Church and Leadership:

Hospital Visitation: The Ins and Outs
by Ed Vasicek

**A realistic & honest approach for pastors and lay leaders**

1. **Introduction and Purpose**

In many churches, the purpose of hospital visitation is simply that it is expected. The custom of a pastor, lay leader, or other church visitor (as opposed to a visit by a friend or relative inside the church or without) is just something churches or pastors do.

Sometimes the issue can become silly. Some people may want to visit if they are having simple outpatient tests. Some people practically want you to go with them to the dentist. The demands and expectations of people, culture and custom can cloud the reason for visitation completely. This is especially true among rural churches.

The custom of visiting church members in the hospital is derived from the principle of visiting and encouraging the sick or helping people during times of distress. A couple of generations ago, people often went to the hospital for only the most serious situations. Babies were born at home, surgeries were done in living rooms and doctors made house calls. When you went to the hospital, it was a truly traumatic event.

Hospitalization went to the other extreme in the 1970s and early 80s. Doctors would put their elderly patients in the hospital for two weeks just because they had the flu! When I first came to Highland Park Church, I inherited some practices that I considered silly. I had to visit elderly women in the hospital who merely had the flu—and I was expected to visit them every day of the week. In those instances, the ladies had plenty of family attention, so it was not a matter of them being without support. Of course, this displaced more productive ministry. Needless to say, we now have a more sensible system in place. Where do these—sometimes silly, sometimes reasonable—rules come from?

Like an old European city that just "happened," many churches and communities have accumulated a hodgepodge of traditions that eventually dogmatize into expectations. A more reasonable approach should be based upon convictions and logic.

Let's begin with the purposes of a church (or clergy) visit to the hospital. Here are a few:

* 1. To share Christ with those who do not know Him (goodwill ambassador)
	2. To express Christian love to a person who may be afraid, discouraged, or lonely (fellowship and love)
	3. To show friendship to a member of the Body of Christ (relational development)
	4. To offer the encouragement of the Scriptures and prayer (spiritual edification)
	5. To affirm that the church family is there to support the person (sympathy, empathy and solidarity)
	6. To minister to the person and family in times of death, fear and uncertainty (emotional, spiritual and psychological support via one's presence); Paul Cedar refers to the "sacerdotal presence" of a pastor. Although theologically questionable, to many people the presence of a pastor psychologically and emotionally symbolizes the presence of God's care.
	7. Rewarding people who have faithfully served our church by honoring them with some attention (recognition) when they feel vulnerable. Though this may sound trite, relationships are built around reciprocity.

**When people are hospitalized, they feel vulnerable and need the comfort of a church shepherd; they need to be pointed toward the Good Shepherd.**

1. **Visits: From Priority to Luxury**
	1. **Crucial visits** include ministering to those who are dying, have been traumatized, or who are concerned about the destiny of their souls. Crucial visits are priority visits.
	2. **Needed visits** are not as time-sensitive or immediate. I suggest visiting before a significant surgery (usually the day before at home, since most folks enter the hospital the morning of their surgery). A visit a few days after surgery is often appreciated as well. For more info on frequency of visits, see section V, letter A.
	3. **Optional visits** include people who are only in the hospital for a day or two, women having babies, or stopping by someone I saw yesterday because I happen to be in the hospital the next day to visit someone else. If I choose to visit someone who is not part of the church family (perhaps a relative of someone who attends), that constitutes an optional visit. If someone from the church asks me to visit a relative (locally), I usually do so (one time only). If they say, "If you are at the hospital and you'd like to drop in..." I will visit them if I am in the hospital, but will not make a special trip.

I do not feel obligated to visit people outside our church family but will do so to maintain good relationships with those who are part of the church family. Occasionally you might have a church member who thinks you have nothing to do and are looking for people to visit. In that instance, you will need to inform the church member otherwise.

* 1. **Token visits** involve making visits for no practical reason other than to please people, keep the peace, or satisfy tradition. You are not really ministering; you are not keeping people in touch with the church because token visits most often involve irregular attenders who do not really care that much about the church. A good example of a token visit would be when you are asked to visit a non-attending spouse who is having a heart catheterization. This patient has no interest in you or use for spiritual things, but his or her spouse thinks that this might provide an opportunity to witness. In rare instances, someone might actually be saved through such a visit, but typically the visit is token. I rarely volunteer to make token visits, but I have made hundreds of them over the years at the request of others. I now will only do this if the visit is local.

1. **Levels of Authority**
	1. **Clergy (Pastor)** are generally acknowledged by hospitals and are typically able to gain entrance anywhere at anytime (if the patient wishes). Pastors who are local are sometimes urged to view a video, etc. to orient them, but this is becoming less common.
	2. **Elder in lieu of a pastor** may have a more difficult time getting into intensive care (other than during family times) or getting admission apart from visiting hours. If you are in this situation, it is good to explain that the pastor is out of town and that you are a member of the church's ruling board. It doesn't hurt to mention that you have received some training. If possible, visit during standard visiting hours to avoid complications.
	3. **Elder** who is just visiting may find it easiest to work within visiting restrictions.
	4. **Layman** (same advice as above)
		* Note: privacy laws are goofy. If you go to the information desk and ask, "Is Joe Cacutza here?" they will tell you that they are not allowed to say. But if you say, "I would like the room number for Joe Cacutza," they will give it to you, but not if you asked that first question first! **So go with confidence as though you are sure the patient is there**. If he has gone home, all they will tell you is that, "We have no one here by that name."

Silly, ain't it?

1. **Description of A Typical Visit**

You drop by the hospital and ask for the room number of John Doe. You take the elevator and locate his room. His door is opened, and so you find John's half of the room. If his curtain is pulled, you should ask him for permission to come in. If John's life is not hanging in the balance and he is sleeping lightly, you call his name or gently touch him. If he does not wake up, leave a note. If you have traveled a long way (e.g., Indianapolis), ask a nurse to wake him if it is advisable.

If he does not know you, introduce yourself and tell John that you are from Highland Park Church (do not just say, "The Church;" don't assume he knows). You mention how you came to hear that he was there, and then you ask, "How are things going today?" Do not ask, "Why are you here?" John may or may not tell you about his condition (maybe he has been castrated or has STD, or maybe a woman is having a partial hysterectomy, for example). Discuss what he wants to discuss. If he wants to tell you all the gory details, listen. If he seems uncomfortable with you, cut it short.

After discussion, read some Scripture (I love **Psalm 86**, **27** and **Psalm 138**; **Isaiah 40:27-31** is special, as is **Philippians 4:4-9**; if he is not a believer, I suggest **John 3:1-18** or **John 14:1-7**). *Avoid reading Psalm 23 (unless the patient is near death) because Psalm 23 has become associated with death and funerals.*

Then I offer a brief prayer, praying for God's blessing upon him, the medical team, for God to prosper the treatment and to encourage his heart.

1. **Important Considerations and Etiquette**
	1. **Considerations**

During the first few years of my ministry, I would pray with people in their rooms the day of surgery. I would try to get there about 6 a.m. before they started injecting them with tranquilizers. As insurance companies and the government cut back, the entire equation changed. Patients now arrive in the surgery area that morning and are usually eager to be ushered right into wherever it is they must go. The pastor or visitor is often in the way, a person who delays the admission process.

Besides the fact that I hate to get up early in the morning, this change forced me to adjust my previous routine. I now try to meet with the patient at home the day (or sometimes two days) before surgery. Why sometimes two days? For some surgeries, the patient has to get an enema and take laxatives to clean them out. The resultant situation is not conducive to a visit!

If a surgery is particularly dangerous, I might stay with the family—or, if local, I check in and out. Otherwise I rarely sit with the family during surgery.

* + - **How long should you visit?** That depends. **The average hospital visit is probably 15 minutes.**Here is a possible guide:
			* A stranger or person you barely know: 10 minutes or less
			* In intensive care: 5 minutes or less
			* A person you know who is in pain, sleepy, or has company over: 5 minutes or less (You might stay longer if the person is feeling well and has company, particularly if you know the company.)
			* A person you know who is alert, not in great pain and feeling social: half an hour
			* Vary with the situation: a widow without family who is feeling well might enjoy your company more than someone who is getting more company than they can handle....
			* Pay attention to clues: yawning, heavy eyelids, or verbal clues; as a rule of thumb, it is better to under-stay than over-stay
		- **How often should you visit?**
			* For local hospitalization, I visit patients twice a week (always at least once and sometimes three or more times).
			* If they are out of the area (more than a 30 minute drive), I'll visit them once a week. If they are in Indianapolis, I usually do not see them unless they are going to be hospitalized for more than 4 days.
			* If they are in an extended care unit (a sort of in the hospital recovery/rehab facility), I'll visit them once a week.
			* If they are in a bad way or near death (in intensive care, for example), I will usually visit them daily and, if near the end, two, three, or even four times a day. If death is at hand, I stay there.
			* If people choose hospitals (or nursing homes) out of our area, the consequence is that they are less accessible. On the other hand, if they must be elsewhere (e.g., car accident, life-lined, need a specialized treatment etc.), then we must be willing to bite the time bullet.
			* The visitor must flex with the situation. It is good to have minimal guidelines, but one must be willing to visit more often when one senses it is making a significant difference (or the need is greater).
	1. **Etiquette**
		+ Do not sit on the bed
		+ Use caution in shaking/holding hands; I often avoid doing so unless the person wants to; I might touch a hand in a distressing situation. You do not want to interfere with IV's, etc. and you don't want to spread germs to a person whose immune system might be compromised
		+ Mealtimes happen. Cut your visit short (less than 5 minutes) if the person is eating (unless they are nearly done); you might offer to come back in 15 minutes, find a lounge and have a devotional time, check out the gift shop, or read the paper.
		+ Medical people enter to do a procedure from time to time; it is best to exit.  If a therapist is coming for therapy, etc., they will often give you 3 minutes to pray if you ask.
		+ Bedpan issues can be embarrassing; if someone says they need to go, get out of there; do not make them cringe. If the curtains are drawn as you enter the room, ask a nurse if it is okay to go on that side of the room. If the person on the bedpan, see #3 above.
		+ Appropriate and inappropriate questions/comments. Do not ask them what their condition is, why they are there, or if they think they are going to make it.
		+ Never minimize the comments people make as though they have no right to have the feelings they have. Encouraging denial is encouraging lying or going underground with one's thoughts.

If they tell you they think they are going to die, they might be right (but they might be wrong). If someone says they are miserable, please, do not say, "Well, it could be worse," or, "Mrs. Jones has it worse." Finding comfort in another's misery is plain foolish.

*Comment:* I think I am going to die.
*Response:* I hope not, we would all miss you. I know you are ready to meet God (if the person is saved), but we would like to keep you with us longer.

*Comment:* Sometimes I wish God would take me. I'm no good here.
*Response:* I don't blame you. A lot of people feel that way, and you are not wrong to think that. Even Paul said he preferred to be absent from the body but present with the Lord. But God has reasons we do not understand, and God's ways are not the same as ours.

*Comment:* Sometimes I get mad at God because He allows me to go through this.
*Response:* Don't feel guilty about that. David wrote a lot of Psalms complaining to God because He felt the same way. Tell God exactly how you feel; He can take it.

* + - Sleeping patient issues are common. If a person's life is not in the balance, I usually try to wake them by calling their name or lightly touching their arm. If this does not wake them, I assume they need the sleep more than my visit and I leave a note (see section IV for exceptions).
		- Visiting out of town? Call first to be sure the patient will be in his/her room and is up to company. Why drive an hour and a half to visit a patient who is so heavily sedated that he or she will not even remember your visit?
		- When you pray for the patient, ask God to bless, comfort and heal his or her roommate as well.
		- Things to pray for: God's peace, wisdom for medical personnel, prospering of treatment, alleviation of pain, God's will for healing.
		- Do not visit if you have a cold or contagious condition. A phone call is better in such cases. A patient's health is more important.
		- Focus on the patient unless the visit is long (longer visits might be appropriate for old friends who are feeling well but are bored).
		- Work around test and bath schedules: afternoons or early evening are usually the best time to visit, or very early morning 6:30 or 7.
		- Avoid being a medical know-it-all and do not put down a patient's doctors.
		- Be alert. If patients eyes are heavy, cut it short. If patient is nauseous, cut it short. If your presence might embarrass a patient, make it short.
		- If the door is closed, check at the nurse's station before entering: someone may be on the bedpan or receiving a bath or change of dressing.
		- Hospital Rules
			* Privacy laws limit what they can tell you at the desk or over the phone. Never ask, "Is so and so there," but I'd like the room number of..." (or if on the phone, "I'd like to speak to a patient, Jack Sprat.")
			* Volume issues: do not talk too loudly, but loud enough for the patient to hear you.
			* Number of visitors is sometimes limited by hospitals to two at a time although this has become less common.
			* Intensive care visits are usually restricted to family only (except when death is imminent) for five minutes on either odd or even hours; clergy can generally visit any time. But remember, people who are in intensive care are there for a reason; keep visits short.

1. **Hospital Areas**
	1. **Standard room, before surgery**
	2. **Standard room, after surgery**
	3. **Emergency room**: Sometimes, in dire situations, I will stay with a family in the emergency room or waiting room; often I have a 5 to 10 minute visit and leave; it depends who is there (someone alone may appreciate your company) and the situation.
	4. **Intensive care** means limited access except for clergy; you really want to avoid getting in the way here.
	5. **Hospice care** is a section for those who are in the process of dying often of cancer.
	6. **Deathbed situations** are hard to call. I mostly visit in and out during the day/night and take my best guess as to when death is near; I try to be present when the person actually dies and for maybe an hour afterward (while the family grieves). Laymen, in a pastor's absence, would be expected to stop in several times for maybe 15 minutes at a time. He might return (depending upon his schedule) when called in at the point of—or immediately after—death. He should pray, perhaps reading from **Romans 8:18-39** or **1 Thessalonians 4:13-17** and then offer prayer. I sometimes leave at that point, at other times I wait for the undertaker. Every family expects or needs other things. Sometimes a minister can be in the way or, while not in the way, not necessary either.
	7. **Contamination hazards** may require you to wear a robe, gloves, and/or a mask. As you leave, dispose of them in the appropriate container and wash your hands with disinfectant soap. In these instances, a sign is posted on the door. You can ask a nurse for assistance.
	8. **Psychiatric wards** are tough to get into. Even family and clergy are only allowed to visit at the request of the patient and then at certain hours (since patients are often participating in group sessions). Laymen should probably not even attempt to make these visits. Pastors should work through a family member for direction.
	9. **Maternity ward visits** are great if you have time to make them, but I do not stress out my schedule to do so. If there is a problem with the baby, they obviously become a necessity. Because of issues like nursing babies, etc., I have long felt that women friends are the best visitors in the maternity ward. When I visit, I always knock first and I keep my visit brief. I never ask to hold or touch a newborn. I offer prayer for mom, the family and the newborn.

1. **Conclusion**

The question still remains, "Where do these rules come from?" There is no ultimate authority when it comes to hospital visitation. Customs vary between regions and expectations vary from one congregation to another, from one generation to another. Unfortunately, much of this ministry is defined by the expectations of tradition and culture rather than reason and actual spiritual impact. Nonetheless, much (perhaps most) of the ministry of hospital visitation is valuable, in my view.

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**Appendix: Anointing with Oil and Taking Communion**

1. **Anointing with Oil**

**James 5:13-16** is a text that raises many questions. It reads:

Is any one of you in trouble? He should pray. Is anyone happy? Let him sing songs of praise. Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective.

Like the style of Jesus when preaching the Sermon on the Mount, the book of James reduces things down to black and white and is far from complete in what it addresses. This is part of the Rabbinic "Hot and Cold" style of teaching and this style of teaching often raises more questions than it answers. It presents truth but not whole truth.

Very quickly, my understanding of the "prayer of faith" is that God gives that prayer (it is not conjured up by our own willpower or adrenaline).  If He gives that prayer, the person will be healed. Some sickness may be a result of sin and so confession of sin to God—and a confession to a Christian confidant—may itself prevent some (though not most) sicknesses.

But our focus is the use of anointing while visiting in the hospital. I would suggest doing so as follows:

* 1. The sick person (or a close family member) should request it.
	2. The elders of the church should administer it. This would not necessarily require ALL the elders but at least two and preferably more.
	3. Some interpreters understand oil to be one example of medicine and that James is talking about a combination of medicine and prayer. Although it is right for Christians to take medicine while also praying, I do not think that this is James' point.
	4. Others see the oil as symbolic of the Holy Spirit. I believe this is more accurate. But some say that since the oil is symbolic, it is unnecessary. I have a problem with that reasoning. I am among those who believe that both baptism and the Lord's Supper are symbolic. Yet, because the symbol represents something greater does not mean we should eliminate the symbol. It is true that the symbols seen in the Law foreshadow the work of Christ, but we are not talking about Old Testament symbols. If God commands us to use the symbol, we should assume God knows what He is talking about and that the symbols are important. God is not out to entangle us with busywork.
	5. How we do it, when we are called in (usually for a serious illness) is as follows: I (or any elder) rub a little olive oil on the forehead of the sick person. The elders lightly lay one hand on either the head or shoulders of the sick person and we each pray for God to heal that individual, according to His good will.
	6. In my experience, I have noted one instance where God has miraculously healed a man with an irreversible disease (interstitial fibrosis). In other instances, I have noted no difference between prayers with anointing and other prayers. Still, it is important for us to obey God for no other reason than to obey. But there *are*other reasons: the rare instances of healing that may not occur otherwise, the blessing it is for the sick person to feel loved and the way it ministers to all (the sick person, his/her family and the elders themselves).
1. **The Lord's Supper**

Many churches have their own traditions regarding the Lord's Supper. I am writing primarily for independent churches who hold to 1) the priesthood of all believers and 2) the symbolic nature of the Lord's Supper.

In my view, any believer is free to celebrate the Lord's Supper with any other believer at any time. I have rarely celebrated communion with someone while in the hospital, though I have partaken of the Lord's supper many times with shut-ins at nursing homes or in their homes often around Good Friday.

Simply bring a couple of paper or disposable cups, some grape juice (or wine, if that is your custom) and some matzo (or oyster crackers).

* 1. Read **1 Corinthians 11:23-26**.
	2. Have a moment of silent prayer to confess any sins and to prepare our hearts. Then offer a short prayer mentioning the broken body and shed blood of our Lord Jesus Christ.
	3. Distribute the bread saying something like, "This pictures the Body of Christ; let's partake together." Then eat the bread.
	4. Do the same with the cup saying, "This cup is a picture of the Blood of Christ; let's partake together."
	5. Close in prayer thanking God for the salvation these elements symbolize.

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|  | Pastor Ed |