

## “The Priest’s position in the Hospital”

### 6th SESSION

#### Round Table Discussion: Pastoral Care in Hospitals

From ancient times, healing was seen as a divine act and medicine was seen as an extension of God’s grace. In Ancient Greece, the sick were brought to the Asclepiad so that they could be cured by divine intervention while receiving medical care. During the early years of Christianity, either in the East and the West, hospitals were built, either next to the Cathedral or they were directly associated with monastic communities. The most outstanding examples of such complexes in the East are those of the *Hospital of St. Samson* (6<sup>th</sup> century), which was located just next to the Patriarchal Church of St. Eirene, toward the side facing the Great Church of Christ (St. Sophia), and the *Hospital of the Pantocrator Monastery* (11<sup>th</sup> century), both in Constantinople. Another is that of the *Hospital of the Holy Spirit* in Rome (12-13<sup>th</sup> century), which was part of a monastic community and also had a school of medicine during the Frankish rule. In all of these therapeutic communities, the center point of reference was the καθολικό or καθεδρικό. In certain care facilities, such as that of the Hospital of the Holy Spirit in Rome, there was even a sanctuary within the wards so that the sick could always have a view of the holy altar.

Whether the hospital or “ξενώνα” was founded by the emperor, the bishop or a layman, the institution was always placed within an ecclesiastical context. This expressed a very clear attitude about illness and health care. 1) The institution was founded not just to provide means to attain good health but to provide all the means for one’s salvation – both the founder’s and the sick. 2) That one of the major components of health and wholeness (body and soul) is directly related to one’s faith. 3) That one’s faith and salvation cannot be seen separate from the whole body of the church as expressed in the Eucharistic community of the faithful.

Therefore, there is a direct relationship between healing and the Eucharistic community. It is through the Eucharist, celebrated by and in the name of the bishop, that Christ and the Holy Spirit become present in the healing process, each in their own way, expressing the philanthropic love of the Father, uniting the sick with God’s healing grace as a sign of the advent of the His Eternal Kingdom.

The Typikon of the Hospital of the Pantocrator is precise in its Eucharistic orientation. It states that four liturgies were to be celebrated a week, with liturgies on special feast days in both chapels of the institution, and one priest was designated to hear confessions. All the staff, including the doctors, would embark toward their daily tasks after common prayer. Also, funerals and memorial services were chanted by special choirs for those that reposed in the

hospital, expressing an eschatological perspective to the institution and to healing itself.

In a very symbolic way and throughout the history of the Church, the cathedral has a central place in each man's life and in the life of the community. It is the place where we turn to in our deepest distress, where we seek advice, healing, meaning and joy. Today, the "Cathedral of Health" has been moved from the Church to the secular hospital and has become a commodity. Health has gone from *caritas* to marketplace. Health care is one of the main products given to the general population from the state authorities. Using high-tech tools, from the laboratories and factories of impressive modern medical research, it promises the commodities of wealth, happiness, miraculous victory over diseases, control and administration of life and death. It even attempts to control whether life should start, be prolonged or be ended, whether it be before birth and or at the end of illness. In this cathedral, divine grace, as the main source of healing, has been replaced by wealth and economy that relies solely on the "progress" of medical science. This "progress" is the basis of optimism and truth-finding. In the past, priests and medical doctors worked side by side in the traditional cathedral of Divine Grace, each taking on a therapeutic role and performing miracles. Today, we see that economists, administrators and legal advisors have taken over the "cathedral of health" and direct it as if it were an industry.

Where is there room for pastoral care in this post-modern "cathedral of health"? In fact, is there any room for faith and the clergy in this cathedral at all? What is our position and role as pastors within this cathedral's hierarchy?

Before answering these questions, we must determine the identity of the pastor within health settings. It is important to do this because today, there seems to be a great deal of confusion regarding this basic question, basically because of the changes of the hospital and the way the priest is seen. The identity and role of the pastor in health care settings basically has not changed in time. Both in antiquity and modern times, the presence of the pastor expresses the confrontation between life and death. His symbolic presence will often provoke questions in the sufferer, questions that have to do with origin and destiny, with existence and extinction.<sup>1</sup> This confrontation does not have to do just with one's physical well being but with existential concerns. It centers on fear of loss on a personal and interpersonal level, the fear of dependence and the fear of facing one's personal vulnerabilities and limits.

When one suffers, one is not only confronted with human limits and with human finitude, but, most significantly, with sin and its consequences. It is an encounter with the broken nature of man as it is seen in the light of eternity, and it affords us the possibility of coming into the knowledge of the truth about our own being, the world around us and God Himself. Confronted with the knowledge of the Truth, we must decide whether to remain exclusively concerned with the quality of life as a physical condition or to transcend our

own beings, concerning ourselves with the quality of our relationships and the world around us and beyond us.

In this crisis, the pastor's responsibility is not to remove the symptoms of physical suffering, but to journey with the sufferer to find the meaning suffering holds about life. He is there to assist the sufferer and those around him to find true life on a relational level. His task is to help the sick move from the quality of one's physical condition to the quality of relationships. This is why *metanoia* (repentance) is so central in caring for the sick. The meaning of *metanoia* in relation of life, illness and death is a clear decision to transcend ourselves, to redefine our relationship with God and man and to enter into the community of the Saints through the Eucharist. Thus, the pastor's diachronic role is not to provide a lenitive antidote to one's suffering with encouraging words, but to become a co-sufferer in one's pain, offering acceptance and compassion in one's journey to redefine life and his or her relationships. What we must remember though is that when one enters another's suffering and pain, one enters into a sacred space where God's grace may reside. Therefore, one must enter this space with utmost reverence, respect, caution and care, not disregarding the distinctiveness of the personhood of the other.

In an Orthodox context, the identity of the pastor has not changed. What has changed though is the context in which he must play out his role.

1. Today's hospital for the most part has lost its community character. Today there is an obvious depersonalization of medicine and health care and, correspondingly, to the hospital setting. The result is that the patient is not seen as a person – *πρόσωπο* and is not treated in a "personal way" and the medical staff does not really interrelate with one another on an interpersonal level as in the past.
2. The role of the priest serving the hospital has lost its pastoral content. He is seen by patients, family and staff as someone who performs "liturgical rites" and administers the sacraments in a totally legalistic way. In many cases, this image of the priest is perpetuated because he sees himself in this way. In many cases, this is perpetuated because the priest sees himself in this way. The presence of the priest has thus become an "omen" of death and not a door to life.
3. The loss of the pastoral content of hospital care has lowered the qualifications for being a hospital chaplain. Very few times have I personally heard of a priest being assigned to a health care facility because he has special qualifications for such a diaconia. One thing is for sure. Without qualifications, he will run short in being able to foster the proper communication skills needed in dealing with patients and staff, creating distancing on his part and by others.

4. There is a breakdown of the ecclesiastical community, particularly in urban situations. This is a characteristic that is particular to Greece, where there is a greater Orthodox population, and less so in the parishes of the diaspora. With the breakdown of the ecclesiastical community, the priest is not really aware of who is sick or hospitalized in his parish. His parish operates within the realms of anonymity. The inability to identify the patient in one's parish is also complicated by the various superstitions people have in relationship to clergy and illness.
5. There is not a working relationship between the hospital priest and the parish priest. Therefore, there cannot be any pastoral continuity upon admittance or after discharge. Specific spiritual and psychological needs of the patient are left "to fate", without any follow up. This is coupled with the growing problem in that the duration of hospitalization is decreasing rapidly. Therefore, patients with chronic illnesses that undergo frequent hospitalization, such as kidney patients, cannot be cared for properly.
6. With the privacy acts and data protection acts that have been passed on all international governmental levels, a priest may never be informed as to who the Orthodox patients are being hospitalized. On another level, the hospital chaplain may be denied by the staff to be informed regarding the patient's medical condition. Thus, we are not able to provide the care which is greatly needed, particularly to those who are alone and abandoned from family and friends.
7. The great increase of migration across Europe and Americas has resulted in individuals of many Orthodox minority groups who live very much alone. They often are separated from family, trusting relationships and their church. When they undergo hospitalization, they often do not have contact with anyone that knows their cultural and religious background. In many cases, these individuals cannot even speak the language of the country they reside and work in, resulting in poor communication for even the most basics of their medical care. These patients usually remain alone in their attempt to deal with their physical, psychological and spiritual pain.
8. In Orthodox countries, there is a disproportion of the priests serving the hospital in ratio to its patients. In many cases we have hospitals with 1000 beds that are served by one priest! Compared to many European Standards, this is unacceptable. In Spain, for instance, a hospital with 1000 beds would have four

full time priests. This disproportion verifies how we have lost our pastoral consciousness.

9. The privatization of medical care and the development of a “medical industry” have given way to the establishment of many private hospitals, most of which do not have any “religious” or ecclesiastical identity. Rarely does the Church’s administration or the private health care facility pay attention to the need pastoral needs of the patients in these institutions.

With all of this in mind we can now begin to answer the three basic questions posed earlier. Where is there room for pastoral care in this post-modern “cathedral of health”? Is there any room for faith and the clergy in this cathedral at all? What is our position and role as pastors within this cathedral’s hierarchy? Without answering these questions, we cannot find solutions to the difficulties stated.

We must first realize that whether or not there is room for pastoral care in the post-modern “cathedral of health” does not depend on the hospital administers and doctors as much as it depends on how we, as pastors, see our work within the hospital setting. We must never forget that we are a symbolic figure that brings to light the conflict between life and death. We need to remember that, regardless how much one tries to avoid this conflict, it will eventually have to be faced. The question is if we will be present and available to help others face life and deal with death. In order for us to do this, it is important that we realize that we must be able to relate to all those in the hospital on a personal level, in a natural and friendly way, from the simple patient to the scientific staff of high medical technology and knowledge, with absolute understanding. Regardless of one’s position in the hospital’s hierarchy, there is always a very human level of existence that desires compassion. In touching on this human level, we become co-suffers and co-workers to all in a very special way. Allow me to state that this is the basis of what we call today multidisciplinary cooperation. Without being co-sufferers, we cannot be co-workers in God’s grace. There is nothing directly didactic or legalistic in this role. Serving as a priest in one of the larger hospitals of Athens, I can remember how doctors, even those most distant from any religious or ecclesiastical life, would seek me out for support and reassurance when faced with personal illness or death, whether it was his own, a close relative or especially a fellow doctor. Once we faced the conflicts of life and death, where we cried and laughed together, a bond of friendship and fellowship would form. Thus, we were able together to help others who were facing this conflict as well.

Our position and pastoral role as priests within a hospital setting is based exactly on this relational identity. Ernest Becker said: “if I were asked for a single most striking insight into human nature and the human condition, it would be this: that no person is strong enough to support the meaning of his or her life, unaided by something and or someone outside himself or herself.”

Within the hospital setting and in times of illness, the priest is this “someone”. As an “ecclesiastical man”, who personifies the Eucharistic community - the Great, Universal and Catholic Church of Christ- in reality he is the only catholic point of reference of community, communion and communication within the disjointed post-modern hospital. In this sense, he brings Communion to the sick and creates a community amongst those that serve them. So, the question is not if *others* see the priest in this light. Consciously or subconsciously they do and their expectations are that he will carry out his ecclesiastical role amongst them. The question is if we carry out our role as “ecclesiastical men” on every relational level of our own existence. If we do, all the practical aspects of our ministry will be dealt with in the best, constructive, productive and collective manner. If we do not, our position will be doubted; we will be rejected and isolated by others, and we will become a target for their anger.

**Fr. Stavros Kofinas**  
**Friday October 10, 2008**  
**Rhodes**

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<sup>1</sup> Lawrence E Holst , “The Ministry of Paradox in the Place of Paradox”, *Hospital Ministry-The Role of the Chaplain Today*, edited by Lawrence E Holst, Crossroad, New York, p. 9, 1985