor ever felt that they were running out of ideas as to how to engage spiritually with a patient. Under the rubric of "psychological care and emotional support," the author encourages visitors to help patients express emotions and feelings, while empathizing with them and helping them experience respect and care. Listening, providing company, encouraging patients to discuss subjects they care about, are all helpful techniques. This author even suggests that visitors might join patients in listening to music or reading books. The author encourages patients to re-examine their own family connections, their social relationships, and their faith practices and believes. The author suggests that visitors refer patients to chaplains (SHPs). I concur wholeheartedly.

Governed

Hospital volunteers from churches are governed in two specific and literal ways: by the church, and by the hospital. While some volunteers might find these two governance bodies to be constraining, they can be understood as liberating. One can learn to move freely even within a set framework. Rules keep us in our lanes, help us keep time, help us move in concert with others without getting in their way.

In practice, rules governing volunteers help them realize that their role is not the same as that of the healthcare professionals (HCPs) or the spiritual care providers (SHPs). They do not help with physical care, for example, that is the role of the HCP team member. Nor do volunteers engage with people from other faith communities; that is the role of the SHP. Volunteers also need to be mindful of any specific temporary restrictions governing how and if sacraments can be offered.

Yet as many a classroom teacher has found, or anyone, really, engaged fully in a one-on-one conversation, there can be considerable freedom even when one has a specific curriculum to cover. In the case of the visitor, there is no real set "curriculum" aside from attentive listening. Anointing and blessing and prayer are always possible, even if the Eucharist cannot be administered. Then too, within reason, visitors can have some positive influence and say on where a visit might take place. Ambulatory patients can often be signed out. A few minutes in a garden outside, or just *being* outside can make a world of difference to a patient. If a patient is not ambulatory, quiet sitting (with permission, and with care paid to time), and judicious conversation and prayer, are usually welcomed. Blessings and anointing can eventually be offered if the person so desires.

Volunteers are also governed by "best practices" as regards issues such as confidentiality, respect for other points of view, and a knowledge of the best teachings from the disciplines of pastoral care. One could also with accuracy speak of being *grounded* in such an awareness. I prefer the stronger word "governed" here. Its certainty connotes what ought to be the inviolability of some procedural practices.

If the hospital and the faith community are two ways by which the visitor and the patient are "governed," a third and perhaps even more important way of understanding governance is to comprehend each patient as a self-governing entity that a person governs through one's freedom and freewill. A RCV who approaches the visit with this sense in mind will be more effective in their role because they will understand that each patient has a unique way of responding to the world. Seeing each person as a self-governing entity is another reminder that RCVs need to attend and listen rather than propose direct solutions.

Respecting confidentiality is crucially important for hospital visitors. Special cases are not likely to cause problems. Quite ordinary ones are far more likely to cause problems. For example, we might possibly see someone famous in the hospital, and need to respect that person's privacy. It is far more likely that visitors will the treasurer of their own church, or the choir director, or someone from another church that they might have previously attended. Confidentiality needs to be exercised in such cases. It also needs practice to make it if not perfect then at least correct most of the time. Conversations over supper can so easily turn to, "you never will guess who I saw today!" While natural, such a line of conversation is inimical to the role and the practice of hospital volunteering. That's why I employ the stronger term "governed" here as opposed to "guided."

Accountability in Pastoral Care. Another way of understanding governance in this two-fold model is to think of it as accountability. Accountability means understanding our own acts in relationship to a supervisory body. This is essentially what happens for the hospital visitor, who is accountable both to a church body and to the spiritual care and volunteer resources staff in the hospital. In terms of pastoral care, this is part of the cycle of pastoral assessment. Carrie Doehring discusses pastoral assessment in detail in *The Practice of Pastoral Care: A Postmodern Approach*.[211]

Disaster chaplaincy provides opportunities to explore the two dimensions of accountability with respect to chaplaincy.[212] Some translation of its tenets can be made so that it can be applied to the principles of accountability more generally. After discussing the "systemic accountability" of chaplaincy, and the specific and time-based mission of the work, the author reminds readers of the second dimension of accountability, observing that "we are accountable also to the spiritual realities of symbolizing the presence and care of the divine, in ways that go beyond our personal presence, and the particularities of the disaster." [213] One can also speak of being governed by the knowledge of the therapeutic alliance.[214]

Intuition. Can we speak of being governed by intuition, grounded by it, or neither? To imagine oneself as governed by intuition is the more interesting concept. In a stimulating and original article that links heart health and spiritual awareness, Micheline

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[211] Doehring, *Practice of Pastoral Care, Revised and Expanded Edition*.

[212] Swain, "'We Are All Disaster Chaplains Now.'"

[213] Swain, 84.

[214] Derald Wing Sue et al., *Counseling the Culturally Diverse: Theory and Practice*, 8th ed. (Hoboken, N.J.: John Wiley & Sons, 2019), 196–97.

Anderson writes that "pre-stimulus forms of perception including intuition, have been shown to initiate in the heart providing biological evidence of 'heart knowing,' a metaphor for spiritual perception and sacred wisdom that transcends intellectual and academic forms of knowing"[215] For Anderson, the heart can be understood as a locus of life and inner wisdom. As she writes, "The spiritual heart is one in which gratitude, wisdom, intuition and interconnectedness radiate in myriad ways, not merely in the metaphors of time immemorial, but with radical consequences that extend beyond oneself to other living beings, to Nature, and to the rhythms of our universe. Immediate growth and recovery may initiate at the individual level but may, if initiated en masse, eradicate social injustice, environmental degradation and bring about a 'heartfelt' global spiritual awakening."[216]

Regardless of whether one is ready to accept fully the premises that Anderson offers in this article about the heart standing in for an incipient or potential global spiritual awakening, one might wish to hear such ideas about intuition and heart-knowledge with open ears and an open mind. I have valued head-learning for much of my life. Yet hospital visiting has invited me into a quite different realm where heart-learning is something to be sought and respected.

There is nothing necessarily arcane or mystical about this: family members' demeanor and body-language will speak loudly of what is going on. A well-grounded visitor—saying a parking lot prayer like a mantra before entering a room—will gauge the mood and atmosphere of a place and of the gathered people there. I have come to trust

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[215] Micheline R. Anderson, "The Spiritual Heart," *Religions* 11, no. 10 (2020): 2, https://doi.org/10.3390/rel11100506.

[216] Anderson, 5.

those for whom intuition is a tangible, gut-felt response. Given the infinite combination of possibilities that one can encounter in any given situation, one might well think of intuition as one of the points by which we are governed.

Graced

A major premise in this dissertation is that both the patient and the visitor can experience mutual grace from a visit. Grace might be defined as finding insight and an awareness of the Holy amid the tumult of life, and the sometimes-tangled skein of our own life-thread. Grace can occur when one becomes sensitive to the transformative and grace-filled gifts of being attentive to another human being, with a sense that the Divine, the Holy, is also present. We can be graced by interactions, graced by surprises, and graced by comfort received and comfort offered. There is also the grace of the gift of time, with the unpredictable paths of listening.[217]

There is also the grace of story. What stories need to be spoken? I remember watching in vigil with a family for a week as a beloved matriarch transitioned towards death. What stories needed to be spoken? Even as she was preparing to leave, and before the final descent to silence, she told stories about dancing when she was younger. She remembered laughing. She remembered the joys of being outdoors. I have heard other, unexpected stories: a dear friend of a grandchild who died suddenly. Another story of a miscarriage. Stories that floated up and said, in effect, "*I need to be told in order to be released."* There is a grace in waiting, in hearing, and encouraging such stories to be

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[217] Mundle, *How to Be an Even Better Listener: A Practical Guide for Hospice and Palliative Care Volunteers*.

released—either so that they can do no more harm to the person or their family, or so that they can bring joy and become part of family lore. Yet the constituent elements of what defines grace, and how it can be experienced, need to be more closely defined so that how grace is experienced during hospital visit can become clearer.

Two strands of insights are most relevant here. One concerns grace that stems from an awareness of kindness, mercy, gentleness, and attentiveness. Christians might describe grace of this sort as stemming from God's indwelling call to us all. We are sometimes aware of these insights—the blinding, "aha" grace *in the moment*—yet more characteristically such insights emerge to us more gradually. This latter sort of grace typically enters in silence, on stockinged feet. We might only realize such insights after the fact, when we reflect on an encounter or a situation.

Trappist monk and teacher of Centering Prayer Basil Pennington compares an awareness of such insistent insights as becoming aware of "the mind of Christ." He suggests that an attitude of grace—he terms it "mindfulness"— "comes with an almost worshipful reverence that invites patients to be aware of their own dignity, of their own goodness, worth, and beauty. With such a sense of self the patient can open more readily to the Divine Love, can accept the invitation to an intimate trusting friendship. When the brother or sister who comes is obviously happy in such a friendship, when they speak gently and tenderly of such a friendship, they can be readily heard. We want to be the sacrament, the outward sign of all that we say."[218] When we behave in this way to others, filled with God's presence, we can experience "the heart of God, the delicate touch that

[218] Pennington, *The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry*, 42.

forms and shapes us to feel as Christ feels is crafted within us as we sit in silence with the Beloved and let silence do its work."[219]

Most of us will not possess anything like Basil Pennington's deeply spiritual presence. We are human flawed yet seeking grace. The second strand of insight about grace stems from an awareness of our own human fragility, blindness, obdurateness, and selfishness. These insights can also be realized in the moment, yet again, more characteristically, are realized later (sometimes much later) when we reflect on an encounter, a conversation, an opinion voiced or held back. Chen Chen's poem "In the Hospital" might help make this point.

> My mother was in the hospital & everyone wanted to be my friend.
> But I was busy making a list: good dog, bad citizen, short
> skeleton, tall mocha. Typical Tuesday.
> My mother was in the hospital & no one wanted to be her friend.
> Everyone wanted to be soft cooing sympathies. Very reasonable
> pigeons. No one had the time & our solution to it
> was to buy shinier watches. We were enamored with
> what our wrists could declare. My mother was in the hospital
> & I didn't want to be her friend. Typical son. Tall latte, short tale,
> bad plot, great wifi in the atypical café. My mother was in the hospital
> & she didn't want to be her friend. She wanted to be the family
> grocery list. Low-fat yogurt, firm tofu. She didn't trust my father
> to be it. *You always forget something*, she said, *even when*
> *I do the list for you. Even then*.[220]

The first stanza of this poem reveals how Chen is distracted by ordinary events, making lists in his mind, judging others, thinking of simple pleasures ("good dog, bad citizen, short skeleton, tall mocha"). His busyness seemingly makes him unaware of the potential for human kindness that is around him ("everyone wanted to be my friend"). By

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[219] Pennington, 33.
[220] Poetry Foundation, "In the Hospital by Chen Chen," text/html, Poetry Foundation (Poetry Foundation, December 12, 2022), https://www.poetryfoundation.org/, https://www.poetryfoundation.org/poems/143239/in-the-hospital-5944115fa6ca7.

repeatedly asking the question "who wants to be a friend?" Chen brilliantly points out the different roles and the different expectations of mother, son, wife, and friends. The last lines reveal Chen's awareness of his mother's wish to remain relevant, as she asserts that she will always remain the Queen of the Shopping Lists even while she is taken away from her role as the family's heart-centre. ("*You always forget something,* she said, *even when I do the list for you. Even then.*")

Grace in this poem may be found in the author's self-revealing as imperfect and flawed. Trying to be a good son, he nonetheless thinks of coffee, of watches; he is put out by some of the people he sees. He mentally compares those who are "cooing sympathies" to pigeons. He finds good wifi in the café. Yet while he fiddles with his wifi settings, his family structure is crumbling.

Chen's poem reflects on how ordinary people can be distracted from thinking about what is important. The hospital experience is above all *dislocating*, and *disequilibrating*; grace is experienced when the visitor realizes that the patient is experiencing above all an interruption of their regular patterns. Patients might feel frightened, angry, or simply bored. To realize this is a compelling insight; it is one that the visitor should never lose sight of. Grace is experienced when visitors realize that they are flawed human beings who, like Chen Chen, might be sitting in the presence of a patient who is struggling, yet be playing an interior a B-roll about coffee, groceries, relationships, parking…in short, all the things that the human can do to avoid being fully present with another human being's distress or discomfort. Or their own.

Fortunately, an "*and yet*" clause applies to this potentially dismal, predictable, scenario. Yes, visitors might be only dimly aware of their own proclivities for distraction.

And yet, with the benefits of the parking lot prayer, with the benefits of a regular spiritual practice, they will at least have gained the *possibility of being aware when they are unaware*. This is no small insight. Visitors can correct course internally when distractions occur. They could even abandon ship as it were, if necessary, admitting to the patient their human frailty and imperfection, saying something like, "You know what, I came in here wanting to have a great visit with you. But I find that I am distracted by some things that are going on in my own life, so maybe I can come back at another time when I am able to listen better. Would that be okay?" The visitor admits human frailty—something that patient will already be acutely aware of! —and asks permission to have another visit. Grace might occur not only in the moment, but later, when a second visit is attempted.

Another poem points to the inherent grace and dignity of the patient, something that the visitor needs to always keep in mind. Here is Terri Kirby Erickson and her poem "Hospital Parking Lot:"

> Headscarf fluttering in the wind,
> stockings hanging loose on her vein-roped
> legs, an old woman clings to her husband
> as if he were the last tree standing in a storm,
> though he is not the strong one.
> His skin is translucent—more like a window
> than a shade. Without a shirt and coat,
> we could see his lungs swell and shrink,
> his heart skip. But he has offered her his arm,
> and for sixty years, she has taken it.[221]

This poem conveys a simple tenderness about human beings. In contrast to Chen Chen's poem, Erickson reveals nothing about herself. Instead, her poem seems to have at

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[221] Poetry Foundation, "Hospital Parking Lot by Terri Kirby Erickson," text/html, Poetry Foundation (Poetry Foundation, January 30, 2023), https://www.poetryfoundation.org/, https://www.poetryfoundation.org/poems/57776/hospital-parking-lot.

its core an admiration and respect and affection for those who are vulnerable. She looks and finds meaning and tender connection where others might see nothing at all. Her poem above all shows us the power of the telling vignette. Some might find Erickson's transparent efforts to tug heartstrings to be manipulative, even maudlin. Yet there is unexpected power and beauty here, as epitomized by the description of the old man's skin as so translucent that it is "more like a window than a shade." *And yet,* he still has the strength, the love, and the will to accompany his wife; "he has he has offered her his arm, and for sixty years, she has taken it." By conventional society's terms, they are agèd, irrelevant, unattractive (i.e., her "vein-roped legs"). Yet measured in terms of their mutual love and devotion to one another, they stand as a lighthouse amid darkness. Such a vignette eloquently gives witness to grace in these moments of vulnerabilities perceived and experienced. Visitors would do well to be open to the grace and beauty of each person they see. Many stories of love are waiting to be witnessed and shared; they provide grace and tenderness to all those with eyes to see and ears to listen.

Aging and spirituality are other key themes revealed in this poem. A descriptive sentence from an article that discusses spiritual care, particularly for the elderly, helps potential visitors be aware of their calling to provide care to whole persons, regardless of their life stage. "Spiritual care involves serving the whole person, addresses questions of identity, meaning, and purpose, affirms the inherent dignity and value of all persons, and respects different spiritual perspectives and practices—that may or may not be expressed in religious terms."[222] The goal of the visitor is essentially to recognize each encounter as

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[222] Najmeh Jafari, Katalin Roth, and Christina Puchalski, "Spiritual Care," in *Hazzard's Geriatric Medicine and Gerontology, Chapter 60: Spiritual Care*, ed. Jeffrey B. Halter et al., 7th ed. (New York, NY: McGraw-Hill Education, 2017), 5, accessmedicine.mhmedical.com/content.aspx?aid=1136591659; Mark

possessing a spiritual component, defining that term as Lepherd et al. do: They write, "Spirituality is a complex concept because it relates to the inner feelings and experiences of every human being. Humans are all different and we are all spiritual in some way. We have a central core that helps us to develop purpose and meaning in our lives. There are many dimensions of our lives which help to give us peace and to lift (transcend) us above everyday experiences and bring into focus elements of our spirituality."[223]

Vulnerabilities and Dislocations. Seeing this elderly couple through Erickson's eyes invites us to experience their vulnerability yet also their grace. Vulnerabilities come in many different forms; only some of these are visible. For example, anyone in the hospital is already vulnerable because of their changed state of being a hospital patient. There are others who are experiencing additional vulnerabilities, such as cognitive impairment and/or decline, physical or intellectual challenges, traumatic experiences of abuse or neglect that have left lingering marks on the person, as well as ongoing physical conditions (including, but not limited to, conditions such as blindness, hearing impairment, painful and debilitating conditions, damaging relationships—or some combination some all these and more). Adding to this there are those who experience a sense of being "other" because of gender identity and/or sexual orientation.

All these vulnerabilities are exacerbated by the setting of the hospital itself. Hospitals are complex social organizations where, as observed in an earlier chapter, the patient has few privileges and next to no power. With few exceptions, individuals find

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Cobb, Christina M. Puchalski, and Bruce D. Rumbold, *Oxford Textbook of Spirituality in Healthcare*, Oxford Textbooks in Public Health (Oxford: Oxford University Press, 2012).

[223] Laurence Lepherd et al., "Exploring Spirituality with Older People: (1) Rich Experiences," *Journal of Religion, Spirituality & Aging* 32, no. 4 (2020): 306–40, https://doi.org/10.1080/15528030.2019.1651239.

themselves uprooted and out of touch with their typical frames of reference and comfort. Hospitals can be a spiritual desert for those who are used to a regular spiritual life and practice. They can be places where the food is unpleasant and unappealing. Above all, hospitals are places of interruptions. The visitor needs to remember this, too, as they arrive, smiling and wishing to impart their own version of grace. It could be that they are perceived as simply another distraction. Paying attention to the cues, and asking permission, will help them determine whether to visit. It can be a larger grace, sometimes, to defer or demur.

Otherness. It can be a grace to recognize that another person possesses integrity, purpose, and beauty, yet also to recognize that they are deeply mysterious and, in the end, unknowable. Writings on the concept of the Other provide helpful perspectives. As Jay Rock astutely observes in the 2017 article "No Longer Strangers or Aliens: "Otherness" as a Binding to Be Loosed in Christian Tradition," "'Otherness'" as difference is a reality; we do encounter people and practices that are strange to us. But, however great the initial jolt, this experience of otherness is not a valid conclusion about another human being. Rather, it is a starting point for asking ourselves how we ought to behave toward people who differ from us. What is our responsibility toward them? What sort of hospitality is it appropriate to give or to receive?"[224]

Some people's view of the Other can seek to make those differences permanent. This is one of the sad characteristics of discrimination and racism. By treating another person as a stranger, their humanity is diminished, as are any possibilities for real connections. The painful grace of this truth awaits the visitor's realization. Yet as Rock

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[224] Jay T Rock, "No Longer Strangers or Aliens: 'Otherness' as a Binding to Be Loosed in Christian Tradition," *Journal of Ecumenical Studies* 52, no. 1 (2017): 113.

observes, “The Christian tradition includes a strong emphasis on confronting and transforming the perception and experience of “otherness.” It recognizes and honors difference as a reality but calls on its practitioners to dissolver barriers between “us” and “them” and to move from constructions of “self” and “other” to the building of the one human community in relation to the One all-loving God. In this strand of Christian thinking, the condition of being strangers and aliens is a dimension of our unreconciled state. In that state, we practice the drawing of boundaries that exclude certain groups of people.”[225]

Citing Robert J. Schreiter, Rock observes that there are at least seven different ways of treating the person as a stranger. We can demonize them. We might choose instead to romanticize them, in that way treating the other as superior to ourselves. We can colonize the other, treating them contemptuously and regarding them as inferior. Generalizing the Other is yet another means of treating them as a non-individual. Or we might trivialize differences, ignoring even disturbing differences, instead homogenizing the other by claiming that there really is no difference. Or, finally, Schreiter writes that “we can vaporize the other, refusing to acknowledge the presence of the other at all. This is often found in cases of racism, where the oppressed people’s existence is not even acknowledged.”[226]

In contrast to these disturbing ways in which a person is not fully seen for who they are, and what and who they love, as expressed in their own voices, in Rock’s view,

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[225] Rock, 114.

[226] Robert Schreiter, *Reconciliation: Mission and Ministry in a Changing Social Order*, The Boston Theological Institute Series 3 (Maryknoll, NY: Orbis Books; and Cambridge, MA: Boston Theological Institute, 1992), pp. 52-3, cited by Rock, 2017, p. 115, n. 2.

"Overcoming the separation of self from other is at the heart of Christian reconciliation."[227] Christian writings, Rock observes, "offer a theology not of exclusion but of embrace. The self-emptying (kenosis) of Christ is in part a dissolving of "self" and "other" in surrender to God, whose will is to heal and unite all creation."[228]

Rock builds up to a beautiful crescendo: God calls us to a unity that not only reduces otherness but shatters it. He quotes from David Tracy, who once observed, "God's shattering otherness, the neighbor's irreducible otherness, the othering reality of "revelation" (not the consoling modern notion of "religion"): all these expressions of genuine otherness demand the serious attention of all thoughtful persons."[229] Rock's conclusion provides a powerful model for regarding otherness through the redemptive lens of Christian unity, as he writes, "The reality of difference and otherness calls Christians to respond by confronting and transforming their own other-making, taking with utter seriousness Jesus' call to build a life of reconciled, beloved community."[230]

Painful yet Healing Graces. Can we carry these insights about grace into suffering and uncomfortable places, places where we are revealed as bigoted, capable of stereotyping, capable of generalizing a person and not seeing either their inherent beauty and dignity or their unique stance on the world? Chen Chen has already shown how grace can be experienced amid distraction. So, yes, grace can be experienced during experiences and interchanges that reveal us to be less than what we would wish to be.

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[227] Rock, "No Longer Strangers or Aliens," 117.

[228] Rock, 117.

[229] David Tracy, "The Hidden God: The Divine Other of Liberation," *Cross Currents* 46 (Spring, 1996): 5-6, cited in Rock, p. 118, n. 10.

[230] Rock, "No Longer Strangers or Aliens," 119.

Not all graces are quick, easy, or palatable to experience. Some graces are slow, hard, and painful to swallow. This was the case for Mark Freeman, who writes with insight and grace about his mother's physical decline and living with dementia. Drawing on philosophers such as Emmanuel Levinas, and on Sigmund Freud's 1915 meditation "On Transience," Freeman describes his complex relationship with his mother for the ten years that she lived with dementia. Despite all the challenges, he was able to see his mother through a lens of "sacred beauty, the sacred beauty of finite life."[231]

Not that he quickly attained this level of grace and acceptance! As he admitted, he sometimes thought that "Her incessant repetition of questions could be annoying. Her refusals to believe the truth—for instance, that she had hidden things away only to have become convinced that they had been taken from her (most likely by the help, of course)—were frustrating. And her accusations, especially those having to do with the (alleged) fact that my brothers and I had placed her in assisted living against her will, that none of us wanted her, that I never came to see her, and so on, could be downright maddening and this, of course, despite the fact that she was utterly helpless to do anything but exactly what she was doing. So there I was getting angry at my failing, frustrated mother for doing things she couldn't possibly help doing. Hardly a model of sensitivity. As for her face, well, suffice it to say I hadn't arrived at the sacred beauty stage quite yet."[232]

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[231] Mark Freeman, "The Sacred Beauty of Finite Life: Re-Imagining the Face of the Other," *Psychoanalytic Inquiry* 40, no. 3 (April 2, 2020): 162, https://doi.org/10.1080/07351690.2020.1727205.

[232] Freeman, 165.

Freeman's frank self-disclosure provides similar insights about vulnerability and imperfection as those Chen Chen wrote about in his poem. Being an attentive son or daughter is far from easy. Nor is it easy to be a good human being. In Freeman's case, he draws inspiration from philosophical writings on the Other (capitalized in his article), ones that have a very different meaning from what we have been considering thus far. Freeman cites Emmanuel Levinas, who has written about "our being 'hostage' to the face of the Other, captivated by its very presence, its nakedness and need. "It is through the condition of being a hostage that there can be pity, compassion, pardon, and proximity in the world—even the little there is, even the simple 'after you sir'" (p. 91)."[233] The Other here means a sacred territory that we can enter only when we abandon our own ego preoccupations.

Freeman quotes Iris Murdoch's *The Sovereignty of Good* (1970). Murdoch asks: "are there any techniques for the purification and reorientation of an energy which is naturally selfish, in such a way that when movements of choice arrive we shall be sure of acting rightly?" (p. 53). Yes, she answers. "It is...a psychological fact, and one of importance in moral philosophy, that we can all receive moral help by focusing our attention upon things which are valuable: virtuous people, great art, perhaps ... the idea of goodness itself" (p. 55). Attention to what is other is key: "We cease to be in order to attend to the existence of something else, a natural object, a person in need" (p. 58).[234]

Freeman defines the sacred by referring to terms and concepts introduced in Emmanuel Levinas's *Alterity and Transcendence* (1999). "It is precisely in that recalling

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[233] Freeman, 165.

[234] Freeman, 167.

of me to my responsibility by the face that summons me, that demands me, that requires me—it is in that calling into question—that the other is my neighbor" (p. 25). "Responding to the summons issued by the face of the Other is a matter of necessity, even obedience." [235] "My generosity, our generosity, is called forth by the Other. She demands it. Her face demands it. It calls me to attention. And, following Weil, the more unmixed this attention is, the more it becomes a kind of prayer." [236]

Perhaps there are two keys to grace: attentiveness and love. Benedictine monk and meditation teacher Laurence Freeman links these two in a lecture series from 2021 called "Attention and Love."[237] At the conclusion of his retreat teaching, he offered this final comment to the retreatants: "I'd like you to just take one thought away during this retreat— it's the equivalence of love and attention. They are the same thing. To pay attention is to love; to love is to pay attention."[238]

Grace therefore is experienced when one pays attention, when one shows love to another—and as a result, experiences the possibility both of that person's human love in response, and the larger presence (and perhaps also purpose) of divine love that calls visitors to volunteer in the first place.

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[235] Freeman, 169.

[236] Freeman, 170.

[237] Freeman, *Attention and Love*.

[238] Freeman, 26.

PART III: EVALUATION AND FUTURE STEPS

Chapter 4. IMPLEMENTATION AND ASSESSMENT

The Goldilocks Formula for Visits and Visitors: Finding What's Just Right

Sailors savor salty, snappy sayings. "If you don't know knots, tie lots!" comes to mind when thinking about what is necessary to know for a religious community visitor. Sailors need to know how to tie the right knot, rather than to finger-fumble a tangle of knots either inappropriate for the task or unsafe. How might this apply to the context of the teaching religious community visitors? Just as the wrong knot can leave a line in a rat's nest, too much information risks overwhelming potential visitors and leaving them dispirited at best, or uncertain about whether to continue at worst. There is so much to know, so many ways of approaching a visit, so much written on the subject, that there is a strong risk of overwhelming people with too much information. After all, Spiritual Health Practitioners, or chaplains as they are often known, spend years focusing on how to respond to patients. Through the techniques learned during intensive units of Clinical Pastoral Education, they learn how to apply the latest clinical research theories regarding patients and spiritual care. The challenge therefore is to develop a Goldilocks' formula for visitors—not too much, not too little, just enough.

Keeping these ideas in mind, what does the visitor need to *do*? The visitor needs to engage in a sequential three-fold practice summed up by three words: *preparation* (gaining some self-understanding in relationship to the world and to God); *presentation* (how one manifests oneself during a visit); and *playback* (self-consideration and reflection following a visit). To put this in another way, a successful visit will include these three components: self-perception; self-presentation; and self-consideration.

To achieve these goals, and at the risk of oversimplifying, a visitor's program might be reduced to these essential categories:

1. Knowledge about oneself—one's preferences, personality type, and a willingness to reflect on some of the significant events that have shaped us.
2. Knowledge about one's spiritual values and practices (combined with some interest in, and knowledge of, other faith traditions).
3. Some understanding of the social and institutional frameworks in which people live and work—and therefore, a basic knowledge of how individuals function within a system.
4. Some acquaintance with critical teachings of pastoral care and counseling, e.g., active listening, empathy, hope, knowledge of the life cycle (including cognitive decline, palliative care).
5. A basic understanding of and ability to respond to persons raising issues of theodicy and grief and mourning.[239]

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[239] Charlene P. E. Burns, "Theodicies of Protest and the Evils of Theodicy," in *Christian Understandings of Evil*, The Historical Trajectory (1517 Media, 2016), 197–204, https://doi.org/10.2307/j.ctt1c84fr6.10.

6. A humble and genuinely open attitude that will allow visitors to say, "I don't know, but I will ask," thus deferring to those with more knowledge and admitting limitations.

Adult Education Theory. To become co-learners, to utilize teaching to meet a felt need, to result in personal and institutional change, to foster healthy intimacy, and to be interesting, is a complex series of goals to strive for. The dissertation project attempts to do so by developing a radically simple structure that can be applied continually, and with refinement and internal growth.

As Kevin E. Lawson observed in an editorial entitled "Equipping the Saints" in a 2017 thematic issue of *Christian Education*, "one of the major goals of the educational ministry of the church is to ground people well in their faith and help them discern how God has equipped them to serve others through the gifts and experiences God has given them." [240] The goal of this dissertation project is to train volunteers who are members of the United Church of Canada so that they feel well-equipped to offer gifts and skills as trained visitors to help hospital patients feel better equipped themselves to respond to health and spiritual challenges. "Equipping the saints" in this context means that volunteers who participate in the hospital visiting training will feel ready to contribute their gifts by visiting in hospital patients. The program is informed by the Biblical injunctions to visit the sick (Mt. 25:36) while also being responsive and attentive to the contemporary social issues and concerns of a large, professionalized health-care institution. A key part of the training will be to help equip volunteers with the skills to

[240] Kevin E. Lawson, ed., "Editorial: 'Equipping the Saints,'" *Christian Education Journal* 14, no. 2 (Fall 2017): 243–46, https://www.proquest.com/docview/1960973263/abstract/205FE6E75E594441PQ/1.

when and how to delegate and refer to more specialized members of the health-care team when faced with specialized medical and/or psycho-social problems.

While this goal is easy to describe, to achieve it in a setting as complex as a contemporary acute-care hospital is daunting. Hospital volunteers are sandwiched between two distinct, highly professionalized groups—on the one hand, the medical team (with its many different sub-branches), and on the other, the increasingly specialized realm of the Spiritual Health Practitioner, one of the terms now employed to describe what used to be described as a chaplain. To "equip the saints" in such a context is not easy. Nor is it easy to help them feel as though they are a valued member of an interdisciplinary team. These are nonetheless some of the key goals of the facilitation program documented in this dissertation.

Drawing specifically on the theories of andragogy (adult learning) advanced by Knowles, this dissertation project presumes that adult learners are self-motivated and able to learn on their own—and that in their learning, there is an invitation to transformation, and self-realization.[241] To put it another way, the spiritual and the personal might be said to merge in a holistic way. Christopher Beard describes this holistic vision well in an article linking spiritual formation and adult learning, writing, "The holistic view of formation and the focus on identity in missional discipleship is consistent with a

[241] Malcolm S. Knowles, *Andragogy in Action: Applying Modern Principles of Adult Learning*, 1st edition (San Francisco: Jossey-Bass, 1984).

philosophy of adult education concerned with the development of the entire person, rather than just the transmission of information."[242]

As Terry Linhart observes in *Teaching the Next Generations*, "it's too common that there's not a stated aim for a learning event or lesson."[243] This comment invites me to frame an overarching goal for this proposed hospital visitors' program. Students are invited to embrace the active call of God by bringing empathetic listening skills and a ministry of presence to those who are in hospital.

Amanda Drury's chapter in Linhart's book, "Teaching Adults," discusses several strategies that have informed this dissertation project. [244] The theoretical basis of Drury's work is derived from Malcolm Knowles' Andragogy in Action: Applying Modern Principles of Adult Learning The five essential principles of teaching adults, or andragogy, are:

- we are co-learners with our adult students.
- teaching should meet a felt need.
- it should result in change.
- it should foster healthy intimacy,
- and finally—it should be interesting.[245]

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[242] Christopher B. Beard, "Connecting Spiritual Formation and Adult Learning Theory: An Examination of Common Principles," *Christian Education Journal* 14, no. 2 (Fall 2017): 252, http://www.proquest.com/docview/1960970657/abstract/81DB740B52884674PQ/1.

[243] Terry Linhart, *Teaching the Next Generations: A Comprehensive Guide for Teaching Christian Formation* (Baker Academic, 2016), 143.

[244] Linhart, 164–75.

[245] Linhart, 164–75.

Navigating the Shifting Terrain of Hope. A key goal for the program was to empower participants to feel hopeful so that they in turn could embody a hopeful presence to those they visit. Hope can change for a person. That is, they might at first hope for physical healing. If that proves impossible, they might hope for comfort for loved ones, for peace in relationships, and so on. The University of Alberta operates a program of Hope Studies, which they describe as "the only research unit in the world devoted to the study of hope in human living."[246] The power of hopeful thinking is a key element in this program.

Developing Facility in Offering Extemporaneous Prayer. It is important that visitors develop a facility to offer extemporaneous prayer. For this reason, the current program provides participants with a structure and a space where they can practice extemporaneous prayer. A technique known as the You-Who-Do-Through prayer method, widely known across ecumenical circles, provides people with some guidelines.[247] In such a prayer, using "You" encourages people to address God directly. "Who" refers to God's actions throughout the ages. "Do" refers to the specific nature of the prayer. "Through," in Christian practice, refers to Jesus Christ.

Prayers are most effective when they are simple and direct. For example, Frederick Buechner movingly describes the death of his brother Jamie.[248] Although Jamie didn't go to church and he didn't want a funeral, Jamie did ask his brother for a prayer he could use. Found on the table beside the bed in which Jamie died was this prayer: "Dear

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[246] "Larsen Publications - Hope Studies Central," accessed February 1, 2021, https://sites.google.com/a/ualberta.ca/hope-studies/publications-presentations/about-us.
[247] "How to Make a You-Who-Do-To-Through Prayer," accessed January 23, 2023, https://worship.calvin.edu/resources/resource-library/how-to-make-a-you-who-do-to-through-prayer/.
[248] Buechner, *A Crazy, Holy Grace*, 85–105.

Lord, bring me through darkness into light. Bring me through pain into peace. Bring me through death into life. Be with me wherever I go, and with everyone I love. In Christ's name I ask it. Amen."[249] There is much to admire and to learn from in a prayer such as this. First, it is directed *to* someone (to God); second, it is clearly expressed and direct. Many of the prayers that participants developed had that same direct, powerful presence.

Sometimes, prayers exude beauty and peace, as is shown in the last few lines excerpted from James Agee's 1938 prose-poem, "Knoxville: Summer of 1915," about a third of which Samuel Barber memorably set to music in 1947. (The poem is widely and easily available online, so no reference is provided for it.)

> The stars are wide and alive, they seem each like a smile of great sweetness, and they seem very near. All my people are larger bodies than mine, with voices gentle and meaningless like the voices of sleeping birds. One is an artist, he is living at home. One is a musician, she is living at home. One is my mother who is good to me. One is my father who is good to me. By some chance, here they are, all of this earth; and who shall ever tell the sorrow of being on this earth, lying, on quilts, on the grass, in a summer evening, among the sounds of night. May God bless my people, my uncle, my aunt, my mother, my good father, oh, remember them kindly in their time of trouble; and in the hour of their taking away.

Reflections on Planning, Delivering, Offering, and Learnings from the Program

Recruiting Participants. Despite continuing to experience aftereffects of the pandemic, along with residual concern about in-person meeting, we decided to see whether people were interested in an in-person program. We recruited participants by placing a notice in our weekly regional email newsletter. We hoped for twenty people to sign up. Fifteen did. They came from all over the Chinook Winds Region, and one from

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[249] Buechner, 102.

our second large city, Edmonton. To put that in perspective, one participant drove more than two hours from Bow Island, which is in the far south of the province of Alberta, near the border with the United States. A participant from Edmonton would have driven nearly three hours. Other participants came from Communities of Faith (COFs) in Calgary and vicinity. The wide geographical range of participants and the number of them testified to a need for an in-person orientation program.

Pre-Program Considerations. Even though I was very much looking forward to being together with a group of people from across the Chinook Winds Region, I found it nerve-wracking as the clock ticked down towards the date for the program. Several deadlines loomed, including timelines for essential approvals from the SFTS and University of Redlands. Other practical and strategic deadlines needed to be met, such as making sure that the space for the program was booked and that hardware and Internet were working together. I spent the day before the program addressing last-minute details, from buying refreshments to checking all the spaces for break-out meetings. I was surprised to see how much it cost to print copies of the supporting documents. Summing up my feelings, I experienced not only some anxiety and felt rusty about my skills in facilitating a large group in a two-day workshop. Would there be enough information? Too much? Most importantly—would people buy into the program structure, which focused heavily on group participation?

I designed the program so that people could take away specific learnings from it, yet not be overwhelmed by too much information. I wanted to test the viability of the "Three-G" structure for the program, and to assess whether participants found this helpful. I wanted them to take control of their own learning by offering numerous

occasions for case-study interactions. This was my way of putting adult-learning pedagogy into action—to make sure that people engaged as co-learners with material so that they could take it into their own repertoire and skill set and make it their own.

I credit the Canadian Mental Health Association with the genesis of the idea for introducing case-studies into the program. I experienced these case-studies during a two-day Mental Health First-Aid course I took in the spring of 2022.[250] That program provided me with the impetus for developing a similar strategy for this program. That program also provided me with the model for setting participants into changing groups of three—a "patient," a "visitor," and an observer. (People shifted roles and groups during the program.) My reason for doing this was so that they could learn by doing and by observing.

Another key goal was to introduce Atul Gawande's *Checklist Manifesto* as a means of putting the Three Gs (Grounded, Governed, and Graced) into practice. In this way, people could develop their own set of goals, and assess after a visit whether these goals had been met. I wanted people to do this by writing their own "parking lot prayer." I suggested that according to their personal preferences, they could either keep using the same prayer, or else adapt it to each changing circumstance. I encouraged people to do the prayer before a visit (literally, in the parking lot before they go into the hospital) and afterwards (so that they could debrief themselves).

I left blank spaces into the supporting materials (see Appendix B) and provided samples of both the pre- and post-visit prayers. I encouraged people to use each of the

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[250] "Mental Health First Aid," accessed January 30, 2023, https://www.mhfa.ca/.

Three Gs in each prayer. Thus, beforehand, they might pray, "Loving God, help *ground* me in this work today; help me realize in which way I am *governed* by the hospital as well as the church, and may I feel that this is not a burden but a gift; and help me be open to ways in which you show me *grace* in this visit." The post-visit prayer would be substantially the same, but with a retrospective focus and one that might offer specifics and names and circumstances inviting compassionate reflection.

A participant might offer something like, "Dear God, thank you for having *grounded* me while I visited [name of person]; thank you for giving me a calm spirit when they shared information about [their illness, or other circumstances in their lives]. Thank you for calling me to pay attention to the ways in which I was *governed* and thank you for [a helpful nurse, etc.]. Thank you particularly for the *grace* you showed me by hearing [e.g., a story from a person's life].

In other words, the parking lot prayer is really *two* prayers, one prospective, one retrospective. They work together. Such was my hope in planning the program. How would people respond?

The Chinook Winds Region offices are located on the upper floor of the commodious and beautiful Okotoks United Church, whose generous shaded porches makes the building look more like an antebellum mansion than a church. Okotoks is a rapidly growing town located about 45 minutes south of Calgary, the region's largest city. We offered the program in the regional offices because there is ample parking beside the church and the internal spaces are generously proportioned and beautifully maintained. This was important because we wanted to provide break-out rooms. There are also no fewer than six gender-neutral restrooms, a helpful plus with a larger group.

Having fewer than twenty people proved to be beneficial to the program. The boardroom where we met accommodated the fifteen participants with little space for more. We met in the boardroom for large-group sessions, with breakout spaces provided throughout the large building complex.

The program was designed with time and space for personal reflection combined with enough materials for learning so that people could be stimulated and made aware of larger currents, trends, and issues that we would not have time for in the program. Case-study role-playing, with changing roles and perspectives, combined with the invitation to write (and share) prayers, were the hallmarks of the program. I also employed music, poetry, and videos from television and popular psychology sites as a means of broadening both our perspectives and our pedagogical toolbox.

I sowed the seeds of the program's main goals in every communication tool at my disposal—the recruiting email; our PowerPoint slides; and our documentary materials. People came to the program knowing that we would focus on: Limits and possibilities; learning by doing; and ongoing practice. I also said that we would focus on our key goals of being Grounded, Governed, Graced. I told participants that we would be creating a Parking Lot Prayer, that we would focus on role-playing case-studies and scenarios, and that I wanted people to think about how well they knew themselves, and to provide them with opportunities to reflect on key moments in their own life journey.

Summing up the program goals, I said that it would be to equip people to provide a "Ministry of Presence," defining that as "Being gentle and accepting of yourself and do what you can to help others by providing them with a compassionate, listening presence." I wanted people at least to consider a "Theology of Wholeness," which is to say, an

understanding of the human being as being loved into creation by a God who never ceases to love them. As explained elsewhere in the dissertation, the work of John Swinton helps frame this understanding.

I felt immensely fortunate and humbled that such a diverse cohort signed up for the program. The group was somewhat racially and culturally diverse, with one ordained minister and the rest of the participants being lay people. The participant from Edmonton is the minister in that city's Korean-United congregation. Each participant offered a rich palette of life-experiences, including one participant who had worked more than forty years as a nurse, and another who had recently retired as a social worker. Our region's Indigenous Minister signed up for the program. He provided many insights into how hospital visiting might be adapted for Indigenous hospital patients. The common thread among the participants was an open heart and a desire to make a difference. As mentioned above, under recruitment, I was touched that people chose to drive nearly three hours to participate in the program. I felt honored that people had chosen to participate in the program. It was a privilege to facilitate it.

I invited people to come a little early so we could get to know each other. I provided coffee, fresh fruit, and water for refreshments. Nearly everybody did come early—even those whose morning had started with a two- or three-hour drive. With everyone having served themselves a hot beverage of choice, we started the program with good energy and good humor.

I appreciated it that our Pastoral Relations minister came early on the first day to offer an opening prayer and hosted a group lunch the second day. We had done all we could to build a genuine and caring community, even if also a transient one.

The Holy Spirit seemed palpably present among us early in the program. I had invited everyone to share something about themselves, and about what had motivated them to sign up for the program. “Well, that went fine,” I thought, and prepared to move on to “program content.” Someone gently observed that I had not said anything about myself. “What motivated you to get involved in this sort of work?”

Responding to the question, I experienced a sudden, familiar surge of memory and sadness. I reflected on my sister Karin who died of a heroin overdose while we were both still in our teens. I have shared the story many times; her death undoubtedly exerted a strong influence on my call to pastoral care ministry. I told the group what I have told others before— “I was angry at her for ten years, angry at the System for another ten, angry at myself for still more ten years, then I ran out of situations and people to be angry at. I could feel sadness.” All this is; these feelings still move in me, occasionally surprising me as I am brought to moments of deep sorrow that contrast with my more typical optimism and joy. Ministry, to me, is a way of helping people find their way to healing and wholeness through experiencing God’s love for us all. I shared this and then we sat quietly in a moment of owl-in-the-daylight blinking silence, as we reflected on how sharing from one person can change the mood and tone of a gathering.

I could not have predicted the ways that this question fostered an atmosphere of genuine sharing, but on reflection I was glad that it had been posed. That unexpected vulnerability from me seemed to establish a level of confidentiality and honesty that characterized the rest of the program. People shared openly and genuinely, sometimes relating quite painful experiences. We held each other in silence, and sometimes in spoken prayer.

There were also many moments of lightness and laughter, which is a territory that is equally at home to me. We laughed at some of the videos, which made the subject of Active Listening palatable and humorous. I relaxed and remembered why I like leading programs. The energy was positive and clear. We quickly settled into the rhythm of large-group discussion, small-group role-playing, and individual reflection. Amid the laughter and a few tears, people generously engaged with the program concepts and practices. We proceeded methodically through the Three Gs. People were particularly receptive to the first one, being grounded (as confirmed by later program assessments). Inviting them to consider the ways in which they could deepen self-awareness and self-knowledge seemed in retrospect to have been a good way to begin. We looked at self-awareness tools such as the Junto Institute's Emotion Wheel. I encouraged people to become aware of self-knowledge tools such as the Enneagram and the Myers-Briggs type indicator.

In this section on Grounded, we spent considerable time and attention focusing on spiritual practices and spiritual awareness. I talked about the Ignatian Prayer of Examen and provided references to Ignatian spirituality more generally. We talked about some of the many apps that are out there for spiritual practices. I shared a screenshot of my phone, which has on it, just as an example, the Insight Timer App, Daily Prayer, The Daily Office, the World Community of Christian Meditation, the Ignatian site "Pray as You Go," The Centering Prayer app, as well as links to the lectionary and to the Methodist Church in the United Kingdom. Spiritual resources are widely available. I encouraged people to seek out appropriate resources that they can use in their own practice.

We talked at some length about mental health and spiritual self-care, which reinforced the underlying key points in the program: take care of yourself first, and then

you can take care of others. We spent quite a bit of time in this unit talking about Active Listening, using both examples drawn from popular psychology and from television. Everybody Loves Raymond contains a gem of an example of Active Listening, for example.[251] We looked at an Active Listening Clip from *Inside Out.* Summarizing these clips, I offered the following four statements to help guide visitors: Listening, not judging, being present, and empathetic responses. I was somewhat nervous about showing a long clip called Trauma and the Nervous System, but it was well received.[252]

Also well received was a clip about trauma developed by the Manitoba Trauma Information and Education Centre. I used this discussion about trauma to talk about not knowing what a patient might have experienced in their lives. What this association share on their website seems wise and helpful. Here is just one brief excerpt of what they include on this site: "Trauma is a part of the human experience. Trauma is unavoidable and is something we all have in common. Traumatic events can bring us together, and we can even grow out of trauma. Trauma is also the cause and at the heart of much human suffering and many of the problems that challenges our society today. Even though you might continue to struggle with the effects of trauma, you have survived and that took courage, strength, and resourcefulness. We suspect though that because you are exploring

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[251] *Everybody Loves Raymond Uses Active Listening - from Parent Effectiveness Training*, 2013, https://www.youtube.com/watch?v=4VOubVB4CTU.

[252] *Trauma and the Nervous System: A Polyvagal Perspective*, 2021, https://www.youtube.com/watch?v=ZdIQRxwT1I0.

this website it means you want to do more than just survive and that in and of itself is hopeful."[253]

I used this material to reinforce that we need to approach each patient with the view that their life-story is sacred ground, and we step onto shared sacred ground when we engage with them empathetically and attentively. I used the material on trauma as a bridge to link to current statistics on trauma among Canadians, as provided by Survey on Mental Health and Stressful Events, August to December 2022.[254] These statistics are grim and provided us with real-life situations that enriched the scenarios. Among the statistics (I am quoting from the Survey mentioned above): "One in ten Canadians will develop Post-Traumatic Stress Disorder (PTSD) during the course of their lives. Sexual assault is the most commonly reported worst event among those who meet the criteria for probable posttraumatic stress disorder. Although almost two-thirds (64%) of Canadians reported being exposed to at least one potentially traumatic event during their life, not everyone develops PTSD. Among Canadians who met the criteria for probable PTSD, sexual assault (14%) was the most commonly reported worst event they experienced. This was followed by life-threatening illness or injury (10%), situation involving sudden accidental death (6%) and physical assault (6%).[255]

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[253] "Trauma Recovery," accessed January 30, 2023, https://trauma-recovery.ca/.
[254] Statistics Canada Government of Canada, "The Daily — Survey on Mental Health and Stressful Events, August to December 2021," May 20, 2022, https://www150.statcan.gc.ca/n1/daily-quotidien/220520/dq220520b-eng.htm.

[255] "Post-Traumatic Stress Disorder," accessed January 30, 2023, https://cmha.bc.ca/documents/post-traumatic-stress-disorder-2/.

Wishing to conclude this section on an optimistic note, I found one in a video offered by an empathetic and wise trauma specialist named Karen Poole. She was able to situate trauma into a helpful perspective. She stated that although we may not understand all the theodicy questions of why we might experience traumatic experiences, maintaining regular spiritual practices can provide an effective way to preserve and maintain a sense of equilibrium and hope.[256] These videos were well-received and added rich content to the program.

To prepare for the unit on Governed, I had worked with AHS employees and prepared a detailed handout with the names of people to contact and the process by which volunteers can be registered. I emphasized that people need to accept the appropriate governance role of both the hospital and of the overseeing church and explained that this was so that volunteers could be trusted in their role not to exceed their boundaries. From the AHS perspective—and I haven't seen this from our volunteers—they worry that volunteers will proselytize hospital patients. I made sure to mention that our role is to stay within our lanes.

The unit on Graced served as the culmination of the program, as potential visitors were reminded that what they were doing could bring reciprocal grace—to the hospital patient and to the volunteer. In this unit, I emphasized the role of prayer and of openness to the Holy Spirit. The sacredness of each person's sacred story, yet also the deep mystery of their being, sum up what I hope visitors will feel and experience during their

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[256] See https://vimeo.com/72286630 (retrieved 10 October 2022).

visiting. Grace is an unfolding and continuing opportunity to see the Spirit at work in the lives of those we visit—and in our own lives.

We closed this section on Graced, and the program, with a responsive prayer written by Alydia Smith and Teresa Burnett-Cole, liturgists in the United Church of Canada who developed this prayer to respond to the church's new self-declared vision in 2023, short-handed by the three terms Deep Spirituality, Bold Discipleship, and Daring Justice.

One: God, we've come thirsty—thirsty for your Spirit.

All: Living water, bubble up from inside us and lead us toward deep spirituality.

One: God, we've come hungry—hungry for community.

All: Bread of life, feed our spirits, and lead us toward bold discipleship in community.

One: God, we've come searching—searching for wholeness.

All: Source of Life, guide us, and lead us toward daring justice.

One. God, feed, nourish, and prepare us to be your church in the world.

All: Amen.[257]

Key Learnings

I felt deeply touched by how people eventually shared their own vulnerabilities during their parking lot prayers, which were a highlight of the program. (Some examples

[257] "Call and Vision Opening Prayer."

of these are included below.) One of the key insights I reached was that even transitory communities can be genuine despite their temporary nature.

Reflecting on all these caring souls, I felt some incipient concern that the program would need sustaining in ways that I could not support. I will discuss these concerns in more detail below. Another more positive insight was to reflect several weeks later that people had felt empowered enough by the program to write their own parking lot prayers, and to share these. I hadn't planned for this, but the sharing of these prayers became the emotional high points of the program. Future conversations would be valuable to see whether a specific program could be offered for our Indigenous community members.

Including a Territorial Acknowledgement was helped provide a justice-focused beginning to our program. Indigenous spirituality, leadership, and participation are now vital to the life of the United Church. But how can Indigenous spirituality, leadership, and participation become perceived as active and vital to everyday congregants? One way of doing this is through a territorial acknowledgement. Readers will note that I included a territorial acknowledgement at the beginning of this dissertation. I also included a verbal acknowledgement of the fact that we were meeting on Treaty 7 lands each day during the introductory remarks of our orientation program. By doing this, I hoped that participants would be awakened not only to the relevance and historical veracity of treaty agreements, but also to our own spiritual and justice-oriented work required to make true the national church's goals.

Including a Territorial Acknowledgment in the orientation program provided a way to acknowledge the tragic history of relations between Indigenous and non-

Indigenous peoples. By doing so I not only wished to acknowledge pain and injustice, but also to proclaim hope—hope for a future in which reconciliation and specific concrete actions are full partners.

Some historical contexts may be useful here. The United Church of Canada participated actively in the residential school system. According to the United Church's website, "The United Church is responsible for 15 residential schools operated between 1849 and 1969. About 6.7 percent of the approximately 80,000 residential school students still alive today attended United Church schools."[258] Attempting to recognize the historic wrongs of this system, and church's complicity in it, has taken the church many decades. That work is not complete. As one recent study on United Church history has noted, "Apologies and calls for repentance have been important part of the church's life, especially since the 1986 "Apology to Native Congregations." Some of its most powerful words were: "We tried to make you be like us and in so doing we helped to destroy the vision that made you what you were."[259] This initial apology was received but not accepted.[260] The church engaged with ongoing soul-searching and justice work, operating from the hopeful premise "We have apologized as a church for our broken relationship, and we have pledged to heal it."[261] In 1988, the Indigenous church acknowledged the apology, expressing its hope that the national church would live into its words. The

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[258] "The Apologies," accessed March 27, 2023, https://united-church.ca/social-action/justice-initiatives/reconciliation-and-indigenous-justice/apologies.

[259]"The Apologies."

[260] "The Apologies."

[261] "The Apologies."

national Church then offered a subsequent apology, in 1998, in which it apologized specifically for its role in Indian Residential Schools. Since 2008, the United Church has actively engaged in the Truth and Reconciliation Commission of Canada, which was created to assess the history and legacy of Indian Residential Schools.

The church recognizes that "Transformative legal and social changes are needed to resolve the crisis that has devastated Indigenous communities across the country."[262] To work towards these changes, the church simultaneously took other steps to mark both its contrition as well as its intention to work words a spirit of reconciliation. Since 2012, the United Church's crest has included Mohawk phrase "Akwe Nia'Tetewá:neren"—all my relations—as a means of acknowledging and honoring the Indigenous contribution to the church. The Church has also established a Healing Fund to support diverse initiatives directed to help heal survivors of the residential school system, while also recognizing the ongoing multi-generational impact of the schools. Information is available on the church's website on residential school claims document, as well as the historic "calls to the church." The Missing and Murdered Indigenous Women and Girls Final Report and Calls to Justice.

By a fortuitous circumstance, Rev. Tony Snow, the Chinook Winds Indigenous Minister, decided to take the program. His presence provided a reminder of the importance of Indigenous ministries. He actively participated in the program, and we discussed possible ways in which we might be able in the future to bring more

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[262] "Indigenous | The United Church of Canada," accessed January 2, 2023, https://united-church.ca/worship-theme/indigenous.

Indigenous visitors into the hospital. That would need to be done in a spirit of partnership and humility. This will be a potential area for future development and discussion.

The general structure of the program seemed to be viable and well-received. Concentrating on the Three Gs proved to be a viable way of introducing complex ideas in a palatable and comprehensible way. Focusing on role-playing case studies and on role-playing was worthwhile and really engaged people and allowed them to take ownership of the materials that they were being exposed to, which was a key learning goal for the program. Providing people with encouragement to develop "parking lot prayers" was an experiment that I felt was tested and well received. As detailed below, videos from TV, music videos, as well as selections of poetry, were also well-received and provided helpful grace-notes.

Motivated people are empowered people. People engaged with the case-studies wholeheartedly. I could sense them becoming fluent and fluid in their discussion about concepts. While one facilitation strategy was to show videos on active listening, the participants' own engagement as active listeners in the role-playing case-study scenarios provided them with more applicable skills, and likely longer-lasting ones, than had only been shown the videos.

People are generous with their hearts and their time. I thought of this again and again, giving thanks for people's willingness to be there and to engage with the concepts and give of themselves. An example: I remarked at the end of the first day that I hadn't managed to do any shopping for refreshments for the second day. Would anyone want to bring some in? The next day, two boxes of donuts magically appeared. Having read in the literature that volunteerism among church congregants is on the decline in North America

(Shellnutt 2022), I celebrated the generosity and good will of this group. I felt like bottling them and sending them out to provide water to a thirsty world.

Meeting in person brings new energy and new possibilities to a group activity. Building community requires planning and yet also depends on intangibles, such as people finding a common place together and shared goals. After the estrangement of the pandemic, this work needs to be undertaken judiciously and with due care for people's potential concerns about being near one another.

Providing people with reasonable expectations is important. There is so much to know for a hospital volunteer! As noted earlier, the volunteer is the only non-professional among a group of highly educated and specialists, notably, but not limited to, on the one hand the nurses, physicians, and other members of the healing team, and on the other, the spiritual health practitioners (SHPs).

***Enriching the curriculum by means of content-focused videos, music videos, and poetry, was well-received and was something I would like to continue to do*.** In keeping with the point just raised about providing people with reasonable expectations, the content-focused videos I offered focused on relatively few subject areas. These were associated with two main themes: the first was self-knowledge (including knowledge of the science of stress and trauma), the second having to do with Active Listening. Sometimes, one video made it unnecessary to show another on the same theme. For example, we viewed Brené Brown's well-known video on empathy versus sympathy.[263] We explored the important teaching that "we can only create a genuine empathic

[263] "RSA Short: Empathy," Brené Brown, December 10, 2013, https://brenebrown.com/videos/rsa-short-empathy/.

connection if we are brave enough to really get in touch with our own fragilities." Brown's video made such an immediate and favorable impact that there was no need to play another otherwise excellent video from the Cleveland Institute entitled "Empathy: The Human Condition." [264]

Videos can convey different messages to different audiences. As observed throughout the dissertation, it is crucial to limit the amount of knowledge that is expected from hospital visitors. This is essential for the visitor's well-being and sense of satisfaction. I chose two videos to reinforce this point—a comparison between Fred Astaire and Ginger Rogers in the 1937 film *Shall We Dance* compared with Elaine's "Little Steps" skit from *Seinfeld*, Season Eight, Episode Four.[265] Later, I wondered whether I had been tone-deaf in making these choices. Fred and Ginger are all elegance, all grace, all suaveness. Elaine is…well, it's hard to describe! She is maladroit to the extent that people turn away in embarrassment. My point was that we might *think* that as visitors we can be as suave and as graceful as Fred and Ginger, but we might look more like Elaine. I used this example to make a gentle plea for understanding our own limitations and for accepting it if we are not "perfect" in our role. "Strive for presence, not for perfection," I told the group.

Two potential issues came to my mind later. First, some viewers might have seen this as an example of ableism, with me implying that physical grace is a desirable

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[264] *Empathy: The Human Connection to Patient Care*, 2013, https://www.youtube.com/watch?v=cDDWvj_q-o8.

[265] No reference is provided for these videos because they are so readily available online, and these sites often change over time.

attribute. Elaine's maladroitness, however, is not why the clip is funny. The clip is funny because she doesn't get it that that she doesn't have it. Still, some groups might not have received this video in the same generous way that this group did. I need to keep this in mind.

A second and perhaps more interesting issue is that The Elaine and Fred and Ginger clips were tangentially linked to the main point I was making, which was about awareness of our own limitations. As a teacher and facilitator, I sometimes make jumps in logic or content that leave others wondering how I got to the place I did. This might well be an example of such a working method. On the first level, the clips seem to be about physical grace versus maladroitness. On a secondary level, the Elaine clip is about unawareness. Yet I showed them to make a tertiary point about being kind to us, and not expecting ourselves to be perfect. Viewers might be forgiven if they didn't follow this trail of thought, which was twice removed from its point of origin. In the future, I will try and be conscious of occasions when I make such logic leaps. In this case, I really enjoyed the Elaine versus Fred and Ginger clips and found them funny and apt. This group had no difficulty in following my logic. Yet once flagged, an issue needs to be kept in mind for the future. I will keep an eye out for other examples that might make the point about perfectionism more directly.

Just such a direct link in content came from the delightful 2001 film, Amélie. The Academy of Social Competency has flagged this as an example of "Beautiful Life

Moments."[266]Motivated to help a blind man who has not asked for help, Amélie seizes him by the arm, then leads him across the street and past shops, telling him all kinds of things he didn't ask to know and doesn't need to know. Talking faster and faster, Amélie suddenly comes to a stop and leaves him alone at a subway stop where he probably wasn't intending to go to. This clip caused us all to laugh out loud, yet also provided opportunities to talk about how and when we can offer help. We all agreed that we need to wait to be asked for help rather than offering it the way that Amélie did.

Much can be said without saying anything—and music speaks eloquently about feelings. The gifts conferred by offering music videos and poetry became apparent because of observing their effect on participant's behavior, and the mood of the room generally. Specifically, during our program time, I included music and poetry without saying anything to introduce it. I chose moments such as after a nutrition break and noticed with interest as the atmosphere in the room shifted from inattention to focus. In one specific instance, we had been talking about empathy, and viewed Brown's video on the subject, then took our break. When group members came back from their break, without saying anything I played Carrie Newcomer's "You Can Do This Hard Thing." (This song is included on Newcomer's 2016 album *The Beautiful Not Yet.*) The video tugs at your heart yet is also gentle and beautiful. Movement through time and space reveal themes of transition, loss, and vulnerability. As the video played, I could sense the

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[266] *Look at the World: Beautiful Life Moments - Amelie, 2001*, 2021, https://www.youtube.com/watch?v=ayuSl4Hxz-s.

mood in the room change. Rapt attention replaced a mood of happy randomness. For the reader's interest, here are the lyrics.[267]

There at the table
With my head in my hands
A column of numbers
I just did not understand
You said add these together
Carry the two now you
You can do this hard thing
You can do this hard thing
It's not easy I know but
I believe that it's so
You can do this hard thing.

At a cold winter station
Breathing into our gloves
It would change me forever
Leaving for God knows what
You carried my bags
You said I'll wait for you
You can do this hard thing
You can do this hard thing
It's not easy I know but
I believe that it's so
You can do this hard thing.

Late at night I called
And you answered the phone
The worst it had happened
And I did not want to be alone
You quietly listened
You said we'll see this through
You can do this hard thing.

You can do this hard thing

[267] Interested readers can find these songs via online music resources such as Spotify and Apple Music.

It's not easy I know but
I believe that it's so
You can do this hard thing.

Here we stand breathless
And pressed in hard times
Hearts hung like laundry
On backyard clothes lines
Impossible just takes
A little more time.

From the muddy ground
Comes a green volunteer
In a place we thought
Barren new life appears
Morning will come whistling
Some comforting tune for you
You can do this hard thing
You can do this hard thing
It's not easy I know but
I believe that it's so
You can do this hard thing.

Carving into the hardwood-dense block of meaning in this song almost steals its power. A few observations about it might nonetheless reveal why our group members may have responded the way that they did. Carrie Newcomer is a deeply spiritual person who resonates with those who care about feelings and vulnerability.[268] Described by the Boston *Globe* as a "prairie mystic," she has released 19 albums and three books of poems and essays. With well-known spiritual teacher and writer Parker Palmer, she has collaborated in a program called the Growing Edge. *Spirituality and Health Magazine* listed Parker and Carrie Newcomer among the top ten spiritual leaders for the next twenty

[268] "Carrie Newcomer," Carrie Newcomer, October 28, 2021, https://www.carrienewcomer.com.

years. Her memorable, attractive singing voice, her long training in matters spiritual, and her close collaboration with those whose currency is the Spirit, means that Carrie can tug heartstrings as ably as a marionettist raises a puppet's hands.

"You Can Do This Hard Thing" traces the arc of a life, from a child's vulnerability at being unable to complete a school assignment to moments of unnamed transition through to other experiences of unnamed loss. Yet beyond these dark days lie hope: "From the muddy ground/Comes a green volunteer./ In a place we thought/Barren new life appears." The song presages an eschatological moment of pure grace.

As we analyze this song, two themes emerge for contemplation. I have written earlier about hope and its central importance in this ministry. This song offers us an insight into why and how hope can function. Hope is truly the only currency that we can spend in the hospital; all other currency is debased and worthless.

The group reacted equally warmly to Ed Sheeran's gentle yet powerful song, "Visiting Hours," which is a gentle reflection on the way that love can be stronger than death. He wrote this, we read, as a tribute to mentor and friend Michael Gudinski an Australian record label founder and music producer. Such beautiful lyrics! The last stanza reads:

> I wish that heaven Had visiting hours
> And I would ask them If I could take you home
> But I know what they'd say
> That its's for the best
> So I would live life the way you told me
> And make it on my own
> And I will close the door, but I will open up my heart
> And everyone I love will know exactly who you are

Cause this is not goodbye, it is just 'til we meet again
So much has changed since you've been away.[269]

We listened quietly, then engaged in some good discussions about thoughts of life, death, and life beyond death. It felt like a blessing to be given this song in the context of our shared time as a group.

I shared other musical selections with the group, albeit none with the power and plangent purposefulness of "You Can Do This Hard Thing" or "Visiting Hours." I offered music by the well-known Canadian performer and songwriter, Linnea Good. I also played selections by Bruce and Cheryl Harding, who are likewise Canadian composers and performers (Bruce was the editor of the United Church of Canada's 2007 hymnbook, *More Voices*, which Amazon describes as a "stunning collection of 225 songs [that] is a diverse, ecumenical collection that is theologically relevant and musically uplifting, and is designed for the global Christian community, offering more styles, more genres and more liturgically special music." Looking back on the group's reactions to these songs, people seemed to find them comforting, perhaps comfortable…whereas the Newcomer and Sheeran songs stunned us into silence. The French word "époustouflant" came to mind; *Collins Dictionary* translates it as "breathtaking…extremely beautiful or amazing." Such moments of breathtaking grace cannot be predicted or often repeated. Yet striving to attain these kinds of peak experiences is all worth it: As Carrie Newcomer says again and again in her refrain, "You can do this hard thing."

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[269] *Ed Sheeran - Visiting Hours [Official Lyric Video]*, 2021, https://www.youtube.com/watch?v=pVqX2u6YWqI.

Sacred story is another theme I have tried to hold up as crucially important in this ministry. Allusive in meaning, this song walks us onto the sacred ground of a person's life. In retrospect, it was a moment of unalloyed beauty and power. As sometimes happens during worship, when a child offers an unexpected gem of a comment, or when music leads us into places of deep feeling, or when a moment of vulnerability, either from the preacher or from a congregant, leads us onto the common ground of suffering and yet also hope, words became superfluous. I was deeply touched and moved onto the next stage of the discussions with due care.

Parking Lot Prayers: Some Examples. Participants generously shared with me some of their prayers and have given me permission to include these in the dissertation.

Kathy's Prayer Before a Visit. Loving and mysterious God who created and is creating, I pray that I will recognize and experience your grace. Be with me that I may be courageous, compassionate and that I can demonstrate God's grace and love.
Help me to be fully present with the patient. I pray I will listen fully and speak with God's love by words, vision, and body language. Let me show joy in God's presence. This I pray, knowing that we are all God's beloved children. Amen.

Junior's Prayer Before a Visit. Gracious God, I thank you for this day.
The wonders of life that you have provided for each of us.
Thank you for your love and mercy.
As I visit with this client, I ask for your presence in the situations that will present themselves for this individual, all who care for this client, and me.
Give me a listening ear free from judgement, that I may be able to provide some comfort and peace of mind to this client.

God, I thank you for your love for each of us, in Jesus' name I pray. Amen. ()

Junior's Prayer After a Visit. You, Holy One, are the source of life.

Our beginning and our end.

Our hope and our joy.

As I leave this place, continue to be with this client and all who provide care.

Thank you for the gift of the work that you have allowed me to do.

Your love never fails.

You are the ultimate keeper of grace. Amen.

Kay H.'s Parking Lot Prayer Before a Visit. Loving God, ABBA, please ground me in your peace and atonement. Thank you for the possibility of sacred time with your beloved _____name___. Equip me to be your servant and conveyor of hope and love. I trust in your Spirit to guide and protect myself and ___name___. AMEN.

Kay H.'s Parking Lot Prayer After a Visit. Loving God: ABBA, thank you for being the ground of this sacred time with __*name*___. I place all his/her/their concerns – physical, mental, emotional, and spiritual in your capable hands. Thank you for entrusting me with this opportunity! All praise, glory and honor are yours. AMEN.

Norma's Parking Lot Prayer Before a Visit. Gracious God,

believing in you, I ask for your guidance.

Be with my thoughts and words as I offer comfort/peace/joy to

your beloved child, "Jean."

Grant me wisdom.

Norma's Parking Lot Prayer After a Visit. Thank you, Dear God,

for your presence in my life today.

I'm grateful for this closeness.

Allow compassion to flow within me through your grace, love, and light

as I travel on this journey.

Norma also offered this prayer to be used if she was offering Healing Touch to a patient:

May God's love and light flow through me and into your body, "Peter," for

your highest good. Amen.

Janet's Parking Lot Prayer Before a Visit. Heavenly Father, I thank you for this ministry in your name at _____. Keep me true to the path of this ministry within the walls of the facility and the church. Please let me feel your guidance in my words and actions today.

Help me "rejoice always, pray without ceasing, give thanks in all circumstances, for this is the will of God in Christ Jesus for you." Thessalonians 5: 16-18

May my presence bring peace, hope, joy, and love to the residents (patients) I meet. I pray that we are all encouraged and comforted by you Spirit as we spend this time together.

If, and when, things don't go according to plan, let me be kind to myself and accept your unconditional love and forgiveness. Amen.

Janet's Parking Lot Prayer After a Visit. Loving and merciful God, thank you for the opportunity to visit today. Where I was open and aware, thank you for the guidance and wisdom that allowed me to find the right words and actions to bring hope to those I *visited.* When I stumbled or missed the mark, I pray that you will help me learn and grow for the next time. For the times I stayed true to the roles and restrictions of this

ministry, I am grateful. Where I strayed, help me practice until I am confident and comfortable in my role.

Thank you for the blessings and joy my visit brought those I met and to me. I pray that where I failed or struggled to connect, I will have a future visit that does bring your Spirit into the mix. May I continue to experience your grace and love in this role. Amen.

In structuring the program, I had hoped that participants would create prayers that were deeply personal and relevant to their unique setting in which they found themselves. I hoped that participants would feel empowered to create their own prayers. Empowering them to feel equipped was very important to the program. It is a way of helping people feel that they are truly part of a priesthood of all believers. On the last afternoon, as the culmination of our time together, participants shared these prayers, and others like them, with others in the group. It was as if we were being transported into the hospital when they did so. I felt a surge of emotion. Each of these prayers share a deep sense of grounding in the Holy. We all felt prayed for, prayed with, and, I hope and believe, empowered to create prayers such as these for whatever context the volunteer would find themselves in. These prayers traced a high-water mark in our shared time.

Challenges and Opportunities

I never got around to talking about Clinical Pastoral Education or about verbatim reports. When I offer the program again, I will point out that CPEs can provide in-depth training that would help some volunteers develop greater fluency in addressing complex issues. CPEs might also be attractive for some who wish to pursue professional chaplaincy.

PowerPoint slides were complementary to but not precisely parallel with the written documentation and support materials I provided. I am not sure whether these could be brought closer into sync. I would want to look at this again as I continue to refine the program for future groups.

We need peer-to-peer support and opportunities to share learnings, challenges, and gifts. When I undertook my first graduate degree, in Art History, students met in a "coffee room" that was formerly a storage closet. Five or six or even eight of us would squeeze into that tiny room, challenging each other and our professors in their absence, building up the discipline and tearing it down with equal enthusiasm. Where are those opportunities for volunteers in hospitals? Where are those opportunities to grow, to feel supported, and to feel nurtured? In the absence of these support systems, I am concerned that there will be no way to keep volunteers happy and motivated. All this takes place amid a trend already noted—the precipitate decline of the numbers of church volunteers.[270]

How can we support, and nurture committed volunteers? Literature exists on this, focusing on how to motivate, reward, and continue to challenge and support volunteers.[271] The orientation program that I have developed is missing such a component, which raises concerns about its long-term viability and effectiveness.

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[270] Kate Shellnutt, "Church Leaders Are Still Waiting for Volunteers to Come Back," Christianity Today News & Reporting, January 14, 2022, https://www.christianitytoday.com/news/2022/january/church-ministry-volunteer-gallup-survey-lifeway-wr.html.

[271] Andrea Galiette Skoglund, "Do Not Forget about Your Volunteers: A Qualitative Analysis of Factors Influencing Volunteer Turnover," *Health & Social Work* 31, no. 3 (August 2006): 217–20, http://dx.doi.org.ezproxy.redlands.edu/10.1093/hsw/31.3.217.

Ongoing challenges with the varying structures of the different hospitals. One potential volunteer who took the orientation program subsequently presented herself as a potential volunteer at her local hospital. She was told that she wasn't needed. The chaplain could do all the visiting herself. The potential volunteer was placed on a list to offer worship to patients, although this had not been something that we covered at all in our orientation program. She certainly was not made to feel part of the healthcare team. I felt deep concern about this experience, which reminded me of how opaque and impenetrable systemic inertia can be.

Words have power—to hurt, heal, confuse, and clarify. This became evident when I reflected on my use of the word "governed." Some people (it became clear in the post-program assessments) possess an anti-Establishment outlook. Being "governed" by anyone is anathema to them. I have given the use of this word considerable thought. I prefer it to a more anodyne word such as "guided." We are not "guided" in these roles; we are governed. The hospitals don't give us options as to whether to gown up or not, for example, masks are mandatory, both in hallways and in patients' rooms. And although I recognize that individuals may hold different views about vaccinations and other public health-care measures, hospitals are not the place to make individual statements about individual freedoms. We are governed by the rules and practices of the place in which we offer ourselves and our ministry.

Nevertheless, I realized that I could have been more judicious when I introduced the concept of being governed. I could have said something like, "Some of you may not find this term appealing and might find the term guided to be more to your liking. That's OK, but what I would like you to remember when I use the word is that when we

volunteer in a hospital, we don't make the rules. The same goes for the churches for which we volunteer. They have the right and responsibility to determine who is a volunteer on their behalf." That might have made the term more palatable and acceptable. I commit to ongoing reflection on the ways that words can hurt, help, or heal.

Insights From Participants: Process and Outcome

I invited input from participants by means of two separate Google Form documents. I chose this platform instead of SurveyMonkey because it allowed for more comprehensive responses from participants. The questions invited participants to reflect on their level of awareness of spiritual practices, their awareness of their own unique gifts and challenges. It also invited comments on their level of awareness of hospital procedures. Essentially, the questions asked for some proof of concept or not about the Three-G model. The research tools by which participants contributed their responses to the program content consisted of two separate Google Forms, one sent out before the program commenced and the other following its completion. Here follow the responses received for both questionnaires. I was touched and pleased beyond measure at the generosity of the people who participated. Their responses helped me realize that people who take orientation programs such as this have a wide range of life-experience.

Participants in the orientation program completed the questionnaires at a high rate. For the pre-program questionnaire, 75% (12 of 15) completed the questionnaires. For the post-program questionnaire, 73% completed the questionnaire (11 of 15). Each of the questionnaires comprised several different pages. There were ample opportunities for participants to provide written comments as a means of amplifying or expanding their

graded responses. Each form provided detailed information about the purpose of the research, as reviewed, and approved by the University of Redlands Institutional Review Board. Here is the information that was provided to participants.

General information about this study. You are being asked to participate in a research study. Whether you do is entirely up to you. You may choose not to participate, or you may stop participating at any time for any reason without any penalty. The goal of this research is to study how participants in the Chinook Winds Hospital Volunteers Training Program respond to the training program offered to participants.
You are being asked to participate in this study because you have registered to participate in the Chinook Winds Hospital Volunteers Training Program.[272]

What will happen if you participate in this research. If you choose to participate in this study, you will review this consent form and complete an online survey form. By completing the survey, you indicate your consent to participate in this study. Your identity will not be connected with your survey.

How long will this take (i.e., duration of participation). If you choose to participate in this study, your involvement will take about 20-30 minutes. (The amount of time will vary if you choose to offer optional comments.)

Protecting your privacy. This study was approved by the University of Redlands Institutional Review Board (IRB). This board tries to ensure that your rights and welfare are protected if you choose to participate in the study. If you have any questions about your role or how you were treated by the research personnel, you may contact the Chair

[272] Please note: the title of the program was eventually changed to an orientation program rather than a training program. At the time the questionnaires were distributed, this was the terminology that was used.

of the IRB at [specific contact information was provided but is here omitted as unnecessary].

What will happen if you experience any problems or discomforts during or after your participation. It is possible that there are unknown risks or discomforts. Please report any problems immediately to the researcher. Anything you do, including participating in research, carries with it some chance that something problematic or unwanted may happen. Although the researcher may direct you to medical, psychological, or other services, any costs related to such problems are your or your insurance company's responsibility.

Compensation for participating in this pilot project. None.

Questions about this research. You may ask and have answered any question about the research. If you have questions or concerns, you should contact Geoffrey Simmins at [contact information omitted here].

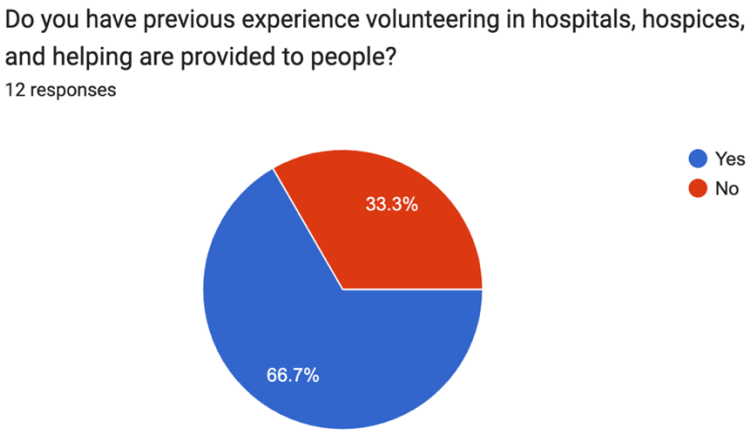
Questions or concerns about the investigators, staff members, and your participation in the pilot series. This study was approved by the University of Redlands Institutional Review Board (IRB). This board tries to ensure that your rights and welfare are protected if you choose to participate in the study. If you have any questions about your role or how you were treated by the research personnel, you may contact the Chair of the IRB at [information omitted here].

Consent. By clicking to proceed to the survey, you are giving your consent to participate in the research.

Summary of Pre-Program Participant Feedback

The questionnaire was subdivided into several categories, starting with a request for the participant to share something about themselves and their training, a section on education, and then a section on the hospital. Please note that the fonts in the following section are those provided by Google forms. I was not able to alter them to accord with the document's general style sheet.

About You. These questions are intended to provide us with an idea of who you are and how this program fits with your other interests, including other volunteer experience and training.



Please elaborate your answer if you wish. (10 responses).

Visiting in a Hospice. While working as a Social Worker in Community Mental Health, there were occasions to visit clients in hospital.

I have visited people in hospital through our church.

As a 20-year associate member of L'Arche Calgary, I visited people with disabilities when they were in hospital or a long-term care center as a volunteer, and a friend. Two people in care, I accompanied in their final hours of life on earth. I was part of a pastoral visitors' team at Living Spirit United Church in Calgary. My mother had dementia from age 70 until her death at age 77. I companioned her with regular visits and outings weekly when she lived in an Assisted Living setting and took her to medical appointments and many times to hospital emergency. I had the privilege of being with her in her final hours on earth in hospital. I took the course "Spiritual Arts of Pastoral Care," designed and delivered by Betsy Young in Calgary. I am a Licensed Lay Worship Leader for the united Church of Canada.

Act as medical interpreter within the AHS system. Help [former chaplain] Arnie Chamberlain in his work as chaplain the Carewest Sarcee.

I have just retired after 43 years of being a health care professional- Medical Radiation Technologist.

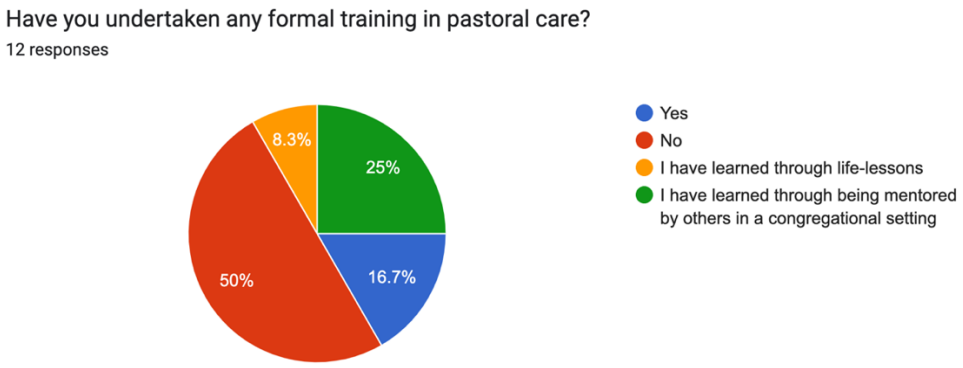
Have taken courses in Healing Pathway and Healing Touch, am a member of healing ministry at Red Deer Lake United Church for 11 years. Retired palliative RN. Assist three seniors in their residences.

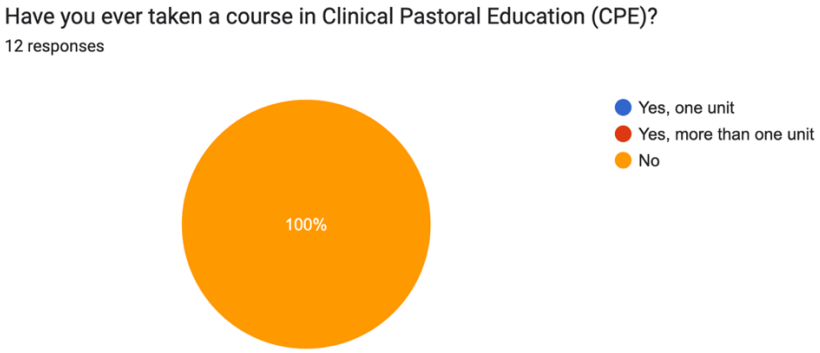
Visiting members from our congregation who have been in the hospital.

Have Health Care Assistant experience in group setting.

I have a mother living in extended care so have "volunteered" by helping with activities at the care facility but nothing formal.

I have done hospital visitation and home visits to members of my congregations.

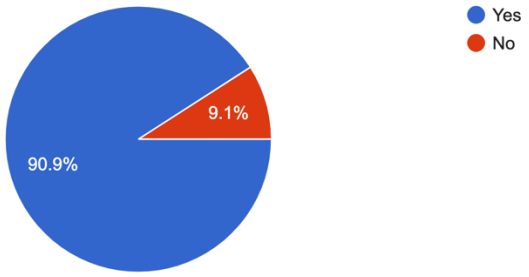




Two participants offered comments here. One observed: The courses that I took through Calgary Presbytery [now absorbed into a different structure, that is, Chinook Winds Regional Council] are likely outdated in terms of the requirements today. Confidentiality of personal information likely prevail and precautions due to the pandemic must also be important factors. The second simply offered, I would like to!

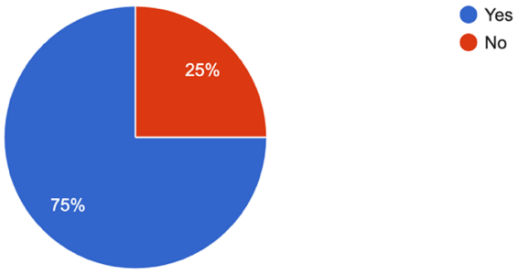
How much would you agree with the following statement? I have a good idea of the history of the United Church of Canada and of where the United Chu... the Gospel in how we live out our faithful life.

11 responses



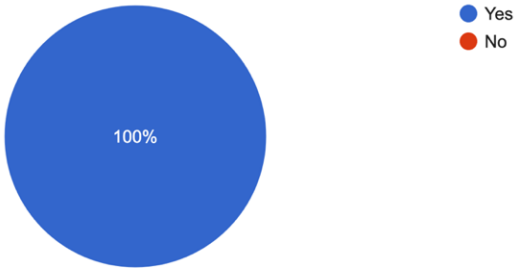
Have you ever completed a personality type assessment, such as the Myers-Briggs Type Indicator® (MBTI®) or Enneagram?

12 responses



If not, would you potentially find such a resource to be of interest to you?

6 responses



If you regularly engaged in specific spiritual practices, please share briefly why these are important to you. 12 responses

Meditation and reading the Bible give me a sense of closer relationship with God. I am a lay minister and find these practices absolutely necessary for my spiritual growth and for my own mental health.

I believe that God is guiding my life. I read something inspiring every day. When preparing to lead a worship service, usually once a month, I reflect on lectionary bible passages. I enjoy creative activities, and I perceive my connection with God as the inspiration for a wide variety of projects. I take daily walks and meditate enroute. I garden and reflect on the wonder of the life cycle.

Help develop your Christian life. How to lead a life of service and gratitude.

I find them grounding and centering. Walking a labyrinth clears my mind and centres my thoughts.

For mind clearing, grounding, focussing.

prayer and devotions help to strengthen me mentally and physically; having a connection to my creator keeps me grounded.

Breathing techniques, meditation.

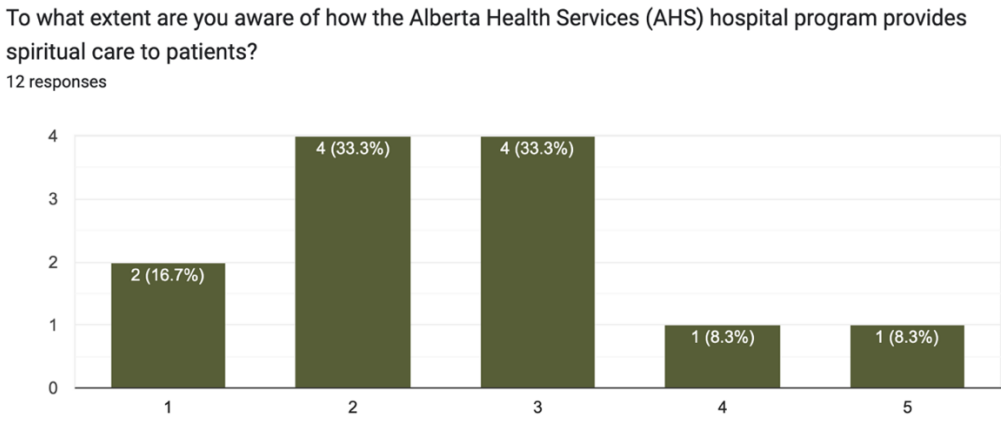
They keep me grounded and focussed on the important things in life.

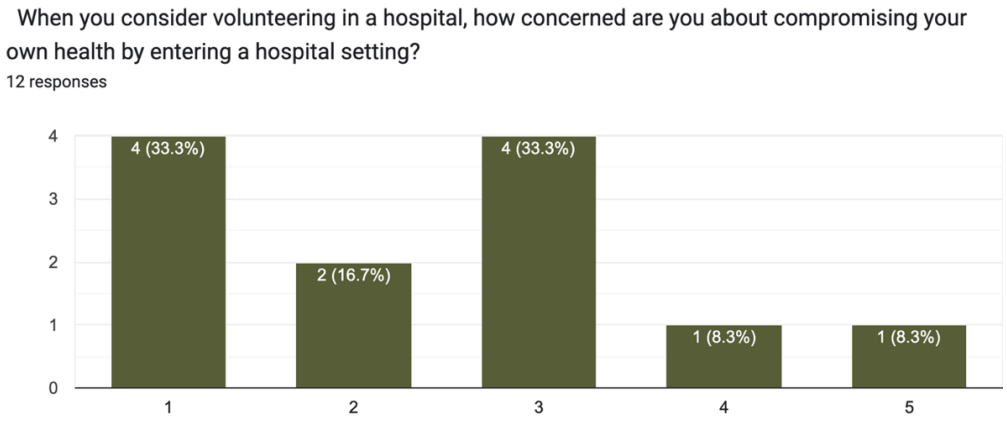
They ground me and remind me of what is important in life.

To give my life meaning/fulfillment/direction.

I pray, read scripture, and practice a Christian form of meditation. They all nurture my relationship with God and keep me growing in my faith.

These questions are intended to provide us with information about your knowledge of the Alberta Health Services (AHS) hospital system, including spiritual care. The sliding scale is ascending from 1, "Not at all" to 5, "very much."





Please elaborate your answer if you wish. 6 responses

Masks provide protection.

I am blessed to have a strong immune system at this moment in time. My life-partner however has compromised lungs. I will be cautious not to bring home communicable diseases.

I'm concerned to follow protocols that protect the patients and myself from communicable illnesses in the hospital.

In the future.

My answers pertain to long-term care facilities.

I have some physical issues that impact my immune system.

Can you describe your main hopes and fears as you think about becoming a hospital volunteer?12 responses

I hope to increase my connection to God and believe I gain from all personal interpersonal connections.

My main hope is that I can learn how to be a loving presence for those who are dying.

My main hope is that I can be a calm presence and listening ear to people in distress. I can reassure through prayer. My main fear is that the process will be riddled with red tape.

Hope that this will foster further growth in my journey following Christ's footsteps. Currently, I do not have any fear.

My hope is that I can ease a patient's anguish. Bring comfort to the patient and their family. My fear is that I will say something that will create more anguish for the patient or their family.

Hoping to make a positive difference, concerned about following rules as a visitor, when I used to work as an RN.

I hope to have more confidence and to be relevant to the people I visit.

Helping others.

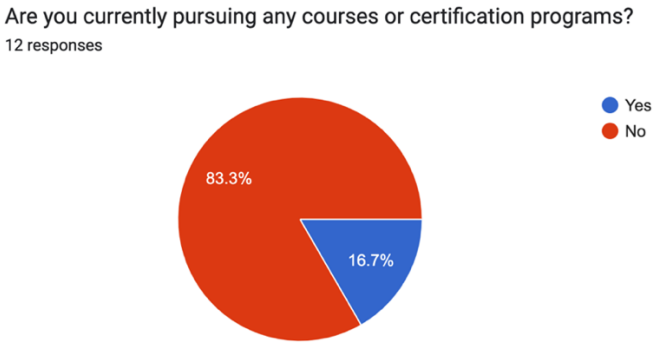
Expand my skills and comfort level in volunteering with programs in the facility that will make the lives of the residents more engaged and cheerful.

My main hope is to help people in pain and fear find hope and peace through spreading God's love. Along with a good chuckle. Main fear is that I will be too hyper. My parking lot prayer reminds me to be calm.

Hope to benefit others and myself. Fear of becoming over-committed.

I don't really have any fears about doing visits.

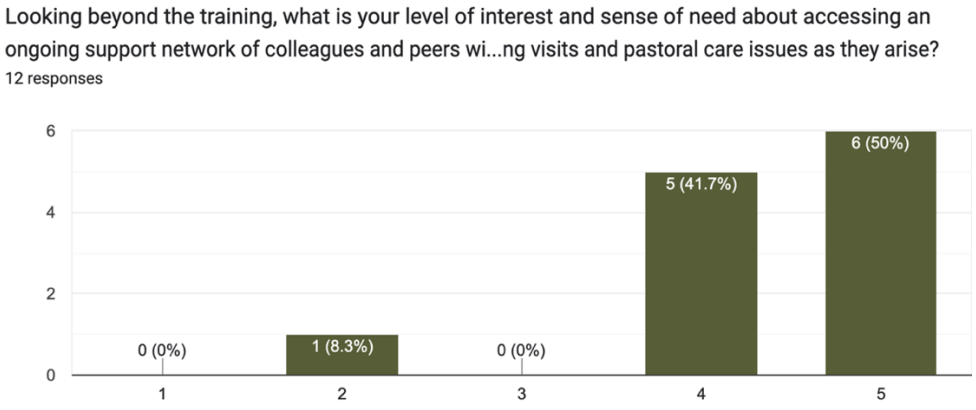
Next Steps



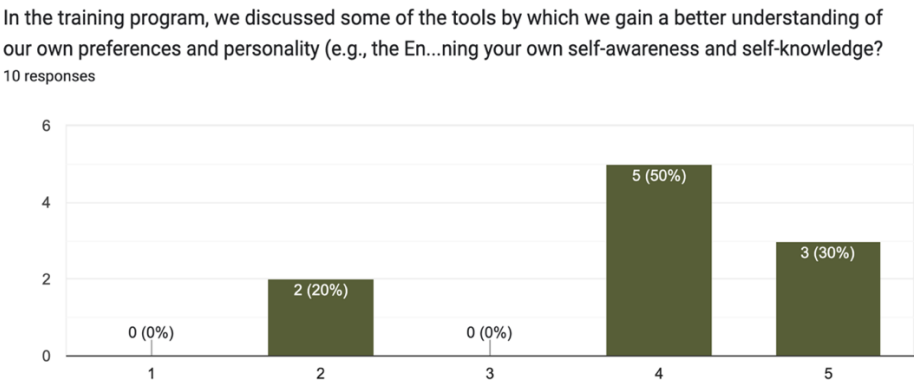
If you answered "yes," how might this training program align with your longer-term goals? 2 responses

I hope to be approved by the Region to offer Communion in one community of faith that does not have a minister. It is all part of a gradually expanding role in pastoral care. If rules are not too strict, perhaps I could bring communion to United Church people in hospital!

Attending this program, learning with and from others.



Summary of Post-Program Participant Feedback



If these tools were useful as a means of deepening your own self-awareness, can you share with us how and why they have been helpful for you? 8 responses

They are effective because they explain both the benefits of my personality type, and also the challenges. Knowing what the challenges are helps me recognize them in myself and then work to overcome them.

I have sone similar tests, but not these. They are very useful in helping me understand why I do certain things, make certain choices, etc. and help understand others as well. i.e., why I avoid conflict but then feel like I am being taken advantage of. It has helped me learn to make choices that are better in life, rather than being afraid of conflict.

I was familiar with both of these tools before this course, and they help me to know myself and others with whom I relate.

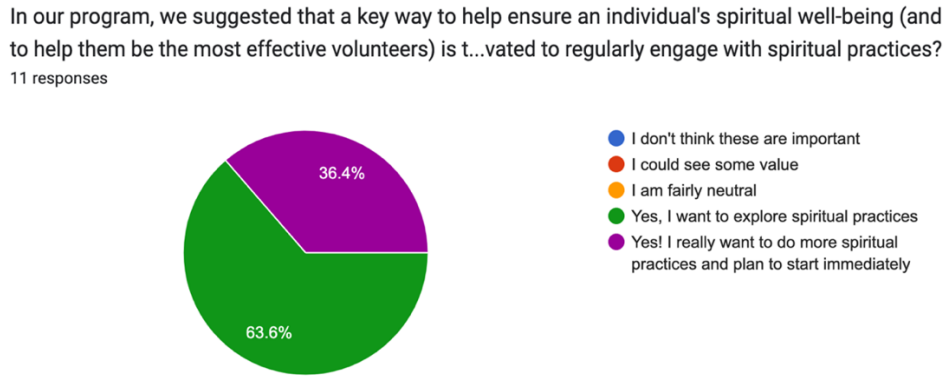
Knowing my limits on what I should and can do.

Real world examples help to ground us.

Learning to ground and parking lot prayer.

I plan to do the Test. I know it will be very helpful. Know thyself first.

Confirmation of what I know to be true in becoming more self-aware.



Please elaborate your answer if you wish. 7 responses

Morning devotions and evening examen seem very beneficial in staying on track, but it is easy to get sidetracked by life so need to work on my focus and commitment to practice.

I am adding a nature walk among trees to my practices.

Very important for me to grow.

Morning meditation.

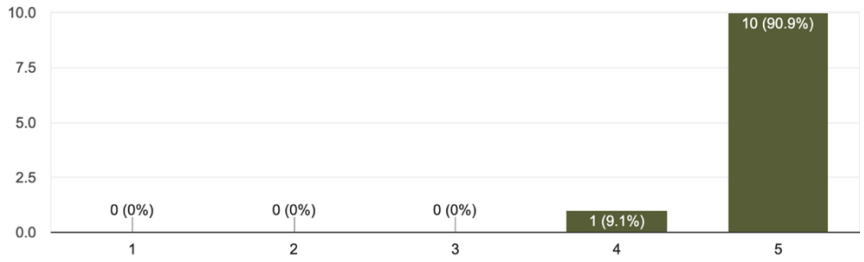
Walking an outdoor labyrinth has also been a place of centering for myself. Winter will soon be upon us, and I will seek out different avenues.

Crucial. Spiritual practices ground me. I wish to allow more time in meditation, etc.

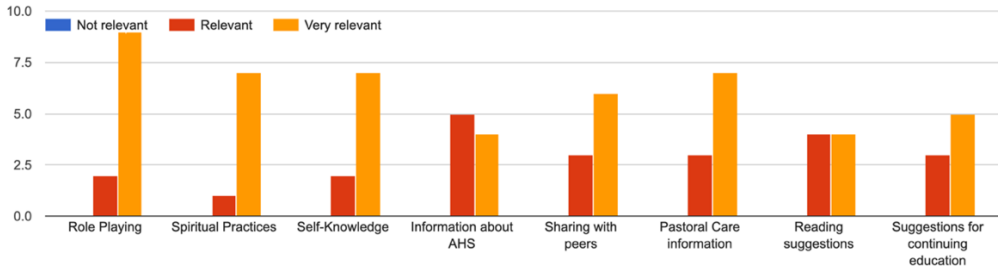
Already do some! Shall continue.

How relevant and helpful do you think the training program was to help equip you for your role as a Religious Community Visitor?

11 responses



Which sessions did you find most relevant?

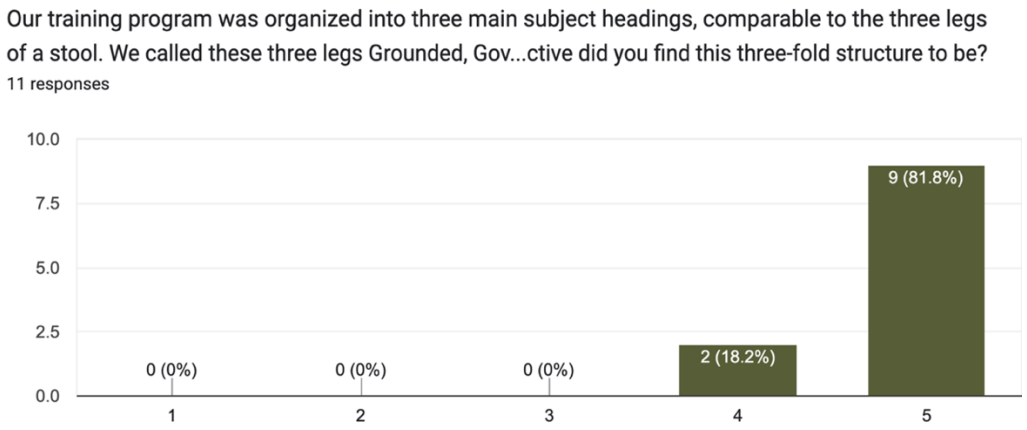


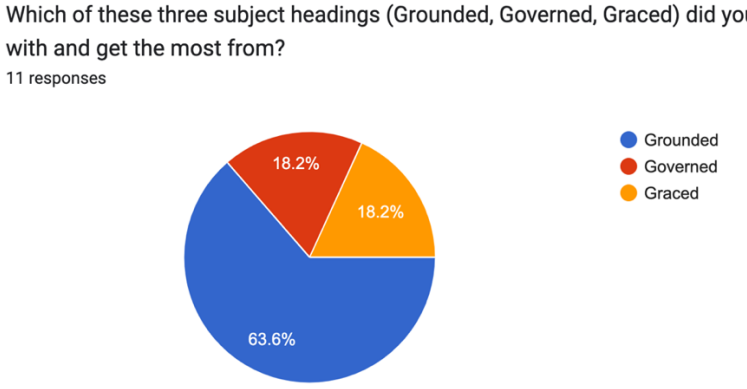
Please elaborate your answer if you wish. 3 responses

I could have said everything was really relevant. All parts worked very well.

Role playing for me was very important. Even though we were given a general idea of the situation, as humans we changed the scripts and we had to deal with the unknown in an instant. Very worthwhile.

All good information.





Please elaborate your answer if you wish. 6 responses

I already knew this was necessary for me to accomplish to be a good visitor, and this course gave me insights into how to do that. Especially the parking lot prayer. I appreciated your knowledge of how we can get uptight because of time and travel constraints before we get to the hospital, and that it is imperative to let those go so we can be there for our people.

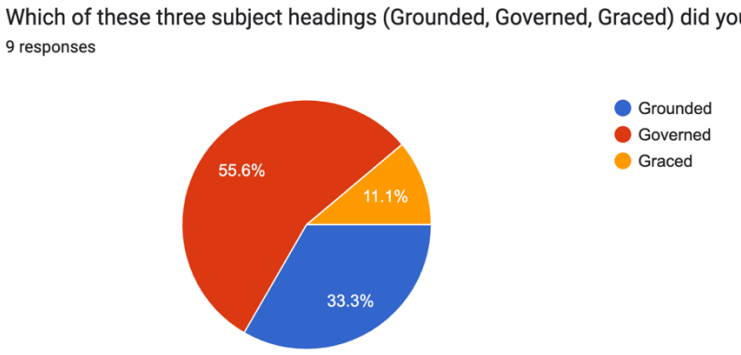
Like putting a good foundation under the house, this part gave me great insight into the need to go in prepared and in the right mindset.

The parking lot prayer will become part of my ritual pre- and post-visit.

We must begin with honesty and vulnerability.

Be aware of all sides of a situation. Think things through. Respond with God's love.

Confirmation of what I know to be true for supporting others.



Please elaborate your answer if you wish. 6 responses

I have a problem with authority... :) But I totally agree we need to work within the system. I have no trouble agreeing to AHS policy.

All were very helpful.

It was difficult to pick "least" valuable as they all were so useful. I chose this because I will not be taking part in the Calgary program so there were parts that did not relate to my situation. Still good info though, I just have to translate to my use of the program.

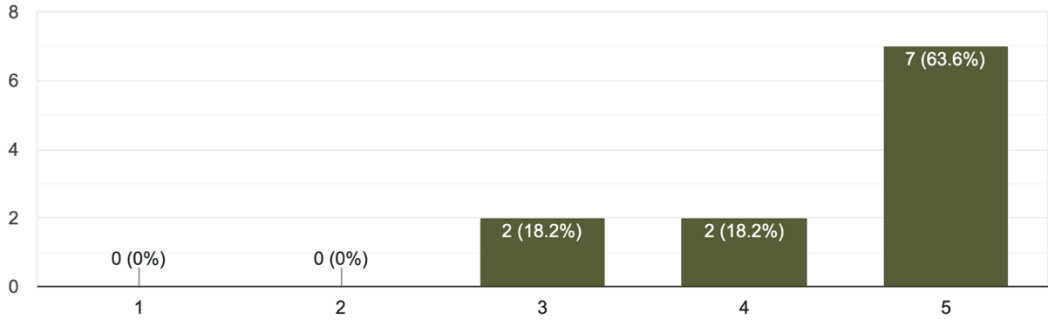
I anticipate that I will attend to the AHS expectations in the near future.

As a healthcare professional for the past 43 years, I have worked within the confines of the healthcare system, AHS, and others. I understand their governing

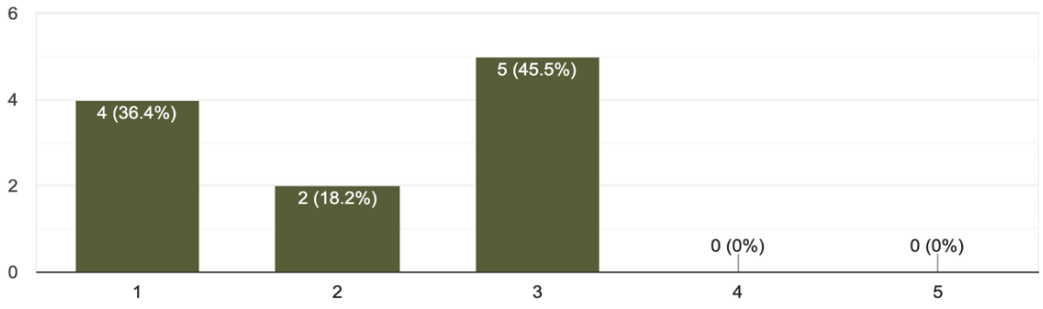
body. Also, as a Licenced Lay Worship Leader (LLWL), I understand the governing boundaries of that as well.

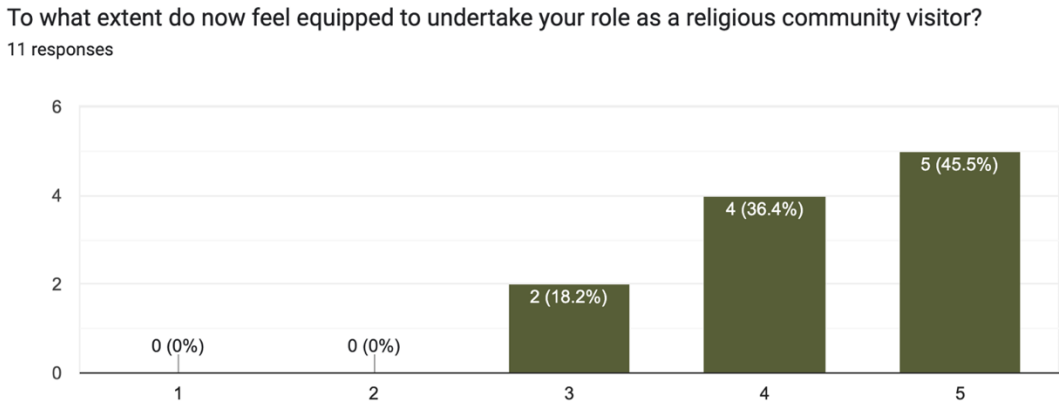
No surprise here. Just need to practice more.

How much more knowledgeable do feel about the specific ways that volunteers interact with Alberta Health Services (AHS) Spiritual Care providers to offer spiritual care to patients?
11 responses



After receiving the training, are you more or less concerned are you now about compromising your own health by entering a hospital setting?
11 responses





If you answer above indicated that you do feel adequately equipped to become a Religious Community hospital volunteer, what are some of the key learnings that have helped you feel equipped for the role? 9 responses

Practice with the role playing. Your faith in our abilities. Seeing how wonderful all the people at the course were and recognizing my intent is the same as theirs. Learning the three Gs and NOD [Name, Occupation, Duty] and about the RCV [Religious Community Visitor] program.

Learning about Governance of AHS.

So many helpful things! The script with ideas for what to say, what not to say, how to greet the person, whether or not to stay, and especially the emphasis that our greatest gift is the time we can devote to being with them, and that we do not have to give the perfect speech, response.

The most important aspects of interactions with patients are active-listening and calm non-judgmental presence.

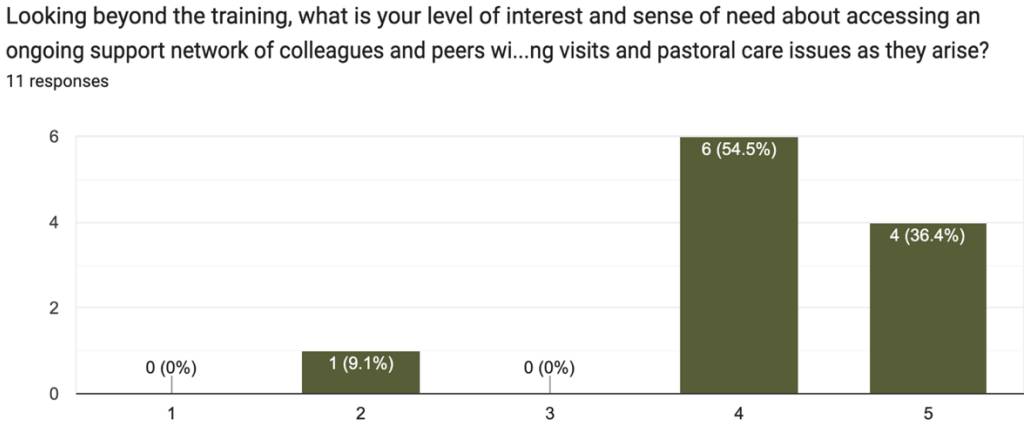
Want to serve my children and family for now.

Previous experience, concern for indigenous people.

If your answer above indicated that you do not feel adequately equipped for the role, what would have helped you feel more adequately equipped to serve as a religious community volunteer? 2 responses

More experienced.

I feel more role playing would have been very beneficial. It is great to talk in community, but I learn by doing.



Please elaborate your answer as you wish. 5 responses.

The support network is important but since I do not plan to participate in the Calgary program may not be as useful to me. I will connect with others in my area that volunteer and with the chaplain (yes, we still use that term here).

It would be good to have at least one phone number or email address to debrief a challenging visit. This would lessen the likelihood me of burdening my spouse.

Important to share my experience and thoughts.

I am retired in June from the healthcare system after 43 years. I'm not sure I am ready to get back into the “rat race” as yet. I would rather do our own congregational member visits in hospital, care homes, palliative care etc.

Debrief with an educated, trustworthy person: like yourself.

Do you have any additional thoughts you would like to share about the training you have received, or your views about serving in hospitals as a religious community volunteer? 8 responses

The course was absolutely wonderful. I especially appreciated the humour, and the intentional creation of a safe space for us. The material was on point and well delivered. Using videos from TV shows was smart—it kept interest level up and was also so good at showing exactly what you were explaining. The other videos were also fantastic. Intermingling them with your teaching was helpful to keep us from falling into the long glassy-eyed stare that can happen when a presentation, no matter how interesting, is done in only one format. I loved that you integrated music. Especially as a clever way to get us back into learning mode without having to shush us. So smart! And your selections added greatly to the whole experience. It is obvious you enjoy teaching, and that you believe in this program, which makes learning from you delightful. Your enthusiasm is contagious! Thank you for a wonderful experience in lifelong learning.

The role playing and extensive information provided by Geoffrey.

I am so glad to see that this important role is being treated as a valuable and necessary one and that volunteers can get some training to make it better for everyone involved (patient and volunteer).

I believe that the instructor organized the material in a logical progression, developed some relevant scenarios, and managed a good balance between the flow of the course and receiving input from all 15 participants.

An indigenous focused program would be helpful for indigenous clergy in the region.

This was a wonderful experience and I have gained knowledge that I would not receive elsewhere.

Some concerns if the patient doesn't share similar values and beliefs (twisted).

Great program!

Chapter 5. FUTURE STEPS

Expansion within the United Church and within Ecumenical Circles

As mentioned in my Acknowledgements, I benefitted immensely from taking comparative hospital visiting training programs from colleagues in the Lutheran and Anglican denominations. I also learned a great deal from discussions with a long-serving deacon in The Roman Catholic Church. My hope is that the program that I developed might be found useful in a wider context. Its main tenets are not denominational, but rather procedural, focusing as they do on how individuals are grounded, governed, and graced by their activities as volunteers. Yet as in any initiative of scholarship, one needs to look with humility and an open mind as to whether its tenets will be found useful. This is my hope; this hope aligns with my ecumenical spirit. Only time will tell.

Meanwhile, I continue to reflect on the best way to offer the program. So far, I have offered it twice—on Zoom as a trial basis during the pandemic, once in person (the program that served as the basis for the dissertation). I much preferred the in-person version of the program, not least of which because it encouraged and enabled real connections between people. The case-studies would be difficult (albeit not impossible) to undertake in a Zoom format.

Nevertheless, there may be ways to develop a way of offering the program online with some of the benefits of the in-person connections. I am in discussion with Stephen Fetter, Coordinator, Continuing Education at The United Church of Canada, who

coordinates the United Church of Canada's national education office, with a view to seeing whether this program might be extended into a wider regional basis, perhaps even nationally. Some combination of synchronous and asynchronous access would be possible by using a teaching platform such as Moodle, it would be possible to provide for discussion groups and to upload videos and other copyrighted materials so that they could be viewed freely and at the time a person wished to view the materials. Stephen Fetter suggested that perhaps one way of offering the program would be with five modules, offered synchronously every two weeks, with intervening week providing time for reflection and perhaps group sharing. Stephen has a lot of experience in leading large educational programs, and I find his suggestion both intriguing and promising.

Peer Support

Before any expansion of the program can take place effectively, however, it seems important to address the issue of peer support alluded to in my self-assessment of the program's effectiveness. This might also be described as volunteer nurturing and maintenance.

As part of my assessment of the pilot project, I realized that a key missing element was the provision of peer support. Wilson and Waggoner write that six critical factors are essential to establish an effective peer system: establishing a safe place; determining (and agreeing upon) accountability; encouraging and practicing theological reflection; supporting each other via prayer partners; establishing a stance that allows people to seek solutions and problem-solving rather than seeing issues as insurmountable;

and finally, mutual encouragement—peers helping each other to achieve a "better perspective on life and ministry."[273]

Indigenous Perspectives and Partnerships

Another possible extension of the program would be to develop partnerships with Indigenous clergy and lay-people interested in hospital visiting. A partnership role seems to be the most promising avenue to consider when counseling members of Indigenous communities.[274] This takes time, sincere effort to bring about—and linear results are rarely achievable. Strong and able Indigenous communities can help bring about healing for individual members and help Indigenous persons move towards healing and wholeness. When this takes place, Indigenous persons can serve once again as prophetic witnesses of the harmony between humans and the spiritual world.

Gardens and healing spaces

Lying beyond this program is the much broader concept of how to practice wellness in a setting where illness is the norm. One of the most promising avenues in this sense is the research associated with the healing power of gardens and of nature more generally. Volunteers could be made aware of some of the research associated with wellness and gardens. In practical terms, and if HCPs allow a patient off the ward, volunteers could take a patient outside. The healing power of sitting amid greenery has

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[273] Wilson and Waggoner, *A Guide to Theological Reflection*, 73–76.
[274] Julian A. Robbins and Jonathan Dewar, "Traditional Indigenous Approaches to Healing and the Modern Welfare of Traditional Knowledge, Spirituality and Lands: A Critical Reflection on Practices and Policies Taken from the Canadian Indigenous Example," *The International Indigenous Policy Journal* 2, no. 4 (2011).

been firmly established.[275] Some promising projects have been developed, such as an Indigenous Healing Garden at the Alberta Children's Hospital.[276]

Self-Care

I return to this important theme. "Are you replenishing your energy?" Wilson and Waggoner write.[277] This is a good question both for paid-accountable ministers and for regular volunteers. Seeing people at times of stress and vulnerability can be draining. Yet many people do not recognize how much just seeing people can deplete their energies. They pour out their energy as if they were drawn from a well of infinite capacity. We are human beings, not wells; if we pour out our energy as if it were water, the well will surely run dry. A key goal of this program will be to help potential volunteers become aware of two things essential to practice self-care in ministry and dedicated volunteer work: first, to ground ourselves in God's infinite supplies of water, the water of which Jesus said, "those who drink of the water that I will give them will never be thirsty." (John 4:14). Second, we need to be accountable and honest in determining whether we do anything to help our physical bodies and spirit replenish.

Perhaps the only viable long-term solution for volunteers and those engaged with other forms of ministry to maintain their equilibrium is to schedule in regular physical activity combined with prayer and reflection time. Wilson and Waggoner quote Marti

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[275] Sue Stuart-Smith, *The Well-Gardened Mind: The Restorative Power of Nature*, Illustrated edition (New York London Toronto Sydney New Delhi: Scribner, 2020).
[276] "Indigenous Healing Garden Unveiled at Alberta Children's Hospital," calgaryherald, accessed July 29, 2022, https://calgaryherald.com/news/local-news/indigenous-healing-garden-unveiled-at-alberta-childrens-hospital.
[277] *A Guide to Theological Reflection*, 108.

Olsen Laney's *The Introvert Advantage: How Quiet People Can Thrive in an Extrovert World*, observing that if we are aware that a day will bring particularly heavy energy demands, we can in effect schedule time as a means of replenishing mental energy during the day.[278] For example, a person could schedule some "continuing education" during an afternoon when an evening is sure to have heavy energy demands. Continuing education might entail a time for quiet reflection and prayer.

Another way of planning for energy demands is quite simple: to divide the day into three parts (morning, afternoon, and evening) and to try and schedule only two parts per day of active engagement. Demands on ministers, and dedicated volunteers, are numerous and sometimes unpredictable. A stated policy of practicing self-care can help a person maintain healthy boundaries and model how self-care can be practiced.

We will surely pay a price if we do not practice self-care. In an article defending both the use of the term "self-care" and the need to practice it, Leanna K. Fuller provides statistics showing that those in the caring and ministerial professions have significantly poorer health profiles than the public. Arguing against "contemporary critiques of self-care, which describe it as potentially self-indulgent and theologically problematic," she maintains that "such critiques are based on a highly individualistic understanding of "self" that is inattentive to social location and that obscures the relationship between self and community."[279]

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[278] Wilson and Waggoner, 109, n. 13.
[279] Fuller, "In Defense of Self-Care," 5.

Chapter 6. CONCLUSIONS

Participants in the pilot project responded favorably to the Three-G structure of the program. Organizing the material into the three categories of Grounded, Governed and Graced is flexible enough to be adapted into different contexts, yet consistent enough to provide a framework that will be benefit to the United Church of Canada as it continues to strengthen its programs and help enhance the ministry of care. While it seems premature to assert whether the program can be expanded to an ecumenical context, results suggest that it could be contextualized more widely in a future iteration.

The Societal and Personal Benefits of Kindness. Perhaps what matters most of all is that we move through this world and try to leave traces of kindness behind us. As mentioned in the Introduction, research has shown that just the simple act of reaching out to others can result in benefits to others that people might expect.[280] In a 2022 BBC Radio program, "The Anatomy of Kindness," broadcaster, author, and psychologist Claudia Hammond explores how and why despite many negative observations about people, altruistic kindness seems to be deeply embedded in what it means to be human. Hospital visiting is indeed one kind of kindness; it benefits others while benefitting the visitor.

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[280] Claudia Hammond, "BBC Radio 4 - The Anatomy of Kindness - Ten Things We Learned from the World's Largest Study of Kindness," BBC, accessed December 28, 2022, https://www.bbc.co.uk/programmes/articles/2zcD7zvfnkj6MKDgfhyTCBT/ten-things-we-learned-from-the-world-s-largest-study-of-kindness.

Reading the rocks. We live in Calgary, located near the Canadian part of the Rocky Mountains. One of my sons is a climber. I watch him admiringly (and with some parental concern) as he heads up nearly vertical rock faces. Using his fingers to inch his way along and up what seem like impossibly small openings in the rock, he makes his way purposefully up the rock face.

Watching my son while climbing came to mind while I was attempting to describe Alberta's hospital system and my role within it as a single volunteer responsible for a small, nascent program. The Alberta Health Services (AHS) is Canada's first and largest provincewide, fully integrated health system. AHS has more than 108,600 direct AHS employees and approximately 12,200 volunteers. Nearly 11,000 physicians are responsible for providing health services to more than 4.4 million people living in Alberta, as well as to some residents of Saskatchewan, B.C., and the Northwest Territories.[281] In other words, the AHS is one big rock. The church I work for in some senses represents yet another large and challenging rock wall. Volunteers are hard to find; ministry staff feel overworked. Hospital visiting is a laudable goal, yet hard to find time for.

Finding a navigable route between the hospital system and the church sometimes has felt like being caught between Scylla and Charybdis, those dread mythological creatures that beset Odysseus as he tried to navigate through the Strait of Messina. At the risk of mixing a metaphor, I thought of the old Breton prayer, "O God, thy sea is so great, and my boat is so small," a favorite quote of President John F. Kennedy. (Composer Sarah

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[281] These statistics are derived from https://www.albertahealthservices.ca/about/about.aspx (accessed 4 November 2022).

Rimkey set this text in a 2017 choral work.).[282] In other words, I feel miniscule and insignificant when I consider both the hospital system and the church, two different social structures that govern how I operate. Yet as my son and other trained climbers demonstrate, nearly any obstacle can be surmounted, albeit with care and due attention to the hazards.

What helps?

Resilience.

Hope.

Jesus.

Perhaps this program can help enflesh this abiding belief that transformation is possible.

[282] "O God, Thy Sea...," Sarah Rimkus, Composer, accessed January 30, 2023, http://www.sarahrimkus.com/o-god-thy-sea.

APPENDIX A: CASE STUDIES AND SCENARIOS

Role-Playing Scenarios for Hospital Volunteers

Please try to see your own actions, and those of others, through a positive lens and with an encouraging spirit. Human beings are capable of many great things, including the generous gift of empathetic listening. Hospital volunteers can provide a ministry of presence that makes a positive difference for patients.

We discourage all-or-nothing, success-or-failure views about visiting. We aren't perfect, nor should we try to be. Certain techniques and practices consistently bear good fruits; other techniques and practices result in less fruitful outcomes. Human interactions defy formulae. Even after many years, we may still find ourselves making rookie mistakes. Perhaps the best way to approach our role is with what Buddhists call "Beginner Mind"—looking on every visit is if it were the first one ever. Meeting another person for the first time takes us into the mysterious ground of another self that can be partially known, but never fully.

A key technique in our orientation manual will be to consider imagined scenarios of visiting, both in the large group and in smaller groups. Our goal will be to highlight what went well, and what might have gone better. Our goal here is to consider what visitors should strive to do, as well as what they probably should *not* do when they visit someone. Eventually, it is good practice to review visits with a trusted confidant, a group of peers, or both, as a means of becoming more aware of our gifts, our places of natural comfort, our shortcomings, our trigger-points.

The World's Worst Hospital Visitor?

(Two volunteers with a sense for ad lib are invited to develop a short skit based on the following prompts.)

Visitor: "Hi! I saw your door was closed, and there were no staff around, so I didn't have to sign in or anything. Maybe you were sleeping but here I am! Your visitor!"

Patient: (*Was* asleep.) Blinks. Frowns. Crosses arms. Furrows brow. Tries to speak. Words fail.

Visitor: "Gee…you sure aren't looking too good! Guess you're in here for a reason! Maybe I can cheer you up!" (*Sits on the bed without being asked.)*

Patient: "OUCH! That HURTS! Don't sit there! Who are you anyway?"

Visitor: (*Moves from the bed, stands over the patient, looking down.*) "I'm from that big church downtown. I go around to all the hospitals. I ran out of people from my church so I came to see who else I could find. Tag, you're it!" (*Play-punches the patient on the arm. Smiles and laughs at their own joke.)*

Patient: Winces. Pulls arm away from the unexpected touch. Doesn't say anything.

Visitor: (*Finds a chair, pulls it close to the bed. Leans in with a serious expression.*) "Uh, yeah, you are thinking that I should maybe do something religious, right? Well, I have a prayerbook here. I use the same prayer for everyone. How God answers every prayer, heals every illness, and never gives us more than we can handle. When we die, God has another angel in Heaven."

Patient: “Hmmmmm. That doesn’t sound like a prayer I would like to hear. But could you give me the Eucharist?”

Visitor: “I’m not authorized to do that but sure, why not?”

Patient: “Before you do that, can you help me up so I can sit in that other chair?”

Visitor: “I’m not authorized to do that either, but sure, why not? What could possibly go wrong?”

And so on…have fun developing the rest of this visit along these lines!

Group debrief: What went well here? What did not? What did you notice about the visitor’s interactions with the patient? What words would you choose to characterize the visitor?

We Can Do Better! (Scenarios and Role-Playing)

OK, now let's try and imagine doing a visit more effectively than that.

Instructions: Please engage in role-playing one of the several suggested scenarios. Pick the one you feel drawn to. In your group, decide among yourselves who will play the role of the patient, who will be the visitor, and who will be the observer. We will do three role-plays, so please switch up your roles so that you have been the patient, the visitor, and the observer at least once.

Please be sure to introduce yourself according to the NOD acronym: your Name, your Occupation, and your Duty. For example, "Hello, Vera (or: Mrs. Smith). My name is Rhonda Glade. I am one of the Religious Community Volunteers. Our role is to check in with people about how they are feeling. May I sit down with you for a bit?" (In our scenarios, our patients say yes. Real patients might say no. Be ready for that. Be aware of body-language and other signs that indicate whether a person is receptive to a visit. Be ready to make your first sentence formal, basing your choice in part on the person's age, degree of formality, and so on. A breezy "Hi!" works for many people but can be irksome for those who don't respond favorably to casual introductions.)

Use the suggested prompts to help you get started. Take about ten minutes for your visit. Before you conclude your visit, please offer to pray for the person. Ask them what they would like to pray for/about, then give it a go. Keep the prayer short and try to develop the wording in the prayer based on what you have heard in the visit.

After the visit and prayer, take a moment to regroup. Then have the "patient" share how they felt about the visit. What did they notice about their "visitor?" The visitor will then share what their main thoughts about the visit. Then have the observer offer

his/her observations about what they noticed. When you offer observations about the visit, please use direct personal I-voice, e.g., I noticed, or I thought. If you are offering an observation for another person to consider, please couch it in tactful language, such as, I wonder whether…when you said this, I noticed that…

Here are some specific pointers that you might find useful in debriefing your visit.

Patient: Did you notice any emotions in yourself during the visit? Did you feel listened to? What did you notice about your visitor, e.g., body-language, facial expressions, verbal patterns, and so on? How did it feel to be prayed for?

Visitor: What did *you* notice about yourself during the visit? What emotions, if any, did you experience during the visit? Overall, did you feel awkward or at ease? Did you ever feel a sense of rapport developing with the patient? When did this occur, and how and why? What was the best part of the visit for you? What was the most challenging? How was it to pray for that person? Did you feel out of your depth at any point?

Observer: What were some of the things you noticed about the interchanges between visitor and patient? Did the visitor pick up on cues that were offered about how the patient was feeling? Any other observations?

Afterwards, please avoid discussing the scenario as a group. Instead, silently debrief what you thought were positive aspects of the visit to continue to build upon as practices you might wish to engage with more consciously (let's call those "Practices to Encourage") and the aspects of the visit that seemed less positive to you, or less resulting in a good sense of connection and rapport with the patient. (Let's call those "Practices to

Avoid.") You might want to note these, and/or share them in the group debriefing that will follow.

Please note: these case-studies are fictional composites of many actual visits, chosen to highlight scenarios that visitors might encounter. Any reference to specific individuals is coincidental.

Case Study 1. Kalisha, 39, met Jon in high school. They have been married since their early 20s. They have two daughters, aged 12 and 9. Kalisha has recently returned to teaching after some years staying at home with the girls. She loves her work. She is a regular volunteer in her church and in her community. After experiencing persistent back-pain, Kalisha has just received test results. When you introduce yourself using the NOD acronym, she invites you to sit down. (You do not sit on her bed but on a chair. You ask nursing staff to help you find one if necessary.) She looks withdrawn and downcast. During the visit, Kalisha reveals that she has liver cancer. You have read that liver cancer is not often found until it is at an advanced stage, when it can no longer be removed by surgery. You also know that on average, fewer than 20% people diagnosed with liver cancer survive beyond five years. Kallista says that she is frightened that she will die and leave the girls without a mother. She asks you specifically to tell her how long she might live. She asks you how a loving God could let this happen to her. *What do you respond? What directions to do you try to steer the conversation towards? Is your conversation hopeful? What thoughts and hopes does your prayer with her contain?*

Case Study One: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

Case Study 2. Maureen, 83, has been in hospital for nearly a month while recovering from surgery. She is a lively, funny person with a raucous laugh and a zest for life. When you drop by to check in with the duty-nurse, he tells you that Maureen's daughter came in yesterday and that Maureen seemed quite happy to see her. But when you greet Maureen during your afternoon visits one day, she seems morose, and complains that no one ever comes to see her. You also notice that she is repeating a story that she told you last week—and when you get ready to leave her, she wishes you a good morning. What do you infer from your visit? Should you correct Maureen about the visit and the time of day? What thoughts and hopes does your prayer with her contain?

Case Study Two: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

Case Study 3. Kamsi is 21 and is one of the best cyclists in the Pacific Northwest. While training for an important regional race, he fell and broke his arm badly. He won't recover in time to train for this race—and if he can't race and get a good result, he won't get on the national team. When you see him, he is lying on his back, and is wearing his cycling shoes. You don't say anything about the shoes and ask if you can sit down. He nods curtly, and you start to chat. He says that if he can't get on the national team, he doesn't know what he will do. There won't be anything worth living for. *What do you respond? What directions to do you try to steer the conversation towards? Is your conversation hopeful? What thoughts and hopes does your prayer with Kamsi express?*

Case Study Three: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

Case Study 4. Willem is a lean, fit man of 69 who has spent most of his life out of doors, first as a rancher in South Africa, then as an arborist working for the city to which he emigrated 25 years ago. He is proud of the many years he has spent working. "God worked hard for six days," he likes to say, "and rested on the seventh. That's what I do too." Recently, however, while operating a chainsaw while perched high in a tree, he noticed a tremor in his arm. At home, he noticed a slight tremor while looking in the mirror. "Parkinson's," he said to himself with a scowl. His self-diagnosis proved to be correct. He has been admitted to hospital to assess his treatment options. You nearly recoil when you enter his room: he sits ramrod straight in a chair, staring straight ahead, his arms crossed so hard that they appear to be glued to his chest. Yet you introduce yourself to him and he invites you to sit down. You do so, noticing a slight tremor discernible in his face behind the frozen body language and angry look. Without being prompted, he tells you that without work, his life will have no meaning. He has decided that the only way forward for him is to end his life by choice. (Medical Assistance in Death, or MAID, has recently been approved in the region in which you volunteer.) This subject makes you deeply uncomfortable because you have a family member who died by suicide. You also harbor grave misgivings about such a choice on theological grounds. Willem ignores your hesitation and peppers you with questions about how and when he can obtain the procedure. Moreover, he wants to ask you about what you think God might think of his proposed decision. Would God judge him? Would God respect a decision based on free will? *What do you respond? What directions to do you try to steer the*

conversation towards? What thoughts and hopes does your prayer with Willem express? What do you think would be a good outcome here?

Case Study Four: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

Case Study 5. Svetlana, 33. Life has been challenging for Svetlana, who came to this country as a refugee. Your church was the first place of worship that she saw when she arrived in your city as a refugee. She started attending and has become a faithful member. Yet she yearns for the powerful faith tradition of her childhood. She remains haunted by some of the things she witnessed in her homeland and by some of the things she did. She has come into the hospital because she fell and injured herself after an evening when she had too much to drink. She is deeply embarrassed. She seeks absolution, a new start. She asks you whether God will forgive her for what she has done in her life. She asks whether you can offer her the Sacrament of Reconciliation. *How do you respond? What might you offer her in a prayer? What do you think would be a good outcome here?*

Case Study Five: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

Group Debriefing. Which elements, if any, do all the scenarios have in common? How do they differ? What is a legitimate expectation you might have as a visitor? When might you wish to set limits and boundaries on your role and your response to the persons you have visited? What other observations do you have either in your role as visitor, patient, or observer?

Group Debriefing: Notes

General Observations

Positive Techniques Observed

Less Positive Techniques Observed

APPENDIX B: SAMPLE PARKING LOT PRAYER

We hope that you will pray as you get to the site you are visiting and continue to pray as you approach a room, and after you have left the person you have visited. Prayer like this might be likened to having a generator faintly humming in the background, or, if you find this concept more appealing, like having glints of sunlight constantly accompanying you. So, when we invite you to say a "parking lot prayer," we are encouraging you to do what we are instructed to do in 1 Thessalonians 5:16-18 (): "Rejoice always, pray without ceasing, give thanks in all circumstances, for this is the will of God in Christ Jesus for you."

During the facilitation program, we will leave space and time for you to complete at least one parking lot prayer. You can share this with others or keep it to yourself. You might find it helpful to use the following prompts as a starting point. Or, if you prefer, feel free to develop your own prayer as time and circumstances dictate. We would only ask that you use the triadic formula of grounded, governed, and graced somewhere in the prayer. We believe this will help you before you visit, and afterwards, as you reflect on how the visiting went.

A Sample Parking Lot Prayer Before a Visit. Your prayer might start something like this, using the language for God that seems most comforting for you… Loving and gracious God [or, Holy One, or Heavenly Father—pray as you can, not as you can't], please help me be aware of your presence in my life, and in the life of the patients and staff I encounter today. Grant me patience and help me convey hope and optimism to all those I encounter.

Open my eyes and ears to the ways in which I am grounded in your presence.

Open my mind and my awareness to ways in which my activities are governed, both by the church as well as the hospital. Help me to see these as ways that I can keep myself and others safe and well.

Open my heart to opportunities for grace in my encounters with others—God moments when you come into the world. Thank you for the opportunity to serve you and others. May I do it as well as I can, with your help. Amen.

Use the space provided below if it is helpful and convenient for you to write your own prayer.

My Prayer before a visit. (Participants were invited to write a prayer. Examples are provided earlier in the dissertation.)

A Sample Parking Lot Prayer After a Visit. Your prayer after visiting might start something like this:

Holy one [again, use your own language to refer to God] please help me see the ways in which you were present in the people and places I visited today. Open my eyes and my heart to your healing touch and your grace. May I be grateful for all that went well, and humbly attentive to all that might have gone better.

Open my eyes and ears to the ways in which I was grounded in your presence, and the ways in which you may have surprised me with your holy touch, given directly and given indirectly through others.

Open my mind and my awareness to the ways in which my activities were governed and help me see wisdom in the rules designed to help keep me and others safe and well.

Open my heart to the graces that you brought to my encounters with others—God moments when you came into the world. Thank you, loving and gracious God, for the opportunity to serve you and to bring hope to others.

Use the space provided below if it is helpful and convenient for you to write your own prayer.

My Prayer after a visit. (Participants were invited to write a prayer. Examples are provided earlier in the dissertation.)

APPENDIX C: INVITATIONS TO AWARENESS

Potential volunteers will find it useful if they undertake some conscious examination of how they respond to interactions with others. This appendix consists of some examples to provide food for discussion. As an exercise in self-awareness, participants are encouraged to reflect on these sample examples, and to prepare at least one of their own.

Each of these sample discussions ends with the rubric "Invitations to Awareness." These address how one become aware of one's power, privilege, and relative degrees of agency and autonomy. Such thinking is influenced by Leach and Paterson's book, *Pastoral Supervision*, discussed elsewhere in the dissertation.

The $1,000,000 Heart Attack. Graham grew up golfing with his dad. He treasures those memories. He has taken pleasure in teaching his daughter Jenni to golf. They day before they will go to the Coast for a father-daughter trip, Graham wants to get in one more round with a familiar foursome. They get out early on a beautiful mid-summer morning. Graham birdies two of the first three holes. A great round is coming!

Then he experiences a distinct tingling in both arms. Before he tees off on the fourth hole it feels as though someone is stepping on his chest. "Ah, no, not now!" he tells me later that he thought at the time. "I can't be having a heart attack now, not when I have a round like this going!" But yes: those signs were unmistakable. He remembers fading and falling. Two doctors on the next green see what happened and provided first-aid that probably saved his life. He knows nothing of this. He wakes in a hospital bed,

with white-coated doctors gathered in a huddle. Their verdict: he needs to undergo triple-bypass surgery. In two days.

I visit Graham the day before the surgery. He is cheerful and upbeat. “That’s a million-dollar heart-attack I just had!” he tells me happily.

I can’t help raising my eyebrows.

“Really!” he says. “What if something had happened out on the Coast? Or on the road? Could have been a lot worse.”

I see his point.

“Yes! I am thanking God that this happened. I am not asking God why this happened, but how God wants me to use what has happened to me so that I can go on with my life with God even closer to me than before.”

I am impressed and touched by his confidence and gratefulness. Before I leave, we have a prayer, giving thanks for what has happened, and asking that the surgery go well. Two weeks later, Graham is back at church, surrounded by admiring, caring friends. A million-dollar heart attack indeed.

Invitation to Awareness: We cannot know what a person thinks about an illness or medical condition until we hear it from them. In Graham’s case, he expressed such a positive, upbeat attitude that it was initially surprising. One person will be crushed and deflated by news that another shrugs off—or in Graham’s case, welcomed it. One of our main roles as visitors is to explore where and how a person sees hope in each situation. And if they do not see any hope lying ahead, we need to be ready to refer them for more specialized interventions. We are spiritual first aiders. People expressing hopelessness can lie beyond our competence to respond to. Nevertheless, people still often experience

hope, like glimmers of light in the darkness. Careful listening, and straightforward questions can help a person identify their resources of hope and optimism. Hope can also change its aspect, as people experience different phases of illness, recovery, or need to accept that recovery will not take place. Healing can still take place. In Graham's case, his optimism and hopefulness helped renew my own. Welcome such occurrences as they grace that they are.

Paddler. Sun rises above water: lambent light flashes orange and pink. Backlit by the flickering light, a single paddleboarder knifes across the water, each stroke propelling her powerfully forward. Calm, poised, relaxed and powerful, she exudes calmness and grace. The next moment, the water ripples; fleeting morning light changes. She disappears into mist.

Some moments we instinctively treasure: the first sight of a newborn child; a key gesture of affection in a loving relationship; an unforgettable view or experience. Then there are beautiful, ephemeral moments when bodies are in sync with the world and when we feel most happy and at peace. A poised, practiced paddler in her perfect place. Just seeing her, appreciating her strength, her poise, her grace.

We are all differently abled: few of us possess that paddler's power and grace. Some of us might experience circumscribed movements and physical challenges that make such acts, simple for our paddler, unimaginable for ourselves. We may have experienced pain, violence, neglect, or abuse. If that has been our experience in life, the paddler's purposeful movements might be something we will never experience directly.

We still search for and seek beauty and peace. We each have our own personal perfect place. Part of human experience and human aspiration takes us towards those places of perfect peace and grace, both real and imagined.

Invitation to Awareness: Where are such happy memories or imagined places of peace when we are in hospital? Is the visitor aware that a hospital patient might be thinking of their own perfect place or happiest time? The visitor does well when leaving space and time for imagination to spark and memory to awaken. The human spirit is capable of powerful feats of imagination, memory, and joy, regardless of our personal circumstances. As visitors, we want to be aware that each person we visit has a happy place—a time or experience that they take sustenance from and are nurtured by. Open-ended questions, such as "What were some happier moments for you?" or "Looks like a beautiful day out there. Do you like summers or winters better? What are some of your favorite activities?" can help awaken real pleasure and a sense of peace in the patient. Visitors can gently encourage such imaginings. But the timing must be right: opportunities are as fleeting as the flickering light that flashes orange and pink on the rippled water. As visitors, we cannot force any confidences or dreaming. We must be humbly grateful when they occur.

Heat. A few miles west of Calgary's downtown skyscrapers, between railway tracks and the Bow River's uneven, flood-shaped banks, a walking and bike path meanders amid fields, bordered by thick stands of Douglas firs, poplars, and spruce. My daily walking route. Deer, moose, and coyote find a home here. Northern Flickers rattle the trees even during winter. On this frigid January day, it is minus 30° Celsius.

I gradually come beside and greet a broad-shouldered young man. A pink-orange sunrise backlights and haloes his hair and beard, which are covered by thick ice formed by water vapor from his breath. Dressed in several layers, striding purposefully, he is the only other person I have seen today. He wears a backpack and awkwardly carries a grocery bag over one shoulder, filled to overflowing. In a repeated cycle, the grocery bag drifts forward, getting in his way. He slings it back, where it stays for a while, before drifting forward again. He shrugs it away from him in a Sisyphean cycle he has become inured to. He cradles to his chest a full-size propane tank, hoisting it the way a shepherd brings in a lamb from the field, with hands locked together beneath it. He walks rapidly but a bit unevenly due to having to balance his load, like a sailor on land who still has his sea-legs. He seems to be in his late 20s, strong, fit, and friendly. We fall into step.

"What's it been like lately, sleeping out?" I ask him. We are in one of our winter cold snaps: for the past two weeks, it has been at least minus-20° C every night.

"It's not too bad," he says. "We keep our tents warm with propane barbeques. When it's super-cold, hand-sanitizer sure burns hot!"

"Can I help you carry the tank?"

"No, I'm good." My well-meaning efforts would just slow him down.

I ask about why he sleeps rough. He dislikes the shelters and doesn't feel safe there. Being in a tent, burning hand sanitizer, or having a propane barbeque feels safer. He is waiting for spring (a few months away in our part of the world) when he can return to work building decks and fences. Meanwhile, life is just fine.

I wish him well and gradually leave him behind. I hear several times the slide-shift of the bag being resettled, then nothing. Over the next few weeks, I look for him but

don't see him again. I sometimes smell wood-fires and I can see tents in the woods. Perhaps he is still there, waiting for spring.

***Invitation to Awareness**:* Jesus walks with us on the road to Emmaus, offering hope and warmed hearts. Hope is crucial for everyone. Despite living outside in temperatures that could lead to his death if he does not take care, this man was optimistic, hopeful, unself-pitying. He had agency over how he lives and feels good about it. I left him feeling admiring both of his physical strength but also his mental toughness and positive attitude. As one of my co-workers from the Maritimes says, quoting a favorite uncle, "You'll be alright."

Pity for hospital visitors is also misguided and unhelpful. People want to be heard. They want to be respected and not judged. They want to feel that their lives matter. They want to be seen as more than a person with an illness. The role of the hospital visitor is to meet and greet the human essence in another person, without pity and without judgment.

Privilege. "Hey, nice shirt! I like the pattern!" A guy at the next table in the little café says that to me as I stand up and get ready to leave after my breakfast out—my first restaurant meal in quite a while.

"Thanks!" I say, happy that someone noticed the shirt—a bright one, paisley red and blue on a white ground. I chose it to celebrate that yesterday my dissertation proposal was approved. "Mark the milestones," my dad used to say. I try to do that. When I walked my wife to work, she suggested that I continue to this café, located in a renovated old industrial building beside the Bow River here in Calgary. Seemed like a nice way to celebrate a step along the road. "Take a picture!" she says. I do and text her: "Me and My Breakfast."

From overheard comments while I ate breakfast and enjoyed my coffee, my neighbors in the restaurant are both medical professionals. I took pleasure from the fluid flow of their conversation, animated by their flashing intelligent eyes. Buoyed by the man's unexpected compliment, I smile at the couple and head out. I have dropped nearly twenty bucks for breakfast, coffee, and a tip. No big deal. Need to celebrate occasionally, right?

Walking home, I pass a makeshift yet quite substantial camp, consisting of dozens of tents and tarps interspersed among the riverside poplar trees. A man stumbles along the sidewalk, draped in a blanket. He looks down. A couple of minutes later, another man, also wrapped in a blanket, emerges from the camp, and walks towards me. Catching my eye, he gives me a nod as sharply coiled as a tight spring—as if to be able to retract his greeting if I did not respond to him. I nod back. He passes me without saying anything. Where is he going? What will he do for the rest of the day? Is someone going to say to him, "Hey, nice blanket!" the way the guy in the café told me that I had a nice shirt?

Invitation to Awareness*:* Seeing those two people draped in blankets made me aware of my own privilege—privilege to go to a café, drop twenty bucks on breakfast, have someone compliment me on a nice shirt. This privilege is both inherited because of who I am, because of what resources I have, and because my legs obey me when I ask them to take me walking.

Many hospital patients are catapulted from places of privilege (both the privilege of good health as well as the privilege of the sorts of choices just related) into a realm where privilege no longer can be wielded like a credit card. In Alberta, all hospitals are

public. Everyone has equal access and treatment. Those with considerable privilege in their normal lives can experience this as a privation. We/they are all equal—but the visitor still has two huge privileges that the patient does not: the privilege of being able to go home; and the privilege of living in the Land of the Well. Every encounter with a hospital patient invites us to become aware of our own privilege. We can try to wield it with grace.

Power. Locker room conversations: foreign travel over the holidays. Warm weather, beckoning beaches fringed by gentle lapping surf, great food. Frustrating Covid-19 restrictions returning home. Complaints of bureaucracy and lost time, the high cost of tests, of inefficiencies, unnecessary required steps they must submit to. Missed flights and connections. Juggled schedules. Kids late for the start of school.

One person didn't go through any of that.

Bought a negative test from a crooked doctor.

Tries to make the story sound OK— like putting lipstick on a pig—cash offered, tests avoided, homecoming simplified.

"Of course, I did a rapid test when I got home. None of us had any symptoms anyway!"

Problem? What problem?

"It's all unnecessary anyway."

Muttered, shared assent: "Yes, all unnecessary. All measures should have ended long ago."

Conversations drift to a close; these fit and favored people head back into their world—a world where much is possible if you can pay for it and know where to ask, and whom.

Invitation to Awareness*:* The Bible abhors crooked ways. As we read in Proverbs 11:3, "The integrity of the upright guides them, but the crookedness of the treacherous destroys them." Yet as we know, also from Proverbs, the wicked continue to flourish.

How might this apply in a hospital setting? For better or worse, in Canada, there are very few opportunities to pay your way into better treatment, at least in acute-care settings. A riveting counterexample is provided in Québécois director Denys Arcand's brilliant film, Barbarian Invasions, which won the Oscar in 2004 for Best Foreign Language Film. Sébastien flashes and shares wads of cash to ensure that his cancer-stricken father, Rémy, gets better treatment on an otherwise closed-off floor. Great filmmaking. Fortunately, also not generally true.

People who normally wield both power and privilege can be frustrated (and frustrating) when they are in hospital. People who are normally decisive and powerful can sometimes use volunteers as factotums to request services that might not otherwise be available. These might even include running errands or contacting people outside the hospital. Persons who normally wield power in their regular lives can be particularly persuasive; being aware of appropriate limits to what we are being asked is part of being forewarned to be forearmed. Volunteers need to be aware when this is starting to happen, so that they can legitimately refer and defer such requests. Visitors with a need to please, and those who find it difficult to say no, will find such patients particularly hard to be with. On the other hand, such encounters also can provide opportunities to listen

empathetically and genuinely—if one can say gently that it is not within one's scope of practice to be able to do things for them. When a person resigns themselves to their situation, they can reveal their vulnerability. Volunteers prove their worth in that precise moment of honest exchange between humans graced by the Spirit's loving guidance.

Tears. "Weep! Poor woman, weep!" Thus sings Giorgio Germont to Violetta Valéry, the doomed heroine of Verdi's opera La Traviata (Germont and Violetta's duet, Act II, Scene 2). This duet is an emotional high point of the opera: Giorgio Germont, father of Violetta's hapless lover, Alfredo Germont, confronts Violetta and forces her to abandon any claim on his son's affections, so that Germont's affianced daughter will not have her reputation sullied by any association with Violetta. When Germont gradually realizes that Violetta is capable of self-abnegation and generosity, he becomes more tender and considerate towards her. Still insisting that Violetta abandon hope of remaining with Alfredo, Germont enjoins Violetta to weep. The lyrics are beautiful—achingly plangent, one might say. Here they are in an English translation:

VIOLETTA (to Germont, weeping)	GERMONT
Say to your daughter, pure as she is and fair, That there's a victim of misfortune Whose one ray of happiness before she dies is a sacrifice made for her.	Weep, unhappy girl, weep! I see the sacrifice I ask Is the greatest one of all, In my own heart I feel your sorrow; Have courage, and your generous Heart will conquer!

A refined version of this duet, easily available online, is sung by Ermonela Jaho (Violetta Valéry) and Dmitri Hvorostovsky (Giorgio Germont).

How can operatic tears bridge an awakening of the power and purpose of tears with a hospital volunteer's role? Tears are the sacred language of sorrow. While it is true that most encounters for hospital visitors will not be accompanied by tears, some may be. How do visitors feel when they are confronted by other people's sorrow and suffering? More to the point, how can a training course provide them with the grounding that will enable them to sit with tears? Part of their response, of course, is innate; some people will be better at it than others, due to individual differences in temperament and life experience.

Volunteers might feel strengthened and supported in their role when they learn that there is a strong and important theological defense of the power and necessity of tears, through the process of lament. Although tears are wept by individuals, and the reasons for them to issue forth are intimate and personal, the self can still be viewed as "self-in-relation." Doing so helps the person see that they cry with others. Volunteers are invited to see their role as being present and attentive when tears are shed, rather than seeking to do or say anything. The ministry of presence can be a sacred gesture that makes lighter the human burden of grief and lament. No other language or gesture is necessary.

What follows that poignant duet between Germont and Violetta? Before our heroine, Violetta, eventually dies, deep healing takes place. Giorgio, Violetta, Alfredo, Annina (Violetta's maid) and Violetta's physician, Dr. Grenvil, share a deep moment of reconciliation and healing. So too in real life, in the hospital hallways and rooms, can moments of deep pain be followed with unexpected and welcome moments of grace and

healing. Such is the work of volunteering in hospitals: tears of joy can follow tears of sorrow.

Invitation to Awareness*:* Tears are perhaps our most uniquely human capability. When we shed tears, the healing flow of the Spirit can enter a person's senses. Because each encounter with a crying person will be unique, a single response to tears is hard to find. In the presence of tears, volunteers need simply to sit, to attend, and not attempt to fix. Even one of the most natural gestures of the care-giver—namely, passing the crying person a tissue—might only be done judiciously, if at all. Passing a tissue to a crying person suggests tacitly that the time of tears needs to end.

It is hard just to sit, and not to do anything. Yet sitting in silence, attentively, empathetically, is often a helpful response—particularly if visitors remind themselves that their sitting helps the suffering person see themselves as "self-in-relation," and therefore has a grounding in theological practice.

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