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THE CHURCH WORKER AND SICK VISITATION

A Thesis

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Master of Religious Education

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by

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CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

When compared with his predecessors of yesterday, the Christian minister in our day is required to be responsible for numerous tasks. Since in the larger churches these are usually beyond the strength of the pastor, a provision is sometimes made for securing the assistance of a "church worker," a woman who serves the parish either on a volunteer or salaried basis. Such a worker engages in a variety of tasks, varying with the needs of the Church and the inclinations of the pastor. These may be, for instance, the administration and supervision of a program of leadership education, the direction of membership visitation, the regulating of literature for the Sunday school, and the planning of special services. A significant part of her task is that of sick visitation.

It is with the problem of sick visitation that the present study is concerned. The church worker presumes to be neither a social worker nor necessarily a trained nurse. She does, however, undertake to bring spiritual comfort and cheer to the sick and, in a practical way, minister to their needs generally. Such visitation must necessarily be a shared responsibility, for there will be occasions when only the pastor is able to render the needed service, as when a

member of the flock is critically ill or dying. Yet there are numerous occasions when the church worker can render real service to the sick.

But to do effective visitation, such a one must be alert to certain needs of the sick room; and she must know how to meet those needs.

I. THE PROBLEM

Statement of the problem. It is the purpose of this study (1) to ascertain the responsibility which the Church has assumed in the past in caring for the sick; (2) to appraise the Church's present responsibility in this direction; (3) to discover what is being done by denominations, seminaries, and local churches to train church workers for sick visitation; and (4) to recommend certain types of training most appropriate for the various church situations.

Importance of the study. In many Protestant denominations little or nothing has been done to train church workers. Perhaps the reason for this is that this position has usually been on a volunteer basis. For such work, the formal training in a seminary or other institution should prove adequate, but pastors who have a vision of both the needs and the possibilities of the church workers, can themselves help train and equip young women for the important task of

sick visitation. Some pastors who do no more than recommend a reading list feel that even this is beneficial.

It seems all too true that many people are neglected by the Church in their sickness. If the hospitalization has been only for a short period, perhaps the patients do not mind the neglect. Yet even in such cases, the Church needs to be alert. Whatever their reactions, it remains a fact that all too often the Church misses excellent chances to show men and women that she cares. She loses golden opportunities to buy up those times when men and women often grow reflective, when they are specially sensitive to attention and neglect.

Because few Protestant denominations or churches in general seem to have a well-defined policy for the work of sick visitation on the part of church workers, this study is of necessity limited in its scope. Seminaries provide courses in which the minister is given advice on the psychological handling of old people and the sick generally, but comparatively few denominations furnish formal training of this kind specifically for the church worker. It would seem that little attention is being given to equipping the handmaiden of the Lord in the task of sick visitation.

II. DEFINITIONS OF TERMS USED

Acute illness. This term refers to any illness which lasts no longer than six to eight weeks.[1] The onset is sudden and the symptoms are severe.[2]

Chronic illness. This term refers to any illness which lasts more than eight weeks, unless the patient is in imminent danger of death.[3] It is likely to develop in the middle age group and may start as an acute illness, but the onset is usually gradual and hidden to the patient.[4]

The diaconate. That order of the Church that is made up of deacons and deaconesses. They have assigned duties, including assistance with communion and watch-care of the sick and needy.

III. METHODS USED

Besides the bibliographical research used, a questionnaire was sent out to thirty-one denominational headquarters

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[1] Russell L. Dicks, When You Call on the Sick (New York: Harper and Brothers, 1936), p. 3.

[2] Clarence W. Taber, Taber's Cyclopedic Medical Dictionary (third edition; Philadelphia: F. A. Davis Company, 1945), p. 24.

[3] Dicks, loc. cit.

[4] Bertha Harmer and Virginia Henderson, Textbook of the Principles and Practice of Nursing (fourth edition, revised; New York: The Macmillan Company, 1939), p. 722.

in the United States to discover what, if anything, is being done to assist church workers in the duties of sick visitation. A number of seminary catalogs were examined to discover the courses of training offered to those planning to make a career of Religious Education. A list of the social agencies in a large metropolis was obtained, as an example of the possible facilities available to the church worker in a sick visitation program.

IV. ORGANIZATION OF REMAINDER OF THE THESIS

The second chapter presents a brief history of the Church's care of the sick. Chapter three discusses present-day practices, as discovered in a study of the questionnaires and catalogs, in the training of the church worker for sick visitation. The fourth chapter suggests the recommendations for the training of the church worker in this phase of her ministry. The fifth, and final chapter, is the conclusion of the study.

CHAPTER II

THE CARE OF THE SICK IN THE HISTORY OF THE CHURCH

It is always the concern of the Christian religion to relate all phases of man's life to the Kingdom of God; not the least, man's physical being. In these days the Church is seeking more than ever to conform to the pattern of the Good Samaritan. True, in her history, she has not always shown too much interest in the "maimed, the halt, and the blind," but in modern times she has become acutely aware of her obligations in this direction.

The example of Jesus. The life of Jesus on earth showed His concern for the sick. He anticipated modern times in His recognition of the importance of psychological and spiritual factors in sickness and health.[1] In His ministry, miracles of healing of the body were usually associated with the healing of the soul, as seen, for instance, in the healing of the paralytic,[2] the woman with the issue of blood,[3] and blind Bartimaeus.[4] James (5:16) shows clearly

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[1] Carl J. Scherzer, The Church and Healing (Philadelphia: The Westminster Press, 1950), p. 26.

[2] Mark 2:3-12.

[3] Mark 5:25-34.

[4] Mark 10:46-52.

a causal relationship between physical health and spiritual well-being: "Confess your sins to one another and pray for one another, that you may be healed."

Jesus, it may be asserted, set the example for His followers in His concern for the sick. Did He not leave three divine imperatives for His disciples to follow: preach, teach, and heal? These imperatives were so emphasized by His own life that there seemed to be no doubt in the minds of the twelve concerning the specific aims of their ministry. The New Testament record contains ample testimony to the healing ministry of the apostles, including Peter healing Aeneas of the palsy and restoring Tabitha to life (Acts 9:33-41).

The Early Church. The Early Church Fathers--Irenaeus, Justin Martyr, Tertullian, and Origen--refer to the Church as having the power to heal and to raise from the dead. Origen, speaking of his own day, writes about the healing power of Jesus' name, and adds that more cures were effected in that way than through the teachings of Aesculapius, who was, in Greek mythology, the god of medicine.[5]

The most common practice in connection with healing in the Early Church was the use of oil. Water and bread

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[5] Benjamin E. Smith, editor, The Century Cyclopedia of Names (New York: The Century Company, 1894-1897), p. 17.

were sometimes consecrated for that purpose also. One Father Fuller, in his book, Anointing of the Sick, tells that healings were effected by patients by drinking water that had previously been blessed by the priest. Oil and water were used internally as well as externally. It was the custom in those days to preface with prayer the use of all medicaments. Holy Communion was regarded as a time specially suited for healing purposes. Paul seems to imply that when the sacrament is received in faith and reverence it should have the effect of raising the vitality and strengthening the body (I Corinthians 2:29,30). The use of relics in healing also goes back to these early years of the Christian Church.[6]

While the ability to heal miraculously seems to have belonged in some peculiar sense to only a few of the early followers of Jesus, yet it is safe to assume that the early Christians were much interested in the care of the sick. Such service became one of the functions of the diaconate, a kind of early religious order which is as old as the Christian Church. The term is derived from Latin and means "service". This office originated at Jerusalem to give assistance to apostles in their work among the members of the congregation. The first helpers were men only, but soon deaconesses were

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[6] Scherzer, op. cit., pp. 35-38.

added. The first deaconess mentioned in the Bible is one Phebe, who was associated with the Church at Cenchrea (Romans 16:1,2). That there were deaconesses, in practice, during the time of Jesus is hinted at in one of the Gospels which speaks of certain women who "ministered unto him of their substance" (Luke 8:3). That there were voluntary helpers who ministered to the needs of the saints is evidenced from some of Paul's letters. Examples of these are Typhena, Tryphosa, and Pereis (Romans 16:12), and the women in the household of Stephanas (I Corinthians 16:15).[7]

Officially appointed deaconesses in the early Church served as doorkeepers in the temple, helped to prepare female catechumens for baptism, cared for orphans and the infirm, and assisted generally in the work of the Church. In fact, they and their office were so highly respected that they were counted among the clergy.[8] Important information concerning the diaconate is to be found in the Apostolic Constitutions, a collection of laws and precepts of the early Church, probably written in the latter part of the third century or in the fourth century. From Weston's translation it seems evident that the bishops ordained

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[7] Ibid., p. 29.

[8] "Evangelical Deaconess Society Bulletin" (St. Louis, Missouri: [n. n.], 1951), p. 7.

deaconesses whose duty it was to minister to the women. These were assisted by an Order of Widows, which seems to have been divided into two groups--ecclesiastical and non-ecclesiastical widows. In actuality a member did not necessarily have to be a widow. Included in the orders were those women who offered themselves and their homes for the performance of all manner of Christian service, especially the care of the sick and the poor. The Order of Widows was supervised by the deaconesses and directed by them in the work of ministry to the needy. At one time a member of the Order was required to be at least sixty years old before she could enter into office, but the age limit was subsequently changed. A third order of women connected with the diaconate was composed of virgins. Basil, in 379 A. D., recognized the Order of Virgins as an order of the Church. The virgins dedicated themselves to a life of virtue and service, renouncing marriage and embracing a life of holiness.[9]

The nursing profession traces its origin to these early Christian orders. One of these early deaconesses, Fabiola, founded the first charity hospital at Rome about 300 A. D. She was apparently very wealthy, for her home was so large that a portion of it was used as a hospital.

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[9] Scherzer, op. cit., pp. 41,42.

She and other noble ladies did not hesitate to do the most menial tasks in their care of the sick.[10] About the same time, a "hospital" was built in Jerusalem to aid the Christians making long pilgrimages to the Holy Land. It was really a house of Christian hospitality which only casually and incidentally cared for the sick.[11]

Another name should be mentioned in connection with these "hospitals". Paula, a friend of Fabiola and of a distinguished Roman family, had become interested in giving herself to religious service following the death of her husband. She met Jerome through some of the bishops she had entertained in her home when the Roman Synod met in 382 A. D. Jerome approved of her work and encouraged her to continue. In the next four years two daughters died, and she gave more of her time to this work and established a number of hospitals in Rome. It is said of her that because she so loved her work she was afraid it would be without merit as a Christian charity. She later founded a hospital at Bethlehem.[12]

Stemming from the diaconate in the fourth century was an institution known as the xenodochium, a kind of relief

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[10] Ibid., p. 43.

[11] Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick (New York: The Macmillan Company, 1936), p. 4.

[12] Ibid., p. 45.

center. It proved to be a definite step in development toward the modern hospital. Rooms in it were set aside for the sick, and the nursing was done by the Orders of Deaconesses, Widows, and Virgins. Priests acting as physicians were stationed in these institutions to direct the work.[13]

Bishops and monks also were to play their part in ministering to the sick. Saint Basil, a Greek Bishop of Caesarea, is credited with setting up a system of sick visitation and nursing care. He founded a number of xenodochia, planning the institutions carefully, and building them at the edges of towns and cities. As far as possible, each institution included an inn for travelers; facilities for ambulatory patients; a hospital for bed care; and homes for the aged, crippled, orphans, and foundlings. A building for lepers was usually included. "Ductores", or guides, went out and found patients and brought them to the hospital. During epidemics, even the hermits would lend a helping hand in the hospital work. But the greatest influence of the Early Church on healing is to be found in men of position like Basil and others, who devoted much time to this particular area of the Church's ministry.[14]

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[13] Ibid., p. 45.

[14] Ibid., p. 45,46.

It was in her caring for the poor that the Church in the postapostalic period made one of her greatest contributions. The care of the sick was not regarded with esteem by the pagan Romans, who placed much confidence in magic and quackery. There was little compassion toward the poor in the pagan world; the attitude of the authorities was to keep the masses of the poor in subjection. Even the guilds, formed by the lower classes themselves, seemed to be without compassion for their own. This attitude was opposed to the teachings of Christ, as to the importance of the individual and the dignity of man.[15]

The Medieval Age. In this age the Church was the primary medium through which the healing arts were promoted. Secular physicians there were, of course, but it was to the Church the people were likely to turn. It had the confidence of the people. It was not unusual for secular physicians to leave town on the death of a prominent patient. Roots and herbs were cultivated by the monks in their monastery gardens. Surgery was performed by some of the monks, until the Church in 1163 passed a law forbidding the shedding of blood. About 1300, at the time of the Crusades, Pope Boniface VIII decreed that a human body could not be cut up. Surgery therefore came

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[15] Ibid., p. 47.

into disrepute. In the course of time, surgery was to become an adjunct to the business of barbering.[16]

The esteem in which the Church as Healer was regarded is obvious when it is remembered that during this medieval period, it was believed that merely to sleep in an holy place meant that the patient would be under healing influences. Miraculous cures were attributed to the power of the Church. It was customary to bring a patient to the Church, where after prayers for healing were made, the patient was allowed to sleep. Some of the diseases on record of which patients were relieved are paralysis, dumbness, blindness, barrenness, scrofula (a type of tuberculosis), dyspepsia, broken legs, deformities, lameness, gout, cataract, ulcer, and dropsy.[17]

The Crusades helped to expand the Church's healing ministry. Crusaders returning from the Orient brought back leprosy. The situation soon called for hospitals which the monks themselves had to build. These institutions were called lazarettos, after Lazarus, the leper in the New Testament. It is said that at one time there were two thousand lazarettos in France and two hundred in England. The demand for nursing care in these institutions was a significant factor in founding the Knights Hospitalers and other similar orders during these

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[16] Ibid., pp. 48,49.

[17] Ibid., pp. 51,52.

"dark ages". Some of the most skilled physicians of the day were to be found in these predominantly lay orders. As the knights, however, became more engrossed in fighting Moslems, the monks began to outnumber them in nursing orders. The Knight Templars was another lay order. Today it is known as the Masonic Lodge. Yet another was the Order of Teutonic Knights, which later turned militaristic, promoting commerce and offering police protection to the people. Some of the other orders were the Alexians, Orders of Saint Anthony, Order of the Holy Ghost, Bethlehemites, Brothers of Charity, Orders of the Cross, and the Sack Brethern. Membership of the orders was composed of clergymen and laymen.[18]

One reason for the rise and popularity of these orders was the decline of the diaconate brought about in part by the barbarian invasions which made it very difficult for women to travel alone. But with the establishment of many new hospitals came greater opportunities for women to do Christian service.

Another important avenue of service for women was to come through the monasteries. The Order of Benedictines, one of the most advanced of its kind in the Middle Ages, offered women a place where they could perform Christian service and cultivate intellectual tastes. Convent life in such a reli-

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[18] Ibid., pp. 53-56.

gious order was interesting compared to the humdrum existence of women in those days. Under Benedictine auspices, women nursed the sick both in hospital and home. Some of these Benedictine settlements were large; one in particular had three thousand monks and nuns.[19]

In the Netherlands in the twelth century, Lambert le Begue, a priest, renounced his own property and used his wealth at Leige to build a church, a religious community, and the hospital of Saint Christopher. Many war widows joined his society and in time the order became known as the Beguines. Members could withdraw at any time and were not required to renounce their money and property, although many of them did. They cared for the poor and the sick without cost to the patient. This order spread to France, Germany, and northern Italy, and acquired great wealth because many prominent and wealthy widows joined it to assist in the building of hospitals and nunneries. The Beghards, a corresponding order for males, was inspired by the accomplishments of the Beguines.[20]

During the period under discussion many other religious orders for women were established, such as the Sisters of Mercy, Sisters of Charity, and Little Sisters of the Poor.[21]

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[19] Ibid., p. 56.

[20] Ibid., pp. 56,57.

[21] Ibid., p. 57.

What may be considered a land-mark in the progress of the Church's healing ministry is the appearance in the fourteenth century of a series of booklets on preparation for death. The Black Death in that century threw Europe into a panic. Mental aberrations, such as the dancing mania, people barking like a dog or mewing like a cat, were common. It is said that half of Europe's population perished in the plague.[22] Convinced of the need of spiritual preparation for death one Dr. Jean Gerson published several booklets on the Art of Dying. The booklets depict the deathbed as a battlefield on which malign and gracious spirits are contending for the soul of man. To make a good end was felt to be an "art". And so the Christian is taught to die with dignity.[23]

The Reformation Period. It was in the middle ages that Paracelsus, popularized in Browning's poem of that name, began his study of medicine. Paracelsus, contrary to prevailing practices of his day which regarded research with superstition and thought illness due to evil spirits, studied the patient and wrote about heredity and the predisposition to disease. He is known as the first modern doctor.

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[22] Ibid., pp. 58-65.

[23] John T. McNeill, A History of the Cure of Souls (New York: Harper and Brothers, 1951), p. 85.

Curiously enough, the Church accepted the results of his research without protest.[24]

About the time when Paracelsus was leading the way in a break with the past, a Reformation was taking place in the Church. Luther and his followers refused to accept the use of relics and shrines for healing purposes. Luther felt that confession was necessary for distressed consciences. He advocated confession but insisted that every Christian be allowed to hear confessions and every sinner free to make his confession to a Christian neighbor of his own choosing, who should absolve him in the word of Christ. Luther, himself, enjoyed visiting the sick, and to them he commended Christian resolution and steadfast faith. Before leaving them, he would remind them that God was a gracious Father and that Christ had wrought our reconciliation. He also commended music to those who were sad.[25] Luther set the pattern for much that is fine in Protestant preaching. His supreme emphasis on the pastor as one who is concerned with the health of the soul anticipates the pastoral counseling movement in the Church of our day.[26]

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[24] Scherzer, op. cit., pp. 66,67.

[25] McNeill, op. cit., pp. 171-174.

[26] Scherzer, op. cit., p. 69.

Another great Reformer, John Calvin, seems to have left the care of the poor and sick to the deacons. Calvin revived the deaconess office in his church for the purpose of ministering to the sick. All the reformers rejected the belief in the efficacy of relics and shrines, at the same time stressing the salutary effects of prayer, faith, confession to God, and consultation with the pastor.[27]

The Counter- and Post-Reformation Period. Among Catholic reformers working to abolish abuses that caused the Reformation, was one Saint Philip Neri, born in Florence in 1515. Neri founded the Roman Catholic Order of Oratorians, for the purpose of caring for strangers and the convalescent poor. Saint Philip and his friends not only tended the sick but performed the most menial tasks about the hospital. The order emphasized purity of life; no vows were demanded of its members, who could withdraw at any time. Saint Philip is credited with many instances of spiritual healing by virtue of his strong faith in God. The brothers of the order would periodically quit the monastery for days to engage in nursing duties and practicing medicine.[28]

A requirement of a recruit in the Society of Jesuits was that he spend a month in a hospital doing menial work and

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[27] Ibid., pp. 70-72.

[28] Ibid., pp. 73-78.

another month traveling as a mendicant. Saint Francis Xavier, the founder of the order, set an example for his followers by his efforts to combat the Black Death with the usual medical practices. All his life he maintained an interest in the sick.[29]

It was in this Counter-Reformation time that Saint Vincent de Paul started the order that is one of the greatest institutions in Roman Catholic History, the Sisters of Mercy. De Paul, unable to find peace until he vowed to devote his entire life to helping the poor, became parish priest in the town of Chatillon-les-Dombes, where poverty was rampant. Here he organized his first sisterhood of charity, composed of women who voluntarily gave personal aid to the poor. He also established a hospital for galley slaves. His example inspired other priests to care for the poor. He organized the Order of the Lazarists in Paris, whose house there became the headquarters of the order. De Paul's priests were detailed to visit the soldiers, the blind and the sick, and the poor and the laborers. Vows of his sisterhoods were, in part, as follows:

> They pledged themselves to care for the sick regardless of how loathsome the disease might be. They were never to fear death or leave the impression that death is to be feared, and they were to minister to the needs of

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[29] Ibid., pp. 79-81.

> each patient as if they were doing it to Christ personally. Each patient must be treated like the others; there must never be partiality or any favoritism. No matter how disagreeable the patient was, they were always to be kind and agreeable. Neither were they to become intimately friendly with one another.[30]

In the Roman Church the use of relics and shrines for healing purposes continued during this Counter-Reformation Period. The custom of anointing with oil in healing declined being replaced by the "sacrament" of extreme unction.[31]

In Protestant England, it became the custom during the period just preceding the Reformation for the king to lay hands on the sick. This practice continued for many years, being interrupted only during Cromwell's reign, and Queen Anne was the last of the rulers to engage in this practice.[32]

Since in the days following the Reformation, it was commonly believed in England that some people were possessed of a spirit that enabled them to heal others, it was also felt that some were possessed of the devil to do evil. Publications appeared purporting to inform men how they might discern a witch. One book in particular, The Witches Hammer, started a witch hunt that resulted in the execution of many.

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[30] Ibid., pp. 82,83.

[31] Ibid., p. 84.

[32] Ibid., pp. 88-90.

Catholics found Protestant witches and Protestants found Catholic witches. The witch-hunting craze grew, until no one felt safe. Victims were cruelly killed. Finally even the English Parliament, early in the seventeenth century, passed laws against the practice of witchcraft. The hunt for witches became more vicious. It spread to the new colonies in America, centering in Salem, Massachussetts, where the Mather family used their influence to encourage witch-hunting.[33]

Nursing orders in the Post-Reformation Period. During this period a lack of interest in nursing care caused many hospitals to close down in Europe. Municipalities were then forced to build and operate hospitals. The new set-up led to a "dark period" in the history of nursing, for hospital matrons and lay nurses were frequently unskilled and quite lacking in morals. It was not until a few centuries later that lay nursing became an honored and consecrated profession.[34]

Local effects here and there in the Protestant Church helped to revive the nursing orders. In 1530 the Church in Minden, Germany, formed an order of district nurses who were religiously motivated. In 1567, one Pastor Keppel of Minden

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[33] Ibid., pp. 94-98.

[34] Ibid., pp. 103,104.

established a charitable institution for the care of the sick, with an order of Protestant nurses in charge. At Walsdorf there was a similar organization; their members were called sisters. A girl had to be at least eighteen years of age before she was admitted and she served a one-year probation period. If her character and ability were of a sufficiently high standard, she was consecrated with a religious ceremony. The sisters were free to leave or marry at will. They were trained in various fields--nursing, teaching, visiting, and the care of the poor. In the Reformed Church at Wessel the deaconesses were chosen by the congregation and employed by them to nurse the sick of the Church. The General Synod of the Reformed Church, for some reason, did not confirm the action of this congregation and discouraged the movement.[35]

Protestants in the city of Amsterdam divided the city into four districts for nursing service, engaging sisters or deaconesses for this visiting nursing service. These were chiefly mature women, for the work was strenuous.[36]

The Moravians, a Protestant group founded by Count Zinzendorf, also had sisters who gave nursing care. The

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[35] Ibid., pp. 104,105.

[36] Ibid., p. 105.

Mennonites in Holland, organized in the sixteenth century, also had deaconesses.[37]

At least four nursing orders in the Roman Catholic Church were established in the early days of the Reformation period. The Brothers of Saint John of God were founded by the Portuguese Juan Ciudad, who became interested in the sick, especially the insane, following a period of hospitalization in which he himself was treated as insane. The rules of his order demanded that the members of its hospital staff possess a sound knowledge of medicine. Camillus de Lellis, a pious priest, founded the order of the Agenizants or Agony Fathers. He himself converted in a hospital, decided to become a priest and devote his life to the care of the sick in hospitals. This order spread from Italy to Spain, Portugal, and France. He instituted a similar order for women known as the Camellines. Because of their nursing plague victims, the entire order died. Virginia Bracelli became the founder of the Daughters of Our Lady of Mount Calvary, better known as Brignoline. Starting her order by taking orphans and girls into her own home, she cared for her girls out of her own funds until the government gave her a number of "protectors", or wealthy sponsors. During an epidemic

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37 Loc. cit.

this order demonstrated such devotion and skill that it became recognized as a distinct nursing order.[38]

Denominational interests during the Post-Reformation Period. By the sixteenth century, Protestant church denominations in Europe went on record as beginning to show a more intelligent interest in the sick. Some of Luther's contemporaries and followers in religious thought, such as one Urbanus Regius and one Frederick Myconius, wrote handbooks for pastoral use in ministry to the sick and dying. The Strasbourg Reformer, one Martin Bucer, wrote On the True Cure of Souls, which appeared in 1538. He argues that we owe one another mutual care in things of the body as well as of the spirit. The passage of which he makes most fruitful use is found in Ezekiel 34:16: ". . . and will bind up that which is broken, and will strengthen that which was sick:"[39]

Pastors of the Reformed Church in Switzerland were urged to visit the sick promptly, to pray with them, and to prepare the dying for a peaceful death. Zwingli's sermon, "The Pastor," stresses that preaching must be followed up by instruction and devoted service to the people. Henry Bul-

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[38] Ibid., pp. 109-111.

[39] McNeill, op. cit., pp. 177,178.

linger, Zwingli's successor in the leadership of the Church of Zurich, found time to visit the sick and dying in prison and out of prison; he not only redoubled his efforts but wrote a book on preparation for death.[40] The Church seems to have regarded the diaconate as indispensable to the Church, but she failed to maintain institutions to train deaconesses. Individual congregations employed deaconesses, who did work similar to that of the widows of the Early Church.[41]

The Presbyterian interest in the sick in the late sixteenth century is seen in the elder's office in the Scottish Kirk. As redefined in the Second Book of Discipline adopted in 1581, the office included assisting in visiting the sick. The pastor was to admonish the people in time of health to prepare for death, and the people were to confer with him frequently about the estate of their souls; and in times of sickness, they were to seek his advice before their strength and understanding failed them.[42]

In the seventeenth century, Richard Baxter, a Puritan, used much wisdom and human sympathy in his visitation of the sick, and felt that visits to the dying should begin long

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[40] Ibid., pp. 196,197.

[41] Scherzer, op. cit., p. 102.

[42] McNeill, op. cit., pp. 249-252.

before death approaches. He insisted that if the sick person recovered, he must hold himself to the good resolutions made during his illness.[43]

Two Anglican ministers deserve mention for their work in the seventeenth century. Jeremy Taylor wrote a book on Holy Dying, saying that preparation for death involves the daily scrutiny of our actions. He gives directions for prayers at various stages of the sick man's experience. He gives rules for repentance in sickness, including restitution of "all unjust possessions". He has little faith in deathbed repentance. Gilbert Burnett, Anglican Bishop of Salisbury, wrote the Discourse of Pastoral Care. He felt that visiting the sick was one of the pastor's duties. He said that it was "treachery to souls" to accept an inadequate deathbed repentance as it led not only to loss of the dying man's soul, but also to the ruin of observers who see how slight a repentance is needed for reassurance of salvation. He believed that the sick should make solemn vows of amendment in case of recovery, and thereafter be reminded of those vows.[44]

In the eighteenth century, John Wesley organized "bands", or groups, for mutual confession and discipline. These were

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[43] Ibid., p. 267.

[44] Ibid., p. 279.

the earliest units of organization of Methodists. The groups were subdivided into classes of about twelve members each, men and women, under a class leader. The members were supposed to do all the good possible, including visiting and helping the sick.[45] Wesley was a strong believer in the therapeutic value of prayer. Many of the hymns which he and his brother, Charles, wrote have played no small part in relieving people of strong emotions and tensions. But John Wesley's compassion for the sick led him to do something more, for he studied diseases and remedies and published the results of his research in a book entitled Primitive Physic. Wesley regarded highly the profession of medicine, yet he was sensible to the fact that much physical sickness is the result of spiritual darkness. His followers founded dispensaries, orphanages, strangers' societies, refuges for widows, hospitals, and other philanthropic institutions.[46]

John W. Fletcher, who had taken Wesley as his spiritual guide, was a man who felt the summons to instant action at the sight of a stranger in need, the news of a miner hurt in a pit, or of someone likely to die. Francis Asbury, another follower of Wesley, likewise showed a passionate desire to help the sick.[47]

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[45] Ibid., p. 279.

[46] Scherzer, op. cit., pp. 106-109.

[47] McNeill, op. cit., p. 282.

A Lutheran pastor, Henry M. Muhlenberg, came from Halle to his church in America with an elementary knowledge of medicine. In the courses of his personal religious ministry to the sick, he prescribed physical remedies.[48]

The pastoral interest in the sick continued into the modern period, (19 century--). Thomas Chalmers, a Presbyterian pastor, left a record of numerous pastoral visits during a period of epidemic influenza when many of his parishioners were dying. Spurgeon, the Baptist, was in constant visitation during a cholera epidemic, and later gained a reputation for the healing of hundreds of sick through his bedside prayers. Washington Gladden, another nineteenth century minister, recommends that the pastor be pleasant and sympathetic at the sickbed, ready to hear the sick person's anxieties, but not inquisitive into his secrets. On occasion, he would serve communion to the sick. He felt that the pastor should not conceal from the patient the approach of death, but should try to help him prepare for it.[49]

Protestant nursing orders and hospitals in the modern period (19 century--). In 1820 a German clergyman, Pastor Kloenne, published a pamphlet entitled The Revival of the

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[48] Ibid., pp. 187,188.

[49] Ibid., pp. 258-278.

Deaconesses of the Ancient Church in our Ladies' Societies. In it he suggested that the choice of deaconesses be made by the synod or presbytery rather than by the individual congregation. The women should be single or widows and be trained to work among the sick and the poor. This pamphlet received wide circulation. At least four different individuals gave themselves to the work of establishing diaconates between the years 1820-1845. Occasionally one reads of single women dedicating their lives to work with the sick. Amalie Sieveking, a young Lutheran girl, is a case in point. Her reputation and influence did much to promote among Protestants in Germany, a more general interest in nursing care.[50]

A German pastor named Fliedner, of Kaiserswerth, was so impressed by the work some of the Mennonite deaconesses were doing in Holland during his visit there, that he opened a training school for deaconesses at Kaiserswerth. The work prospered and became known all over Europe, its reputation eventually spreading to America. The following is a grouping of the work these deaconesses were prepared for: the first group to care for the sick, the poor, unmarried pregnant girls; the second group to teach; and third group to do parish work. Christian character was imperative in the

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[50] Scherzer, op. cit., pp. 115,116.

deaconess, who, after a period of probation, was officially consecrated for her work. She had to promise to serve for at least five years. Fliedner acted as administrator and he was assisted by a mother superior who had charge of the domestic life of the institution. He traveled extensively and founded deaconess homes and hospitals in Jerusalem, Constantinople, Smyrna, Alexandria, Hungary, Holland, France, England, Scandinavia, and the United States. The idea of the female diaconate was regarded with favor everywhere and in twenty-five years as many as twenty-seven institutions were founded. These deaconesses served for only a small stipend. They were expected to be skillful and compassionate nurses, equipped to meet the spiritual needs of the patients with Scriptures and hymns; they should be able to read fluently and write legibly, and know enough arithmetic for bookkeeping purposes. Most of these institutions were under the direction of the Lutheran, the Reformed, and the Evangelical Churches.[51]

In England, Dr. Robert Gooch, with the poet Robert Southey, founded an organization known as the Protestant Sisters of Charity. The mother house was in connection with Guy's Hospital in London. Its founding is regarded as the beginning of the nurses' training school in connection with

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[51] Ibid., pp. 117-120.

a municipal or secular hospital. After they had received their training, the sisters were permitted to nurse in private homes. It was not until 1848, however, that the first thoroughly religious nursing order in England was established at Saint John's House in London by the Church of England.[52]

The diaconate was established in the United States through the interest of an English Lutheran pastor, a Mr. W. A. Passavant. In the section of Pittsburgh, Pennsylvania, where he worked, there was no place where the sick poor could be taken for adequate treatment. Hearing about the Kaiserswerth institutions he visited them, receiving encouragement from Fliedner. On his return to Pittsburgh, in the spring of 1848, he rented a house. His first two patients were soldiers, and since he could not find nurses, he took care of them himself, with the aid of a divinity student. When an epidemic of cholera came, the house was too small to meet the needs, so he purchased property that would accommodate forty beds. Later Fliedner, with four deaconesses, came to assist him. This institution is regarded as the first Protestant Church hospital in the United States. Interest spread and before long Christian people of different denominations wanted to do the same thing. Miss Dorothea Dix, as

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[52] Ibid., pp. 120, 121.

superintendent of female nurses for the Union Army, was favorably impressed with the work of these deaconesses and gave them much publicity.[53]

Other Lutheran groups which started hospitals were the Norwegian Lutheran in Brooklyn, New York, which invited Sister Elizabeth Fedde, of Oslo, Norway, to come and establish a deaconess home and hospital, and the Swedish Lutheran Church which started hospitals primarily through the efforts of Pastor E. A. Fogelstrom, of Omaha, Nebraska.[54]

In 1855 Rev. Horace Stringfellow, an Episcopal clergyman of Baltimore, Maryland, interested two young women of his parish to become nursing deaconesses. The bishop of the Maryland Diocese assured them of a livelihood if they devoted their lives to nursing the sick members of the parish, and he recognized them as deaconesses. Their order became known as the Sisters of the Good Shepherd. Other deaconess orders were soon formed among the Episcopalians.[55]

A missionary training school, previously organized by Mrs. J. S. Meyer, herself a physician and the wife of a Methodist minister, became the first home of Methodist deaconesses

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[53] Ibid., pp. 121,122.

[54] Ibid., pp. 123,124.

[55] Ibid., pp. 125,126.

in this country. She and her deaconesses worked among the poor in the tenement districts of Chicago. Due to interest aroused in her work, a group of Methodist men met in Chicago in 1888 and founded Wesley Hospital. Deaconesses became influential in founding a number of Methodist hospitals.[56]

Four other denominations were also active in the care of the sick. The first hospital and deaconess home of the Evangelical and Reformed Church was the Evangelical Deaconess Hospital in St. Louis, erected in 1889. The Mennonites started the Bethel Deaconess Hospital in Newton, Kansas, in 1907, and later added two others, one at Mountain Lake, Minnesota, and another at Beatrice, Nebraska. Their deaconesses nursed for a pittance. The Presbyterian Hospital in Pittsburgh, Pennsylvania, was founded in 1895 to give medical and surgical aid to all who needed it, together with ministrations of the gospel. The Baptist Church has many hospitals which were in the beginning inspired by the need of caring for its own sick as well as by the need of institutional training for its deaconesses.[57]

Interdominational Protestant deaconess groups were also organized which founded such hospitals as the Deaconess

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[56] Ibid., pp. 126,127.

[57] Ibid., pp. 127-131.

Home and Hospital of Cincinnati, Ohio. In 1950 there were 516 Protestant church-related hospitals in the United States having 74,047 beds and 11,093 bassinets, with an average daily occupancy in all of 60,629 patients. Four hundred of these hospitals are affiliated with the American Protestant Hospital Association.[58]

Catholic nursing orders and hospitals in the modern period. The first Catholic nursing order in the United States was founded in 1809 at Emmitsburg, Maryland, by Mother Elizabeth Ann Seton. Father du Bourg, later archbishop, recognizing her devotion and ability, called on her to found the Sisters of Charity of St. Vincent de Paul, a society which was to prove influential in establishing hospitals and nursing orders throughout the United States. The Sisters of Nazareth was founded in Kentucky by one, Father David, an exile from France. At the same time, another priest, Father Nerinkx, also a French exile, founded the Sisters of Loretto in the same state. It was no unusual sight to see the sisters riding on horseback to visit the sick.[59]

By 1823 Mother Seton's Sisters of Charity were running the Baltimore Infirmary, now the University of Maryland

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[58] Ibid., p. 131.

[59] Ibid., p. 132.

Hospital. The sisters received instruction in nursing care from professors of the University. They read a portion of the Bible daily in each of the wards.[60]

In 1828 four sisters from the Emmittsburg Community near Baltimore, Maryland, took over the work in the Mullanphy Hospital in St. Louis, Missouri, generally recognized as the first really Catholic hospital in the United States. Even though other orders came into existence, there were not enough sisters to meet demands. In Nashville, Tennessee, for instance, Catholic girls from a nearby orphanage were trained by the sisters to help in hospital nursing.[61]

The Catholic Hospital Association of the United States and Canada lists the total number of Catholic hospitals in these two countries in 1947 at 1,038 with 160,058 beds and 25,384 bassinets.[62]

Catholic faith healing in the modern period. The story of Bernadette and her vision of the Virgin Mary inspired many to make healing pilgrimages to Lourdes, France. The year 1872 saw pilgrims from all over France who visited the Virgin's shrine. Since then the sick have formed a long line in front

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[60] Ibid., p. 133.

[61] Loc. cit.

[62] Ibid., p. 134.

of the Church of the Holy Rosary there. When the consecrated Host is carried by in procession, miraculous healings have been reported. Doctors examining the patients have frequently issued certificates verifying a work of healing. To prove the authenticity of such healings the Roman Catholic Church invites doctors of all faiths to investigate.[63]

The healing shrine in America that attracts most attention is that of St. Anne de Beaupre in Quebec, Canada. Once, several storm-tossed sailors from Brittany vowed to build a shrine if they were afforded a safe landing. This shrine is the result. In the laying of the foundation, one of the workmen suffering from severe rheumatic pains was reputedly healed. At the base of the statue of Saint Anne are hundreds of crutches and offerings, evidences of past healings.[64]

Protestant faith healing in the modern period. Pastor John Blumhardt, the Lutheran pastor of a village church, was a faith healer of some reputation in the nineteenth century Germany. Through his prayers, one Gottlieben Dittus, affected by apparitions and noises, was healed. This cure was followed by a religious revival over a large area, during which many people came to him for spiritual help and for healing. In 1852 this

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[63] Ibid., pp. 135-138.

[64] Ibid., pp. 141,142.

pastor purchased the watering place at Boll, noted for its sulphur springs, and dedicated it to Christian healing. More than a hundred patients could be treated in his "hospital" at one time. The pastor devoted much of his time to personal interviews with people in stress and to a large correspondence with inquirers after help. He never professed to be of himself instrumental in healing. He believed that God was the author of healing. He did feel God had given him a special gift for discerning His will in these matters, and he always insisted that the patient sincerely repent of his sins. Pastor Blumhardt was more interested in the salvation of the soul than in the healing of the body.[65]

The Shaker sect started in a Quaker revival in England in 1747. Mother Ann succeeded the original leaders, Jane and James Wardley, and she traveled the country, becoming well-known as a faith healer. The community believed they had power over physical disease.[66] Their influence extended into the modern period.

In the nineteenth century there were many advancements in medicine, surgery, and in the care of the sick. Magic and superstition were gradually being superceded by scientific

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[65] Ibid., pp. 142-144.

[66] Ibid., pp. 144,145.

research. Nursing grew to a professional status. The standards of lay nursing were brought to a par with those of the religious orders. And, when lay nursing was vastly improved in professional and clinical requirements, the religious orders, in turn, embraced the new standards.[67]

Christian Science. Following a serious fall on the ice, Mary Baker Eddy (b. 1821) felt that God healed her according to her faith. She says that in this experience she discovered the Christ science of divine laws of life, truth, and love, and she named her discovery "Christian Science". Retired from the public for three years, she devoted herself to study, prayer, and to the writing of the principles of health and life. Believing that she had grasped a great truth she felt that her next step was to teach it to others. She first formed a class in Mind Science at Lynn, Massachussetts, but soon saw that if the healing of Christian Science were to continue, a college of instruction must be founded. In 1879 the Christian Scientist Association was formed and incorporated as the Church of Christ, Scientist, in Boston, with Mrs. Eddy as pastor. The Journal, founded in 1883, was designed to bring health and healing into the homes.[68]

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[67] Ibid., pp. 145,146.

[68] Ibid., pp. 149-152.

The first meeting of the National Christian Scientist Association was held in 1888 in Chicago. The first Boston church, built in 1894, was in 1906, replaced by a large granite and stone church. By then "The Christian Science Monitor" was reaching a wide audience. In 1909 the First Church of Christ, Scientist, was dedicated in London, England.[69]

The doctrine of this church emphasizes the power of mind over matter. A quotation suggests the direction of the teachings of this organization:

> There is only one reality, and that is mind and mind is God. The divine science enables the individual to understand life, truth, and love, and these cast out error and heal the sick. As the believer accepts this principle, he achieves a oneness with God that denies the existence of sickness or pain.[70]

This movement assumed such significance in American life that it caused both the Church and the medical world to re-evaluate their approach to the patient. Some doctors began to observe for the first time the effects of spiritual states on the body. In summary, the Christian Science movement has led to a greater degree of mutual understanding between Christian ministers and medical men concerning their respective callings.[71]

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[69] Ibid., pp. 153-156.

[70] Ibid., p. 157.

[71] Ibid., p. 158.

Two offsprings of Christian Science, having their inception in belief in healing, are the New Thought Movement, which has gained a considerable following in America, and the Unity School of Christianity.[72]

A Mr. and Mrs. Charles Fillmore, identified as founders of Unity, advertised themselves as healers and teachers, and soon had followers. The first Unity Church was established in Kansas City in 1906. Unlike Eddyism, this school teaches the reality of the body and its ills but insists that the recognition of one's own deity brings deliverance from sickness. All enlightened persons can say with Christ, they teach, "I and my Father are One." Their system of belief is pantheistic.[73]

The Emmanuel Movement. Two clergymen, Dr. Elwood Worchester and Rev. Samuel McComb, and a medical doctor, Isador Coriat, organized the Emmanuel Movement, which teaches that God has power to cure disease but that His method varies. If the disease needs medicine or surgery, God uses these to serve His purpose. If the disease is functional, God heals through the mind or the spirit. The leaders of this movement in studying miracles of healing in the Gospels, concluded there was

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[72] Ibid., pp. 161,164.

[73] Ibid., pp. 164-166.

sometimes a high correlation between physical illness and moral states. With this in mind, they began working with consumptives in tenement districts, engaging them in weekly meetings. Results were reported to be as good as those found in the most favored sanatoria. Interested state officials discovered that the personalities of the three men was a vital factor in the improvement of the patients. Their work attracted the attention of medical men of national reputation who subscribed willingly of their talents to its further progress. Patients were first examined by a psychiatrist or physician, who in turn referred them to the clergymen, who ministered to them in spiritual things, making much use of Scripture and prayer.[74]

This movement which began early in the twentieth century, became well-known by the second and third decade. Other ministers began to investigate the possibility of working alongside physicians in treating patients for functional disorders. Dr. Samuel Fallows, the rector of St. Paul's Church in Chicago, for instance, established a spiritual healing clinic in his church on the Emmanuel plan, with the cooperation of certain physicians.[75]

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[74] Ibid., pp. 169-178.

[75] Ibid., pp. 181-183.

Medical missions. The primary motive in early missions was to save souls for eternity, but it is only in recent years that the healing compassion of Jesus has become a dominant force in Christian missions. One of the early Protestant missionaries to show much interest in medical work was Robert Morrison, who went to China in 1808. Not a doctor himself, nevertheless he opened a dispensary in Canton, placing a native practioner at the head of the clinic.[76]

As the work of missions grew and missionaries became increasingly aware of much needless physical suffering, they inevitably felt like doing something about the situation. It became a growing conviction with them that the work of healing bodies could be a most valuable adjunct to that of saving souls. And so today medical missions is an established part of the entire missionary program of the Church. Many thickly populated and thinly populated regions still must depend largely on the medical missionaries caring for their sick.[77]

A summary of the history. In the Early Church were those appointed to care for the sick. Other Christians, even though not among the appointed few, did what they could to assist the needy. In process of time, the care of the sick

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[76] Ibid., pp. 186-188.

[77] Ibid., pp. 190,191.

came into the hands of the monks and nuns in the monasteries. About the time of the Crusades when hospitals were needed, many widows gave of their time to the care of the wounded and the diseased. In the twelth and thirteenth centuries many nursing orders were founded. In the decades preceding the Reformation the Church's interest in the welfare of the sick waned considerably. An era of apathy toward them set in, which was to last for almost three hundred years. In the seventeenth and eighteenth centuries private initiative in helping the sick appeared in Europe when individual clergymen here and there took the matter into their own hands. The corruption of the nineteenth century turned many to religion, at the same time awakening in them a new social conscience which began to express itself in attention to the ill. The advances in medical science and the raising of nursing standards had by then also made for renewal of interest in the sick, so much so that in the latter part of the century hospitals were largely in secular hands. This trend has continued till now most hospitals in America are not affiliated with churches.

Our century has witnessed a distrust in man's ability to discover material sources of healing, and there has been a consequent turning to individuals and sects believing in faith healing. Some of the exponents of healing gospels are sincere in their following the Bible teachings. Some

place undue emphasis effecting a cure by the discipline of thought--a technique not in harmony with the teaching of Jesus whose emphasis is on the power of God.

As will be discovered in the next chapter, some churches are still active in the care of the sick, but the majority leave the responsibility with the family and the hospital.

CHAPTER III

PRESENT DAY PRACTICES IN THE CARE OF THE SICK

To discover to what extent Protestant denominations employ church workers and to learn what is being done by way of preparing these workers for the task of sick-visitation, questionnaires were sent to thirty-one denominational headquarters. Twenty-seven replies were returned. Many of these responses included addresses where further information might be obtained. These suggestions were followed. What was considered to be an adequate sampling of seminary catalogs revealed that at present almost no courses are being offered the minister or the church worker to prepare them for a sick visitation program. Ten seminaries offered some clinical training in sick visitation in general or mental hospitals. Only one denomination, Church of Jesus Christ of Latter-Day Saints, seemed to have an adequate denominational program of training for church workers. Six denominations recommended reading courses; and thirteen advised that the worker take courses in the denominational seminaries. Findings from the questionnaires are discussed according to denominations. The catalogs are discussed in alphabetical order. Two special courses in clinical training are discussed at the end of the chapter.

I. FINDINGS FROM QUESTIONNAIRES

Weslevan Methodist Church. A deaconess course of study is provided for in the local church. It leads to the consecration of deaconesses, who hold office on a volunteer basis. Among specified readings required in preparation for the work, one book in nursing is recommended: Anna C. Maxwell and Amy E. Pope's Practical Nursing.

United Lutheran Church. This body maintains two schools where young women may elect courses in visiting and caring for the sick. The Lutheran Deaconess Motherhouse and Training School, in Baltimore, Maryland, in training young women for parish work as deaconesses and as lay workers, offers a course, Theory and Principles of Parish Practice, in which visitation is stressed. Students spend one afternoon each week of one semester in hospital and congregational visiting. The hospital visiting is done under the supervision of the hospital chaplain, who lectures on such visitation.

The Lutheran Deaconess Hospital in Chicago has a deaconess training school as well as a fully accredited nurses' training school. Those in the deaconess course often choose parish missionary work, which work involves contacting new families, visiting the sick, and being a pastor's helper.

Evangelical Lutheran Church. If the local church here has a parish worker, the work of visiting the sick is shared by the pastor and parish worker. In addition, there may be teams of lay workers who visit the sick. The parish worker receives a salary but the lay workers are usually volunteers. The only requirement for the parish worker is graduation from one of the five denominational senior colleges, from one of the three Bible institutes, or from a state university.

Preparation for sick visitation seems to have no part in the formal training of the church worker. Literature dealing with her duties, however, advises the study of R. C. Cabot and R. L. Dicks' The Art of Ministering to the Sick and Stanley Anderson's Every Pastor as Personal Counselor.

United Brethern Church. This denomination urges the church worker to take pastoral courses at Huntington Seminary or at the Institute of Pastoral Care in Boston, Massachusetts. The course in pastoral work at Huntington includes work with the sick as a definite unit of instruction together with a field project of sick visitation. The instruction given at the Institute of Pastoral Care will be discussed later in the chapter.

This church usually solicits its workers on a volunteer basis. For those who have had no courses dealing with visitation, the following home reading course is recommended:

Edwin F. Hallenbeck's Passion for Souls; Irving Fisher and Eugene L. Fisk's How to Live; Walter L. Pyle's A Manual of Personal Hygiene; Judson E. Conant's Every-member Evangelism; Lanoreaux' The Unfolding Life; and Golden's History of the Deaconess Movement.

Church of the Brethern. Church visitors are not trained locally but may receive training at Bethany Biblical Seminary, Chicago, Illinois. The Seminary teaches a course entitled, Clinic in Ministering to the Sick, which gives the student opportunity to receive practical experience in the hospital associated with the Seminary.

Evangelical and Reformed Church. There are several deaconess homes in this denomination, the largest one being located at St. Louis, Missouri. All deaconesses receive their education in the "Mother house". After completing her course of training, the deaconess takes her vow in a consecration service held in the church, which vow is comparable to the pastor's ordination vow.

Even though this training is available, this church is finding it increasingly difficult to secure young women willing to devote their lives to deaconess work. And what is true of the Evangelical and Reformed Church seems to be true of most churches.

Church of Jesus Christ of Latter-Day Saints. The care of the sick in this group is handled through an organization known as the "Relief Society of the Church of Jesus Christ of Latter-Day Saints." The purpose of the society is two-fold: to make investigations and recommendations for ward bishops in regard to the needs of Church families; and to conduct educational work in all local churches for the study of uniform courses in theology, literature, and social science.

A unique aspect of the Relief Society program is its visiting teaching activity wherein families are visited once a month by two visiting teachers. The teachers deliver a spiritual message and note cases of need or illness. These are reported to the president who discusses the cases of need with the bishop; the sick may then be visited by the president himself. The visiting teachers receive instructions at a monthly meeting at which they also report on their visits. If a sick person needs hospitalization or other special medical care, he is provided for under a Church-wide Welfare Plan. If care at home is needed, it is arranged for either on a voluntary or professional basis.

Protestant Episcopal Church. There is no special training for the church worker required by the denomination. There are sisters and deaconesses who care for the sick, but their work is regulated by a particular sisterhood which is not directly related to a local church.

These books constitute a core of suggested reading for the church worker: R. C. Cabot and R. L. Dicks' The Art of Ministering to the Sick; R. L. Dicks' And Ye Visited Me and Who is My Patient?; William Goulooze's Pastoral Psychology; and Religious Communities in the Episcopal Church, by Holy Cross Publishers.

Mennonite Church of North America. Individual congregations sometimes employ a church visitor, and the position is usually on a salary basis. The Church has a training program at their Chicago Seminary and one at the Bethel Deaconess Hospital and Home for the Aged, Newton, Kansas.

The deaconess training includes a survey of what the early churches did in caring for the sick. Deaconess students are required to do a minimum amount of actual visiting of the sick. In connection with this work they are furnished with appropriate Scripture passages and short devotional messages and prayers.

Suggested reading materials for the church visitor are the following books: William Goulooze's Pastoral Psychology and R. C. Cabot and R. L. Dicks' The Art of Ministering to the Sick.

Seventh Day Adventist Church. Among the Adventists no training is given the church worker in sick visitation other than that which workers gather incidentally in courses

in practical church work and procedures given in the denominational colleges. These institutions offer courses for "Bible instructors", who are young women preparing to devote their lives to reading the Bible to the people in their homes.

Presbyterian Church in the United States. Some of the churches in this denomination employ directors of religious education whose duties may or may not include visiting the sick. The denominational training school at Richmond, Virginia, gives a course, Personal Evangelism and Parish Visitation, which touches upon the opportunities, privileges and responsibilities of visiting the sick. But these are primarily for pastors.

Congregational Christian Church. This body, as seems to be the case with most denominations, leaves the question of church workers entirely to the discretion of the local church. It offers no advice on the duties of church workers.

Disciples of Christ Church. In the larger Disciples churches are persons designated as church workers or pastoral helpers, but insofar as the writer knows, no courses are given to prepare for visiting the sick. The denominational headquarters recommended that church visitors read R. C. Cabot and R. L. Dicks' The Art of Ministering to the Sick.

Southern Methodist Church. This group has been organized for just eleven years and, thus far, the pastors have assumed the duties of visiting the sick.

Methodist Church. Many of the more progressive churches of the denomination have organized a program of lay visitation which includes visiting the sick. There is no formal program of training for church workers in sick visitation in the denomination but the denominational seminaries, such as Drew University Theological School and Emory University School of Theology, offer clinical training courses which are of value to the church worker.

Nazarene Church. The Nazarene churches that are able to provide for trained church workers include visiting the sick as one of their duties. The denomination has no training program but the church workers usually have seminary training, which includes some psychology courses.

Assemblies of God. Here again there was found no denominational plan for training church workers in sick visitation. Some local churches do use church workers but whatever preparation given, if any, is left to the local church.

Church of God. Although the Church of God makes no particular provisions for the work in question, a local church may use initiative and engage independently in using church

workers for purposes of sick visitation. The church at Anderson, Indiana, has four to six women who do visitation work, the number varying from time to time. The work is done on a volunteer basis and the workers spend on an average from two to four afternoons a week calling on the sick and the shut-ins of the church. Because this church is the "headquarters" church of the movement, many of the retiring ministers come to live at Anderson. Most of the ladies who do the calling are the widows of ministers. Their years of experience well qualifies them for the task.

American Unitarian Association. No training program for church workers is mentioned in response to the questionnaire, but the ministers of the denomination are urged to attend the pastoral training course at Massachusetts General Hospital in connection with the Institute of Pastoral Care. This course is also available to church workers.

Baptist Church, North. Each local church in this affiliation plans its own visitation program. Many of the churches use retired ministers or assistant ministers to do sick visitation. The Baptist Missionary Training School in Chicago and the Baptist Institute in Philadelphia are designated to train young women for church work generally, including field work in sick visitation.

II. FINDINGS FROM SEMINARY CATALOGS

The writer examined the catalogs of thirty-five representative American seminaries and learned that all offered psychology courses for pastors and church workers. Only a few offered courses specifically dealing with the problems of the sick. Some of the seminaries offered, for pastors, clinical experience in general or mental hospitals. Several seminaries recommended that pastors and church workers take the courses offered at the Institute of Pastoral Care in Boston or at the Council for Clinical Training in New York City. These two centers for training in the care of the sick will be discussed at the end of the chapter. Meantime those seminaries whose catalogs include courses in sick care are mentioned, with some description of their offerings.

Andover Newton Theological Seminary, Newton Centre, Massachusetts (Northern Baptist). Courses are offered in psychology and in counseling. Emphasis is centered in the summer school clinical course offered in conjunction with the Institute of Pastoral Care.

Austin Seminary, Austin, Texas, of the Presbyterian Church. One course is offered in pastoral counseling which includes a discussion of sick visitation, counseling of individuals and groups, and the selection and training of church

leaders. A study is made of various cases illustrating normal personality problems. Each student is assigned patients in a local hospital for his clinical experiences and reports of his visitation are studied collectively.

Berkeley Baptist Divinity School, Berkeley, California. The course in pastoral counseling includes the care of the afflicted, the sick, and the bereaved. This course is not regularly offered, but only as requested.

Bethany Biblical Seminary, Chicago, Illinois, of the Church of the Brethren. The course, Pastoral Ministry, includes the call to the ministry, preparation for service, choice of a field, entering and leaving a pastorate, pastoral calling, calling on the sick, and the pastor's records and reports. The Christian Education department maintains a clinic in ministering to the sick. The student spends time in a hospital as a nurses' aide, during which she attends seminar sessions with members of the medical and nursing staff. For the remainder of the quarter, visitation of patients is done under the supervision of the chaplain, who also conducts seminars each week discussing interviews written up by students. Prerequisites for the course are a course in Mental Hygiene and one in Personal Counseling.

Biblical Seminary, New York City. In the department of Christian Education, the course, Psychology of Religious

Behaviour Problems, is a study of those who react against normal religious life and faith in an exaggerated manner, becoming the behaviour problems in the Christian home, church, and society. The findings of psychology and mental health clinical methods are studied to discover the contribution which religion should make to deviates such as these.

Boston University School of Theology, Boston, Massachusetts. At the Boston Psychopathic Hospital, this Methodist school has a full-time clinical practicum for pastors and other professional workers. Also in cooperation with other theological schools and agencies of the Boston area, the School participates in the Institute of Pastoral Care. The purpose of this Institute is to organize, develop and support a comprehensive educational and research program in the field of pastoral care, with special reference to the sick, using opportunities offered by clinical training as a primary means to this end. The Institute offers several seminars during the regular academic year.

Butler University School of Religion, Indianapolis, Indiana, offers several courses which might well serve the needs of the church worker. Three of these courses are: Psychology of Pastoral Counseling--an analysis of the treatment of religious difficulties in individuals; Pastoral work--a consideration of primary pastoral duties including

special types of calls, such as calls on the sick, the shut-in, and the bereaved; and Advanced Pastoral Counseling--a study based on case materials of problems of special interest such as religious doubts, conflicts and anxieties, guilt, physical illness, and marriage.

Calvin Seminary, Grand Rapids, Michigan, of the Christian Reformed Church. The course in Pastoral Theology deals with scriptural principles governing the oversight of the flock of God and aims at preparing the future minister for the wise, sympathetic, and devout exercise of the shepherd's office.

Chicago Theological Seminary, Chicago, Illinois, of the Congregational Church. Two courses are offered to assist the pastor in counseling, one of them being case-centered. There is also a course entitled Client-centered Therapy and the Work of the Pastor.

Chicago Lutheran Theological Seminary, provides clinical opportunities under the Council for Clinical Training and the Institute of Pastoral Care at Chicago's Augustana Hospital.

Columbia Theological Seminary, Decatur, Georgia, of the Presbyterian Church, presents a number of psychology courses for preachers, one of which should prove most helpful,

Personal Therapy. This course describes general problems of personality difficulties and presents a survey of procedures commonly employed to remove them.

Drew University Theological School, Madison, New York, of the Methodist Church. This seminary offers a Clinical Pastoral Training Course which requires twelve weeks of residence either at a general or mental hospital, or at a correctional institution. A clinical seminar course is also given in the state mental hospital. A course, The Church and Mental Health, discusses the relation between religion and health.

Emory University School of Theology, Atlanta, Georgia, of the Methodist Church, has a course in clinical training that requires a three-months' internship in Grady Hospital under the instruction of the hospital chaplain, who is accredited by the National Council for Clinical Training.

Episcopal Theological School, Cambridge, Massachusetts. This school requires twelve weeks of clinical pastoral training under the Institute of Pastoral Care, the Council for Clinical Training, and other facilities approved by the school.

Garrett Biblical Seminary, Evanston, Illinois, of the Methodist Church, has these courses: Social Welfare and the Community, which discusses the parish system of relief, the

development of health programs, and aids to the physically and socially handicapped; Advanced Pastoral Counseling which includes studies of religious doubts and conflicts, guilt, and anxiety; a clinical course under the auspices of the Council of Clinical Training, which offers clinical experience in fields of mental illness, physical illness, and delinquency; and Laboratory Course in Pastoral Counseling.

Harvard Divinity School, Cambridge, Massachusetts, gives a seminar in Pastoral Care centering around a study of illness and bereavement.

Huntington Theological Seminary, Huntington, Indiana, of the United Brethern in Christ Church, catalogs a course in Pastoral Work which includes procedures of counseling and visitation.

Lutheran Theological Seminary, Gettysburg, Pennsylvania, has two courses: Pastoral Ministry, which discusses the preparation for the work of ministering to the individual, the sick and suffering, the sorrowing, and the family; and Pastoral Ministry to Problem Parishioners, which informs concerning physical, mental, and moral illness. Training at the Council for Clinical Training is recommended.

Mennonite Biblical Seminary, Chicago, Illinois, has one unit on the Pastoral Ministry which emphasizes calling on

the sick, and another, Personal Counseling, which includes counseling in physical and mental illness.

Princeton Theological Seminary, Princeton, New Jersey, of the Presbyterian Church, through Dr. John S. Bonnell offers, The Cure of Souls. Clinical Training at the New Jersey State Hospital in Trenton gives experience in counseling the mentally ill.

Southern Baptist Theological Seminary, Louisville, Kentucky, seems keenly aware of the needs of the pastor in the care of the sick. The course listed as "The Pastoral Care of the Sick and the Bereaved" covers the psychology of the various illnesses, both mental and physical, which a pastor encounters clinically. It continues with a psychological analysis of bereavement as it has been observed under controlled conditions, and as it appears under the pastoral situation. The particular role that religious experience plays in giving these common crises of people an ultimate meaning and determining the pattern of their lives is predominant in these psychological descriptions. This course uses the material which students bring from their parish situations as course data. In some instances, students are employed as part-time chaplains of hospitals. In this capacity they are sometimes able to provide fellow students with clinical opportunities.

The course listed Psychology of Religion is taught entirely in the context of hospitals over a period of ten weeks, summer term, when the student must spend full time taking this course. The case history, seminar, staff conference, and individual supervision of students' pastoral work are techniques used in the teaching of this course.

III. SPECIAL COURSES IN CLINICAL TRAINING

The Institute of Pastoral Care. There are six training centers in the United States that offer summer training in pastoral care of the sick. Four of the centers offer two sessions of six weeks each and two centers only one session. The location of the centers are chosen upon the basis of availability of competent pastoral supervision, the accessibility of staff members, and the institution's standing in its own profession. The aims as listed by the Institute are as follows: (1) to enable the student to gain an understanding of people, their deeper motivations and difficulties, their emotional strengths and weaknesses; (2) to help each student develop effective pastoral methods for ministering to people, recognizing his unique resources, responsibilities, and limitations--as a clergyman; (3) to help the student learn how to work cooperatively with representatives of other professions and to utilize community resources toward achieving more effective living; and (4) to encourage a desire for further

understanding, particularly such as may be obtained through appropriate research.

Full time work at an approved hospital is given during the period of training. During the first two weeks of each session, the students work three hours daily as volunteer orderlies, to become acquainted with the total task of caring for the sick. For the remaining four weeks, they serve as assistant chaplains and call on patients under the close supervision of the chaplain and his staff. Two meetings are held each day when members of the medical staff give lectures to the students; representatives of the Nursing Service, Social Service, and Admitting Office also meet and talk with the students.

All applicants must either be enrolled in, or alumni of seminaries or other accredited training schools, or have had three years professional experience, or present other qualifications which will bring them within the scope of the Institute's function and purpose.

The Council for Clinical Training. The aims of the Council are almost identical with those of the Institute of Pastoral Care. At the present time, the Council is composed of a group of approximately twenty-five well-trained chaplains who conduct clinical pastoral training programs in their separate hospitals, being representatives of the Church.

The Council accepts students for not less than one twelve week quarter. Increasingly students are requesting a year of clinical training which will furnish a more thorough and widespread experience.

Theological students in good standing in their seminaries, and their wives, receive first preference in appointment. This is particularly true during summer quarters. Clergymen and other religious workers receive second preference. They are encouraged to enter training at other than the summer quarters.

In the groups that come for training, it has been found that some students manifest tendencies that make for group disruption. Members of the group usually expect something to happen on their notebooks, not within themselves. Experience has shown, however, that the need is not always for more information; frequently a group atmosphere must be created in which the student can see himself in interaction with others, can dare to face his own needs, and can find help in effecting changes in his own behaviour. By accepting hostility without retaliation, permitting and encouraging expression of a variety of feelings, and continually striving to clarify what is happening, the group leader helps create the atmosphere in which members can be themselves and discard their defences. The inspiration of a good leader encourages members of the group to analyze their own social

interactions. Dr. Leslie[1] in this connection makes the following observation:

> The goal of the clinical training group is thus indicated as being one of stressing the importance of interpersonal interaction. Maturity in dealing with others cannot be learned from a book or from lecturing; it comes only after individuals have learned to accept each other with appreciation and have learned to set aside individual roles or personal prejudices or egocentric needs in the interest of working toward common purposes. It is the leader's task to initiate a permissive atmosphere in which the students feel free to talk of their own concerns. The goal of the group is then to seek out the deeper, more personal implications of each topic discussed. Contacts with patients suggest the topics for consideration; interaction within the group helps to make possible a personal application of phenomena observed in the wards.

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[1] Robert C. Leslie, "Growth Through Group Interaction," The Journal of Pastoral Care, 5:40, Spring, 1951.

CHAPTER IV

RECOMMENDATIONS FOR THE TRAINING OF THE CHURCH WORKER IN SICK VISITATION

The more desirable type of training available for the church worker is no doubt to be found among the various courses being offered at the seminary level. For here the basic biblical studies are likely to be taught against a background of modern scholarship, and much stress is now being placed on the practical aspects of the minister's work. Seminaries are offering clinical courses through the facilities of mental hospitals and general hospitals. While the seminary work is primarily for preachers, yet many of its offerings are in areas of interest to the church worker.

In the absence of seminary training, perhaps the best means of preparation for the duties of the church worker is a workers' training class conducted by the local pastor, who is a seminary-trained man himself. This plan seems to prove acceptable with the local church using volunteer workers.

Such a training course could be divided into three phases of study: (1) spiritual preparation; (2) intellectual preparation; and (3) psychological preparation.

Suggested content values for each of these areas of study are presented in this chapter. The way in which the

course is taught will of course depend somewhat upon the needs of the local situation.

I. SPIRITUAL PREPARATION

The writer, without pretending to include everything, suggests a core of values which in her opinion constitute a minimum requirement in preparation for the work of sick visitation.

Recognition of office. The church worker is, first of all, God's ambassador. The degree to which she will be a blessing to the sick will depend largely on what she herself is, and on the manner in which she will adorn the doctrine that she seeks to teach.

Courage. It is not an easy task to carry the "good news" to those who are ill. The secularity of the age tends to make it a matter of embarrassment to discuss religion with individuals face to face. It is often easier to speak to a group such as a congregation concerning religious matters.

Convictions and beliefs. The church worker not only needs to possess a sound Christian experience herself but also to be able to instruct others in the way. Although there will be questions of faith that she herself cannot answer and perhaps should not try to answer, she must nevertheless be a woman of firm conviction as regards the basic

Christian beliefs. She must herself be assured concerning the doctrine of God, the plan of salvation, the authority of the Bible, and other great truths. Without such convictions, the church worker can hope to do no more for her patients than offer them the consolations of psychology or sociology. Intellectual clarity concerning one's beliefs enables one to express them to others. The Christian is admonished to furnish reasons for the hope that lies within him (I Peter 3:15). Being able to present one's religious convictions coherently gives a needed confidence when dealing with others who have spiritual needs.

Confidence in God. The confidence that comes through quiet faith in God brings an inner poise and quietness to the worker. The believer wages his life that there is an explanation for much that he cannot explain. Strength to face tasks and tragedies and to explain the absurdities of daily life come in part from a fighting faith.[1] The Christian "is certain of God and so whatever comes to him after he has done his best, must be good. He will win even when he loses."[2] Even evils become good when they are welcomed as challenges

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[1] Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick (New York: The Macmillan Company, 1936), p. 116.

[2] Ibid., p. 328.

to the best in one.[3] A genuine religious faith enables one to rise above his suffering and not be defeated by it.

Prayer. Through prayer, one is brought into fellowship with God. The church worker can expect to sense the presence of the supernatural in her life if she will spend much time alone with God in prayer. To those who yield their lives to Him and wait for His guidance, there comes a deepening of the spiritual life that can be sensed even by non-Christians. One must know the power of prayer in his own life before he can appreciate what prayer will do for others. McElroy[4] states the results of prayer thus:

> There invariably comes to all who pray earnestly a peace of mind, a serenity and ease, a calm and composure, an inner poise, a contentment of mind, and a confident trust in a greater power, God--all of which gives a new lease to life.

There is therapeutic value even in the act of giving thanks to God. Quietness of spirit may come from a silent prayer. In confessing that his deeds and thoughts are evil, one can gain strength. Failure to confess not only may prevent healing of the sick, but it is very often the cause of illness. One gains a sense of perspective through prayer. Such perspective may be defined as "the ability to accept

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[3] Ibid., p. 112.

[4] Paul Simpson McElroy, Wings of Recovery (New York: Fleming H. Revell Company, 1947) pp. 32,33.

life as it comes, and then to stretch one's imagination and one's thought beyond the immediate."[5] Through prayer, patience and fortitude are received. These are not qualities which one can attain by his own strength.

Scripture and devotional literature. The Bible can really be appreciated by one who recognizes it as the revealed Word of God, and who loves and obeys its precepts. The strength of the Bible as a devotional guide lies in the fact that it speaks to the needs of the reader, challenging the best in him. The "Kingdom" within one must be cultivated, or it will respond to the stimulation of life and life's experiences only in a limited sense.[6] By daily reading and rereading, the church worker receives new insights of far-reaching value which escape the casual reader. There are many passages which meet specifically the needs of those who are sick. When the church worker understands the needs of the patients she should apply herself to finding those passages. When patients sense that the worker has a grip on the Scripture, they are more likely to place confidence in her.

The Bible must be kept central, yet much help can be received from other literature. Some principles may here be

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[5] Cabot and Dicks, op. cit., p. 235.

[6] Russell L. Dicks, "Devotional Literature in Pastoral Care," Pastoral Psychology, 1:45, February, 1950.

suggested to guide the church worker in evaluating devotional literature: (1) the material must be interesting; (2) it must be readable--the print large enough so that it can be easily read, the page not too full, and the style easily read and comprehended; (3) it must come to grips with life situations and living--be realistic without being sordid; (4) it must be theologically sound; and (5) it must stand up under repeated readings.[7]

II. INTELLECTUAL PREPARATION

This particular section discusses briefly the position of the worker in relation to the pastor, some facts about common diseases, certain knowledge concerning hospital rules, the health of the worker, and some of her miscellaneous duties.

Division of duty. The methods of the medical profession are often spoken of as modern and progressive while the methods of the church are frequently criticized as being impractical. It is true that hospital administrators and doctors have not always appreciated the part the Church has played in the care of the sick. Part of this failure has been due to mutual misunderstandings. However that may be,

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[7] Ibid., pp. 46-48.

let it be understood that the care of physical ills is the responsibility of the doctor while the minister is responsible for supplying an atmosphere in which the growth of souls is favored. When both professions understand each other, there comes a sense of comradship in the task that is shared.[8]

The church worker can do much to assist the pastor in his responsibility for the sick. Her duties will be limited as a rule to visiting parishioners. She will recognize that occasions will arise when the patient needs to see the minister rather than the church worker.

Common misconceptions concerning sick persons. Some people think that all sick persons are lonely. True, some of them are. But hospital care is now so enriched and the length of the hospitalization period has been so shortened through improved methods and medicines that the patient rarely has a solitary hour to himself. Others think that all sick persons are bored. If one takes a little time, however, to discover the areas of patients' interests, he will likely realize that life in the hospital is anything but boredom. The newspaper, radio, and postal service also do their part to while away

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[8] Cabot and Dicks, op. cit., p. 16.

hours that were in any danger of lapsing into boredom.[9]

Meaningless expressions of sympathy are frequently given by those who feel that sick people are in constant pain. Patients seldom hesitate to ask for medicine when pain gets severe, and they soon get relief. If the church worker happens to be present when a patient suddenly suffers a severe pain, she should notify the nurse in a serious, but not calamitous, tone. It needs to be remembered that a sick person in the midst of stark realities to which he cannot blind himself will probably be relieved if he can express the fears that plague him. Perhaps such expression may itself expose a certain ridiculousness in their content.[10]

There are a surprisingly large number of people who think that hospital patients are starved, forgetting apparently that diets are ordered by doctors according to the disease and condition of patients. There are not only regular meals, but most hospitals serve nourishments in mid-morning, mid-afternoon, and evening. Most of them, too, have rules that forbid the delivery of candy, cookies, nuts, and other rich foods to patients. Well-meaning friends may hinder the progress of the patients by disobeying rules.[11]

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[9] James H. Burns, "Pastoral Care of the Sick," Pastoral Care (reprinted; J. Richard Spann, editor; [n. p.]; Pierce and Smith, 1951), pp. 1-3.

[10] Ibid., pp. 2,3.

[11] Ibid., pp. 4,5.

Although hospital personnel, working hard to make patients well, seek to discourage all talk about death, it can be a very beneficial experience for patients to be permitted to discuss not only the possibilities of death, but in some instances even the details of the funeral. These times usually call for the presence of the minister, yet not necessarily. The worker herself can sometimes do lasting good. At times her main responsibility will end, however, when she notifies the pastor of the need here.[12]

Knowledge of common diseases. The church worker should be acquainted with the names of common diseases and should be familiar generally with the effects of disease on the mind and body. She should know the length of time a given patient is likely to be ill, what parts of the body are affected, what limitations of activity may be expected, and other facts which will add to her understanding of the problems of the patient. A chart prepared by the John Hancock Mutual Life Insurance Company concerning communicable diseases should be helpful (see p. 75). If the worker knows the symptoms of certain diseases, she should be able to advise whether or not the doctor should be called in.

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[12] Ibid., pp. 5,6.

TABLE I

COMMON COMMUNICABLE DISEASES

DISEASE	TIME TO OBSERVE EXPOSED CHILDREN	EARLY SIGNS	LENGTH OF ACUTE STAGE	COMMON COMPLICATIONS	PERIOD DISEASE REMAINS COMMUNICABLE	PREVENTIVE MEASURES
CHICKEN-POX	From 14 to 21 days; commonly 17.	Usually mild fever at time of eruption, which resembles small water blisters, occurring on both covered and exposed parts of body; appearing in crops.	Usually brief, 3-4 days. Child commonly does not feel sick.	Skin lesions may become infected.	From day preceding eruption to probably not more than 6 days after appearance.	Disease so highly communicable that 9 out of 10 children catch it; usually early in life.
DIPHTHERIA	From 1 to 7 days; usually 2 to 5 days.	Mild pain in throat, moderate fever, rapid pulse, swollen neck glands, frequently with grayish-white membrane visible on back or sides of throat.	Usually brief if antitoxin given early. Convalescence is protracted.	Paralysis of heart and throat muscles, bronchopneumonia.	At least 16 days after onset, (usually 2 negative specimens taken 24 hours apart required.)	All children should be protected with toxoid, before first birthday, another single dose is recommended on entering school.
GERMAN MEASLES	From 14 to 21 days; usually about 16th day.	Mild symptoms of head cold for 1 or 2 days, followed by eruption, first on face, then on body. (May be confused with measles or scarlet fever.)	Usually only few days. Child does not feel sick.	None.	From 4 to 7 days after onset of catarrhal symptoms.	Disease so highly communicable that most children catch it during epidemics.
MEASLES	10 days to onset of fever. 13-15 days to appearance of rash.	Moderate fever, puffy, watering eyes, catarrh. Lining of cheeks and lips studded with small bluish white spots. 1 to 2 days later, rash appears first on head, then on body.	Uncomplicated cases usually brief, rash lasts only about 5 days.	Chronic inflammation of ears, eyes, air passages; pneumonia.	Until the 5th day after the appearance of rash.	Avoid contact during infancy. (Babies and children below par may be protected by serum.)
MUMPS	From 12 to 26 days; usually 18 to 21 days.	Swelling of glands in neck, in front of and below ears. One side usually affected first, other side in 1 or 2 days.	Swelling usually subsides in week or 10 days.	Inflammation of other glands in older children and adults.	Not definitely known, assumed to be until swelling has disappeared.	Avoid contact (not a highly infectious disease) --most common in 5 to 15 year ages.
INFANTILE PARALYSIS	Variable; commonly from 7 to 14 days.	Symptoms of digestive upset, headache, fever, vomiting, followed by stiffness in neck, drowsy or irritable for about 3 days, then paralysis or muscle weakness.	Usually long if paralysis occurs; convalescence slow.	Paralysis of affected parts of body.	Not known, probably most infectious during the early stages and usually until after 2 weeks of illness.	Avoid contact with children with any illness especially during summer and early fall, if disease is epidemic.
SCARIET FEVER	From 2 to 7 days; usually 3 to 4 days.	Sudden onset, nausea, vomiting, headache, sore throat, "fur" covered tongue. Followed by bright red rash which fades when pressed.	Temperature usually returns to normal in week. Peeling occurs after 1 to 3 weeks.	Inflammation of middle ear. Damage to heart or kidneys.	Three weeks from beginning, and until all discharges have ceased.	Avoid contact. Children may be immunized with toxin, (usually not given as a routine).
SMALLPOX	From 8 to 16 days; commonly 12 days.	Sudden fever and symptoms of "grippe", 1 to 4 days later eruption appears, first on exposed parts, then on trunk.	Varies with severity of infection. Lesions last 14-48 days.	Infection of skin lesions.	From earliest signs to disappearance of all crusts and scabs.	If not vaccinated within 5 years immediate vaccination after exposure, (protects if given within a day).
WHOOPING COUGH	From 5 to 16 days; usually within 10 days.	Begins as ordinary cough, becoming more persistent and tending to occur in spells. Worse at night. Vomiting frequent. "Whoop" occurs in 1-2 weeks.	Variable; usually 4 to 8 weeks of "whooping" stage.	Bronchitis and bronchopneumonia.	Most catching in catarrhal stage and for at least 3 weeks of whooping period.	Children should be immunized against disease with vaccine.
COMMON COLD	Brief, from 12 to 48 hours.	Running nose, eyes watery, slight fever, "feels bad".	Usually 3-4 days with proper care; rarely more than 7.	Sinus infections, Bronchitis, Grippe.	Believed to be limited to early stages, probably not more than week.	Avoid contact with persons sick with cold. Practice of good health habits is assumed to be helpful.
INFLUENZA	From 1 to 3 days.	Fever, distress, aching in back and limbs, prostration, sore throat.	Usually 1-7 days.	Pneumonia.	Undetermined, probably throughout febrile stage.	Avoid exposure to crowds during epidemics, and contact with all sick persons.
PNEUMONIA	Believed to be short; 1-3 days.	Sudden onset, fever, pain in chest, cough (vomiting and convulsions in children), sputum tinged or streaked with blood.	Variable. "Sulfa" drugs frequently shorten acute stage.		Presumably until recovery is complete.	Avoid contact. Avoid chilling and exposure after colds and influenza.

A few common diseases not listed on the Hancock chart need to be mentioned. Heart trouble is one. Some of the symptoms of this disease are chest discomfort directly related to exertion or excitement, noticeable misbehaviour of the heart beat, shortness of breath when at rest or on slight exertion, and swelling of the feet and ankles due to slow circulation of blood. The person who is found to have some form of heart trouble will probably do well to restrict his activity, and to keep as free as possible from emotional strain. For the heart that has had serious damage due to infection or thrombosis, a long period of rest will be necessary. Often a complete revision of one's way of life must be made, if certain heart conditions are not to grow worse.

Rheumatic fever seems to follow an attack of a disease caused by germs of the streptococcus family--for example, tonsillitis, scarlet fever, or a streptococcal cold. The following concerns susceptibility to this disease:

> What makes an individual susceptible seems in most cases to be an inherited tendency to rheumatic fever, which may be increased by poor diet, inadequate protection from cold and damp, and crowded living conditions that give germs a chance to spread easily from throat to throat. Unfortunately, one attack of rheumatic fever makes a child more susceptible, rather than immune, to further attacks, and repeated attacks are more likely to damage the heart.[13]

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13 "Your Heart," (New York: Metropolitan Life Insurance Company, [n. d.]), p. 5.

The first attack of rheumatic fever usually comes between the ages of six and twelve. The earliest symptoms may be slight fever, nosebleeds, loss of appetite, failure to gain weight, and pain in the joints. The disease may attack all parts of the heart and sometimes clears up with no damage. Usually it leaves scars which interfere with the working of the valves of the heart. By following the advice of the physician with regard to work and play, the individual may be able to lead a productive and normal or near-normal life. Bed rest is essential during the acute stage of the disease and activity is very gradually resumed.[14]

Cancer is often well advanced before the individual is aware of what is wrong. The division of cells in the body is controlled by nature and the "brakes" are silently and effectively applied when adult size is reached. Sometimes the natural brakes fail and cells get out of control and start dividing rapidly to no apparent purpose. Nobody is quite sure what causes this to happen, although chronic irritation or inflammation appears to have something to do with it in many instances. Soon the clump of cells that is formed is crowding other tissues and organs out of space that belongs to them, taking the nourishment meant for other cells, and

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[14] Ibid., p. 6.

contributing nothing. When the clumps of cells grow slowly and remain in a limited area they are said to be benign tumors. Sometimes living bits of cancer are broken off and carried through the blood vessels and lymph channels to other parts of the body. This is called metastasis. When it has spread extensively to the vital organs, there is no surgical cure. The three accepted treatments for cancer are surgery, X ray, and radium; these are effective only if the disease is caught early enough. There are dangers connected with the use of X ray and radium which demand that the administrator be well trained.[15]

There are danger signals which one should be aware of that suggest cancer: (1) persistent lumps or thickening, especially in the breast, lips, or tongue; about the neck, armpit, or groin; (2) irregular bleeding or discharge from any natural body opening; (3) progressive changes in the color or size of a mole, wart, or birthmark; (4) sores, particularly around the tongue, mouth, or lips, that do not seem to be healing normally; (5) white patches inside the mouth or persistent white spots on the tongue; (6) persistent hoarseness, unexplained cough, or difficulty in swallowing that lasts more than two weeks; blood in the sputum;

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[15] Dallas Johnson, "Facing the Facts about Cancer" (New York: Public Affairs Pamphlets, 1947), pp. 6-9.

(7) a bone that is swollen or pains especially at night; (8) persistent and unexplained indigestion after eating or drinking; (9) alternate periods of constipation and diarrhea with no particular change in diet to account for it; rectal bleeding; (10) pain and difficulty in urinating; (11) sudden loss of weight; and (12) unexplained feeling of fatigue.[16]

Diabetes is a disease in which the body is not able to store all the sugar in the food which is eaten. The sugar accumulates in the blood stream, and when its concentration in the serum rises above a certain level it is eliminated in the urine.[17]

The onset of diabetes mellitus (the common disease) is usually acute in children, with loss of weight and strength, large amounts of urine being formed, and sugar in the urine. In adults the onset often is so gradual that the disorder is not noticed for months or even years.[18]

Treatment usually consists of diet regulation and the administration of daily injections of insulin. Patients frequently learn to give their own injections.

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[16] Ibid., p. 14.

[17] Charles P. Emerson and Jane E. Taylor, Essentials of Medicine (Philadelphia: J. B. Lippincott Company, 1946), p. 401.

[18] Ibid., p. 402.

Tuberculosis is caused by a bacillus that invades the lung tissue. Usually the body takes care of the bacteria by forming clusters of tubercles round the bacterial clumps and later depositing calcium. The lesion heals but is still seen on x-ray. If the body does not wall off the bacteria they multiply and destroy the surrounding tissue. Symptoms of the disease are loss in weight, poor appetite, "indigestion", a cough, and an afternoon temperature. The cough becomes more troublesome, the patient has night sweats, and there may be hemorrhage from the lungs as the disease progresses.[19]

Treatment for tuberculosis is aimed at improving the general health with respect to nutrition, control of infection, physical rest and emotional relaxation, and putting the infected lung at rest until signs of activity have disappeared. To rest the lung the patient is confined to bed. Artificial collapse of the lung is indicated in a large number of cases, especially if cavitation is present. Treatment may take only a few months but often takes a year or longer. Much patience is required to obey the rules of treatment.[20]

In addition to some general knowledge of certain rather common diseases, the church worker, visiting the sick, needs to acquaint herself with another phenomenon that sometimes arises in her work, the effects of drugs.

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[19] Ibid., pp. 111-114.

[20] Ibid., p. 117.

The effects of medications. The drugs used to kill or arrest the growth of germs usually have no undesirable reaction on the patient. If there are reactions, the patient will probably become irritable, nervous, nauseated, have a skin rash or some swelling of the tissues. The pain-killing drugs usually cause drowsiness, slow reaction to stimuli, deeper and slower breathing, and inability to concentrate, think clearly, and answer questions requiring mental effort.[21] If the visitor finds the patient dropping off to sleep frequently during a visit, it may be due to the drugs instead of the boredom of the visit.

Knowledge of hospital rules concerning visitors. Ministers are allowed large freedom as to when they may visit patients in hospitals but the church worker must confine herself to regular hospital visiting hours. The visitor should ask at the information desk the room number of the patient whom she wishes to see. She then goes to the floor where, after presenting the visitor's card to an attendent, she locates the patient's room. If the door is closed she should ask a nurse or aide if she may enter. Sometimes a patient keeps the door closed for quietness; at other times she may be having a visit from the doctor or receiving a treatment.

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[21] Harold N. Wright and Mildred Montag, A Textbook of Materia Medica and Therapeutics (third edition, revised; Philadelphia: W. B. Saunders Company, 1944), p. 142.

The church worker will receive information concerning the disease in point from the patient's family, who recognize in her a professional ally to the doctors and nurses. It is wise for the worker to consult the family as to the best time to visit the patient. The afternoon visiting hours are best; in the evenings there are more visitors. Most hospitals allow two visitors at a time with the patients but the rules vary concerning visitors on the pediatric, maternity, and isolation wards. When visiting a patient with a contagious disease, one should carefully observe precautions to prevent cross-infection.

Knowledge of community resources. If the church worker will investigate the social service agencies and private agencies in her town, she will no doubt be surprised at the assistance they offer to people. Such agencies as Family and Children Service, Homemaker Service, and Visiting Nurses Association counsel and work in the home at times of greatest need. Veterans have many benefits which they are often unaware of. A discussion of several social agencies listed in a directory of social agencies of Cincinnati, Ohio, will be found in the appendix.

Health of the church worker. The worker should not visit if she has a cold or is otherwise not feeling well.

Not only is she in danger of giving the disease to someone already in a weakened condition but she is herself the more susceptible to germs.

The duties of the church worker in visiting. If the patient has been an active church member, he will be familiar with the church worker and will perhaps be expecting a call from her. She can reassure him that the Church is interested in him, even though he is not able to attend, and that his friends are missing him. The worker as a representative of the Church, must conduct herself in the best possible manner. She comes in the name of Christ and even though she may not discuss spiritual difficulties with the patient, her manner must reassure the patient that she comes as an ambassador and willing servant of the Lord. Her duties will be determined in part by the confidence that the patient has in her spiritual depth. Normally, she will be expected to read from the Bible and to offer prayer if there are no other visitors present. In all her conversation she will use discretion in referring to the patient's sickness.

She can bring news of the church, especially of the organizations in which the patient has been interested. Easy reading material with a spiritual message may be appreciated by him. Some patients like to be read to. If the doctor feels that the patient is equal to it, the worker may even take a convalescent patient for a car ride.

Assisting the patient's family. If the patient is at home perhaps the most helpful thing that the church worker can do will be to carry a prepared meal to the home. This will afford a little rest for those burdened down with extra work. Sometimes arranging an afternoon away for the children will not only afford the older members a rest but will do much for the morale of the children. During an illness, children are often neglected, and may come to resent the one who is ill.[22] The church worker must be careful not to offer to do errands for the patient or his family unless she is prepared to carry out her promises.

Teaching the patient's family. There will be some things that the worker can teach the patient's family which will be of great value to the patient. Families often fail to realize the effect their expressions of grief have on the patient. They need to be taught to control their emotions before entering the patient's room. Sometimes the hospitalized patient is further afflicted by having to listen to an account of home troubles brought him by some unthinking member of the family. A family can undo much good that the doctor has done by upsetting the patient in these two ways.

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[22] Russell L. Dicks, When You Call on the Sick (New York: Harper and Brothers Publishers, 1938), p. 22.

Organizing sick visitation in the parish. There are usually some people in the church who enjoy visiting the sick. Most invalids have friends who need to be reminded that a visit from them would be appreciated. The family may be slow to suggest it. It is a good practice for the church worker to publicize a list of those who are sick in hospitals, nursing homes, old folks' homes, or at home. It is well to avoid having those on committees to visit the sick who are themselves unsociable, domineering, or busybodies.[23] Sitting up with the dying patient is a service which can be shared by those on such a committee. Families soon become exhausted with constant vigil, and need to be relieved.

III. PSYCHOLOGICAL PREPARATION

Personality of the church worker. Understanding, concern, and affection are requisite qualities in the one who visits the sick. Women are reputed to possess these feelings to a greater degree than men, yet women seem more likely to lack emotional discipline and control.[24] The church worker must be alert, improving her own personality in this direction. If she is rigid, and the ideas and behaviour patterns

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[23] Ibid., p. 25.

[24] Russell L. Dicks, You Came Unto Me (Durham, North Carolina: Duke University, 1951), p. 2.

of others disturb her easily, she should not be a "sick" visitor. A permissive attitude, which allows the patient to express his own opinions, feelings, desires, is essential to the work of visitation.[25]

The church worker should be quiet and composed in manner, able to listen with an understanding concern and to direct conversation into interesting channels. The church worker who tries to make each visit a learning experience, will be able to do untold good for those who are ill. Her primary motivation should be a genuine concern about the sick person's relation to himself, to his fellows, and to his Creator.[26] The effectiveness of the visit will depend upon the needs of the patient and upon the ability of the parish worker to meet the needs. No amount of visiting will help if the visitor is frightened, ill at ease, embarrassed, disgusted, or emotional. Dicks[27] has stated it thus:

> When you visit the sick, have your mind and your emotions disciplined and do not be surprised at anything you see, smell, or hear. . . . More harm can be done in an instant of surprise or awkward embarrassment than weeks of visiting can offset.

Through the visitor's poise the patient's confidence can be gained. It is to be remembered that ill will is

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[25] Ibid., p. 37.

[26] Burns, op. cit., p. 11.

[27] Dicks, When You Call on the Sick, op. cit., p. 7.

sometimes brought about because a visitor is too aggressive, asks too many questions, is too cheerful, or becomes too intimate and too personal, when intimacy is uninvited.[28]

Physical preparation for the visit. Because sick people are hypersensitive to odors, the church worker should avoid carrying into the sick room anything with a pungent odor. Even pungent mouth washes and strong perfume should be avoided.[29]

The church worker's appearance should be neat, with no unusual or bizarre items of clothing to distract the patient and focus attention on the worker herself. Since the patient is under stress to put forth effort to be pleasant, the less energy he is required to expend, the better for him physically and emotionally.

Approach to the patient. Because the visitor does not know the frame of mind the patient is in, she should approach him in a "neutral" mood, slightly on the cheerful side, so that she can adapt her mood to his. A strong introductory feeling on her part often demands an adjustment on the patient's part that is most taxing.[30] Preparation should be

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[28] Ibid., p. 10.

[29] Burns, op. cit., p. 7.

[30] Dicks, You Came Unto Me, op. cit., p. 12.

made for each visit by anticipating the personality of the patient, the type of his illness, and his reaction to it.

If the patient's door is standing open, it is advantageous to approach from the opposite side of the hallway. This gives the patient a little warning that someone is approaching.[31] If the visitor is natural and at ease, the patient will be more relaxed. The first few seconds with a patient furnish a clue to the patient's attitude.[32] If other friends are present it is best to retire, unless they insist on leaving.

It is best to stand unless invited to sit. When sitting, the church worker should choose a place from which she can be easily seen by the patient. It is best to remain stationary during the visit but if one must move the movements should be made in a casual, deliberate manner; quick movements tend to bother sick people.[33]

The visitor should be sympathetic, making the patient realize that his pain is shared, without unduly dwelling on it.[34] Her conversation should concern topics in keeping with the familiar subjects of the patient's interests. Usually a

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[31] Burns, op. cit., p. 11.

[32] Cabot and Dicks, op. cit., p. 181.

[33] Ibid., p. 14.

[34] Cabot and Dicks, op. cit., p. 21.

man is interested in the new hospitalization experience and the events that led up to it. He is interested in the things that have happened in connection with his illness and the things that have been done for him because of it. A woman is more apt to be interested in what has been said about her illness and the feelings and reactions that she and others have experienced. The second area of interest for men relates to their work; for women, family and home life.[35]

Often a patient gets much relief from just talking. Sometimes the listener may disagree, and this is certainly permissable, but she should not argue. Her role as counselor will depend on her past experience. She is not to give advice, but to listen. Hiltner[36] makes the following statement:

> Insight cannot be given; what the counselor does is to set up the conditions so that there is a chance that it may come. Insight means the recognition of connections between elements that have been present, but whose relationship has not been understood; and it may often involve recognition of the presence of elements not previously accepted as being there.

By listening carefully and jotting down the details of the visit afterward, the church worker may be able to tell if the patient has expressed any needs, and if her answers to his questions, or her directing of the conversation was adequate.

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[35] Burns, op. cit., pp. 14,15.

[36] Seward Hiltner, Religion and Health (New York: The Macmillan Company, 1943), p. 168.

The relationship between the church worker and the patient, the mood of the patient, and the privacy of the surroundings are some factors to consider before asking permission to pray. If an opportunity comes, prayer should be offered, but the visitor should be careful to avoid embarrassing the patient, or praying when the patient is not spiritually receptive.

The relationship between illness and emotions. Although the church worker may know the techniques of visiting, she must understand something of the emotional stress that the patient is under. The patient normally calm, friendly, and well-poised may be irritable, complaining, and disagreeable when sick. Illness may seem to cause these changes, yet they have probably been inherent all the time, the illness merely crystallizing them.[37] If the worker herself has had a serious illness she may more easily understand these changes.

Not only do the emotions become involved when one is ill, but emotions themselves can be the basic cause of illness. Dr. Sadler is quoted by Bonnell[38] as saying:

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[37] R. L. Dicks, When You Call on the Sick, op. cit., p. 2.

[38] John S. Bonnell, "Healing for Mind and Body," Pastoral Psychology, 1:33, April, 1950.

> If Christianity were practically applied to our everyday life, it would so purify and vitalize the race that at least one half of our sickness and sorrow would disappear. . . . Faith is an actual remedy for those physical ills which result from doubt, depression, and discouragement. I make this statement as a physician and surgeon. Fear is the cause of the worry and nervousness which are responsible for most of the functional diseases.

The American Medical Association has stated that about 50 per cent of all diseases are rooted in the mental and spiritual life and 50 per cent in the physical life.[39] Wise[40] shows how emotional factors may predispose to organic illness. Robinson[41] clearly delineates the relationship between illness and adverse social conditions, such as inadequate physical protection, inadequate economic protection, faulty personal habits affecting health, dissatisfaction connected with the family or other group relationships, and restricted outlets. Studies of the emotions show that with friendship, understanding and affection go the positive elements of confidence, hope, and faith--the healing emotions. Opposite these are the destructive emotions of resentment, hostility, hatred, loneliness and isolation, coupled with anxiety, fear, anger and discouragement.[42]

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[39] Paul Simpson McElroy, Wings of Recovery (New York: Fleming H. Revell Company, 1947), p. 20.

[40] Carroll A. Wise, Religion in Illness and Health (New York: Harper and Brothers, 1942), pp. 26,27.

[41] G. Canby Robinson, The Patient as a Person (New York: The Commonwealth Fund, 1939), pp. 18-46.

[42] R. L. Dicks, You Came Unto Me, op. cit., p. 22.

These destructive emotions, if harbored, lead to serious mental illnesses. Hiltner[43] affirms that a person tied up in knots inside himself cannot be helped by will power alone; but that if religion gives him a vision of meaningful reality which protects and brings safety and security, it may help him to look for evidences of security and affection that exist all about him and even in himself.

Fear can sometimes be lessened by an explanation or by concentrating on other thoughts. If the patient fears an approaching operation, it relieves him to hear his doctor's explanations of it. General reinvigoration of the body by means of sleep, food, affection, and companionship can be of inestimable value. Resentment and hatred in a patient can be removed by a forgiving spirit. Confession to God relieves the sense of guilt. Loneliness and isolation can be helped by having something to do and by being assured that someone is interested. Even a change of furniture, pictures, and other movable objects, or a daily routine with planned events may assist materially in the work of healing. If the church worker realizes that these feelings are apt to appear, she may be able to help the patient avoid them.[44]

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[43] Hiltner, op. cit., p. 31.

[44] Cabot and Dicks, op. cit., pp. 58-82.

In acute illness, there are fears of pain, of going to sleep under anesthesia, of incapacity resulting from illness, and of death. In a chronic illness there may be a gradual loss of strength as the disease progresses, and an increasing sense of frustration, loneliness, and boredom. If the patient is the breadwinner, the church worker may have to make arrangements for the support of the family. If the patient is the mother, someone must be found to do the housework and care for the children.

Even though patients in hospitals have little time for getting lonely, patients in convalescent homes, homes for the aged, and sanatoriums have much time on their hands, as the illness may lengthen into months and years. There is a need for companionship, for stimulus, for entertainment, and for occupation.[45] Rich returns await one who will take time to visit with some of the lonely sick who lack the will to live.

The shut-in also has emotional problems. Often he has been overprotected, receiving special benefits, having nothing expected from him and usually allowed to do nothing for himself. The worker needs to be alert to conditions of this kind and is in need of discretion in dealing with such cases.[46]

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[45] Dicks, When You Call on the Sick, op. cit., p. 6.

[46] Dicks, You Came Unto Me, op. cit., p. 16.

Spiritual response to illness. The highest purpose of the church worker is to assist the minister in showing men the way of salvation. Patients have been divided into four groups according to their spiritual condition. The first group includes those whom sickness has not aroused from their spiritual apathy. The next group are the spiritually aroused. The third group are made up of nominal church members. The last group is composed of tried and experienced Christians.[47]

The great spiritual crises of illness come before an operation, during a long convalescence when one faces life with a handicap, and when one is dying. Even the true Christian may be made to doubt. The patient needs to be reassured that the immediate cause of his anguish is a physical one, permitted by God to teach him to trust implicitly in Him. Later the experience can be seen to have strengthened faith rather than weakened it.[48]

Unbelief produces a worldly mind, self-righteousness, and ignorance; it causes one to lie on his deathbed indifferent to his soul's salvation. One who has put off repentance in days of pleasure and work may be expected to do likewise

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[47] Johan Christian Heuch, Pastoral Care of the Sick (J. M. Moe, translator; Minneapolis: Augsburg Publishing House, 1949), p. 59.

[48] Ibid., p. 125.

when pain binds him. In an incurable disease, the patient may deceive himself in thinking that the impatient yearning for death means that he is prepared to die. If the patient can be brought to the place where he recognizes even one sin that he is guilty of, then it is possible to begin leading him to Christ. In recognizing his sins, he may become alarmed over them and earnestly desire salvation. There is of course a danger of his mistaking this alarm over the consequences of sin for a true desire to become converted. He should be shown that when he is truly sorry for his sins Christ will save him. The way of salvation should be simply explained. After conversion, the worker should urge the patient to take God at His Word without depending on his feelings and to consider his Bible as the anchor of faith.[49]

It is important that the patient tries to understand his illness and search for causes. He must see too that his illness is not a unique experience. After pain experiences, he should be encouraged to look for hidden values. Jacob, in his wrestling with the angel, refused to let the angel go until he had blessed him. That is the purpose of every such experience of mankind--to leave a blessing behind it.[50] The

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[49] Ibid., pp. 68-108.

[50] McElroy, op. cit., p. 82.

church worker, in dealing with the sick, will never be satisfied until she sees in her patient an active faith that submits to God.

In case of death the bereaved should be encouraged to cultivate the recollections of events in the life of the deceased; this will bring grief as well as thankfulness, reverence, and deepened love. A love forgotten is a love dead, and while it lives there will be suffering in it as well as joy. This is also a time when the bereaved can come to know the comfort and strength that come from the Bible and prayer; this may well lead to a spiritual awakening of the family. Any assistance, both spiritual and domestic, that the church worker can give at such a time will usually be deeply appreciated.[51]

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[51] Cabot and Dicks, op. cit., pp. 317,318.

CHAPTER V

SUMMARY AND CONCLUSIONS

Just as Christ Himself set the example of love and compassion for the sick, so must the Church today exhibit the same loving care for the afflicted. Although the Church's record in caring for the sick is by no means without blot, it may be said that at no time in her long history have the lame, the halt, and the blind been utterly bereft of her healing ministrations. True, there were those times when the Church Universal seemed blind to her duties, yet always there were men and women of vision and love who by their example refused to let the torch of human compassion burn out completely. For a long period, ignorance and superstition played their part in perverting the Church's instinct for doing good. In process of time, however, great and good men and women here and there founded nursing orders, many of them among the religieuse of the Church herself; hospitals were founded and staffed with women of the orders. When secular interests and governments began to take greater stock in the welfare of the sick, the Church's enthusiasm seemed to wane. There are today, however, numerous church-affiliated hospitals, many of them ranking with the best in America. But the church hospital cannot be expected to emphasize in

her program the kind of sick visitation work that is peculiarly the province of the church worker.

It seems that seminaries and denominations, although recognizing the value of the church worker as a visitor of the sick, are nevertheless making little or no provision for preparation in this kind of activity. Only a few denominations maintain deaconess training schools. Certainly there seems to be small inducement to establish special courses in this particular part of the church worker's duties when it is remembered that few young women seem to be offering themselves as church workers. If financial remuneration for this type of work could be made more substantial it would no doubt largely remedy the situation. For it cannot be that the Church is lacking in young women interested in her work. The church worker as a visitor of the sick should command a significant place in the life of any church or community. Not only is her presence almost a necessity in certain church situations, but she can sometimes enter into a home situation more effectively than can the pastor himself.

The seminary courses relating to the work of the visitor are designed almost exclusively for pastors. Clinical training courses will often permit women to enroll, but they all are planned around the problems and needs of ministers. A few denominations suggest reading courses for visitors of the sick but they have no supervised visitation proper.

Perhaps the preparation of the church worker for sick visitation will continue to be neglected until the churches themselves come to realize the significant part that she can play in this part of the church's program.

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APPENDIX

APPENDIX

CERTAIN COMMUNITY PROBLEMS AND CERTAIN WELFARE AGENCIES WITH WHICH THE CHURCH WORKER SHOULD BE FAMILIAR

This chapter first takes up community social problems with which the church visitor should be familiar. Then it discusses resources for the welfare of the distressed that are available in many communities. Not all people have access to all of the agencies mentioned, yet a church worker is likely to be stationed in a city of some size where several or all of the agencies mentioned are available. The Social Work Year Book[1] has been used as a basic source for the material discussed in this chapter.

I. COMMUNITY PROBLEMS

Problems of the aged. Prevention of many problems of old age seems to be possible by the following methods: (1) preparation for old age by educating individuals to look forward to satisfying pursuits; (2) through scientific research as to the cause and amelioration of mental deterioration, such as to studies now being made on arteriosclerosis; and (3) by educating the community conscience to the needs of the older person and provision of appropriate measures for

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[1] Margaret B. Hodges, editor, Social Work Year Book (eleventh edition; New York: American Association for Social Workers, 1951), pp. 19-527.

satisfying outlets for individual expression and purposeful living, as well as services to care for the incompetent aged.[2]

Alcoholism. This has been defined as a complex, progressive syndrome characterized by the chronic uncontrolled use of alcoholic beverages and by various symptoms of psychological, physiological, or social maladjustment. There are two significant aspects to the emergence of modern therapy for alcoholism: (1) the growth of Alcoholics Anonymous; and (2) the development of specialized out-patient clinics for diagnosis and treatment of alcoholism. Alcoholics Anonymous is completely unprofessional, with the members relying chiefly on a nonsectarian spiritual philosophy and a program by which members make themselves available at all times to help fellow members maintain their sobriety. There are now many clinics for alcoholics and most of them combine the coordinated services of internist, psychiatrist, psychiatric social worker, and clinical psychologist. They aim at providing the individual with an insight into his own drinking problems and at helping him to alter his way of life so that he can make a satisfactory adjustment to himself, his associates, and his environment. The most effective outpatient clinical approach

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[2] Ibid., pp. 47-49.

also utilizes general hospital facilities for treatment of acute phases of alcoholism. Clinics also draw upon the cooperation of Alcoholics Anonymous on a reciprocal basis and upon the services of certain social agencies. The Salvation Army's social service centers for men are utilizing Alcoholics Anonymous as a supplement to their traditional religious and work therapy and have developed a program which seems both meaningful and effective for certain of their clients. Education of the general public to recognize alcoholism as a form of disease needing professional treatment is a big task needing attention.[3]

Blindness. Education of the blind is much more difficult when other handicaps besides blindness are present. Federal funds are available to the American Printing House for the Blind to provide books for schools for the blind. The Pratt-Smoot Act authorized an annual appropriation of one hundred thousand dollars to the Library of Congress for books for the adult blind. Talking Books are also available.

State and federal aid to the blind under the Social Security Act must be granted on the basis of individual needs. Missouri, Nevada, and Pennsylvania do not participate in the federal program. The federal government through the Veterans

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[3] Ibid., pp. 50-55.

Administration now assumes full responsibility for the rehabilitation of veterans and provides a disability compensation according to the degree of disability.[4]

II. COMMUNITY RESOURCES

Family Social Work. The social worker may work with an individual member or several members of the family, or with a single individual, but his emphasis is on helping people with problems that affect the unity and stability of the entire family. There are social agencies supported by both governmental and private funds. The governmental agencies are principally state, county, and municipal departments of public welfare which provide general assistance and, in cooperation with the federal agencies, administer the various categories of assistance provided for by federal legislation. The voluntarily supported agencies include local nonsectarian family service agencies established in nearly all the larger cities and many smaller cities and towns. There are also the sectarian family agencies, such as the Catholic, Jewish, and Protestant. Some agencies charge fees, which run from fifty cents to three dollars.[5]

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[4] Ibid., pp. 63-8.

[5] Ibid., pp. 183-189.

Homemaker Service. This is a service rendered in some communities by local nonsectarian agencies and is voluntarily supported. Sometimes it exists as a unit of the Family Social Work Agency rather than as a separate agency. The homemaker actually goes to the home to assume the duties usually performed by the mother. In a crisis, such as a mother's illness, a child is less disturbed if he is with those he loves and in surroundings familiar to him. If he is of school age, he has the additional advantage of not missing time from school or not having to change schools.

There is also a service for adults incapacitated by old age or otherwise. The homemaker goes to the home perhaps a few hours each week to do household tasks and other necessary work. Her presence usually contributes to the morale and the comfort of the afflicted. Some agencies call this adult work "housekeeper service", rather than "homemaker service".

Ideally, homemakers should be staff members of agencies with responsibilities and privileges that membership implies.[6]

Maternal and Child Health. This work has been defined as "the protection, promotion, and conservation of the mental

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[6] Ibid., pp. 225-228.

and physical health of children from the prenatal period through adolescence, and of their mothers throughout the reproductive cycle."

The organization was established by private agencies late in the nineteenth century for the distribution of milk to infants as a means of combating excessive infant mortality, particularly during the summer months. Gradually there were added to these stations the services of doctors and nurses, and of follow-up nursing services in the homes, to teach the mothers how to care for their infants so as to prevent illness.

The Social Security Act provides funds for grants-in-aid to the state health agencies for extension and improvement of maternal and child health services, particularly in rural areas and in areas suffering from severe economic distress.

Among the types of services developed are prenatal clinics, home delivery nursing services in rural areas, infant and child health conferences, school health services, mental health services, and dental health services.[7]

Public Health Nursing. This agency began in the 1880's as bedside nursing to sick poor in their homes, supported through voluntary contributions. The Association provides nursing care and health guidance to individuals and families,

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[7] Ibid., pp. 298-302.

participates in educational programs for nurses, allied professional workers and community groups, and cooperates with other professions and groups of citizens in studying, planning, and putting into action the community health program. There is a great emphasis on prevention.

Some of the larger associations have consultants in special fields, such as maternity and child care, tuberculosis, orthopedics, and dietetics. In some cities public health nurses arrange with the families to give nursing care as needed in the home, whether it be daily, weekly, or monthly. The cost is usually based on the ability of the families to pay for care.[8]

Public welfare. Social Security gives assistance to the aged, to dependent children, to the blind, and to the permanently and totally disabled persons in need. Casework is done to help determine the needs of the applicants. The average payment for old age varies widely, from twenty-five to fifty dollars a month. The aid to dependent children includes all the dependents under eighteen years of age. This organization does much counseling and handles children for foster care and adoptions, and those needing institutional care.[9]

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[8] Ibid., pp. 391-395.

[9] Ibid., pp. 402-411.

Social Insurance. This government organization handles the problems of unemployment and injury while on the job. Workmen's compensation was the first type of social insurance to be developed in the United States. It provides prompt payment to the injured or to dependents of the dying, regardless of who is at fault. Before this type of social insurance came into existence, an injured worker was required to sue his employer for damages and to establish that his employer was at fault. Workmen's compensation is based upon the theory that the cost of work injuries must be considered as a part of the cost of production. In all states, with the exception of four, the employer pays the entire cost of the benefits; in those other states, the employees are required to pay a small portion of the cost. However, benefits payable are limited in amount and takes into account only wage loss. These laws cover only three-fourths of the workers in this country; the largest group deprived of workmen's compensation is farm workers. Domestic workers, casual workers, and employees of nonprofit organizations are, however, also usually excluded. The percentage payable varies from 50 per cent to 80 per cent of previous earnings. There is usually a maximum period during which compensation may be paid. To the person with a temporary total disability, this maximum period varies all the way from one hundred and four weeks to no limitation.

In the case of permanent disability the usual type of law provides a specific schedule expressed in terms of weeks, the number varying with the severity of the disability. In the case of death most laws pay weekly benefits to surviving dependents for a specified period ranging from two hundred and sixty to six hundred weeks.

Unemployment insurance excludes many of the same workers that workmen's compensation does, namely workers in agriculture, in domestic service in private homes, in government service, and in non-profit organizations devoted exclusively to religious, educational, and charitable purposes. Weekly maximum benefits vary by states from fifteen to twenty-seven dollars. The period for maximum potential benefits ranges from twelve weeks to twenty-six weeks in a given year. Most states require that to be eligible for benefits, the claimant must have had a certain amount of employment or earnings in a twelve-month period prior to the beginning of his unemployment. Benefits are payable in weekly amounts which are generally intended to be 50 to 60 per cent of full-time weekly wage. Benefits are paid in no state unless the worker is able and available for work in the week for which he claims benefits. Nor are they paid for any period in which the claimant is disqualified, for such reasons as leaving work voluntarily without good cause, discharged for misconduct, or refused suitable work without good cause.

Under Social Insurance comes railroad unemployment insurance with benefits payable which vary from $17.50 to $50 for a two-week period of total unemployment for twenty-six weeks. Many of the provisions of this law are designed to meet conditions peculiar to the railroad industry.

Federal old age and survivor's insurance provides supplementary benefits for a wife sixty-five years of age or over and for unmarried dependent children under sixteen years of age or under eighteen if regularly attending school. The supplementary benefits for each of these persons amounts to one-half the benefits of the insured worker himself.[10]

Veterans' Benefits and Services. There are certain benefits which may be paid for a maximum of fifty-two weeks, for weeks of unemployment occurring within two years after discharge, but in no case may they be paid after July 25, 1952. There are provisions for vocational rehabilitation for handicapped veterans whose disability resulted from an injury received or a disease incurred in World War II, and whose handicap can be overcome by training. Training may last as long as necessary to accomplish vocational rehabilitation, within a maximum of four years, except as additional time is approved by the Administrator of Veterans Affairs. School

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[10] Ibid., pp. 472-482.

expenses and a subsistence allowance during training is furnished.

Monthly benefits for service-connected disabilities range from fifteen dollars for a 10 per cent disability to one hundred fifty dollars for a 100 per cent disability. Additional amounts are payable for severe disabilities, such as blindness and loss of limbs, with a maximum of three hundred sixty dollars monthly.

Pensions for nonservice-connected disabilities are available for those with at least ninety days' active service during either of the World Wars or the Spanish-American War. They can receive a pension of sixty dollars monthly, increased to seventy-two dollars after continuous receipt for ten years or attainment of the age of sixty-five. A veteran may be eligible provided his annual income does not exceed one thousand dollars, if he has no dependents, or two thousand five hundred if he is married or has minor children.

Veterans in need of hospital treatment for service-connected illnesses or disabilities are entitled to complete hospital care, either in one of the one hundred thirty-five Veterans Administration hospitals or, as authorized by the Veterans Administration, in other hospitals. For non-service-connected illnesses or disabilities, veterans who are unable to pay the cost of their hospitalization may be admitted to Veterans Administration hospitals when beds are available.

However, any veterans in an emergency condition may be provided immediate hospitalization by the Veterans Administration.

Veterans in need of treatment for service-connected ailments not requiring hospitalization may receive out-patient care, including medical supplies and necessary appliances, at out-patient clinics. Medical and psychiatriac service may also be provided by private physicians, upon authorization of the Veterans Administration, under the home-town medical care plan. Those veterans so incapacitated by a disability as to be unable to earn a living and in need, may receive domiciliary care in one of fifteen institutions maintained by the Veterans Administration.[11]

Vocational Rehabilitation. It is estimated that two hundred fifty thousand persons of working age become physically and vocationally handicapped each year because of congenital conditions, disease, or injury. Chronic disease accounts for 88 per cent; congenital conditions, for 2 per cent; occupational accidents and injuries, for 5 per cent; and accidents in the home and public places, for another 5 per cent. To be eligible, a man or woman must meet the following qualifications: (1) be at or near working age; (2) have a substantial job handicap

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[11] Ibid., pp. 522-528.

because of physical or mental disability; and (3) have a reasonably good chance of becoming employable or of getting a more suitable job through the rehabilitation services.

Three criteria are applied in determining whether medical treatment is to be provided at the agency's expense: (1) the mental or physical condition must be relatively stable or slowly progressive, and remedial, which differentiates the conditions from ordinary acute illness; (2) the treatment must improve the person's chances of securing suitable employment; and (3) the individual is financially unable to pay the expense from his own hands. A rehabilitation center should supplement in varying degrees the services existing in a community.[12]

Summary. Only a few community problems and possible community resources have been discussed, yet they should make the church worker aware of the fact that certain welfare agencies are at the disposal of certain types of incapacitated persons in the community. In this way the service she seeks to render should be the more efficient.

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[12] Ibid., pp. 529-536.