Guild of Saints Luke Cosmas & Damian

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THE NEWSLETTER

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FEATURE:

HOSPITAL APOSTOLATE

PASTORAL MINISTRY: AN ESSENTIAL SERVICE IN HOSPITAL APOSTOLATE

"Above all, the Gospel must be proclaimed by witness. Through this wordless witness these Christians stir up irrestistable questions in the hearts of those who see how they live: why are they like this? Why do they live in this way? What or who is it that inspires them? Why are they in our midst? Such a witness is already a silent proclamation of the Good News and a very powerful and effective one." (No. 21-Evangelii Nuntiandi)

In early 1977, the Medical Superintendent, Dr. Conrad K.S. Lam, had a keen desire to establish Pastoral Ministry as a integral health care service at Our Lady of Maryknoll Hospital. After several months of research, the working committee was able to draw up proposal for a Pastoral Ministry Team, to better accomplish the primary objective of the Hospital, which is to give witness to the love of Christ by ministering to the patient's physical, psychological, social and spiritual needs. The submitted proposal was accepted and Pastoral Ministry was officially started at the Hospital in August, 1977.

WHAT IS PASTORAL MINISTRY?

Pastoral ministry/care ... is the sharing of one's life with another person in the light of his/her specific needs. This sharing, which is more than communicating ideas, is made possible not by the power of the pastoral minister herself/himself, but by the power of the Holy Spirit at work in each of us.

One author stated that in providing pastoral care to the patients, we as care givers are not all things to all people. We help patients and families to work out their problems, others to endure them with courage and hope, and still others to accept those which cannot be changed. We try to instill our hope and confidence in some and transmit our faith to others.

Sister Colleen writes that "as people giving pastoral care, we are called especially to be aware of the sacred ground of God's presence in people, and to help them see it in themselves." I want to emphasize that in pastoral ministry, ministering to the whole person

is the main focus of our care. And this is done through what is known as "wholistic' approach.

WHOLISTIC APPROACH:

SPIRITUAL DIMENSION - The spiritual dimension of Gospel values are expressed in many ways. Such as being available to listen attentively; accepting and respecting each patient as he/she is; and being sensitive in serving patient needs of the moment...such as fixing pillows, making a telephone call home, giving water to drink or just being with and staying with the patient at the bedside for few minutes. Words of comfort that we will pray for their recovery are appreciated. At times, we pray together or more often in silence with most of our patients.

For Catholic patients Holy Communion is distributed daily by the Sisters and one lay Eucharistic Minister. All are on the pastoral ministry staff. Sacremental ministry is provided by a volunteer Chaplain, Fr. John Foley, S.J., who visits the Catholic patients twice a week. Hospital staff, patients and families have opportunity to attend the weekly Eucharistic celebration. Mass of Ressurrection is offered monthly in memory of all our patients who have died on the previous month. The surviving family members are invited to attend the Mass.

The majority of the patients at OLMH are non-Christians. The Hospital averages 25-30 Catholic patients per month. The Pastoral Ministry Department staff notifies the Parishes whenever Catholic patients are admitted to the Hospital. Sending notices to parishes has three purposes: 1) to encourage the clergy, religious and parish lay-workers to visit their parishioners during hospitalization whenever possible; 2) to encourage them to make their presence visible to the sick members and their families after hospitalization; 3) to encourage deeper sharing of ones life, not only through the Sacraments but also, for the Church members to be the companion in search for wholeness.

LISTENING - Dr. Abraham Schmitt, author of "The Art of Listening with Love", says that listening can transform people and relation-

ships. This kind of listening the author says, "can free the speaker to search deeper and deeper for a more full understanding and admiration of her/him self. Listening is then a great act of love at that moment, for it makes the other person more whole." Hopefully through the Pastoral Ministers, patients at OLMH have someone to listen to their life stories of sufferings, pains, anger,confusion, disappointments, hopes, fears and joys and that within this caring environment of respect, trust, hope, love and compassison the healing of Jesus is experienced and witnessed.

At the same time, the pastoral ministers continue to listen to their own needs. That is, "unless we can really listen to what is deepest in ourselves, we run the risk of not hearing completely what the other is sharing. And to listen to ourselves means we have to remember who we are - we are unique persons, finite, sinful, lonely and resentful at times, and involved in the joys and pain of living."

CARING DIMENSION - How do we create an environment of care, respect, trust, hope, love and compassion? One author says that caring is an active attitude which genuinely conveys to the other person that he or she does really matter. Caring is listening with empathy, with genuineness and accepting a person regardless of his/her level of undesirable behaviour or opposing beliefs and warmth - a non-possessive warmth which generates in the other a sense of comfort, support and encouragement and a sense of hope to his/her brokenness. Touch of a hand can create an atmosphere of affection and communicate understanding that goes deeper than words.

And how do I communicate love to my patients? For me the deepest level of communication is not communication but communion. And this communion is love, it is wordless, beyond speech, and beyond concept. The word of scripture says: "as the Father has loved me, so I have loved you. Live on in my love." (John 15:9) I remember Mr. Chan, a middle aged gentleman, dying from cancer of liver. He never said more than a couple of words each time I visited him. For weeks, he uttered, I'm OK when asked how he was doing. Yet, his condition was deteriorating and the truth as to how he felt was communicated through his sunken eyes and cheeks that expressed deep fears and loneliness. On the day Mr. Chan died, I held his hand and said to him gently, "I know" and paused and remained silent. He

then looked at me and said, "I know". This was the sacred moment - acknowledging his life and death, and our hearts were in communion.

PRESENCE: SUPPORTIVE DIMENSION - Just being present with someone with an understanding silence is another way of communicating love. For me being present or staying with one who is dying is an invitation to a deeper personal encounter with Christ. As Laurence J. O'Connell stated: "In revealing Christ to others, we find Christ revealing himself to us in ever new and more profound ways." The dying patient, in turn, teaches us the deeper meaning of life and death and our powerlessness. Often dying patients express that they are not afraid of dying but afraid of pain. When caring for the sick, and dying patients, we need to be aware of not only the physical pains but also the social, emotional and spiritual pains. This is "wholistic" healing as Jesus himself went about healing the sick and comforting his suffering people.

In pastoral care the focus of care includes family members. They too need to be listened to, to be comforted and to be understood as they experience helplessness, anxiousness and fears.

Pastoral Ministry staff also need to be strengthened, in order to be companions to the sick and dying patients and to their family members. The source of this strength and support is rooted in ones faith and in daily prayers which is an essential part of our time schedule. For "he who lives in me and I in him, will produce abundantly, for apart from me you can do nothing" (John 15:15). We see ourselves growing in Christian maturity as we work and learn together, sharing problems and concerns, the human fears and anzieties encountered daily among patients, families and the hospital staff. Sharing our weaknesses and strengths, joys and sadness, our brokenness are life giving, life growing and healing the wounds of our journeys.

INTER DISCIPLINARY RELATIONSHSIPS - The Pastoral Ministry Department coordinates with other hospital services to ensure and to help provide quality patient care. The team concept is taking deeper roots. We are frequently called upon by doctors, supervisors, head nurses and staff to visit patients who are facing doubts, fears, emotional outbursts or to assist them to make responsible decisions.

We continue to work as a team, supporting and affirming one another, sharing beliefs, hopes and visions of our lives.

OUT-REACH DIMENSION - We feel this dimension is important to continue to provide psychological and spiritual support to discharged patients and/or to patients transferred to another hospital. Our out-reach visits are done either through telephone calls or home visits. Attending funeral services and contacting the surviving family members are part of this out-reach services.

CONCLUSION:

It is our hope that through our Pastoral Ministry we will be able to continue to walk on the road to Emmaus, listening and supporting, and ministering to each other. The following are personal reflections on Pastoral Ministry experiences shared with each other during a staff prayer and evaluation day. What am I experiencing as a Pastoral Minister:

-a life giving and life receiving experience
-a mutual re-creation of newness of life - allowing others to minister to us and how to receive it graciously
-a time to deepen one's faith
-Pastoral Ministry is another aspect of Ministry of Reconciliation to carry out Jesus' reconciliation and newness of life
-Pastoral Ministry calls us to be peace-makers, and to be instruments of open communication
-our caring attitudes help tp re-awaken in others the need to look more deeply into their meaning of life
-a realization of our inter-dependency that we need each other to carry out our caring services
-a growing sense of gratitude to be a pastoral minister
-increase of trust in God, others and in self
-value the time of sharing experiences, for support, encouragement and affirmation
-the importance of our daily group prayer, as a source of inner strength and courage, to heal others and to be

healed ourselves.

Our pastoral vision today and tomorrow is to create a deep sense of hope and newness of Life that is worth living, and to see each person's journey as unique and sacred in its own way.

-Sister Mary Louise Higa, M.M.

「……我患病，你們看顧了我……」(瑪25:36)

在小時候，曾經有人問我長大後，將來想做什麼呢？當時很天真地答說做医生。後來才懂得這份艱巨、崇高、兼而要有愛心及忍耐心的工作，都是非我能力所及。而今天能夠被請在這份「医生月刊」中，分享從牧民的医療探訪所感覺到的心聲，实感榮幸。

生、老、病、死乃人生事实。在四者中我想以「病」令人对生命更感痛苦、憂慮、困擾、恐懼等等；甚至因從疾病所帶來的結局死亡感到絕望，悲观的用自決去解決一切。然藥物提供的治療是必須的，但並非能完全解決人內心的不安，唯有寄望賜与人生命的神。而將基督耶穌復活的訊息、安慰、希望及平安傳送於病者，教会的兄弟姊妹所肩負的責任就很重大，特別是我們神職人員；「你們中間有患病的嗎？他該

請教會的長老們來；他們該為他祈禱，因主的名給他傅油：出於信德的祈禱，必救那病人，主必使他起來；並且如果他犯了罪，也必得蒙赦免。」(雅5:14,15)但往往在公立医院實踐这使命時真不容易，常時遇到阻礙。就是探訪病者的時間性問題。原則上我不喜欢早上進行牧民探訪，這会妨礙医護人員的工作。如：量血压、執拾床鋪抽血化驗、巡房等，他們多在早上交更後進行这一切繁鎖的工作。而我又不多願意在探病的時間，只有一小時的探訪，為病者家人及親友幾乎都不足夠，加上四週的嘈雜聲，实在很不適宜与病者傾談内心的事或做聖事等。若另擇時間，並非每位医護人員都接受和体量，故常吃閉門羹及覺得我們給与他們麻煩而拒絕。當然遇到教友医護人員都会通容些。除非病者臨近死亡的边缘，他們才会批准的。但安慰及希

P.1 望的話，似乎都不會得到回應了。其实院方可設立一個部門，專為從事此類工作的人而設，好能夠更接觸到病人的內心世界，特別垂死的病者，需要更多的支持，而非藥物能提供的。在香港有幾間私立及津貼医院都有此部門的設立，外國更多。但可惜都未完全地受到政府的重視。他們多以為這是宗教界的工作。但很可惜医護人員因繁重的工作已吃不消，都会影响到情緒，又怎能再負担此工作呢？如一個病人患上了絕症，試問如何能告訴他呢？而他又有權利知道的。故後續的工作(FoLLowuP)就更形重要了。誰可以去担當呢？如果我們說生命是有意義和價值的、是充滿希望和信心的，我想政府亦不會否定的，那麼照顧人生命的医院，是更應該負担或鼓勵去实踐這使命吧！

劉富根 中秋

EQUAL DIGNITY TO ALL PATIENTS

I was requested to reflect on 'Equal Dignity to all Patients' from the view point of a visitor, of a volunteer who does not yet belong - per se - to Hong Kong medical or paramedical hospital staff. My personal reflections and sharings will some-what be based on my own experiences while visiting the sick in hospitals here in Hong Kong and also previously out of Hong Kong.

Being a nurse by profession, I was often challenged and confronted by many reactions of sick persons in the hospital. Through the years, I came to experience that when admitted to the hospital, the client feels fearful, anxious and alienated. All of us are familiar with the admission procedure where the sick person needs to answer possibly embarrasing questions such as age, marital status, immediate reasons for admission. Then the patient is given a bed number; an identification band is placed around his wrist and he proceeds to the unit, which is for him an unfamiliar environment amidst other strangers. The the nurse performs the admission routine: charting the vital signs, requesting the patient to give a urine specimen and to wear the hospital gown. The doctor officially comes in later for the case history.

During this ordeal the patient's anxiety rises as he is often left alone with his thoughts, his fears, his many questions, his worries about leaving the family surroundings and now facing the unknown. In a matter of a few hours the patient leaves the family unit where he feels loved, secure, independent, to face an entirely new world of strangers - dressed in different uniforms - where his identity, his dignity, his sense of worth and security are being threatened. The patient loses control over his life because now he is under the control of doctors, nurses, technicians.

His anxiety increases when procedures, diagnostic tests and various treatments are explained in hospital jargon that sounds like a foreign language to him. And most of the time because he is under emotional pressure, fearful, threatened, and does not dare to ask the doctor to explain medical information in more simple terminology. Patients are often afraid of doctors' reactions toward them so they will either turn to the nurse who may or may not provide immediate

information, or will simply keep their questions and their insecurity to themselves.

Of course patients need to be recognised in their sense of worth, in their dignity as persons and they sometimes feel obliged to behave as adults for such recognition. I say to behave "as adults" according to social hospital norms, that is: what they think the hospital staff expects of them, otherwise they could risk to be classified by the staff as "uncooperative or difficult patients" and thus feel they are not receiving optimal medical and nursing care.

Besides working through his needs for dignity and recognition and also adjusting to his new environment, the patient will easily worry about the financial situation at home, wondering how the other members of the family will manage without him. Another area highly susceptible to increase the patient's sense of insecurity is the outcome of his own illness. A most common fear among patients, especially if the illness is prolonged or unexpected complications suddenly happen, is the fear of cancer as cancer is one of the leading causes of death and brings with it a significant amount of pain.

This emotional interior environment is part of the normal psychosocial make-up of a sick person and will be experienced with more or less intensity, according to the patient's individual coping mechanisms. Given this general picture as a background of our patient's challanging situation, how can we, as members of the medical and paramedical staff reach out to them with a touch of human dignity and understanding? Can we make them feel that they are persons and not "a case history or a bed number"? How can we personalize our approach to them to improve a sense of dignity - equal dignity to all?

I do not pretend to give exhaustive answers; moreover, I do feel that the medical and prarmedical staff are doing their best, within the limitations of a lack of nursing personnel, to sincerely care for the patients. However, may I share some of my reflections on this matter.

We are all human beings with the same basic need to be treated with dignity. And according to the generally accepted definition of the term, "dignity" is the fundamental recognition that a human being has worth and value in himself by the simple fact that this person is alive. Whether the person is healthy or sick; whether he is productive or unproductive; whether he is of sound mind or mentally handicapped; young or old; rich or poor; a professional or a manual worker; a religious or a lay person; a prisoner or a free man in society; whether this person is a friend or an enemy - the simple fact that a person has life, he has worth and value and ought to be treated with respect, recognition and care. We are all created in God's own image - equal to one another - as we are all sons and daughters of God.

When a person becomes a patient in a hospital, he retains the full privilege of being a human being, even though for this transition period of sickness the patient becomes unproductive according to social standards.

Is it possible, then, to make our patients feel that they are still persons? Can we make them feel that they are not only an 'interesting case', 'a terminal case'? or solely a mastectomized woman or a tracheostomized man: one who happens to duffer the loss of a breast or of the larynx?

1) Perhaps the first element to answer this question is to ask oneself another question: what is my own personal perception or definition of a human being? We all know that each one of us here has a value system - a belief system that has been developed through our upbringing years due to our cultural, social, family, religious, educational background and life's experiences. This belief system is now carried over in our adult years and is reflected in our way of thinking and in our process of perceiving reality. Consequently, this personal belief and value system that each one has developed and adopted will obviously influence one's approach and one's personal relationship with the patients. It is also assumed that the patients do have their own personal value system that ought to be respected, inasmuch as possible.

2) A second element could be found in another queston: how do I personally feel in front of the many categories of people that were mentioned a while ago? What is my spontaneous feeling or reaction in daily life in front of a poor or rich person? a professional or a manual worker? in front of an old person or a very efficient productive person? Perhaps if we become more aware of our own positive and negative feelings and reactions, it may be easier for us to revise our inner attitude - that we convey externally - in our service to the sick. Perhaps then, we will discover which aspect of our mentality needs to be improved or changed and also which positive elements need to be reinforced to actualize truthfully our many gifts.

I am deeply convinced that if one is rather clear in his heart and in his mind about his value system reflected in his attitudes and behaviour, one can very easily know his quality-service to the sick. Is he serving them with a sense of rejection, of carelessness, of indifference - or is it with a sense of respect, of compassion, of dignity. Each one of us, here, whoever we are, has an inner quality to serve the patients, has a personal involvement concretized in one way or another; otherwise we would not remain, in hospitals, only to earn our living.

However, we all know that working in a hospital environment, one will forcibly be faced with daily stressful situations and it is not always easy to cope with overwhelming emotional and traumatic medical crises. And perhaps one aspect of our difficulty to give a better sense of dignity to our patients may simply be our own vulnerability to stress. We have all experienced in serving our patients severe challenges to both our technical skills and to our ability to manage our own emotions. How hard it can be at times to cope smoothly in the midst of additional stressful situations such as:

- -unexpected and often traumatic medical crises;
- -disease-related reactions which increase emotional needs of the patients;
- -loss and separation;

-changing work shifts;
-the complexities of the hospital social system;
-etc.... only to name a few examples.

We are as human as our patients with our own limited capacity to absorb additional stress. Therefore, a sense of dignity toward our patients can be somewhat improved if each member of the staff has personal abilities to ventilate feelings, problems, frustrations; to learn new ways of solving problems and coping with stress. Maybe a Staff Support Group could be organized for meeting such needs if these needs arise.

Once a medical staff member finds his personal convictions grounded in his love, in his choice to really dedicate himself to the service of the sick, then, and only then, can he face and accept the daily challenges of "Equal Dignity to all Patients".

Of course if my personal perception of a sick person, or of an old person or of a terminally ill cancer patient is in my mind a "second class citizen", my service will obviously demonstrate a "second class service". On the other hand if my inner attitude and perception toward the sick people in general is one of basic recognition of their human worth, consequently, my service to them will be expressed with dignity. Hopefully, if I am a beliver in God, my faith will sustain - challenge my attitude.

And now let us ask our last question: Can we give EQUAL dignity to ALL? Is it humanly possible to achieve or does it remain an unrealistic dream? Let us now be more concrete. When I approach a patient who has disfigurement, or an amputation, or when I witness any destructive effects of illness on the human body, how do I feel interiorly? Is it anger? pity? indifference? dislike? rejection? happy that I am not the victim? or do I let myself become close to the patient by expressing a thoughtful word? a caring presence? a respectful silence? a human solidarity? while attending to the patient's physical needs?

In my opinion the main aspect is NOT to DO more than one is actually doing (because our working days in hospital are more or

less busy days) - but I feel that the MOST important point is THE QUALITY OF ONE'S ATTITUDE IN PERFORMING ONE'S DUTY.

If, as a doctor, when I ask a question to the patient to fill up a blank on my history sheet, I listen with distraction for the answer, of course the patient may easily feel that he is just a "case history". When as a nurse, I wash a petient or change a dressing or give medication or any other nursing services do my gestures convey indifference? routine? or does my touch convey a caring, personalized, sympathetic relationship? Is my approach a wholistic one where I consider the psycho-social needs of the patients interrelated with his physical needs? If my service are BUT routinely performed, of course any patient will easily feel he is but a "bed number", an insignificant "useless person", "a burden" for the staff. The main aspect remains that is not so much WHAT ONE DOES that will convey a sense of dignity to all the patients but HOW ONE DOES ITS WORK - HOW ONE SERVES THEM. - It is basically one's QUALITY of BEING that radiates, that comes through, in everything that one does.

Is it a dreaam? Is it humanly possible to give EQUAL dignity to ALL patients with what they are when they come to us for help? I will answer by saying what I have already pointed our:

- it is a DAILY CHALLENGE;
- it is a CALL from within our CHOICE of profession as medical and paramedical agents;
- it is a call of ur human maturity - to grow more in extending oneself in love toward our sick clients;
- it is a call for growth in our many experiences of vulnerability in our service;
- it is a call for growth in our learning process to become a more compassionate human being in solidarity with a suffering human being;
- it is a deep call from our FAITH to be a significant witness to God's love for humanity, because in Christ we are all brothers and sisters.

Equal Dignity to all Patients: a dream? an achievement?

a challenge? The answer is in each one's heart being personally confronted by his perception and attitude toward human being in general, by his perception of sick people in particular and by the many choices that one makes to live a QUALITY LIFE for a better service to the sick people.

-Mireille Bourdeau, M.I.C.

INTRODUCING ....

THE BIRTHRIGHT SOCIETY

The Birthright Society is a non-profit making social service agency. It was set up in 1973 by a group of enthusiastic volunteers who respected life and were aware of the adverse effects that caused by abortion. Its aim is to provide various, practical services to all pregnant women, regardless of their age and marital status, to go through pregnancy so as to safeguard the birthright of the unborn baby and the dignity of the pregnant women themselves.

The services of the Society are as follows:-

1. Counselling - the Society, with the help of its workers, tries to educate the pregnant women their parental duty and the value of life. At the same time it gives them spiritual support and encourages them to face difficulties bravely.

2. Finance - the Society pays for the pregnant women the medical and accommodation expenses if necessary. It also prepares daily necessities for the newborn baby such as clothing, etc.

3. Accommodation - the Society has a hostel that was specially designed for those pregnant women who require accommodation service. In the hostel, the house mothers help the pregnant women develop a 'stay-at-home' feeling. They can also learn cooking, handicraft etc. in their spare time. Besides that, the workers of the Society will get in touch with them from time to time so as to help them overcome their problems.

4. Nursery - some pregnant women may be in difficulties when making their decision if they will keep their own baby or not. In such case, the Society will give them 6 weeks' time after the baby is born to make their final decision. During these 6 weeks the Soceity will temporarily look after the baby for them.

5. Adoption - if the woman decides not to keep her own baby, the Society will make arrangement with the Social Welfare Department Adoption Unit for the baby to be adopted.

Apart from offering services to pregnant women, the Society

also runs education programmes such as holding exhibitions, giving talks, showing films and slides. It is hoped that through these activities the public can be educated to respect life, especially the unborn and hence unseen ones.

The Society has 2 telephone hot lines for pregnant women in need of its services: 3-375551 (office hours) and 5-227071 (7:30 p.m. to 9:30 p.m.). Enquires can also be sent by letter to the office: 130 Waterloo Road, Kowloon. All services provided are strictly confidential.

WORDS FROM THE MASTER

Dear Members,

"To cure sometimes, to comfort always."

I might have forgotten a lot of what the professor of medicine taught me about diseases, but I still remember this quote from an unnamed source that he gave us at our first lecture in medicine. This vividly defined the humanistic role of physicians, an aspect which tends to be drowned by the busy daily practice, or lost in the wholehearted scientific pursue of medicine.

The role of a comforter is a demanding one, but it is consoling to know that the doctor is not alone in performing this duty. The hospital Pastoral Ministry Team, the Catholic chaplain and the volunteer sister who contribute articles to this issue are also doing this work quietly, sharing out the doctors' responsibility in providing a comprehensive, or wholistic, care to patients. Nor are they the only ones to help us out. Other agencies and persons, be they governmental, voluntary or religious, are also active in looking after the non-medical aspects of diseases. This we have to be thankful for. But the call to be a comforter remains a call to physicians, and we cannot deny this duty. A genuine greeting and a consoling word can go a long way to cheer up the depressed patients and bring us nearer this end, but an unwary word or deed by the doctor can negate all the good work done by the supporting team.

** A questionnaire on readers' response to the Newsletter went out with the last issue. Of the 300 strong questionnaires sent out, about 10% responded. Admittedly this is a low response rate, but we are encouraged by the acceptance of the Newsletter among the responders, who find the articles stimulating and informative. The format of the magazine is also acceptable. There are a few suggestions on topics and general improvement of the Newsletter. Fortunately no one find the magazine revolting enough to ask us not to send him further issues. Because of the small number of returns,

we find it not worthwhile to give a statistical report on the questionnaire. We sincerely thank those who have taken the trouble to return the questionnaire and share with us their thoughts, and appreciate that many might have responded had not the hum-drums of daily life and demands of the practice distracted them.

** I must thank a senior member of the Guild for offering her advise on membership drive and reminded us of Catholic dental graduates. We certainly have dentists on our roll, and fresh Catholic dental graduates can add to our membership and expand our horizon. We also wish to maintain and strengthen our contact with medical and perhaps dental students and enlist them into our fraternity. This is a slow process, but a worthy one. If you have any idea on membership, or if you know some Catholic doctors who are not receiving our publication and information, kindly let me know.

Yours in Christ,

George Chan