PASTORAL CAREGIVERS IN THE NIGERIAN HOSPITAL CONTEXT: A PASTORAL THEOLOGICAL APPROACH

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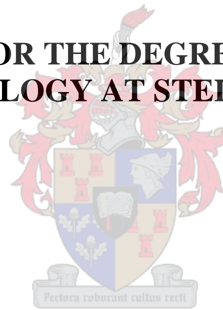
DISSERTATION PRESENTED FOR THE DEGREE OF DOCTOR PHILOSOPHY IN THE FACULTY OF THEOLOGY AT STELLENBOSCH UNIVERSITY



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ABSTRACT

This study investigates the relevance of Pastoral Caregivers (PCGs) in the Nigerian hospital context from a pastoral theological perspective. It argues that illness is a reality that confronts all humanity at certain times. It brings untold pain and suffering to the afflicted, physically, emotionally, psychologically and spiritually. As such, wholeness and health are some of the most important concerns of Nigerians and the global community as demonstrated by the Millennium Development Goals (MDGs) of the United Nations (UN). The Nigerian quest for wholeness is a search for meaning, significance, and purpose in life especially in illness, pain and suffering. This search involves questions about God's involvement in suffering. For this reason, illness comprises a complex reality that defies easy remedy. However, affected persons often seek remedy in the hospital. But research shows that the medical model, despite its benefits, has limited capacity to fulfil the human quest for meaning. Also, the Draft Health Policy for Nigeria (DHPN) (2005:np) and National Strategic Health Development Plan (NSHDP) 2010-2015 (2010:5) has also stated that the health system of Nigeria is poor and Nigeria is not "on track towards significant improvement in meeting the health expectation of its people inclusive of achieving the health MDGs" (NSHDP 2010:10). However, the NSHDP 2010-2015 (2010:11) has also stated that a purposeful reform of the national healthcare delivery system is necessary for strengthening the weak and fragile national health delivery system and improving its performance towards achieving quality caregiving and quality of life. In line with these Ministry of Health reform plans, this study argues that such healthcare reforms should necessarily include pastoral caregivers (PCGs) as valuable and a necessary human resource for health, partnership for health and research. Religion and spirituality (the domain of pastoral care) have been put forward as best responding to many people's quest for meaning.

Consequently, this research has employed a practical theological methodology. Within this methodology a postfoundationalist paradigm according to Park (2010) has been utilised. In this regard, the structure of the chapters is aligned with the four tasks of practical theology as proposed by Osmer (2008). It further utilised relevant literature in the fields of theology, medicine and other social sciences from within Nigeria, Africa and beyond. It has been argued that the absence of meaningful pastoral care dimension is a significant weakness of the medical model as practised in Nigeria. It is inconsistent with the promotion of the health of patients and the community which the Nigerian Code of Medical Ethics (2004) articulates

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as the goal of medicine in Nigeria. It is also inconsistent with the holistic view of Nigerians on illness. Additionally, it is not consistent with the National Policy on Private Partnership for Health in Nigeria (NPPPHN) (2005) declaration that "alternative health providers, whose practices are of proven value, shall be encouraged and supported as frontline of health care provision for many people". As the above Nigerian policies on health suggest – and this is also the position of this study – illness demands a holistic and multidisciplinary approach to combat it. This study has established that pastoral care embodies a vision of wholeness which resonates with the Nigerian holistic view of life whose practices are of proven value. Therefore, the inclusion of the PCG with a holistic theological approach into Nigerian hospital care could contribute to holistic and quality care of patients in hospitals. They could contribute towards the implantation of the NSHDP 2010-2015.

This study is strongly motivated by the fact that human beings are made in the image of God and deserve love, respect for their values and desires, and dignity especially in the face of illness and suffering. Therefore, it recommends that hospitals and clinics in Nigeria should of necessity include PCGs in their hospitals and on their clinical team, as well as provide basic training for all members of the medical team in the pastoral assessment of patients.

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OPSOMMING

Hierdie studie ondersoek die relevansie van pastorale versorgers (PV's) in die Nigeriese hospitaalkonteks vanuit 'n pastoraal-teologiese perspektief. Daar word geargumenteer dat siekte 'n realiteit is wat die hele mensdom op bepaalde tye affekteer. Dit veroorsaak ongekende pyn en lyding vir die sieke, hetsy fisies, emosioneel, sielkundig of geestelik. Gevolglik is heelheid en gesondheid van die belangrikste oorwegings vir Nigeriërs, asook die globale gemeenskap, soos duidelik blyk uit die Verenigde Nasies se Millennium-ontwikkelingsdoelwitte. Die Nigeriese strewe na heelheid is 'n soeke na betekenis, belangrikheid en sin in die lewe, veral in tye van siekte, pyn en lyding. Hierdie soeke betrek ook vrae oor God se rol in lyding. Om hierdie rede behels siekte 'n komplekse realiteit waarvoor daar geen maklike oplossing is nie. Siekes soek egter oplossings in die hospitaal. Navorsing bewys desnieteenstaande dat die mediese model, ten spyte van die voordele daarvan, beperkte kapasiteit het om die menslike soeke na betekenis te vervul. Nigerië se konsep-gesondheidsbeleid, die Draft Health Policy for Nigeria, of DHPN, (2005) en strategiese gesondheidsontwikkelingsplan, die National Strategic Health Development Plan, of NSHDP 2010-2015, (2010:5) stel dit verder dat die gesondheidstelsel in Nigerië swak is en dat die land nie op koers is na beduidende verbeterings in die voldoening aan die gesondheidsvereistes van sy mense gedagtig aan die gesondheidsbepalings van die Millennium-ontwikkelingsdoelwitte nie (NSHDP 2010:10). Die NSHDP 2010-2015 (2010:11) stel dit ook dat 'n doelmatige hervorming van die nasionale gesondheidsorgvoorsieningstelsel nodig is om die swak en breekbare nasionale gesondheidsvoorsieningstelsel te versterk en die werking daarvan te verbeter ten einde gehaltesorg en lewensgehalte te verseker. In lyn met die hervormingsplanne van die gesondheidsministerie, stel hierdie studie dit dat sodanige gesondheidsorghervormings noodwendig PV's moet insluit as waardevolle en noodsaaklike menslike hulpbron vir gesondheid en vennootskap vir gesondheid en navorsing. Religie en spiritualiteit (die domein van pastorale sorg) is al gestel as uiters geskikte respons op mense se soeke na betekenis.

Gevolglik het die navorsing 'n praktiese teologiese metodologie gebruik. Binne hierdie metodologie is gebruik gemaak van 'n post-fondamentalistiese paradigma volgens Park (2010). In hierdie verband is die struktuur van die hoofstukke belyn met die vier take van praktiese teologie soos voorgestel deur Osmer (2009). Verder word gebruik gemaak van relevante literatuur in die teologie, mediese wetenskap en sosiale wetenskappe van binne Nigerië, Afrika en verder. Dit word gestel dat die afwesigheid van 'n betekenisvolle

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pastoralesorgdimensie ’n beduidende swakheid is van die heersende mediese model wat in Nigerië geld. Dit is nie in pas met die bevordering van die gesondheid van pasiënte en die gemeenskap wat gestel word as die doel van die mediese wetenskap in Nigerië volgens die Nigeriese kode vir mediese etiek (2004) nie. Dit is ook nie in pas met Nigeriërs se holistiese beskouing van siekte nie. Verder is dit nie in pas met die nasionale beleid oor privaat gesonheidsvennootskappe in Nigerië, die National Policy on Private Partnership for Health in Nigeria, of NPPPHN (2005) nie, waarin dit gestel word dat alternatiewe gesondheidsverskaffers wie se praktyke as waardevol bewys is, aangemoedig en ondersteun sal word as voorste linie van gesondheidsorgverskaffing aan baie mense. Soos die bogenoemde Nigeriese beleide oor gesondheid voorhou – en dit is ook die posisie van hierdie studie – vereis siekte ’n holistiese en multidissiplinêre benadering om dit te beveg. Hierdie studie het bevestig dat pastorale sorg ’n visie van heelheid vergestalt wat resoneer met die Nigeriese holistiese siening van die lewe, waarvan die praktyke se waarde reeds bewys is. Die insluiting van die PV met ’n holistiese teologiese benadering by Nigeriese hospitaalsorg kan bydra tot holistiese en gehaltesorg vir pasiënte in hospitale. Dit kan bydra tot die vestiging van die NSHDP 2010-2015.

Die studie word sterk gemotiveer deur die feit dat mense in die beeld van God gemaak is en liefde, respek vir hulle waardes en behoeftes en waardigheid verdien, veral in die aangesig van siekte en lyding. Hier word dus voorgestel dat hospitale en klinieke in Nigerië noodwendig PV’s in hulle hospitale en by hulle kliniese spanne moet insluit, en verder basiese opleiding in die pastorale assessering van pasiënte vir alle lede van die mediese span moet verskaf.

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DEDICATION

This dissertation is dedicated to the memory of my late Mother, Inyang D. Inyang, who demonstrated immense, hope, faith and love for God even in the face of suffering and death, and taught me by example the true meaning of Christian faith and living. I also dedicate this work to my father, Mr David Inyang, my husband, Rev. Dr Obaji Mbeh Agbiji, and my children Anointing-Mbeh, Shalom-Achi and Majesty-Obaji. Last but not least, to all the sick and suffering in the hospitals and elsewhere: THE LORD BLESS YOU AND KEEP YOU UNTIL HIS DAY OF COMING!

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LIST OF ABBREVIATIONS

ACPE	The Association for Clinical Pastoral Education
AIC	African Independent Churches
AIDS	Acquired Immune Deficiency Syndrome
APC	The Association of Professional Chaplains
ATR	African Traditional Religion
BST	Bio-statistical Theory
CAM	Commentary and Alternative Medicine
CAN	Christian Association of Nigeria
CAPPE	the Canadian Association for Pastoral Practice and Education
CHAN	Christian Health Association of Nigeria
CPE	Clinical Pastoral Education
CS	Caesarean Section
DHPP	Draft Health Promotion Policy
ECWA	Evangelical Church of West Africa
ENHCC	European Network of Healthcare Chaplaincy
FBO	Faith Based Organizations
FCCCS	the Fellows of the Calvin Centre for Christian Scholarship
HIPAA	Health Insurance Portability Act
HIV	Human Immunodeficiency Virus
HSR	National Health Sector Reforms
IAF	Interpretive Anthropological Framework
JCAHO	Joint Commission for Accreditation of Health Care Organisations
MDG	Millennium Development Goal
NACC	The National Association of Catholic Chaplains
NAJC	The National Association of Jewish Chaplains
NCCAM	The National Centre for Complementary and Alternative Health Care
NHS	National Health Service
NPPPPHN	National Policy on Public Private Partnership for Health in Nigeria.
NSHDP	National Strategic Health Development Plan
PCG	Pastoral Caregiver
PHC	Primary Health Care
PHI	Protected Health Information

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QI	Quality Improvement
SDAT	Spiritual Distress Assessment Tool
SAP	Structural Adjustment Programme
TBA	Traditional Birth Attendants
TBS	Traditional Bone Setter
UK	United Kingdom
UKBC	United Kingdom Board of Healthcare Chaplains
UN	United Nations
USA	United States of America
WCC	World Council of Churches
WHO	World Health Organisation
WHOQOL	World Health Organisation Quality of Life

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CHAPTER ONE

INTRODUCTION

1.1 Background

This study is entitled *Pastoral Caregivers (PCGs) in the Nigerian hospital context: a pastoral theological study*. It suggests a responsible corporate ministry of PCGs with other health care practitioners as a way forward to a more significant holistic caregiving within the Nigerian hospital context. Health and wholeness are among the most important concerns not only of Nigerians as demonstrated in the vision statement for health sector reforms (Draft Health Promotion Policy 2005), but also of the global community as demonstrated by the Millennium Development Goals (MDGs) of the United Nations (UN) (http://milleniumindicators.un.org/unsd/mdg/data.aspx). The quest of Nigerians is a search for life and restoration to wholeness. This is demonstrated in the fact that household out-of-pocket expenditure on health (69%) remains the largest source of health expenditure in Nigeria (NSHDP 2010-2015) (2010:34). However, the health indicators for Nigeria do not seem to reflect this concern as the country is ranked among the worst in the world (National Strategic Health Development Plan (NSHDP) 2010-2015 (2010:11). In any case, hospitals constitute a healing environment where ill persons seek relief, intervention, cure, care and healing. Corresponding to the poor health status, the Draft Health Policy for Nigeria (DHPN) (2005:1-2) and the NSHDP 2010-2015 (2010:5) have also stated that the health system of Nigeria is poor as Nigeria bears about 10% of the global disease burden. "Preventable diseases account for most of Nigeria's disease burden and poverty is a major cause for all these problems" (DHPN 2005:1). The overall health system performance was ranked at 187th of the 199 member states in 2000 (DHPN, 2005). More disturbing is the admission by the NSHDP that "Nigeria is not on track towards significant improvement in meeting the health expectation of its people inclusive of achieving the health MDGs" (NSHDP, 2010:10). However, the NSHDP (2010:11) has realised that a purposeful reform of the national healthcare delivery system is necessary for strengthening the weak and fragile National Health Delivery System and improving its performance. The NSHDP has therefore formulated 8 strategic development areas, including *leadership and governance for health, health service delivery, human resources for health, financing for health, national health management information system, Partnership for health, community partnership* and

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research towards achieving the said goals. Three of these areas – *human resources for health, partnership for health* and *research* – have a direct bearing on this study.

The above background suggests that sickness, pain and suffering are the experience of many Nigerians as a result of poverty, underdevelopment and misrule, and as a natural human experience. This raises questions of meaning, significance and purpose in life and these questions are of spiritual and religious significance in the process of recovery. With regard to the above areas, studies have shown that religious faith and practices have a central role in the lives of many people, especially during illness (Stefanek, McDonald & Hess, 2005:450-463; Hirsto & Tirri, 2009:93; Acevado, 2010:188-206; Driskell & Lyon, 2011:386-404; Piderman *et al*., 2011:1-11). Similarly, many Nigerians take religion very seriously as is demonstrated by the government-sponsored pilgrimages to Mecca and Jerusalem, and daily worship (Dukor, 2010: 129; Falola, 1999:6; Kalu, 2010). These religious practices have been shown to be significant to health and healing. Harold George Koenig (2004:554-564), renowned medical practitioner and researcher in the USA, argues in his research report that religion and spirituality promote better psychological health of the patient. Besides promoting mental health, some studies have established the fact that religion plays a significant role in patients' choice of hospital (Ogunjobi, 1983:585-589), and in their ability to cope during illness (Peach, 2003:414; Koenig, 2003a:415-416; Koenig, 2003b:51-52; William, 2008a:9-14; Syed 2003:45-49; Sengers 2003:4-56). Van Uden, Pieper, Eersel, Smeets and Van Laarhoven (2009:195-215) define coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". Illness, pain and suffering constitute such stressful conditions because they exert a demand for change and adjustment (Barnes, 2010:2; Piderman *et al*., 2011:7). Religious coping (e.g. prayer) is one of the ways that patients respond to the stressful event of disease, illness and sickness. Recent studies have identified a connection between religion, spirituality and health (Koenig, King and Carson, 2012; Cob, Pulchalski, Rumbold, 2012; De Vries-Schot, Van Uden, Heitink & Pieper, 2008; Moreira-Almeida, Neto & Koenig, 2006:242-250). Koenig, King and Carson's (2012) *Handbook of Religion and Health* covers over 3 000 studies on the connection between religion and health.

The connection between religion, spirituality and health, and the multifaceted nature of illness (medical, social, psychological and religious/spiritual) make it impossible to address healing from one perspective only. According to the WHO (1998:7), "the medical model which seeks to treat patients by focusing on medicine and surgery and gives less importance

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to belief and to faith in healing … is no longer satisfactory". According to Peter Barnes (2010:1) "[i]n the strict medical model (cf. 1.8.1) of care, there seems to be little room for spirituality". Therefore the medical model, which may be effective in treating certain diseases, is deficient when it does not integrate all dimensions of sickness, including the spiritual (Hill & Smith, 2010:171). Consequently, Winter-Pfandler, Flannelly and Morgenthanler (2011:31) and Tarpley and Tarpley (2011:311), US medical professionals, as well as Afolayan and Okpemuza (2011:32), Nigerian sociologists, Antai (2009:57-76) Eaten and Agomoh (2008:553) and Okafor (2000:189-202), Nigerian health and medical researchers, among others, have argued that the medical model of health and hospital care has to integrate the religious/spiritual aspects, because cultural values and beliefs which are often embedded in religion and spirituality influence patients' perception of illness and their decisions for or against medical treatment.

The observations of WHO and the scholars mentioned above regarding the place of religion and spirituality in the lives of patients indicate an increasing recognition that healthcare should take into account the entire human person, which suggests that sickness in its many forms requires an approach of healing which takes all the intricacies of disease and illness into consideration. In other words, a more holistic approach ought to be followed in health care that includes the religious and spiritual elements of recovery/healing. In this regard, the WHO (1998:7) has also advised that medicine must "realize the values elements such as faith, hope and compassion in the healing process. The value of such spiritual elements in health and quality of life" demands a move "towards a more holistic view of health that includes the nonmaterial dimension". Similarly, Afolayan and Okpemuza (2011:31-40), Nigerian scholars from the nursing profession, have argued that it is imperative for health care providers to take into consideration the socio-cultural and belief factors while assessing and providing health care to patients. Afolayan and Okpemuza's observations are indicative of the absence of significant religious and spiritual components in Nigerian hospital caregiving. Such religious/spiritual omission also may be considered to be inconsistent with the average Nigerian's worldview regarding illness and healing. As is typical of Africans, most Nigerians are religious, and their religious beliefs and practices are inseparable from their daily lives and experiences (Oluwabamide & Umoh, 2011:48; Dukor, 2010:111).

Interestingly, there are on-going debates about the role of PCGs in hospital caregiving in contexts such as Europe, USA and Australia. For instance, published works from leading medical scholars and theologians in the field of spirituality and health care such as Ignatiew

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(2003:132), VandeCreek and Burton (2002), Williams (2008a: 9-14), Hanzo and Koenig, (2004a:1242-1244) have all argued about the unique role that PCGs play in hospital caregiving. Unfortunately, within the Nigerian context there is no significant conversation regarding the role of PCGs in Nigerian hospitals. However, in their studies Oluwabamide and Umoh (2011:47-52) have to some extent pointed out the relevance of religion to health care delivery in Akwa Ibom state. Diddy Antai (2009:57-76) has also noted the influence of religion on child immunisation in Nigeria. Despite such endeavours which could be considered relevant, it is pertinent to observe that such attempts are narrow and very limited. A broader and deeper engagement of spiritual and religious care that can be brought to bear by PCGs within the Nigerian hospital context, as is being presumed by this study, could bring better results in hospital care to hospitalised Nigerian patients and their relatives.

The inclusion of the PCGs in Nigerian hospital caregiving could therefore be of great benefit in alleviating the suffering of many Nigerians. Such endeavours could further assist the patients and families to cope with their health challenges by offering pastoral support to the care seekers in striving towards possible recovery from illness or grief that may be a result of the death of a loved one. In this light it is assumed that the inclusion of the PCG in the Nigerian hospital caregiving for Pastoral Care, which entails attending to the spiritual and religious needs of patients, could improve the quality of patients' care.

This study is therefore an attempt to engage the modern Nigerian health and hospital care delivery system, the Nigerian government, the Nigerian public and churches on the need to include PCGs in the Nigerian hospital caregiving for patients, family and staff for more holistic care of the sick in the hospital context.

1.2 Motivation for the study

The Nigerian medical sociologist Amaghionyeodiwe (2008:215) has argued that, although there is a steady growth of health facilities in Nigeria, there is no corresponding increase in coverage or quality of health and hospital care. Consequently the quality of health and hospital care provided by the government still remains poor (NSHDP 2010-2015). This poor quality results in the poor performance of the Nigerian health economy, leaving the needs of many Nigerians – especially the rural and urban poor – unmet, thereby reducing their quality of life (NSHDP 2010-2015) (2010:24-25). Nigerian sociologists Oluwabamide and Umoh (2011:48) also assert that scientific medicine as the core of health care in Nigeria can hardly attain true success, if alternative sources of care such as religion are not incorporated into its

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modern health care delivery system. Thus Afolayan and Okpemuza (2011:37) argue that certain factors such as religion, gender and the status of the health service provider can affect the quality of health services and by implication hospital care rendered. Consequently Aja, Modeste and Montegomery (2012:1-15) report from their empirical findings in their research project entitled *Qualitative Inquiry into Church-based Assets for Prevention and Control* that faith community assets (which may also include PCGs) are alternatives through which health care, including HIV and AIDS prevention and control, can be engaged. Therefore this study on the mediation of Pastoral Care in Nigerian health care institutions, with particular reference to the Nigerian hospital context, proposes that a more holistic approach should be followed in health and hospital care delivery in Nigeria for a more holistic hospital care delivery. The plea for the exploration and inclusion of religion and faith community assets in Nigerian health and hospital care as enunciated by Nigerian scholars such as Oluwabamide and Umoh (2011) and Afolayan and Okpemuza (2011) cannot be divorced from the understanding that the resources of religion and faith communities include pastoral care elements of healing and recovery, among other resources. Therefore as a pastor and pastoral theologian, I am motivated to investigate the relevance of PCGs in the care and recovery process of patients, especially in the Nigerian hospital, and establish whether PCGs can have any significant impact on the quality of hospital care within the Nigerian hospital context.

The second motivation for this study stems from some deep personal questions that have cropped up in course of my involvement in the ministry of the sick and studies in pastoral care. At a personal level I have experienced illness and suffering both as a child and an adult. I have nursed sick and terminally ill close family members. I have also been involved in counselling of family, friends and neighbours. On a professional and academic level, I am an ordained minister who has been involved at various levels with the sick and suffering, and a trained PCG who has been involved in Pastoral Care and counselling in churches and in hospitals. I obtained a Postgraduate Diploma and an MTh in clinical Pastoral Care in 2008 and 2009 respectively. My experiences at these levels have ignited within me deep searching questions that relate to the possible role of religious or spiritual care for hospitalised patients. Also, the quest for answers to questions asked by those who are going through challenges of suffering and ill health, and the feeling of inadequacy in handling those situations, have inspired the inquiry into the dynamics of sickness and its relation to the spirituality of the sick person.

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Thirdly, the search for meaning, significance and purpose of life involves questions about God and his involvement in suffering. These questions are vital to the recovery of the afflicted. For instance, there have been spates of ethnic, religious, domestic and sexual violence in Nigeria in recent times[1]. Quite a number of the survivors of this violence end up in the hospital for treatment. Violence brings untold pains and suffering to the survivors; physically, emotionally, psychologically and spiritually. This study hopes to provide a means through which such questions about God, His involvement in suffering and the mediation of spirituality in suffering can be attended to while the patient is in the hospital environment.

Fourthly, as one of the Nigerian clergy and a clinical pastoral theologian, I hope that this study of the ministry of healing in the hospital context will contribute to the realisation of the need for holistic healing of the suffering in Nigeria. In this light, this study is intended to motivate the faith community and health professionals to harness their resources by seeking better collaboration between themselves in hospitals (and health institutions in general) towards harnessing resources for the benefit of the suffering in Nigeria.

Fifthly, based on current practices in Nigerian health and hospital care which are devoid of spiritual and religious care, as substantiated by Oluwabamide and Umoh (2011:48), Afolayan and Okpemuza (2011:37) and Aja, Modeste and Montegomery (2012:1-15), there is an apparent gap[2] between the healthcare professionals and PCGs in the Nigerian hospital context that could hinder the inclusion of PCGs in hospital care and collaboration, should PCGs eventually be given space in the hospital context. This gap may lead to confusion or ignorance on the part of health care workers on the possible contributions of PCGs to the healing environment of the hospital setting. This study therefore hopes to initiate a dialogue between the PCGs and healthcare professionals as co-labourers. If such a dialogue is necessary to addressing the suffering of patients, then this study, attempts to clear the confusion and possibly create an awareness that could lead to meaningful cooperation among PCGs and healthcare professionals and thereby awaken the interest of the religious community and Nigerian society in the sense of devoting attention to Pastoral Care in a more meaningful way that could improve the quality of care in Nigerian hospitals. In this way, this

[1] Violence, especially religious violence, has characterised most of the communities and states in Nigeria in the recent years. These crisis have left communities with orphans, widows and widowers. The most recent incidents are the Jos crises of January and March 2010, which are prime examples of mostly religious crises but which also have political and economic undertones (cf Taye Obateru, 2010).

[2] For example, Aja, Modeste and Montgomery (2012:2) report various obstacles to engaging faith communities' assets, which results in lack of collaboration and understanding of the experience that churches have to offer, which in turn means that such resources not being used by Nigerian health care systems.

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study may also contribute towards the enrichment of the body of literature on the subject of Pastoral Care and hospital care from the Nigerian perspective, thereby providing data that could be useful for policy making and promoting further research towards meaningful integration of hospital care and religious resources (for the scope of this literatures see Chapter 3-6).

Lastly, this study is motivated by the fact that human beings are made in the image of God and deserve love, care, respect and dignity in an all-embracing manner even when they are in difficult times as a result of ill health and other challenges of life, and so deserve to be heard, receive attention and be given a voice (this point will be taken up in Chapters 2.3 and 3.5). Miller-McLemore (2004:57) comments that "Pastoral theology as a public theology must give public voice to the least heard … it must challenge public ideals and structures, listen to those publicly silenced, and reconstruct religious beliefs and practices that perpetuate major social problems". Undoubtedly, our view of human beings will invariably affect the way we recognise their state as one of vulnerability and how we then care for patients in their vulnerable state. Is it, then, acceptable to view a human being as an integrated being of body and soul or spirit, or should one rather adhere to a fragmented view of the person as body apart from a soul – a view which mostly dominates the medical model of hospital care? Or does Jesus' model of a holistic healing ministry – a healing and wellness which addresses the physical, mental, rational, and spiritual dimensions of the human person – promise total wellness of the human person (cf. Luke 5:17-26; 3 John 2)? Would the latter view not help both the medical personnel and PCGs to collaborate in their quest to assist people to be more human in their time of suffering?

1.3 Problem statement

The Public Health and Policy researchers Kruk and Freedman (2008:263-276) have observed a growing interest in assessing the performance of health systems in developing countries, including Nigeria. They propose that success in assessing the performance of such health systems should be measured in terms of *effectiveness* (which comprises health status, patient satisfaction), access and quality of care, *equity* (which involves equitable access, fair financing and risk protection) and *efficiency* (which involves skilled resources, adequacy of funding, cost and productivity and administrative effectiveness). In terms of these three variables, studies on Nigerian health care systems which also include Nigerian hospitals have indicated that Nigerian healthcare systems are ineffective, inequitable and inefficient (Guerin,

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Guerin & Aquarelle, 2007, Amaghionyeodiwe, 2009 & Alubo, 2001). The quest for such performance assessment has led to research into factors that influence hospital care and choice of hospitals by Nigerian patients. Subsequently, Eaton and Agomoh (2008:552- 558) and Antai (2009:57-76) have located the success of health care performance in the patient's belief system. They argue that belief systems are important components of health and illness behaviour and influence the choices that Nigerians have when they fall ill and should be considered in the care and healing process. On a similar note, Olusanya, Roberts, Olufunlayo and Inem (2010:210-216) have identified religion as a source of influence in patient's choice of health facility. Afolayan and Okpemuza (2011:31-40) have not only identified religion as a crucial determinant of the health caregivers' and providers' delivery services to the patients, they argue that religion and spirituality should be taken into account in quality care, besides other issues such as socio-economic factors, which include family and social support systems.

Moreso (WHO, 1998:7) has stated that medicine must realise the value elements of faith, hope and compassion in the healing process. Furthermore, empirical research undertaken by Oluwabamide and Umoh (2011) in Akwa Ibom state of Nigeria assessed the relevance of religion in health care delivery in Nigeria and recommended that pastors be recruited to Nigerian hospitals as patient counsellors. However Oluwabamide and Umoh's research, although very commendable, has a number of limitations. First, their research was restricted to Christian patients only. Secondly, they have neither stated nor defined what types of pastors may be required for such services within the specialised context of the hospital. Thirdly, their research has also not indicated how these pastors will operate in the hospital context. Based on the above, this study seeks to investigate, from a practical theological perspective, the possibility and necessity of the inclusion of professional PCGs in Nigerian hospital care. Should such an inclusion prove to be possible and necessary, an appropriate Pastoral Care approach will be developed through which the PCG may collaborate with healthcare professionals within the Nigerian hospital context. As such, in investigating the relevance of PCGs in Nigerian hospital care, the study will take into account the multi-religious nature of the Nigerian hospital environment. Moreover, the complex nature of illness and disease may not be comprehensively addressed by a single model. For this reason, the Draft Health Promotion Policy (DHPP) (2005:4) has recognised that achievement of health involves a multidisciplinary application of skills and participation. In this regard the National Policy on Public Private Partnership on Health in Nigeria (NPPPHN) (2005) has stated that "…alternative healthcare providers, whose practices are of proven value, shall be

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encouraged and supported as frontline of health care provision for many people. Such providers will be brought under regulations to ensure adherence to rules and healthcare guidelines".

Similarly, Ellis and Hartley (2008:119) have suggested that acknowledging an alternative practice to the medical model of healthcare and working cooperatively with practitioners is usually much more productive than ignoring them. Therefore, the problem this study seeks to investigate is: Can the PCG be considered as alternative healthcare provider whose resources and practices are recognised and valued by the Nigerian healthcare system to the extent that they can be included in hospital care for holistic and quality care of patients? In other words this study investigates the relevance of PCGs in the Nigerian Hospital context.

1.4 Research hypothesis

In view of the problem statement, this study is of the view that Pastoral Care resources and practices are of recognisable value to the Nigerian Healthcare system, and as such the inclusion of Pastoral care and professional PCGs in Nigerian hospital care could contribute to holistic and quality hospital care for patients' satisfaction. PCGs with their unique spiritual and religious resources and appropriate approach can contribute towards the realisation of more holistic care and healing in the Nigerian hospital context.

1.5 Research objectives

The main objective of this study is to ascertain whether creating a space for the inclusion of Pastoral Care and PCGs into the Nigerian hospital context for collaboration with other health care professionals could contribute to the more holistic care and healing of patients and thereby enhance the quality of hospital care and patients' satisfaction with such care in the Nigerian health care system. This objective challenges the argument that the medical model, which dominates the Nigerian health and hospital care system, is adequate to address the spirituality and religious needs of patients and the complex nature of Disease, illness and sickness. Other objectives are:

- To explore the historical, socio-political, religious and hospital context in Nigeria, so as to understand the factors that inform the context in which Pastoral Care may be required;
- To explore the theories of Pastoral Care with regard to health care in the hospital in order to understand the meaning and nature of Pastoral Care;

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- To present the theological resources that the PCG can bring to the Nigerian hospital context for a more holistic health and hospital care delivery system in Nigeria;
- To discuss how the PCG can collaborate with the health care professionals within the hospital context using an appropriate Pastoral Care approach;
- To explore an appropriate approach which the PCG could utilise to function in the hospital context.

1.6 Research methodology and design

Contemporary research specialists such as Paul Leedy and Jeanne Ormrod (2010:6) and Diana Ridley (2009:33) point out that a research methodology directs the study and dictates how data are acquired and organised. In other words the nature of the research question and the data determines the methodological approach. Thus, the aim of this study is to find out how the inclusion of the PCG into the Nigerian hospital context and the collaboration of the PCG with health care professionals within the Nigerian hospital space can improve the quality of health care in Nigeria. In this process this study will attempt to develop an approach to Pastoral Care that could be relevant to the PCG's ministry as he or she functions within the Nigerian hospital context.

This research will include a literature study in the field of Pastoral Care and its relationship, relevance and contribution to hospital care. This research approach is so chosen because the literature surveyed revealed that no significant studies have been conducted on PCGs in the hospital context in Nigeria specifically or sub-Saharan Africa in general to generate a theory of Pastoral Care to be provided in hospital care based on empirical research. Time and space do not permit a combination of theory development and empirical validation of such theory in the same study. As such, the study will engage with the available relevant literature to present its argument. Thus, analysis will be based mainly on available literature such as books, journals, conference proceedings, leaflets, reports, internet sources, etc. Such literature will provide the grounds for the theoretical analysis and will connect the outcomes to broader discussions about the role and importance of the PCG in hospital care. Furthermore, it should also assist to show the benefits of a collaborative approach to health care delivery and an appropriate Pastoral Care approach that can meet the needs of the PCG within the Nigerian hospital context as may be relevant to practical theological methodology.

1.6.1 Practical theological methodology

Theology as defined by Conde-Frazier (2012:234) is “always shaped by and embodied in the practices of historical, cultural and linguistic communities” and deals with the praxis of everyday living. This research is rooted in the field of Pastoral Care and counselling. Pastoral Care as both faith care and life care is rooted in pastoral and practical theology. The theological discipline of pastoral and practical theology “is a field of theological inquiry and practice that seeks critically to discern and respond to the transforming activity of God within the living text of human action” (Brown, 2012:112).

Although pastoral theology and practical theology are sometimes seen as separate terms in the sense that pastoral theology is understood to focus on concerns with the practical and theological questions arising from the pastoral practice of care. On the other hand, practical theology is considered to be wider in focus beyond persons to deal with issues of social and political systems, formation and discipline (Miller-McLemore, 2012:6; Cahalan, 2010). For instance, Miller-McLemore insists that the terms (pastoral theology and practical theology) should be distinguished so as not to risk losing the distinctiveness of practical theology’s contribution to the discipline of theology in academic settings. However, this study agrees with Stephen Pattison and Gordon Lynch (2006:410), who consider the terms to be synonymous. This is because this study is not only concerned with caring for sick and suffering patients, but also understands that the illness, pain and sufferings of many of such patients are connected with issues of power and unjust social-economic, political and cultural systems.

Therefore, this study understands that while there might be a slight difference between the two concepts, pastoral and practical theologies are not mutually exclusive. All the same, Miller-McLemore’s definition of practical theology is valuable for this study: “Practical theology refers to an activity of believers seeking to sustain a life of reflective faith in the everyday, a method or way of understanding or analysing theology in practice used by religious leaders and by teachers and students across the theological curriculum, a curricular area in theological education focused on ministerial practice and subspecialties, and finally an academic discipline pursued by a smaller subset of scholars to support and sustain these first three enterprises” (Miller-McLemore, 2012:4). Miller-McLemore shows that practical theology is not an elitist theology removed from the ordinary people who constantly engage in practical issues through their normal daily living. The implication of this definition is that

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practical theology is a way of life, method, a curriculum and a discipline (Miller-McLemore, 2012:6). Although this study identifies with all of the above in this section, practical theology is used as a method to achieve the task at hand.

The practice of pastoral and practical theology differs in context, however, as suggested by many scholars and implied in the above definition; yet there is greater consensus on the common characteristics that unite pastoral and practical theologians from different contexts. Pattison and Lynch (2006:410), Miller-McLemore (2012:9), Brown (2012:113), Park (2010) and Pattison and Lynch (2006:410-412) identify the five main characteristics of practical theology as indicated below.

1. Reflection upon lived contemporary experience*:* Pattison (2006:411) argues that pastoral and practical theology privileges a methodology that reflects on the daily lives and experiences of people in what practical theologians frequently refer to as the "living human document" or the "living human web". Such reflection employs a "thick description" of issues at hand, be it persons or communities. Thick description is a term popularised by the social anthropologist. Thick description describes a people and their intentions, thereby providing a detailed description of lives unfamiliar or of what has been forgotten or ignored. In this sense it contributes to understanding and eventual explanation of what is happening (Gibbs, 2007:4, Parker, 2004:28). Such an endeavour employs a narrative approach. Park (2010) argues that "this narrative approach is a valid form of doing theology in Africa, since Africans experience life through stories".

2. The critical dialogue between theological norms and contemporary experience*:* In drawing from the insights of both theological and non-theological fields, practical theology enters into dialogue with the cultural norm as well as the theological norm regarding the human experience within its context. Therefore, the process of theological reflection and understandings is informed not by the imposition of pre-existing theological ideas, but by the lived experience. In a sense, therefore, pastoral and practical theology "are interested in what the traditional theological norm can do to help in understanding a particular experience or issue" (Pattison & Lynch, 2006:412). It is also interested in finding ways in which contemporary experience might lead to a revision of a theological concept or other related practices in faith communities and public space. In essence practical theology asks what the normative text of scripture and tradition imply for praxis. Thus there is a movement between the theory of the normative text and praxis. Don Browning (1996:47) called this process

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"revised critical correlational theology", based on Paul Tillich's critical correlational theology of practical theology. In his *Fundamental Practical Theology* Browning (1996:49) proposes three processes or movements of reflection in practical theology as descriptive, historical and systematic in its enquiry. This movement implies a hermeneutical process that engages "the resources of human rationality in different modes of reflection" in a transversal communication between people who have different values and cultures (Park, 2010). Transversality necessarily allows practical theology to undertake interdisciplinary engagement.

3. The adoption of an interdisciplinary approach: Contemporary practical theology is by nature interdisciplinary. Critical reflection on the living human web requires a theological tool that helps practical theologians link the human to theological traditions and perspectives. It also provides a non-theological theoretical orientation in which such life could be understood which includes but is not limited to psychology, sociology, anthropology and cultural studies. Therefore three different approaches of practical theology to interdisciplinary work can be identified: (1) the correlational approach of Paul Tillich and the revised correlational approaches of David Tracy and Don Browning; (2) the more recent transformational approach of James Loder and Deborah van Deusen Hunsinger; and (3) the transversal approach of Van Huyssteen (Osmer, 2008; Park, 2010). The interdisciplinary nature of practical and pastoral theology makes it radical rather than conservative.

***4. A preference for liberal or radical models of theology*:** Pattison and Lynch (2006: 412) argue that pastoral and practical theology privileges a more liberal model rather than a conservative model of theology by virtue of giving present experience instead of tradition a prime place in shaping theological concepts. Therefore, their interest in critical dialogue between the theological norm and human experience within time and space makes them more liberal and radical and transformative.

5. The need for theoretical and practical transformation*:* Practical theology is not just a discipline concerned with the norms and practices of the academy, remote from the concerns of ordinary people. Nor is it a study for its own sake. Practical theologians seek to impact on the way things are understood and done in order to enhance wholeness and wellbeing. In other words, they are not merely interpreting the world in different ways – they want to transform it. Therefore, practical theology combines descriptive theology and historical theology to systematic theology (Pattison & Lynch, 2006:412).

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The above explication of pastoral and practical theology locates this study in the field of pastoral and practical theology. For that reason this study is not merely concerned with undertaking academic research for the sake of obtaining a degree, but is also a reflection on the lived experience of contemporary Nigerian patient care with a view to transforming it. Pastoral and practical theologians such as Miller-McLemore (2012) and Sung Park (2010) have insisted that theology must make sense to the ordinary person. “Practical theology either has relevance for everyday faith and life or it has little meaning at all” (Miller-McLemore, 2012:7). Therefore this study attempts to make a link between the academic endeavour and the everyday experience of Nigerians. Aligning with pastoral and practical characteristics of theology, this study seeks to apply theological reflection to solve real-life problems. By means of a rigorous analysis of the issue of caregiving in the hospital, its causes and possible solutions to associated problems, this study seeks to transform the situation within the Nigerian hospital context (Smith, 2008:204).

This study concerns the lived experiences of Nigerian patients in especially the hospital context and their experience of religious faith, which demands a *critical dialogue* between the theology of Pastoral Care, the practices of the medical profession, and Nigerian patients and their family experience in their cultural contexts and with their unique identities. As such this study is interdisciplinary. Osmer (2008:163) emphasises that practical theology cannot be anything but interdisciplinary. Noting the importance of an interdisciplinary perspective, Daisy Nwachuku (2012:523) states that practical theology is by nature collaborative, multifaceted and correlational with elements of self-disclosure and group experiences. Therefore the study will involve insights from cultural studies, psychology and anthropology in the execution of this task. The understanding on which this study is based is that each context is distinctive in its needs and conditions. Hence, a contextual analysis will be undertaken, without ignoring the broader context. A brief historical background of Pastoral Care and its development will be undertaken to shed more light on the profession, its work and relationship with theology and science. This is important because, as noted by Smith (2012:245), “attention to culture is one of the defining features of the present moment in practical theology”. This study agrees with the notion that context and experience, as well as the Christian text, form the primary source of Knowing. It brings a fusion between text and context (Park, 2010). However, while it pays attention to the context of Nigeria, it is also aware of the challenge of globalisation. “Everyday life is not a purely local affair. It is

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influenced by intricate networks of relationships, structures, multinational organizations, and practices that span the world" (Pattison & Lynch, 2006:422); therefore the contextual theology and practice of this study are in dialogue with the global context as well. In other words, it is a *glocal* pastoral and practical theology (Pattison and Lynch, 2006:423).

The understanding of this study is that each context is distinctive in its needs and situation. Therefore, in order to build a Pastoral Care that is sensitive to this distinctiveness, there is a need for a hermeneutical approach which takes the issue of interculturality and interpathy seriously. The importance of hermeneutics is that it helps this study to recognise that interpretation which is offered in a specific context does not claim to be an absolute and final interpretation, but invites dialogue with other minds (Joda-Mbewe, 2002:19). Such a method of interpretation is therefore "a process of question and correction, refinement and integration" (Brown 2012:120). Hence it has a preference for a more liberal model rather than a conservative model. It is radical and liberationist because it takes the issues of suffering and vulnerability seriously. Pastoral Care in the hospital, as this study envisions it, promises to be liberative and transformative. This is because it speaks for those who are at the margins of the society – the poor, sick, dehumanised sufferers as well as the religious community and society as a whole. To this end Miller-McLemore's (2012:11) assertion that a "distinctively practical theological objective of method is to have a transforming influence on religious faith in congregation and society" is relevant to this study. In essence this study adopts a post-foundationalist practical theological paradigm.

1.6.2 Post-foundationalist research paradigm of practical theology

Post-foundationalism is a theological concept developed by Wentzel van Huyssteen (1999:111) with the view to formulating the way in which theology relates to science. He locates this relationship in rationality. He argues that all academic fields have overlapping goals and interpretive processes to arrive at certain conclusions and judgements which exist at an intersection between disciplines, paradigms and practices. These processes involve presenting good reasons for one's decisions, belief, actions and choices, and therefore have shared resources of intelligibility (1999:128-129). In developing on his post-foundationalist notion of rationality Huyssteen relies on the work of Harold Brown (1990), Nicholas Rescher (1992), Jerome Stone (1992) and Calvin Shrag (1994). A post-foundationalist view of rationality, according to Van Huyysteen (1999:144-148), has three components, namely rational agent, responsible judgment and communal embeddedendess. Sung Park (2010)

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builds on Van Huyssteen to propose a post-foundational research paradigm for practical theology.

The post-foundationalist research paradigm of practical theology, as argued by Sung Park (2010), is premised on contextuality, interdisciplinarity, reason and experience. This means that post-foundational theology fully acknowledges the role of context, interpreted experience and tradition in shaping religious value. As such, post-foundationalist research paradigm also allows cross-contextual and interdisciplinary conversation across communities (of faith, and healing communities) and cultures (Western, African, Christian and medical science). Thus the post-foundationalist approach of theological reflection engages in the process of interpreted experience, use of rationality and transversal reasoning, interdisciplinary conversation and contextuality. These post-foundational engagements which are transformational, contextual, experiential, interrogative, analytical and constructive, interdisciplinary, dialectical and disciplined are at the core of practical theology (Park, 2010). Hence post foundational approach is rooted in practical theology. In consequence, Park (2010) argues that "[f]or practical theology to be transformative, a post-foundational theological framework that allows interdisciplinary work and interpretation of experience in a given context is essential".

According to Park, post-foundationalist research offers an alternative approach over and against foundationalism and non-foundationalism. Generally, foundationalism according to Park, presupposes an objective truth that is rigidly held and which must conform to the laid-down principles. As it relates to theology it suggests biblical literalism or positivism of revelation, which separates theology from science and rejects the crucial role of interpreted religious experience in theological thought (Park, 2010). Thus foundationalism subjects theology to speaking a language that maybe coherent yet not meaningful in content, because it is removed from non-theological dialogues. On the other hand, non-foundationalism claims that no authoritative givenness (or objective truth) exists and that everything is relative and as such subject to one's experience and interpretation. As Park observes, this is incompatible with theological claims of reasoned attempts to understand the authoritative objective truth of God's revelation in the Scripture, or its interpretation in authorised religious traditions. The post-foundationalist approach allows for both the authoritative truth of the scripture and endorsed traditions as well as giving place to religious experience through rationality and transversal reasoning. Therefore, rationality allows for an awareness of the shared cognitive, pragmatic and evaluative dimension of a given issue. Park further argues that rationality

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offers a dynamic dialogue with different disciplines, which allows for multilevel interpretation as one moves across borders and boundaries of different disciplines. This rational reasoning enables a relation with people in a complex cultural structure of the communities, and understands and integrates these multiple dimensions of people's lives. Thus it is based on the experience of the individual and the community in which the individual is embedded.

Park sounds a note of warning that rationality in theology is different from rationality in science in that there are no universal standards of rationality against which other beliefs or competing research tradition can be measured. In any case, theological rationality has a different object, language and method; however, the common ground of both rationalities is that they are based in social, historical and cultural context which validates pastoral and practical theology's interdisciplinary engagement.

The post-foundationalist paradigm engages in critical theological reflection in order to evaluate the roles of experience, tradition and the classical biblical text. In post-foundationalist method beliefs are explored experientially and interpretively. It allows the creative fusion of hermeneutics and epistemology. "Interdisciplinary discourse, then, is an attempt to bring together disciplines or reasoning strategies that may have widely different point of reference, different epistemological foci and different experiential resources" (Park, 2010). This discourse takes place not in the confines of any discipline but within the transversal spaces between the disciplines.

In engaging a practical theological paradigm, Osmer's (2008) practical theological structure is very valuable for this study. This is because Osmer's structure allows for the elements of a post-foundational approach to be organised more systematically and with more clarity. An interdisciplinary research has been identified by Hofstee (2010:130) as having a tendency of succumbing to inappropriate borrowing. Osmer's structure prevents this study from making such inappropriate borrowing. Therefore this research is also designed after Osmer's practical theological methodology.

1.6.3 Research design

Paul Grey, John Williamson, David Karp and John Dalphin (2007: 34) define a research design as the process of combining one's ingenuity with scientific strategy to guide the collection and interpretation of data. According to Kobus Marie (2010:70), "the choice of research design is based on the researcher's assumptions, research skills and research

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practices, and influences the way in which she collects data". The aim of this research design is to structure it in order to maximise the validity of this research.

Richard Osmer (2006:6-15) has developed a research design that is interdisciplinary in perspective, which he describes as covering the four tasks of practical theology, which also gives validity to this study.

- The first task is the *descriptive-empirical*. It pursues the question: What is going on in this particular social context or field of experience? It gives special attention to religious praxis. A particular approach is chosen because it is best suited for the purpose of a particular project.

- The second task is *interpretive*. Research findings are not self-interpretive. Thus, the interpretive task of practical theology seeks to place such findings in an interpretive framework, providing an answer to the question: Why are these things going on? The important point is that contemporary practical theologians move beyond the findings of their empirical research and place them in an interpretive framework.

- The third task is *normative*. Practical theology does more than investigate and interpret contemporary forms of religious praxis. It seeks to assess such praxis normatively from the perspective of Christian theology and ethics, with an eye to reform when this is needed. The normative task thus pursues the question: What form ought current religious praxis to take in this particular social context?

- The fourth task of practical theology is the *pragmatic*. This task focuses on the development of *rules of art*, a concept first introduced by Friedrich Schleiermacher in his seminal description of practical theology. Rules of art are open-ended guidelines that can assist those who are leading or participating in a particular form of religious praxis. This task, thus, asks the question: How might this area of praxis be shaped to more fully embody the normative commitments of a religious tradition in a particular context of experience?

This research will seek to realise these dimensions to that extent that may be relevant to the study. Chapter Two deals with the descriptive-empirical task (not in the sense of a systematic gathering of information through field research, but will work with relevant existing secondary empirical resources as they relate to the Nigerian context and beyond), which addresses the question: What is going on? Chapter Three deals with the interpretive task.

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Chapters Four and Five explore the normative task: What ought to be going on? Chapter Six takes on the pragmatic task addressing the question of how we should respond to what is going on.

The researcher's Christian faith serves as a foundation and background to this work. Thus, Scriptural passages will be alluded to where necessary to support the position of this study. In addition, as a pastor who has acquired some years of experience in ministry, and as a clinical Pastoral Care student in various medical contexts, I will draw from my personal experiences to drive home some arguments. Finally, this research will propose recommendations for the Pastoral caregiving to be considered in the Nigerian health care system.

1.7 Delimitations of the study

This study is not concerned about hospital care in a broad sense that may require detailed discussions of the various practices and professionals involved in hospital care in Nigeria. Rather, it is concerned with the Pastoral Care of patients in the hospital in the sense of the mediation of religious/spiritual resources by professional PCGs for the care and healing of hospitalised patients for a more holistic hospital care and healing approach in Akwa Ibom State, which could lead to the enhancement of hospital care in Nigeria. Hence the focus of this study is not on pastoral caregiving within the church context in the sense of investigating the successes or failure or otherwise of pastoral care practices as carried out in churches and church offices in Nigeria. This does not imply that pastoral caregiving in the church context is not relevant; on the contrary, whereas the study recognises the traditional provision of pastoral care in Nigeria as visitation to the sick by the representatives of the various religious communities of Christianity and Islam, it focuses on Pastoral Care that could be carried out within the multi-religious Nigerian hospital context through professional PCGs. As such, the study affirms the relevance of the occasional engagement of religious persons for prayers and other religious/spiritual resources whenever the medical personnel so desire. However, beyond such interventions, this study argues for a more meaningful engagement of Pastoral Care that entails professional PCGs. The study therefore envisions the intentional and planned incorporation of pastoral caregiving and its resources through professional PCGs as part of the intervention plan in hospital care and healing in the Nigerian hospital environment. In this regard, there is a difference between pastoral visitation and occasional co-optation, and pastoral caregiving and collaboration in hospital care which may involve

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creating a Pastoral Care department in each Nigerian hospital. As such this study is very interested in seeking the creation of a space for the PCG for interdisciplinary collaboration within the Nigerian hospital context. Thus, this research is not advocating mere acknowledgement of the PCG, but it is recommending a policy change that will enable the integration and collaboration of PCGs with healthcare workers in the hospital. In this regard, the discussion of Pastoral Care is narrowed to caregiving in the hospital context.

Although this study acknowledges the relevance of empirical research, it is limited to the literary research of published works as stated in 1.6 and could provide the grounds on which empirical research on the subject matter of the study could be carried out in Nigeria.

1.8 Literature review

There are extensive literatures on the subject of health care, and on team and holistic approaches to work, whether secular/physical or religious / spiritual. The debate about health, health care or healing and questions or concerns about how best it could be attained could be said to have been around as long as people have. Ridley (2009:2) thinks that a literature review serves as the "driving force and jumping-off" point for one's own research inquiries. Therefore, it is important at this point to review some of the existing literature in order to give a sense of the significance of the concerns of this study. Although a literature review has various aims, in this study the purpose is to provide conceptual clarification of the concepts used in this study. For the sake of coherence and clarity, this task will be pursued by addressing the following questions: 1) what is health? 2) What are disease, illness and sickness? 3) What is health care? 4) What is hospital care? 5) What are religion, spirituality and pastoral care? 6) What does it mean to create a space for PCGs in the hospital context? These questions and the answers to them will at the same time serve to provide conceptual clarification of the key terminology that will be employed throughout this dissertation.

1.8.1 Conceptualising health

Depending on their interests and fields of specialisation, scholars approach the definition of health from different perspectives, such as the medical, religious/theological, philosophical and cultural dimensions. According to Law and Widdows (2008:304), the difficulty in defining health arises because various groups have varying needs with respect to the concept. Some are interested in conceptual clarity for theoretical and practical application, while others still are "concerned with wider policy and health promotion issues and seek a concept of health useable in a globalized context". Consequently, the medical philosopher Per-

Anders Tengland (2010:323) has classified the concept of health according to different theories into three broad categories: the medical (objective) definition, the holistic (comprehensive) definition and the subjective (a feeling) definition. Based on the numerous reviews on the definition of health, he concludes that health is variously defined in terms of disease prevention, ability, capacity (Law & Widdows, 2008:303-314), resource, functioning, normality (Nordenfelt, 2003), wellbeing, absence of suffering, welfare (Tengland, 2006:155-167), quality of life (Nordenfelt, 2007:5-10), happiness, sense of coherence, autonomy, freedom (Alkire, 2002:1), empowerment (Tones & Green, 2004:1, Tengland, 2007:197-207), or control, or a combination of some or all of these features (Tengland, 2010:326). Therefore, this study will explore the understandings of health from the following three main perspectives.

a) The medical conception of health

From a medical perspective, Tengland (2010:324) has argued that "the traditional medical model defines health as the absence of disease, where diseases are normally seen as bodily or mental dysfunction". In his article "Health promotion and Disease Prevention: Logically different conceptions?" he argues that the medical model definition is reductionist and mechanistic, focusing on the biology of the parts of the person rather than the whole person. David Greeves (2004:26) summarises the assumptions of the biomedical model of health in terms of disease as a deviation from normal biological functioning, the doctrine of specific aetiology, the universality of disease and the neutrality of medicine. These assumptions are what Nordenfelt (2007:6), a medical theorist, calls the bio-statistical theory of health. Although Nordenfelt acknowledges some value in the medical conception, he, like many others such as Tengland, considers this view as problematic. For Nordenfelt health, when related to human beings, is not objective but value-laden and subjective. Therefore he opts for what he calls a holistic theory of health (Nordenfelt, 2007:7), because it should necessarily include bio-psycho-social dimensions.

Bircher (2005:335) argues that the conception of health should take into consideration the bio-psycho-social nature of human existence. According to him, "[h]ealth is a dynamic state of wellbeing characterised by a physical mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility". However

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Vries-Schot, Van Uden, Heintink and Pieper[3] (2008:104) in their article "Healthy Religiosity and Salutary Faith: Clarification of concepts from the Perspective of Psychology, psychiatry and of Theology" have noted that the bio-psycho-social-model is deficient in its holistic perspective in that the spiritual/ religious dimension is absent. They argue for a bio-psycho-social-spiritual model of health. This dimension has been incorporated into the theological conception of health.

b) The theological conception of health

Arguing from a theological and holistic perspective, Robert Munson (2008:www.bulkalife.org) and Hamel Cook (1990:108-109) in the *Dictionary of Pastoral Care* define health in terms of relationships which could be considered as vital components of the individual's identity. Such relationships in Munson and Cook's view include relationships with:

- *God*. Cook takes as point of capture the conviction that we are made in the image of God to have a harmonious relationship with him. Sin destroys this harmonious relationship. The harmony is restored through repentance from sin, personal faith in Christ's death on the cross, and acceptance of his lordship in our lives. This makes us spiritually whole;
- *Self*. Physical disease can occur when different parts of the body fail to interrelate properly, and psychological disease includes failure to relate healthily to oneself;
- *Others*. Healthy relationships are needed between individuals, in families, in communities and in societies, both nationally and internationally;
- *Environment*. We should respect God's creation for its own sake and for the benefit of our health.

Cook's view of health, which includes functional relationships with God, self, others and the environment is informative and in some ways resonates with African/Nigerian views of wellbeing (health). The resonance of Cook's view with the latter will be discussed in Chapter Two.

[3] These are scholars from the field of psychology, psychiatry and theology. Margreet de Vries-Schot, for instance, is a psychiatrist as well as a theologian.

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Louw (2008:43-44, 169), the South African Professor of Pastoral and Practical theology in Stellenbosch University, in his classic book *Cura Vitae: Illness and Healing of Life*, and the Nigerian scholar Pearce (2000:4) both agree with Munson and Hamel Cook's view. For Pearce and Louw, this relationship is social in nature. Louw (2008: 47) concludes that health is linked with wholeness and is part of the biblical concept of *Shalom (peace*) and *hugies* (quality of life and soundness). He argues that *hugies* and *shalom* are experienced in the context of good relationships with God within a community that ensures coherence and balance of the whole person. This connotes more than a mere absence of conflicts and entails wellness, vigour and vitality in all facets of human existence. As such, Paloutzian, Emmons and Keortge (2010: 75) explain wellbeing as conceived both in spiritual and existential dimensions which demonstrates the sense of purpose and satisfaction one derives from a relationship with God. In other words, it is the integration of all dimensions of the individual's functioning (Ingersoll, 2010:218).

c) The cultural conception of health

Andrew Igenoza (1994:126-135) and Lartey (1994:47) in the collected works of the African Association of Pastoral Counsellors series *The Church and Healing: Echoes from Africa* have expressed their views on the African cultural conception of health. Arguing from the African cultural and holistic perspective, they also share in this more comprehensive understanding of health. Critiquing the definition of health by the World Health Organisation (WHO),[4] Igenoza (1994:126-135) advises that any definition of health in an African context should not neglect the spiritual dimension. This, he explains, is because Africans are fundamentally religious in their view of life. Africans believe that spiritual realities play a significant role in the issues of sickness and restoration to health. It could be on this basis that Lartey (1994:47) insists that health means emotional, spiritual, social and communal wellbeing.

Speaking along the same lines as Igenoza, Louw (2008:43-44), warns that health should not be separated from existing cultural contexts. These African scholars' position is also affirmed by the Swiss medical theorist Johannes Bircher (2005:335) who states that the definitions of health are determined by cultural processes. However, Louw observes that health as a central cultural value is in danger of being idolised. This he calls a "new religiosity" or "healthism" (2008:43-44). According to Stephen Hunt (2003:183-184), "[h]ealthism" is "not only a near cultural obsession with health as a matter of being free from sickness, but has come to denote

[4] The World Health Organisation (WHO) defines health as a state of complete physical, mental and social wellbeing, and not merely the absence of infirmity.

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a positive and proactive attitude to health. This preoccupation is derived from a number of wide but overlapping social developments, namely, instrumental rationalism, consumerism, materialistic lifestyles, and the advance of medical science". In this light, "[h]ealthism" seems to represent an inclination to achieve maximum performance in all aspects of life based on the human attainment of high technological and scientific competence. In opposition to the views that have been dubbed "[h]ealthism", the *Fellows of the Calvin Centre for Christian Scholarship* argue that "if the good of health becomes everything that is good, health becomes a god, and the worshipful pursuit of it, like idolatries, will collapse into a bitter disappointment" (Bouma III, Diekema, Langerak, Rottman & Verhey, 1989:51-52).

Still, on some views of health and the possibility of their leading to the disappointment of the patient, Bouma III, Diekema, Langerak, Rottman and Verhey, (1989:51-52) are uncomfortable with an all-inclusive (physical, psychological, social and spiritual wellbeing) understanding of health. This understanding of health, they argue, "proposes an ideal of health that can never be completely attained in any given individual". In their thinking, "seeking this kind of health for ourselves and others can lead to disappointment and failure" (1989:51-52). They further argue that this all-inclusiveness is in danger of health being equated with happiness as people can be functioning perfectly even though they are not happy. Hence, they suggest that health should be thought of along the lines of "well-working" and "well-functioning" and "accommodation" rather than wellbeing. Thus Christians should view health as "the well-working of imagers of God in their multiple relationships, well working that often involves accommodating themselves to problems caused by the not-yet character of the fallen world" (1989:52-53). The idolisation of health based on the efficacy of medical science which will eventually culminate in disappointment, as Hunt has argued is undoubtedly being experienced in Nigeria just as it is in many other countries as medical science and technological advancement have not successfully unravelled the mysteries around the inability of science to discover cures for some ailments, which can lead to disappointment among patients especially in situations where some of them are sent home to wait for their death as their illnesses have defied all forms of medication. There are also situations where there are no scientific explanations of some ailments. In respect of Bouma III et al (1989:51-52) "well-working" and "well-functioning" and "accommodation" rather than "wellbeing" understanding of health, there seems to be a difficulty on their part to show how their concepts of health are at variance with wellbeing and how wellbeing excludes the fact that wellbeing recognises the brokenness of humankind and the acceptance of the reality

of human challenges, which include incurable ailments. A definition of health that does not include political, psychological, medical, social and religious/spiritual dimensions is hardly tenable, especially within the Nigerian landscape (cf. Chapter 2). Bouma III et al (1989:51-52) views could be useful, but they cannot fully stand the test of time within the African and especially Nigerian context. Nigerians are always optimistic about their faith in God and expect God's intervention by way of miracles, no matter how hopeless the situation could be. In any case, Bouma III et al, (1989:51-52) views should be held as sounding a note of caution on the extent to which health can be defined to avoid frustration and disappointment on the part of the sick.

Thus, unlike Hunt (in Low, 2008:43-44) and Bouma III, et al (1989:51-52), who fear that making health all-embracing could mean promising too much, to the extent that could lead to idolatry and disappointment, Munson (2008), Cook (1990:108-109), Low (2008:43-44, 169), Pearce (2000:4), Lartey (1994:47), De Vries-Schot et al. (2008: 104) and Igenoza (1994:126-135) agree with each other when they include physical, psycho-social, spiritual and ecological issues in notions of health and wellbeing.

d) The alternative medicine definition of health

Another divergent definition of health is that defined by homeopathic theorist Georges Vithoulkas as adopted by Choffat (1995:315), who has defined health as "creativity". Choffat's view of health is drawn from a Judeo- Christian concept of God making humankind in God's own image. The implication of this view is that one can be creative irrespective of the disintegration of the body. Maintaining a balanced view of health in the sense of taking into consideration the various components of human and environmental life is thus apparent, especially in the Nigerian context, as it is this approach to health that adequately accommodates the concrete realities and socio-cultural underpinnings of Nigerians, even before the advent of Christianity and modern hospital care. It will be shown in Chapter Two of this study that Nigerians have not abandoned their socio-cultural views that relate their existence to physical and spiritual/religious experiences, including issues that relate to health and wellbeing. It could be in this light that Louw suggests that a comprehensive approach to health should include psychological, existential, functional, social, scientific medical and religious perspectives.

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The literature review on health so far reflects a movement away from the technocratic definition of health as "the absence of disease", which is widely criticised as inadequate by many scholars researching in the field of health care such as Igenoza (1994), Nordenfelt (2007), Louw (2008) and Tengland (2010). In the view of this study, what these scholars are bringing to the table is very interesting, as it paves way for a more and more robust debate from an interdisciplinary angle. Whereas many of the voices so far reflected in the discussion reflect those of non-Africans, the voices of Nigerians(except Igenoza) on such a salient issue as the various dimensions that should constitute wellbeing or good health, including its relatedness to spiritual/religious dimensions, is hard to detect. The issue of health care is vital to humankind in general and Nigerians in particular, and leaving it exclusively to health professionals may not be a very helpful approach. It could be also argued that whether an individual or a community can realise all the varied dimensions of health, including the spiritual, at a given time should not be the main issue, but whether such components of health do truly reflect the demands of what should characterise health and its desirability to humankind and the entire created order. It is such understanding that should stir humankind to realise such a noble ambition which takes into account all aspects of human welfare. But understanding of health in the different perspective indicated above also necessitates an understanding of the antithesis of health, namely disease, illness and sickness.

1.8.2 The triad of disease, illness and sickness

According to Hofmann (2002:651), the differentiation between disease, illness and sickness has become common practice in medical sociology, medical anthropology and philosophy of medicine. Such practice is borne out of the complexity involved in conceptualising the human predicament. While this is the case, it has also been challenged (Law and Widdow 2008, Nordenfelt 2006). The contention represents differences in views of human ailments. Therefore Hofmann (2002:651,567) asserts that disease, illness and sickness denote diverse perspectives and understandings on human ailments that represent professional, personal and social perspectives. Additionally, "they reveal epistemic and normative differences in concepts" and concern biological, phenomenological and behavioural events respectively.

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Consequently, Hofmann (2002:651) explores the concepts of disease, illness and sickness utilising Twaddle's (1968)[5] conceptualisation. He theorises that *disease* is a health problem that consists of "a physiological malfunction that results in an actual or potential reduction in physical capacity and/or a reduced life expectancy". It is independent of subjective experience and social convention. In other words it is a medical condition authenticated by qualified medical personnel. As such it is epistemically measured by objective means. It is also an objective fact which includes physical trauma and infection (Law and Widdow 2008:307).

Illness is a subjectively interpreted undesirable state of health. As such it consists of subjective feeling states (pains, weakness), perception of the inadequacy of bodily functioning, and/or feelings of competence as perceived by the individual. Illness is a feeling state ontologically referred to as symptoms. Epistemically it can only be directly observed by the person and indirectly assessed through the person's description. In other words, it is an individual's description of his suffering state. Illness, then, is a subjective experience of ill-health. Someone who has infection but is unaware of the symptoms is diseased but not ill (Law and Widdow 2008:307).

Correspondingly, *sickness* is a social identity. According to Hofmann, it is the poor health of an individual defined by others as regards social activity of the individual. This means that sickness is a social event constituting a new set of rights and duties such as exemptions and permissions, in which case sickness alters one's role in the society. "Ontologically it is an event located in the society and defined by participation in the social system. Epistemically, sickness is assessed by measuring the levels of performance with reference to expected social activities when these levels fail to meet social standards" (Hofmann 2002:653). Therefore the relationship between disease, illness and sickness is that a disease leads to illness, which in turn results in sickness. Hofmann (2002:653) gives the relationship between the triad in the form of overlapping spheres as represented below:

[5] Twaddle is known to be the first medical philosopher to conceptualise disease, illness and sickness.

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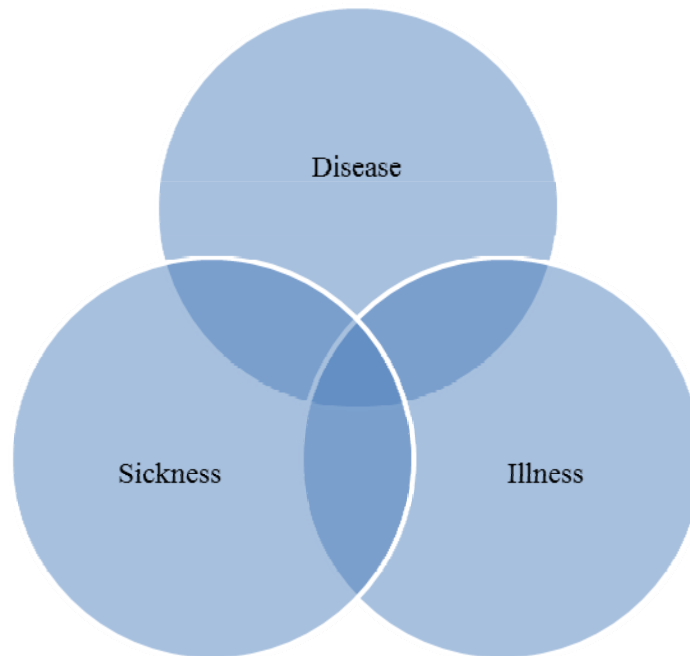
Figure 1: The interconnectedness of disease, illness and sickness



Source: Adapted from Hofmann 2002.

However, Law and Widdow (2008: 307) dispute Hofmann's triad distinction of disease, illness and sickness. They contend that although such distinction may be useful in conceptual terminology, it is not always helpful. They insist that "perhaps the tripartite distinction is too neat, too clear-cut. It imposes a way of thinking even as it permits certain thoughts to be clearly expressed … it may be more theoretically satisfying than practically useful". Law and Widdow's sentiment is noteworthy. However, for the purpose of this study, the conceptualisation of the triad as defined by Hofmann is maintained, while recognising that disease, illness and sickness are not mutually exclusive.

1.8.3 The concept of health care

Although the subject of health care appears in many books that treat it extensively, very few attempt a definition of health care. Health care, like health, is a complex concept that makes definition a difficult task, given that there may not be any universally accepted definition. Little wonder that many writers do not bother attempting a definition. On the other hand, it may be that this term that is often used by humans in daily discussions is assumed to be understood by all. However, modern scholarship leaves no room for such assumptions. More so, a definition frequently guides the content and the process of provision and evaluation of care (Godfrey, Harrison, Lysaght, Lamb, Graham & Oakley, 2011:12) in that it includes

norms, values, judgments and criteria to be used to evaluate care (De Geyndt, 1995:2). However, some scholars have attempted a definition implicitly or explicitly.

Godfrey et al. (2011:24) offer a tentative and simple definition of health care as that activity undertaken by anybody with the purpose of improving health. However, Godfrey et al. (2011:3-24) in their thoroughly researched article "Care of self- care by others- care of others: the meaning of self-care from research, practice, policy and industry perspectives" highlight the complexity of the concept of health care by demonstrating the different nuances of the concept of health care. Their research reveals the different perspectives of health care which can be directed towards oneself, or care given to another, or care received from others. After analysing the content definition of 139 written works on the concept, they argue that self-care should be considered in the most comprehensive understanding and definitions of health care. The implication for this study is that self-care, rather than being a low-quality and effectual behaviour, has an individual, family, community and professional level (Godfrey, 2011:6-7). At individual level it means maintaining physical and mental health, which includes but is not limited to self-medication and good hygiene. At the family level it is supporting a family member who needs help. At the community level it is carried out in the context of group support of vulnerable members, and the acquisition of required skills for health care. At the secondary and tertiary levels it is carried out after discharge from the secondary and tertiary health care centres.

On the other hand, the WHO uses the concept health service to denote the different dimensions of health care. They define the health service as "all activities whose primary purpose is to promote, restore, or maintain health" (WHO, 2010). A health service in WHO's (2012) view could be delivered in the home, community, workplace, or a health facility (www. Who.int/healthsystems). The perspective on self-care posited by Godfrey et al... Represents what the WHO calls "human resource for health" or "health workforce" or "healthcare system" (WHO, 2010). Freedman, Waldman, De Pinho, Wirth, Chrowdhury and Rosenfield (2005:97) have categorised health systems. In their view health systems consist of all kinds of help rendered in households and communities as well as the organisations that support them. As such healthcare systems include "all categories of providers – public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous". It also includes insurance systems as well as the different regulatory and professional bodies that maintain the system. A good health service, according to the WHO (2010) (www.who.int/healthsystems/topics/delivery/en/index.html), is one that responds fairly to the

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needs and expectations of the people, in an efficient manner to achieve the best result in a given situation and with the available resources.

Therefore, some scholars like Wim Smeet, Frank Gribnau and Johannes van der Ven (2011:80-119) in their article "Quality assurance and spiritual care" focus their argument on quality of care or more specifically on quality assurance in health care. They argue that quality of health care is one of the prominent developments in recent health care (Smeet et al., 2011:84). But what exactly does quality care or quality assurance mean? Smeet et al acknowledge that "quality" is difficult to define; however, the term is fundamentally defined as that which contributes to quality of care or means constantly reflecting on quality (2011:85). Consequently they define quality of care as all-encompassing activities geared towards systematically achieving, promoting and maintaining quality service. Quality of care is viewed in both a narrow and broad sense. In the narrow sense it refers to the interaction between patient and caregivers in order to have the desired impact on the patient's health. In the broader sense, it means reasonable, effective and substantively responsible use of available means of care by the care providers and the insurers. Smeet et al. (2011:85) note that quality of care can be assessed at the three levels of micro, meso and macro levels. The micro level refers to the professional patient interaction; the meso level is the care institution such as the hospital, while the macro level is the society. In terms of the goal of this study, the focus is more on the micro and maso levels. In a World Bank Technical Paper "Managing the Quality of Health care in Developing Countries" De Geyndt (1995:2) has also presented his argument on the quality of health care. In his attempt to define quality health care, he cites four examples of definitions. Of significance and most explanatory of the four is that "[g]ood medical care is the kind of medicine practiced and taught by the recognised leaders of the medical profession at a given time or period, social, cultural, and professional development in a community or population group". Thus for De Geyndt health care is equated with good medical care (1995:2).

Allen (1995:70) on his part appears to have a concise understanding of health care when he claims that "like life, health is the gift of God. It is therefore our responsibility to care for it." This statement implies a definition that health care is the care of life. Life, according to him, connotes the entire human being – body, mind and spirit. Therefore, health care must cover a person's whole being, i.e. holistic health care. Any endeavour at delivering health care that does not attend to the needs of the whole person is inadequate (1995:12). Allan's opinion is shared by some scholars such as Louw (2008:41) and Rogers (2001:32-34).

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De Geyndt (1995:4) has also shown his awareness of the complexity of defining health care or its quality. He is of the opinion that a practical way to examine health care is "to examine the factors that influence individual health and to determine to what extent each set of factors is measurable." Such factors include issues such as public policy, a person's genetic make-up, the physical and socio-cultural environment and personal behaviour. In view of these complexities, Louw (2008:36-41) suggests that the delivery of health care should be viewed in terms of perspectives. Louw (2008:36-41) divides these perspectives or approaches into two broad categories, namely "Western" biomedical approach (which include hospitals, clinics and dispensaries) and holistic systemic approaches (i.e. the traditional medical sector which includes spiritual or magico-religious healers, herbalists, technical specialists such as bone-setters and traditional birth attendants).

Sherome (2001:35) and Louw (2008:36) mention the biomedical model as the most dominant models of the approaches to health care. They acknowledge that this model has contributed to the quality of life that people experience. Louw (2008:37), for example, argues that the advantage of this model lies in its "accuracy in diagnosis and sophisticated method of treatment and cure". For Sherome (2001:35) its weakness lies in its insensitivity to people's needs and its inability to serve the majority of people. Sherome's (2001:35) view on the disadvantage of the biomedical model suggests that this model is very limited in the extent to which it deals with the human person in the crisis of ill health and the affordability of the services it provides. Louw (2008:38-41) classifies the weaknesses into seven categories according to the essence of each: 1) the analytical approach that places more emphasis on disease than the person; 2) the diagnostic approach that reduces patients to mere cases; 3) the dualistic approach that reduces patients to mere objects; 4) the atomistic approach which emphasises parts rather than whole persons; 5) the biological-organic approach which emphasises the interactions of the part instead of the whole; 6) The positivistic scientific approach that emphasises objectivity and rationality but neutral to the ethical issues; 7) the pharmaceutical approach that treats symptoms by "prescriptions." Thus, one finds among scholars different ways of defining health care. Allan (1995) defines it as the care of life. Godfrey et al. (2011) conceptualise it as "self-care". The WHO defines it as health services or "resources for health". Friedman et al. discuss it in terms of health systems, while others like De Geyndt (1995) and Smeet et al. (2011) conceptualise it in terms of quality of care.

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In as much as this study appreciates the many achievements that can be credited to the biomedical model and its understanding of health care, it shares in the views of Louw and Sherome that the "gaps" that are associated with such an understanding and approach to health care should not be neglected. As such the pharmaceutical approach to health care should not be thrown overboard, but could be made to work in tandem with or broadened to include an approach that can give more adequate attention to more perspectives on the human being such as the spiritual and religious, which are indispensable to the Nigerian patient especially in the hospital.

1.8.4 The meaning of hospital care

The definition of hospital care by Saunders (2002:159-160) is relevant to this research. Hospitals constitute part of the health care system. In *The New Dictionary of Pastoral studies* Saunders (2002:159-160) defines a hospital as a "place or institution for the diagnosis, treatment and care of the sick or injured and for the management of childbirth". She further explains that "hospital" derives its meaning from the Latin *hospitalis* (guest). This is because historically hospitals were places of refuge for travellers and those in need. It was therefore a place of crisis (Mills, 2005:538) largely managed by religious communities. This view on the definition and origin of the hospital sheds more light as to why Verhay (2001:30-31) argues that hospitals primarily originated from the Christian concern for the poor and the sick. Over time hospitals have evolved to become places where the sick receive active intervention to find the cause of their sickness and to provide a cure. The concern of the church (in the case of Christianity) that led to the establishment of hospitals (and this has been the norm in most places that Christianity made incursions, including Nigeria) may not have been void of spiritual and theological concerns.

In the postmodern times the majority of hospitals have become government owned, while some are still owned by voluntary organisations, churches, mosques and independent bodies and private individuals, which maybe non-profit or business oriented (Saunders, 2002:159). Saunders (2002:159) has divided modern hospitals into two broad groups: the general and specialist hospitals. General hospitals address all kinds of medical or surgical cases, while specialist hospitals provide treatment for a specific type of group of condition, e.g. psychiatric hospitals, orthopaedic hospitals, maternity hospitals etc. General hospitals are usually more common than specialist hospitals.

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Shasha Shepperd and Steve Iliffe (2008:3-12) have introduced another term: hospital-at-home. They define hospital-at-home as services and treatment provided by healthcare professionals at the home of a patient which otherwise would have required the patient's hospitalisation in the hospital. They further write that hospital-at-home is an alternative to hospitalisation in response to the increasing demand for hospital beds in most countries especially in North America and Europe, but not limited to these countries. As opposed to hospitals which present "strange environment" for the patient, the hospital-at-home may provide the familiar environment for patient's satisfaction and recovery (Shepperd and Iliffe, 2008:12). The main purpose behind the concept of hospital-at-home is to reduce the duration of admission or total avoidance of hospitalisation, which may eventually reduce costs for the patients. The concept of hospital-at-home evolved with hospitalisation in France in 1961. However, the forms in which this is implemented in many parts of the world differ in theory and practice of care. For instance, in the UK hospital-at-home focuses on providing personal services rather than technical services, while in US most of the at-home hospitals provide technical services. According to Shepherd and Iliffe (2008:3), hospitals-at-home are either community based or hospital resourced. In this sense Shepherd and Iliffe (2008:4) categorise hospitals-at-home into community-based hospitals-at-home and hospital-based hospitals-at-home. The latter provide a link between the traditional hospital and an at-home hospital. In this sense, the hospital-at-home is equivalent to home-based Pastoral Care in Africa as discussed in Brown (2004), Magezi, (2005) and Ndhlovu (2008). From the definition of hospital, one can almost assume what hospital care is.

Hospital *care* refers to support services or care and often treatment to a person in hospitalisation (Saunders, 2002:159). Mills (2005:538) defines hospitalisation as "the act of being admitted to or placed in a hospital for treatment. The focus of the treatment may be physical illness or injury, emotional or psychological distress or both". Thus, hospital care might be taken as a broader aspect of care, which may or may not include hospitalisation provided by a team of hospital carers.

Consequently, Connie Evashwick (2005:4) has argued that whatever form of hospital care the patient might choose to adopt, such care should be carried out effectively and efficiently. Efficiency and effectiveness can only be achieved by what she calls a continuum of care. According to Evashwick (2005:4) a continuum of care overcomes fragmented care services.

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It is a patient-focused system "composed of both services and integrating mechanism that guides and tracks clients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care".[6] Therefore a continuum of care takes a holistic approach (Evashwick, 2005:5). Evashwick's integrated services therefore corresponds with WHO's (2008:1-10) "integrated health service".[7] Evashwick (2005:5) has given the goals of continuum of care that this study cannot here enumerate because of lack of space. However, the most important relevant to this study is that of enabling the patients to have access to appropriate care services faster and efficiently. In addition, it coordinates the care of many professionals and disciplines as well as integrating care provided in a range of settings. Evashwichk's continuum of care and the WHO's (2008) integrated health service position fit well into this study in the on-going debate of best practices for patient care. The concern of this study is mainly with the institutional hospital, although hospital-at-home or home-based Pastoral Care also receives some attention in the development of the training and curriculum as developed in chapter 6. As already discussed in section 1.8.3, on the availability of the different forms of healthcare delivery system, the concern of the church (and also Islam) that led to the establishment of hospitals had a spiritual and theological motivation. It is therefore worth considering why hospitals(in Nigeria) that owe their origin to a theologically, religiously and spiritually inclined institution are devoid of such vital components; there is still a need to find ways and means through which such vital components can be engaged not just for the purpose of maintaining a tradition but for the benefit of humankind. The connection between health, spirituality and religion also necessitates attention to these concepts.

1.8.5 The concept of spirituality and religion and pastoral care

Many scholars prefer to link spirituality with religion, because in their view such terms are not mutually exclusive and therefore comprehensive (Hirsto & Tirri 2009, Garelli, 2010:318, VandeCreek, 2010:1-10). In the view of some scholars, spirituality is regarded as a broader term that includes religion, while others like Fowler and Rountree (2009:1-2) distinguish spirituality from religion. However they maintain that there is a correlation with both terms.

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[6] All levels of intensity of care refer to the range of services from acute, high-technology, interventions to on-going support services such as housekeeping, help from friends, family members and others groups in the community. These might include Pastoral Caregiving.

[7] WHO (2008:1) defines "integrated health service as "the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money".

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Spirituality implies different meanings to people ranging from religion to occult, witchcraft, to anything intangible (VandeCreek, 2010:6, Liu, Scott & Jang, 2011:139). The concept of spirituality differs among users, context and disciplines. Therefore Hirsto and Tirri (2009:90) argue that spirituality is contextual in nature. They argue that contextualisation of spirituality is relevant and necessary in view of the fact of the varied perspectives and definitions due to the different cultural approaches to human experience and the evolution of the concept over the centuries. Giacalone and Jurkiewicz's (cf 2010:7-8) compilation of fourteen different definitions and ten dimensions of spirituality (yet not exhaustive) as found in the literature supports Hirsto and Tirri's view. In the light of Hirsto and Tirri's view, spirituality will be linked with religion within the theological context with reference to hospital care in Nigeria.

According to Fowler and Rountree (2009:2), spirituality "represents a way of being, awareness of the transcendent, beliefs and practices around meaning and purpose in life, and interacts with the higher power". Similarly, Kotze (2005) gives the following summary of what spirituality is, which is useful for this study. He argues that spirituality involves:

> [a] feeling of connectedness and belonging in the universe. A belief in some kind of power or spirit outside of one's self. The belief that life has a purpose and personal truths while experiencing transcendence and immanence. The conviction that a person can have an internalised relationship with the divine and through his relationship experience love and a personal wholeness
>
> (Kotze, 2005:127).

However, Kenneth Pargament (2006:12-24), who is one of the foremost researchers in the field of spirituality, defines spirituality as "a search for the sacred". For him the "sacred" refers to holy objects set apart from the ordinary and worthy of reverence and respect, which include God and the divine. He adds that sacred objects includes time and space (e.g. church, Sabbath), events and traditions, material and cultural items, people and social attributes (2006:13). On the other hand, research suggests that spiritualty is an active rather than a passive concept. Therefore it is not a static set of beliefs and practices and experiences.

In fact, there is a consensus among many scholars that the distinction between religion and spirituality lies in the sense that religion is associated with organised religious institutions (VandeCreek & Burton, 2001; Orton, 2008; VandeCreek, 2010). Accordingly VandeCreek (2010:3) defines religiosity as a personal or group search for the sacred that unfolds within a traditional sacred text and context. In the same way Fowler and Rountree (2009:1) define

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religion as that which is associated with commitment to the supernatural expressed through ritual within the faith community. The major differentiation then is with organised religion. In this regard Pargemant's conception of spirituality is inclusive of religion as is defined by many scholars.

For this study spirituality and religion are used synonymously. Prince Conteh (2011: 61) has mentioned that religion is a way of life for the African. He/she takes his/her religion everywhere – to the farm, parties, classroom, and politics and even to war. This is the reason why spirituality and religion are regarded synonymously, because in Nigeria religion is not separated from spirituality and vice versa.

Correspondingly, spiritual care in this study refers generally to the dimension of meaning making of patients, while religious care is that aspect of care that deals with the rituals and practices, narrative, doctrines, ethics etc. of the faith traditions and traditions that the patient may associate with. Both dimensions of spiritual and religious care are conveyed in Pastoral Care as a "practical embodiment of beliefs in humanity with a theological framework that is critically sensitive to context and disciplined in his response" (Cobb, 2005:43). It follows that the PCG, is the person rendering pastoral care. The definition of PCG will receive further attention in 4.3.1.

1.8.6 Creating a space for PCGs within the hospital context

Caregiving constitutes human intentions, motives and action within a certain context which includes the setting, place and space. Beyond being a human action or activity, it is praxis. What then is praxis? According to Louw (2008b:103) in his article "Towards a praxis theology of affirmation: the atmospheric dimension of place and space in practical theological ecclesiology", praxis implies more than practicalities, skills, management and action. It refers to the human intention of the action, the meaning derived from such involvement in life issues which consequently could affect the quality of life and dignity of the human being in such relationship. He argues that space and place play a role in the understanding of praxis. Therefore, praxis is related to attitudes and aptitudes within a specific space and place. Louw's argument is of relevance to this study, as it provides a model for this study's proposed Pastoral Caregiving in the hospital context. The question then that should naturally arise is: what does Louw mean by space and place?

Place, as Louw (2008: 104) uses it, refers to location, territory, possession, occupation and belongingness. According to Louw (2008:104), space and place are rooted in the Greek word

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Chora. This Greek word *Chora*, which can be interpreted as space or place, carries both a transitive and metaphorical meaning. As a verb it means to give room and as a metaphor it conveys the sense of intellectual and spiritual understanding that are meaning laden. "*Chora* then becomes an indication of how humans fill space with values, perceptions and associations in order to create a dynamic relational environment and systemic network of interactions where language, symbols and metaphor shape the meaning and discourses of our life". Therefore, space has to do with interconnectedness, presence, values, norms, meaning, perception and attitude. Space is created as a result of attitude and aptitude within the network of relational encounter (Louw, 2004:344, & 2012:48). Pastorally, it is therefore an atmospheric environment of positive self-regard and self-understanding: a relational and systemic setting with which one feels accepted, accommodated and embraced (*Heimat*[8] (at homeness)". Space is created as a result of attitude and aptitude within the network of relational encounter. Space then determines the quality of place. But space is influenced by power dynamics. This power may be experienced with a space and evidence in various positions as alienation/distance or acceptance/accommodation/embracement.

Although Louw (2004, 2008b, 2012) conceptualises space within the framework of care relationship between the caregiver and the care receiver, his framework is relevant for this study which advocates for space for PCGs in the hospital context. Therefore Louw's discussion of the role of space and its place in healing can be extended to Pastoral Care relationship with healthcare professionals in the Nigerian hospital context. In that regard, adapting Louw's conception of space and place in this study, creating a space for PCGs in the place of the hospital context goes beyond merely making room for PCGs. It involves making an ontological space but beyond that a hermeneutical space of an enabling atmospheric and emotional environment where there is a necessary interconnection with the healthcare professionals with an appropriate attitude and aptitude within a systemic network of such relational encounters. It is a space where PCGs can experience acceptance, dignity and *heimat* to carry out their pastoral praxis of care. Louw has argued that Pastoral Care needs to create a space wherein people can develop their courage to be and discover their human dignity (Louw, 2004:341). These hopes may not be fully realised if PCGs experience alienation and distance rather than acceptance, accommodation and embracement within the hospital context.

[8] *Heimat* "refers to a quality of being-with and a constructive dynamics of interaction brought about by emotions, attitudes and positions" (Louw, 2004:344).

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This argument for PCGs in the Nigerian hospital context is receiving attention globally in the literature on Pastoral Care and from other fields of the helping professions as it relates to different contexts. For instance, Wintrop Whitcomb and John Nelson (2000: 12) in *Hospital Medicine* argue that in view of the fact that patients receive care from a number of providers because of the complex nature of health problems and the reality of medical pluralism, hospital physicians should coordinate closely health care delivery.

In the American or British context the argument for creating a space for the PCGs in the hospital context is currently an urgent debate with more in favour than against. But the role or place and identity of PCG differ from hospital to hospital and from context to context. While some argue for inclusion into the interdisciplinary medical team (VandeCreek, 2010:1-10; McClung, Grossoehme, & Jacobson, 2006:147-156), some have argued for collaboration and consultation with chaplains (De Vries Schot et al., 2008). Others still have argued for health care professionals to be aware of the potential benefit of spirituality so as to incorporate it into the treatment procedures (Tarpley & Tarpley, 2011:305-315). Still others speak of the experience of involvement in the team (Sakurai, 2003:26-27). For instance, De Vries Schot et al. (2008:88-107), a group consisting of a psychologist, a psychiatrist and a theologian, have argued in their research that the spiritual dimension should be considered in caregiving (2008:103). In effect, they suggest that the pastor (PCG) should be involved in the healthcare of patients and especially the mental health care of patients (2008:104). De Vries-Schot et al. (2008) point toward the need for collaboration. Similarly, McClung, Grossoehme and Jacobson (2006:147-156) argue for collaboration, consultation and inclusion of professional chaplains into the team. In the same vein in an article “Defining and advocating for spiritual care in the hospital” VandeCreek (2010:1-10) also advocates for PCGs in the hospital.

Meanwhile, Orton’s (2008) exploration of best practices in research on Pastoral Care in the hospital in Australia, America, England and Scotland indicates that Pastoral Care in these contexts has been characterised by change. The characterisation of such changes is that Pastoral Care rather than being marginal, “evidence support the inclusion of Pastoral Care in the holistic health care” in those contexts.

From the Nigerian and African contexts, the most directly relevant contributions to this debate could be said to be that by Oluwabamide and Umoh (2011) (1.3). This study will attend to the issues that pertain to a specialised role of PCGs who may not necessarily be

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pastors in the traditional sense, but who are trained to engage in pastoral caregiving in clinical settings.

1.9 Chapter outline

This research consists of seven chapters. It begins with the introduction which discusses the research focus, design, definition of some key concepts and a literature review of existing works that relate to the study. It is followed by the exploration of the Nigerian, historical, religious, and socio-economic and medical context and their understandings of health, and healthcare, as represented by the Ibibios. The findings in Chapter Two on health, healthcare and the contemporary provision of hospital care among the Ibibio in Nigeria raises the question of whether Pastoral Care can truly and adequately provide for the spiritual and religious needs of Nigerians especially in the hospital context.

In accordance with the hypothesis, Chapter Three then explores the meaning and nature of Pastoral Care. It discusses the goals, functions, context of Pastoral Care. It also explores the different approaches of Pastoral Care in the Nigerian context as well as the distinctiveness of Pastoral Care from other helping professions. It concludes that Pastoral Care with its distinctive character could be suited to provide spiritual needs to patients in the Nigerian hospitals with it holistic view and approach to caring for persons.

With reference to the findings in Chapter Three, the role of the PCG in the hospital context is explored as it could be relevant to the Nigerian context in Chapter Four. The purpose of this chapter is to demonstrate the relevance of the PCG in the Nigerian hospital care and the resources that the PCG can bring to the Nigerian hospital space drawing from best practices. It demonstrates that PCGs stemming from the rich religious background have unique resources which could benefit the patient and family, medical staff and Nigerian healthcare institutions as a whole. However, at stake is the issue of how the PCG's role and resources could be harnessed with the existing hospital structure to provide continuum of care.

As a result, Chapter Five focuses on the PCG and the medical professional in the Nigerian hospital context. It argues that collaboration is the ideal means of integrating spiritual and religious needs of patients into their treatment plan. It discusses the ways and means through which PCGs can collaborate with the medical professionals for holistic patient care. Chapter Six then proposes a Pastoral Care approach that PCG could utilise to adequately function within the medical team. Chapter Seven evaluates the research hypothesis and objectives as well as providing the recommendations, relevance and conclusion based on the outcomes.

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CHAPTER TWO

HEALTH AND HEALTH CARE IN THE NIGERIAN HISTORICAL, SOCIO-POLITICAL, ECONOMIC AND RELIGIOUS CONTEXT – REVIEWING THE CAUSAL LINK

2.1 Introduction

As stated in 1.5 above, the main objective of this research is to evaluate whether creating a space for PCGs in the Nigerian hospital environment could contribute to better quality of hospital care and satisfaction of patients in the Nigerian health care system. This chapter is about what is going on in the context of the Nigerian health care system and society with particular reference to Akwa Ibom State in order to reflect on the Ibibio understanding of health approaches to health care. It will proceed in line with a post-foundationalist paradigm (Park, 2010) and Osmer's (2006:6-15) practical theological design (1.6, 1.6.1, 1.6.2 and 1.6.3), address the descriptive empirical task: "What is going on in the context of Akwa Ibom State?" In other words, the chapter addresses Osmer's descriptive empirical task. The purpose of attending to this task is to understand the culture, context of health and health care system to identify the factors that may inform the relevance and provision of Pastoral Care and PCGs in the hospital. A thorough understanding of health and health care delivery in Nigerian society is paramount to this study because, as Abdalla (1997:15-16) observes, health care systems do not exist in a vacuum; they are a product of both social and cultural systems. Therefore medical care and pastoral care practices are supported by cultural beliefs and values about what constitutes illness and health and consequently decisions concerning treatment. It is important to note that the Akwa Ibom State (AKS) health care system is informed by three traditions of modern health care (hospital), the African traditional and religious (faith healing) systems. As such, the discussion in this chapter will be guided by these broad categories of healing traditions in a Nigerian context. A practical theological enquiry (as argued in 1.6) privileges a contextual reflection. Accordingly Sally Brown (2012:113) rightly argues that contextual analysis should by necessity include the historical, social, economic and political factors that characterise persons and their actions. The contextual endeavour is motivated by, amongst other reasons, the fact that there is need to see whether there is any interconnectedness between physical/medical and spiritual dimensions in negotiating healing specifically within the Nigerian traditional religious worldview, and how

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is it influencing the Ibibios' response to ill-health. In addition, different kinds of illnesses – including HIV/AIDS, leprosy, tuberculosis and malaria – as well as persons suffering from injuries because of domestic violence, tribal and religious feuds seem to be overtaxing the health care systems in Nigeria in general and its modern hospitals in particular. These challenges may require an approach to healing which takes all the intricacies of sickness into consideration, because as stated in 1.1 the medical model may be insufficient to address the challenge of illness among Nigerians in Akwa Ibom State.

Furthermore, the Ibibio perspective is particularly relevant here, because it is the ethnic group of the researcher herself and is therefore the perspective with which she is most familiar. This does of course not mean that there are no similarities between Ibibio practices and views and those of other ethnic groups in the country. Data on health in Akwa Ibom State are very limited; therefore data from other parts of Nigeria shall also be used. The implication is that conditions of health and health care in different parts of Nigeria are in many respects similar. The chapter is divided into six sections.

The first section is the introduction and will be followed by the second section which offers a brief history background that will address the demography, politics, socio-economic and religious context of the Ibibios. In line with the holistic concerns of this study as discussed in Chapter One, Wimberly (1994: 249) argues that people's desire for health and wholeness is multidimensional as well as interrelated, and the desire is influenced by their sociocultural, political and economic situation or context. In the light of Wimberley's assertion, some reflection on the political and religious history of Nigeria with particular reference to Ibibios may bring to light the role and influence of (corporate or individual) spirituality and religion on Nigerians. Narrating Ibibio political and socio-economic history could reveal some of the challenges that are facing Nigerians that may also impinge on their condition of health and the Nigerian hospital care delivery system.

The third section will present a narrative on the religio-cultural worldview of the Ibibio people of Akwa Ibom State and how it relates to illness and health. From a social anthropological perspective as postulated in role theory (4.2), the illness behaviour of a person is constitutive of norms and values which are embedded in the social system of that individual (Gordon, 1966:30-31). Thus Wimberley (1994:251) asserts that "[e]ach culture holds to views of health and wholeness that are embodied in the cultural values and traditional religious approaches to living" that create unique interpretative lenses for people through which they view and critique their desire for health and wholeness, as well as the

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involvement of others in the quest for meaning and health. The intention is to come to some understanding of the role of religion in the wholeness, health and health care of traditional Ibibios. This is important as this research is based on the assumption that an understanding of African spirituality in terms of Ibibio/Nigerian concepts and religious worldviews of wholeness, health, health care and healing and Nigerian traditional healers could have some correlation with the PCG as a spiritual caregiver. Furthermore, many African researchers (Mabunda, 2001:11-16; Appia-Kubi, 1975:230-240; Vontress, 2001:242-250), aligning themselves with the holistic theory, believe that although modern hospitals can often deal quite effectively with the physical side of disease, they are inadequately equipped or inclined to deal with the spiritual dimension of sickness. This study subscribes to this view.

Sections four and five will present the Ibibio concept of wholeness and health, and their understanding on the concept of sickness respectively. The sixth section of this chapter will focus on the quest for healing/caregiving within the Ibibio sociocultural context. The discussions will reflect on some beliefs and practices of African religious faith healers of Christian and Islamic origin for the purpose of gaining an understanding of their views on wholeness, health, sickness or healing (health care) within this Nigerian community. Against the backdrop of all of the above, especially the traditional and religious worldviews of the majority of Nigerian patients in Akwa Ibom State, the contemporary Nigerian medical health care system (hospital care) in Akwa Ibom State will then be discussed.

On the whole, this study identifies three systems of healing: traditional African healing, spiritual/faith healing and modern medical healing. However, in the following section the focus will first be on the Ibibio historical background for the purpose of understanding the broader context in which the Nigerian patient, hospital and PCG function.

2.2 The Ibibios of Akwa Ibom State – historical background

This section considers the historical background of the Ibibios. Attending to the background of this ethnic group is important because the Ibibios have been chosen as the specific context for this study. The aim is to lend some historical depth that might assist in the understanding of current state of affairs of health care in Nigeria with special reference to Akwa Ibom State. Sickness is a systemic issue; therefore any consideration of care to the sick that is holistic must take into account the context, and all the influences that impact on it including location and the political, socio-economic, religious and cultural influences. As stated earlier (2.1), the understanding of the sick within their peculiar context and their relationship to this context

both past and present is a vital step towards wholeness. Therefore to understand health care in Nigeria and especially AKS, the broader history, culture as well as healing practices need to be considered. In this regard, Thesnaar (2010:6) has argued that any serious attempt to provide care that is sensitive and appropriate has no option but to take the cultural and social context of the people into consideration. This involves not only understanding the problem, but also the people within the context and the context itself. Thus this study begins in the following section with the historical background of the Ibibios, which includes their geography and location. This will be followed by linking the historical background to its impact on their health. The background issues will also include politics and health, socio-economic development and health, among other issues.

2.2.1 Geography and location

The Ibibios are found in Akwa Ibom State (usually abbreviated as AKS). According to the 2006 census of Nigeria, AKS has a population of 4 million people with a density of 466 people per square meter (www.aksgonline.com/about_geography.aspx). Created on the 23rd of September 1987 (from Cross River State), AKS is located in the southern part of Nigeria situated between latitude 40 32' and 50 53'N and Longitude 70 25' and 80 25'E. It covers 6,900 square kilometres. AKS is bordered on the north by Abia and Cross River State, on the south by Atlantic Ocean. To the east, AKS is bordered by Cross River State and to the west by Rivers and Abia States (*Akwa Ibom State Information Handbook*, 1994:12). Located at the north of the equator, it has a tropical rain climate with a mean annual temperature that can be as high as 29°C. Its topography is made up of an oil palm belt, tropical rain forests, swamps and beaches (About Akwa Ibom State: Location and Geography, 2012). Its location within the tropical zones of the globe gives AKS a climate favourable for both tourism and agriculture. Apart from its agricultural base, it is also one of the major oil-producing states of the federation and the major source of economic sustenance of the government. However, the climatic conditions also provide favourable conditions for some tropical illnesses and diseases such as cholera and malaria, and such increases the vulnerability of the inhabitants to these diseases. Most of the Ibibios of AKS (about 90%) live in villages in the rural areas (The Development Framework of AKS, 2005:107).

Akwa Ibom State has various ethnic groups and languages such as Ibibio, Anang, Oron, Ibeno and Eket, with Ibibio being the largest ethnic group in the state and the fourth largest ethnic group in Nigeria. The etymology of the name and origin of the Ibibios as a homogenous entity is still a matter of speculation without consensus among scholars (Essen

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1982:4-6; Udo, 1983:1-34; Noah, 1994:26; Esema, 2002:3-9). Little wonder the Akwa Ibom State handbook and their recent website does not include information on the origin of Ibibios (cf. *Akwa Ibom State Information Handbook*, 1994, About Akwa Ibom State: Location and Geography, 2012). Nevertheless, these scholars share the opinion that though there may be different ethnic groups, they share similar cultures, customs and traditions with slight variations in the language. Thus Akwa Ibom people share similar customs with regard to language, music, values, art, styles, literature, family life, religion, rituals, food, naming, public life, as well as common social, cultural, political and economic relationship. Hence "little or no difference exist in the dances, songs, myths, shrine, funerals, folklore, mode of dressing, foods, cults and monuments" (Uya, 1994:22) such as wood carving, sculpture and pottery. The similarities are evident in their proverbs, social and cultural events and practices. Therefore, Akwa Ibom State enjoys a relatively homogenous ethnicity (Uya, 1994:22). According to the *Akwa Ibom State Information Handbook*, Akwa Ibom State is "a homogenous group of people believed to have originated from a single ancestral stock. The people have a common cultural identity and linguistic heritage" (*Akwa Ibom State Information Handbook*, 1994:12-13). Consequently, the Ibibio language is spoken and understood by all indigenous people of Akwa Ibom State alongside the different dialects in the state. Arguably, it could be said that the Ibibio language is the official and written language of the people of the state. The Ibibios are endowed with a rich cultural and traditional heritage which has distinguished them and further affirmed Akwa Ibom State as one of the gifted states in Nigeria (*Akwa Ibom State Information Handbook*, 1994:12).

The Akwa Ibom State is sometimes loosely referred to as *Ibibioland*, the Ibibios in this sense encompassing all the people of Akwa Ibom State (Udo, 1983: vii). In this study the terms Ibibio, Akwa Ibom and Ibibioland shall be used interchangeably, as referring to a homogenous unit, without minimising the differences that may exist among the people. However, this traditional Ibibio entity and identity have from time to time been threatened, raising the question of what kind of people the Ibibio are in what scholars like Esen (1982) have identified as the "colonial political antecedents". These colonial influences invariably may also have impacted on their wellbeing.

2.2.2 Politics and health in Ibibioland: the colonial influence

The impact of the colonial regime in Nigeria had an influence on many institutions in Ibibioland in Nigeria. Esen (19982:1) states that it created new systems that did not go well with the Ibibios. Udo (1983:104) and Abasiattai (1994:34) corroborate Esen's position that in

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terms of the political and socioeconomic development (such as opportunity to rule, good roads, schools, health services etc.) of the Ibibio, the colonial government and eventually Nigerian regional government neglected the Ibibios compared to other areas. Conversely, the colonial presence affected the Ibibios' traditional systems of leadership. Esen further remarks that the colonial rulers devalued and discarded Ibibio kings, referring to them instead as 'chiefs', and the people as 'natives'. In the same vein the African Gods were not spared as they were dethroned and declared heathen along with traditional form of worship. The reason for doing this, according to Esen (1982:4), was to destroy the identity of the Ibibios. According to Esen, before it was realised, "the African was no longer his true self. He had lost everything: his land, his Gods, his freedom and self-respect. When he started looking up to the white man, the colonialism in his mind had begun". The said challenges posed by the colonial era did not exclude the health system. Agbali (2006:322) and Akinyemi (2006:287) argue that the influences were due to the foundational role that the colonial government played in many Nigerian institutions, which are still being run along similar lines today.

Thus some scholars are of the opinion that the colonial enterprise did not only affect traditional systems of leadership, religion and moral values, but also the practice of care of the sick, as is represented in contemporary Nigerian hospital care of the sick and will be explained later. For instance, Abdalla (1997: 29) speaking from the experience of the Hausas of the northern part of Nigeria, which is similar to Ibibioland, argues that some infectious diseases such as cholera which were not prevalent to Hausaland became prominent during colonial rule. Furthermore, diseases like measles, cerebro-spinal meningitis and malaria became more pervasive during the colonial period as a result of faster means of communication which facilitated the spread of diseases.

The experience of colonialism in certain parts of Nigeria such as AKS was similar to other parts of Africa. The colonialists disregarded the African/Nigerian worldview of reality by seeking to impose their secularised and fragmented worldview. According to Uya (1992:21),

> [o]ne major characteristic of the traditional Nigerian mind was the belief in a fundamental harmony which characterised existence, coherence or compatibility among all disciplines – philosophy, theology, medicine, politics social theory and land laws etc. All these were so logically concatenated, in the view of one scholar, in a system so tight that to subtract one item from the whole was to destroy the structure of the whole. This di-unital conception of reality made the traditional man to frown on fragmentation between different elements of being. Life was viewed as a totality with no distinction made between things political, economic, social or religious.

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This means that Nigerians in pre-colonial Ibibioland had defined ideas about sickness and mode of healing that were embedded in their understanding of the body and bodily functions (cf. 2.4, 2.5). The colonialists' attempt to establish a medical hegemony over Ibibios/Africans, built on a scientific foundation based on their Western background, could be well understood in the light of the fact that traditional Ibibios, like Africans elsewhere, were not the primary subject and motivation for the provision of their modern hospital care. Hence their disregard of the latter's cultural values and beliefs in their perception of illness and healing methods. For example, Manton argues that the colonialists' method of treatment of leprosy was rooted in restrictions of the affected persons to leprosoriums greatly undermined the communalism of Nigerians, and invoked social stigma and discrimination on the lepers, which had not been present before. Before colonialism, lepers were not feared and contact with them was not restricted, even though the disease was believed to be a curse from the spirit world (Manton, 2011:124-134).

However, as has been and will again be shown, ailing Nigerians including the Ibibios (especially those who find themselves in hospitals) need holistic and unfragmented care and support in their immediate environment; this includes the religious/spiritual dimension, while not neglecting the psychological and existential challenges that are often accompanied by questions concerning the place of God in their suffering or needs. This also means that the spiritual dimension is not unconnected with the socio-economic situation of the Nigerian people in general and the Ibibios in particular. This is because the socio-economic situation may impact on their sense of meaning and wellbeing in the sense that poverty and social unrest, among other things, have a direct connection with the psychological and health dimensions of persons.

2.2.3 Socio-economic development and health of the Ibibios

One of the determinants of socio-economic development of a nation is its health (Ukpe, 2007:4; Alubo, 2006:313). According to Iwok (1994:116), it is the belief of the people and government of Akwa Ibom State that health is wealth. Consequently, it is perceived that the more healthy a country is, the more developed it is and vice versa. It is constantly noted that the developed countries of the world have a longer life expectancy than developing countries. Akwa Ibom State's average life expectancy at birth, for example, stood at 54 years (The Development Framework of Akwa Ibom State, 2005:106), while that of the developed world stood at 78 years at the beginning of the new millennium (Sachs, 2005:194). Table 1 below

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shows the life expectancy indices of AKS. These indices of life expectancy correlate health with development.

Table 1 Health and Socio-economic Indices of Akwa Ibom State

Basic Health Indicator	**Ratio**
Average life expectancy at birth	54 years
Crude death rate	12/1000
Crude birth rate	32/1000
Infant mortality rate	67/1000
Maternal death rate	800/1000
Doctor population ratio	1:10,172
Nurse Population ratio	1:615

Source: The Development Framework of Akwa Ibom State (2005:106)

Therefore, Oluwabamide and Umoh (2011:47) in line with other social development theorists like Schmid, Cochraine and Olivier (2010:138) argue that health should be a major precondition for development: "Thus, a sick nation is bound to remain undeveloped. That is, a sick people can neither develop nor be developed". Ihunna (2008:306) further stresses that "the chronic problems of debt, poverty, and development find a point of convergence in today's political economy. It is therefore only proper that we should reflect on these issues in evaluating the degree of health or sickness that affects and afflicts African states". Akwa Ibom as a developing state experiences slow progress in its socio-economic developments and health conditions. According to the development framework of Akwa Ibom State (2005:106), "it is substantially less than satisfactory". The major reason for the slow progress has been attributed to colonialism, poor leadership and corruption, as noted in the previous section (2.2.2). There are, however, multiple sides to this picture therefore, one must endeavour to look at all sides of health issues, which includes the relation of disease, poverty and health, in order to have a good understanding of the problems for appropriate action.

It is widely believed that the poverty and suffering of Nigerians including the Ibibios is the result of poor leadership and management of resources, which breeds poor living conditions and disease infestations (Odunsi, 2001:66).

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The renowned economist Jefferey Sachs (2005:188-206) has located an additional reason for the slow rate of development in Africa and Nigeria in addition to the popular theories of colonialism, poor leadership and corruption. He argues that there is yet another factor, which seems to have eluded "both the critics of African governance and the critics of Western violence and meddling" (Sachs, 2005:190). According to him, "politics at the end of the day, simply cannot explain Africa's prolonged economic crisis. The claim that Africa's corruption is the basic source of the problem does not withstand practical experience or serious scrutiny" (2005:190-191). After his careful study of all the assumed factors in most African countries, including Nigeria, for ten years (1999-2005), Sachs, strongly argues that in addition to the other factors disease pandemics are a more plausible reason for why African countries are poor and underdeveloped. In his careful study of malaria and HIV and AIDS in Africa, Sachs concludes that there is a definite link between disease/sickness and poverty, and clearly demonstrates the existence of a hunger-disease-poverty nexus.[9] Poverty, he asserts, leads to hunger and hunger breeds conditions for poor health, and vice versa (Sachs, 2005:190-191).

Ukpe (2007:4) in her evaluation of the Akwa Ibom State health status and Aluko (2006:231-245) in his empirical research findings based on Nigerian communities as reported in *Poverty and Illness in Nigeria: A Parable of Conjoined Twins* substantiate Sachs's hunger-disease-poverty theory of the interrelationship between poverty and illness in Africa. According to Sachs (2005:190-191), "[t]he relationship between poverty and illness is so interrelated and interwoven that it is sometimes difficult to determine which one is the 'cause' and which the 'effect'." With reference to the 2003 World Bank Report, Aluko (2006:235) demonstrates the relationship of poverty to illness in Nigeria at five levels:

- Level 1: Hunger, or lack of food;

[9]In Sachs's study of African mosquitoes he discovered that there are different types of mosquitoes, the harmless and the harmful. The harmful is the *genus anopheles*. Among the harmful mosquitoes are the ones that prefer to bite cattle and the ones that prefer to bite humans. The ones that prefer to bite humans are found mainly in Africa. He discovered that there are four types of human malaria. The malaria caused by the pathogen *plasmodium falciparum* is the most virulent and lethal, which accounts for the vast portion of malaria cases in Africa. The malaria caused by *plasmodium virax* is less lethal and is widely prevalent in tropical and sub-tropical regions outside of Africa. Sachs also discovered that the poor regions were more burdened with the incidence of malaria and HIV/AIDS. This is because, despite the fact that malaria is treatable and there are low-cost treatments, they do not reach the poor. He concluded that poor countries and households lack the means to fight malaria and HIV/AIDS, which weakens the workforce as a result of deaths and frequent absenteeism from work and school, and reduces productivity which in turn exacerbates hunger and poverty. He argues that "everybody in tropical Africa contracts the illness at least once a year. In some cases the entire population lives year-round with the malaria parasite in their bodies (although without clinical symptoms most of the time)" (Sachs, 2005:196-197).

- Level 2: Psychological and *spiritual* dimensions, such as powerlessness, voicelessness, dependency, *hopelessness*, shame and humiliation (emphasis mine);
- Level 3: Lack of access to basic infrastructure, i.e. roads, transportation, clean water, electricity and health facilities;
- Level 4: High incidence of illiteracy, schooling receives little attention or mixed reviews;
- Level 5: Poor health and illness.

In evaluating the effect of poverty and sickness in Nigeria, Aluko underscores the fact that a combination of poverty and sickness is Nigerians' most powerful and massive affliction. The above scholars' opinion is substantiated by the Draft Health Promotion policy of Nigeria (2005:2), which states that "[p]overty is keeping more and more people in poor health, just as the poor health of an increasing number of Nigerians is retaining them in poverty". Consequently, Ukpe (2007:4), advocating for adequate health care for Akwa Ibomites, asks "How can an individual suffering from ill health contribute to economic growth?"

Ogbu Kalu (2010a:296- 307) in turn extends the argument of poverty and sickness even further by linking the rampant poverty in Nigeria also with the prevalence of violence in the country. Agreeing with much of what Sachs, Ukpe and Aluko have posited above, he argues that "violence is intricately woven to poverty". Again poverty (and now also violence) have a connection with health. By using the concept of "social suffering", Kalu explains how a distressed political and social economy exacts severe stress and health problems on the poor. Violence becomes a channel for releasing the anger and tension and unfortunately "the poor take it out on themselves" rather than fighting the structures that keep them poor (Kalu, 2010:307). This could possibly be one of the reasons for the perennial challenge of riots in the Nigerian political and socio-religious landscape, including AKS.

The above illustrations from Aluko, Kalu and Ukpe show that the attainment of development in Nigeria in general and in Akwa Ibom more specifically is inadequate. Given its abundant resources, one may even expect that Nigeria along with her component states such as AKS, which is an oil-producing state, should be the richest country in Africa that could well compete with the developed countries. Unfortunately, in 2010 about 68% of its citizens were living below the poverty line (http://milleniumindicators.un.org/unsd/mdg/data.aspx)[10]. This

[10] Ihonvbere and Shaw (1988:141) in their book *Political Economy* have explained why such a high level of poverty prevails in Nigeria. According to them, precolonial, colonial and post-colonial Nigeria until 1960 depended on agriculture as a major export and was the major profession of Nigerians (and is still the major occupation of the rural AKS and other Nigerian communities dwellers). Agriculture (mainly subsistence)

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means that a greater number of Nigerians, including those in AKS, are living in abject poverty – living on less than one USD per day and under conditions of severe suffering and ill health.

This state of affairs has not gone unnoticed by other Nigerians. Ukaegbu (2007:167) observes, for example, the deplorable state of the Nigerian educational system in general, and by extension Akwa Ibom, which also affects its health sector and this is reflected in the equally deplorable state of the medical education in that sector. Ibrahim (2007:905) therefore understandably notes and decries the substandard training given to Nigerian medical doctors in medical schools. Among the numerous inadequacies of the Nigerian medical education, he asserts that:

> Nigeria is slow to recognise the enormous changes that have taken place in the way medicine is taught and learned over past decades… The result has been a disastrous adherence to a traditional curriculum and archaic teaching and assessment methods in practically all schools in the country. Medical schools in Nigeria require urgent and immediate help from the world Federation of Medical Education, Association of medical education Europe, Association for medical Education Africa and FAIMER.
>
> (Ibrahim, 2007:905)

It is beyond doubt that the poor preparation of medical practitioners will have an adverse effect on the health sector. Accordingly, Ukaegbu's assessment, also with reference to the socio-economic situation, argues that health care infrastructure such as equipment, medicine, buildings and other hospital facilities as well as roads are far from adequate:

> The health sector has not fared better in terms of availability of resources such as equipment, medicine, buildings, and even environmental aesthetics. Many general hospitals in the past were repositories of excellence and commanded public confidence. Today, they are in a state of dilapidation because of neglect by those who run them. Those in charge of public health institutions, in turn point fingers at federal and state governments for not providing the fund necessary to maintain and upgrade the health sector. The transportation sector is in equally bad condition. Roads full of

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provides 60% of the labour force of AKS (www.aksgonline.com/about_geography.Aspx). The discovery of oil in Nigeria (AKS being one of the oil-producing states) led to the abandonment of agriculture partly because of the pollution of farmlands and water by petroleum oil spillage (Petters 1994:305) and partly because the Nigerian elite directly classified agriculture as the profession of the illiterate. Therefore the dependence on oil accounts for the neglect of agriculture because of absence of incentives through taxation, administrative manipulation and the use of marketing boards to reduce their commodity pricing during the colonial and post-colonial era, which eventually led to the decline in agricultural inputs. This also accounts for the drift of Nigerians/Akwa Ibomites from rural to urban centres in search for jobs because they have been dispossessed of their land for industrial and technological purposes (Ihonvbere and Shaw 1988: 80). Ogbu Kalu (2010: 306) also argues that protracted warfare, dependency on one group or one natural resource also contributes to poverty. According to Akintunde (2009:116), on the basis of the demography and statistics on Nigerians suffering from HIV/AIDS, it would be appropriate to deduce that HIV/AIDS also contributes to the present poverty level of Nigerians, including AKS, as the disease mostly affects the productive groups.

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> filth, potholes, crevices, swaps, and outgrowths of grass from nearby forests make land transportation difficult and unpleasant.
>
> (Ukaegbu, 2007:167).

The situation described by Ukaegbu underscores a point that the socio-economic situation in Nigeria, including Akwa Ibom State, is not very favourable and as such it is taking a toll on the daily existence of Nigerian citizens. It reflects an underdeveloped society plagued with poverty. As has been repeatedly shown above, there is a dialectical relationship between poverty and health, hence the lack of social and recreational facilities, low income, unemployment, poor diet and housing all constitute health hazards and aggravate hunger and sickness.

However, Ibibios are not as hopeless as their poor living conditions might seem to indicate. They draw inspiration from their religious resources when they find themselves in such precarious conditions by simply exclaiming "*God dey*" meaning God is alive and will see me through this situation. According to Chinne (2008 :8), "the resilience of Nigerians to go on living in the midst of all the deprivations, and this in the midst of plenty, while telling themselves and whoever cares to listen, "*God dey*!", is an expression of hope against hope". However, the story changes when they find themselves in the hospital as this hope may seem threatened in the face of the existential suffering of hospitalisation. The expression may change from "*God dey*" to the questions: "*Why me, God*?" "God, where are you?" "What have I done to deserve this?" (3.4.1). These expressions taken at face value may look like superficial common expressions in Nigeria, but in a deeper sense they represent hope that is in search of God in the midst of suffering, a search for meaning. It is sad enough that people suffer in situations that may be avoidable if the government was doing its part; however, it becomes a double crisis for people when they are hospitalised, where their vulnerability is exposed, and thus this spiritual question becomes more accentuated as does the yearning for a spiritual response. The above discussion on the interrelationship between poverty and illness and its impact on the socio-economic development of AKS on a macro level and the development of families and individuals on a micro level constitute a significant point for this study. It reveals the fact that disease and sickness are not simple physiological challenges, but involve complex categories that cannot be combated merely by administering drugs and by surgery, but demand a holistic approach that takes into account the intricacies of disease, which is not devoid of a spiritual dimension, and which needs to address the structures that perpetuate poverty and illness. This is even more the case with the socio-economic, cultural,

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gender and moral and spiritual factors attached to some diseases such as leprosy, HIV and AIDS, tuberculosis (TB)[11] etc., which demands nothing less than a holistic approach to illness, care and healing. In this regard Luedke, Jeater and Schumaker's regret expressed in the following remark is understandable, namely that "the definition of disease in biomedical terms has long been rejected especially after the WHO Alma Ata Declaration of 1978 … however most medical practices are still more or less focused on this reductionist approach to illness" (2007:707). Consequently, Kalu (2010b: 70) insightfully asserts that in Africa "political instability, economic disaster, upsurge in mortality rate, increase in robbery and other unwholesome social facts are regarded as disease requiring divinatory diagnosis and spiritual cure", which does not invalidate the need for biomedicine.

This is the context of Nigeria and in which Akwa Ibom people live, especially with reference to the current Nigerian health sector. One of the questions that now needs an answer is what are the religious implications of the impact of poverty on illness and vice versa within the AKS environment? The implication could be sought in the notion that Ibibios are resilient and hopeful. In the light of the link between health, poverty, development and violence, religion has provided a source of strength for Nigerians. In the present Akwa Ibom State, religious bodies are not only playing supportive roles, they are also advocates for changes in socio-economic conditions, most especially in the area of health and education (CAN, 2010:11-12). In consideration of the multidimensional factors of disease and illness, scholars such as Schmid, Cochrane, Oliver (2010:139-149), Swart (2005:21) and Garner (2000:310-312) have all observed that religion and their religious groups are sources of socio-economic change in most countries, including Nigeria. Therefore they are obligated to move beyond just providing support and stand against unjust social structures, which militate against the wellbeing of especially the marginalised groups of society as well as participating in the formulation of policies. However the focus of this dissertation is on the relationship between two variables: religion and health. Therefore, attention will be narrowed to the area of health and the role of religion and religious bodies in the provision of medical care in Ibibioland of Akwa Ibom State.

[11] HIV and AIDS, TB and leprosy are diseases associated with the poor living conditions of the people living with these diseases. Hence the diseases are more prevalent in the poor regions where there are inadequate facilities. HIV and AIDS, for instance, is a behavioural condition which is related to sexual behaviour which may be related to some cultural mores about sexuality. For instance, African women have been reported to be more affected than men because they have limited choices about their sexuality because of cultural norms that may not favor them.

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2.2.4 Religion and health in Ibibio

This section deals with the three religions in Nigeria that have exerted much influence on healing methods among the inhabitants of Akwa Ibom State. In assessing what is going on in Nigeria, it is impossible to sidestep the religions which inform the worldview of most Nigerians. The three religions, namely African Traditional Religion (ATR), Islam and Christianity, will inform the discussion on religious healing in Nigeria. According to Archbishop John Onaiyekan, the President of the Christian Association of Nigeria (CAN) in his article "Dividends of Religion in Nigeria",

> [a]ny casual look at our country (Nigeria) shows the all-pervading presence of religion. We only note, for example, the number of places of worship, the volume of holy noises that are emitted everywhere, the array of religious leaders with various titles and robes and the fervour with which we not only practice our faith but at times violently confront one another.
>
> (Onaiyekan, 2010:2)

Contemporary Ibibio communities are dominated to a greater extent by Christianity. Thus the Ibibios are "predominantly of the Christian faith although some forms of traditional African Religion (in its pure form) are practised by a negligible minority" (*Akwa Ibom State Information Handbook*, 1993). Islam is hardly practised by the indigenous people of Akwa Ibom State. The Hausa settlers within the state, who migrated from the north to the south for business purposes, brought with them their religion and constitute the Islamic fold within the state. Hence, Islam has a small presence in the region (Esen, 1982:6, Iwok, 1994:115).

2.2.4.1 African Traditional Religion (ATR)

ATR is the oldest and the primary religion of traditional Ibibio society. ATR is an embodied religion that is often passed on from one generation to another. Until recently, it had no written literature, though ATR is always evident within its cosmologies in practice (Mbiti, 1999:3, Agbiji, 2001: 26, Esema, 2002:108). ATR thrives in people's myths and folk tales, proverbs, songs and dances, liturgies, shrines, rituals and religious personages such as the priests, rainmakers, officiating elders and even kings (Mbiti, 1999:3, Esema, 2002:107). It does not claim universality or compete for converts. Individuals, families and communities have their own deities as well as venerated ancestors. Hence, as will be evident in the sections that follow, African traditional healing methods were the only healing system that catered for the health of the Ibibios in traditional Nigerian society before the advent of Christianity and Islam. African traditional health care practices were the indigenous health care system of

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Nigerians and traditional Ibibios will receive more attention in the subsequent sections (2.4, 2.5 and 2.6.1).

2.2.4.2 Islam

Islam came in as a conquering missionary religion through the caravan route between the 6th and 11th centuries. It came as a part of the trans-Saharan religious movement, which developed in contemporary Nigeria, after Islam "captured the Maghrib in the seventh century … thus by the ninth century, northern Nigeria was woven into the tapestry" (Kalu, 2004: 244-245). Islam was firmly established in contemporary northern Nigeria between the 13th and 15th centuries. It came through the Arab and Berber races of North Africa. Briefly, Islam was common in the North as well as among some communities in Yoruba land in western Nigeria and Igboland in the east (Metuonu, 1995:103-111). Today it is also making inroads in other parts of contemporary Nigeria, including Akwa Ibom state. The word Islam means "commitment" or "surrender" or "obedience to God" (Rassool 2000:1478; Schirrmacher, 2008:11; Wehbe-Alamah 2008:85). Hence Islamic missionaries felt committed to establish Islam in Nigeria through various means. According to Abdalla (1997:77), one of the instruments contributing to the spread of Islam in Nigeria generally was Islamic medicine.[12] As a major historian of Islamic medicine in Nigeria, Abdalla argues that Western medicine was only lately introduced to the Moslem Hausa in the northern part of the country. Abdalla (1997: 29) explains that this was the result of the problem of distribution of medical resources such as physicians and drugs. Hence, "Islamic medicine was accepted among Muslim and many non-Muslim Hausa as a norm, natural and in time even indigenous" (Abdalla, 1997:103). However, Islamic scholars believe that Islam as the religion of the book had made important contributions to the development and preservation of Western scientific medicine through the works of the early Islamic physicians such as Abu Ali al-Husayn ibn Abdallah ibn Sina (Nagamia, 2003:27) and Abu Bakr Muhammad Ibn Sakariyya al-Razi (865-925 CE; 251-313AH) (Tibi, 2006:206). Nagamia (2003:24) asserts that during the European Renaissance the works of these Islamic scholars "formed the basis on which the European authors gained insight into the medicine of the 'ancient' or early Greek authors whose works were preserved in Arabic". Islamic medicine, as the authors have identified it, has two forms

[12] Islamic medicine is defined by Husain Nagamia (2003:20) as "a body of Knowledge of Medicine that was inherited by the Muslims in the early phase of Islamic history (40-247 AH/661-861 AD) from mostly Greek sources, but to which became added medical knowledge from Persia, Syria, India and Byzantine". This medical knowledge was eventually translated into Arabic, codified and Islamicised.

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– scientific medicine which incorporates *materia medica* (the herbal medicine) and prophetic medicine (faith healing).

Materia medica is Islamic scientific medicine (Tibi, 2006:206). Islamic scholars on Islamic medicine such as Abdalla (1997:77), Nagamia (2003:25), Al Binali (2003:5-7) and Sengers (2003:55) assert that Islamic medicine has its roots in Greek medicine and Greek philosophy of the Galenic and Hippocratic schools of medicine. As Abdalla (1997: 56) points out, the early Islamic physicians were so influenced by the Greek writers so much that they believed there was no authentic source of medicine outside of the Greek sources. The emphasis on *materia medica* was on the general maintenance of health through a disciplined life, moderate diet and the avoidance of sources of sickness and injury. The general approach to illness was through utilisation of herbs and honey, and secondly religious therapy in the case of supernatural illness caused by the evil eye, magic, etc. (Senger, 2003:55). In Senger's view a conflict arose with the passage of time, between the principles of scientific medicine and those of religion. "This came about both through a denial of natural cause and effect and through the fact that professional medicine was practiced primarily by non-Muslims and had strong ties to Greek philosophy" (Senger, 2003:56). Subsequently prophetic medicine gained prominence over scientific medicine.

The *prophetic medicine* consists largely of a collection of *hadiths*, which relates not so much to what the prophet used to do with regards to illness, but to the Muslim lawyers' views on health and illness. Abdalla (1997: 77) points out that prophetic medicine was the medicine of preference for the jihadists who brought Islam to Nigeria. Only later was *materia medica* considered in the Nigerian Islamic development. The prophetic medicine, or spiritual medicine as Syed (2003:48) calls, is believed to cure sickness, infertility, problems with one's job, alleviate fear of failure in an examination, demonic possession and mental sickness (Syed, 2003:48).

Islamic medicine, although it had its root in the Greek philosophy of medicine, separated from Western medicine in the late 16th and 17th centuries as a result of the development of European civilisation and the concomitant decline of the Islamic civilisation (Nagamia, 2003:30; Abdalla, 1997:69). According to Abdalla (1997:69), at the time of its arrival in Nigeria, Islamic medicine had lost its vigour and vitality in institutions, practice and orientation. "The hospitals that once were the centres of medical activity and innovation were rapidly falling into disuse, the lecture halls were deserted, the pharmacies were empty,

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and the library collection disappeared" (Abdalla, 1997:69). The supernatural approach to disease, diagnosis and treatment had replaced the scientific approach to disease and cure.

Christianity, on the other hand, arrived with the Portuguese sailors and missionaries between the 15th and 16th centuries. These missionaries brought with them scientific medicines and hospitals. Successful growth and expansion, however, came with the arrival of the Protestant missionaries in the 19th century, through the South.

2.2.4.3 Christianity

Christianity eventually arrived and survived in Nigeria in general and in AKS through the efforts of the Protestant missionaries in the early 19th century. A former Portuguese Roman Catholic mission in the 15th century was abortive. Its first converts in Nigeria were mainly slaves, women, the poor of the society and very few wealthy chiefs. Christianity was often in tension with the traditional cultures such as the indigenous practices of health care. Hence, the missionaries were often accused of upsetting the traditional structures of its host communities. In spite of this persecution, the Christian faith survived basically through the activities of missionaries.

First from the Calabar axis, the open invitation of Kings Eyo Honesty II of Creek Town and Eyamba V of Duke Town to the missionaries to trade, educate as well as spread the Christian faith was of great advantage. The abolition of the slave trade had affected them adversely, so they had to seek for new ways of utilising slaves lest they become a nuisance to the kingdom (Aye, 1996: 2). This great invitation enabled education and health care through the establishment of schools and hospitals to play a vital role in the expansion of Christianity. The desire for knowledge and to be healthy attracted the indigenous people to the schools and hospitals and invariably to the church (Aye, 1987: 117). In this sense there was a healthy interaction between religion and medicine as the missionaries strove to care for the body and the soul in a holistic vision.

Thus religion plays significant roles in the resilience of Nigerians, including the Ibibios. Many of them resort to religious spiritual resources for their survival in adverse conditions. The concerns raised by Ukaegbu (2007:167) and others touching on issues such as insecurity, crime rates, joblessness and poor health are addressed by spiritual means. Ibibios and other Nigerians as typical Africans have a spiritual interpretation for every physical problem (e.g. illness, joblessness, death). The various religious groups are means by which these concrete situations are addressed.

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Given the centrality of religion to the Ibibios, it is pertinent that religion be given its prominent place in the state's public arena, which includes the hospitals. The health of the Ibibios could be said to be dependent on the political viability and freedom of the citizens. Such health cannot be achieved without consideration of the role that religion plays in the life of the people. Although sometimes religion could be used by some Nigerians in negative ways, such as the use of religion to settle political or ethnic scores,[13] its importance cannot be overlooked. Conscious of how religion has sometimes been negatively used, Sunday Oluniyi (2006:95), in his book *The Council of ULAMA and Peaceful Co-existence in Nigeria*, argues for a responsible engagement of religion in the public arena. According to Oluniyi (2006:95),

> [g]iven that politics and religion are both constitutive of human nature, and indeed that the two have been described as two interpretations of the human conditions; religion cannot be dislodged from the public arena. However, its role does not lie in the exhibition of sectarian language or the promotion of exclusive symbols or in the display of perfunctory piety. Rather religion by its very nature translates into integrity, transparency, and accountability in the public arena and public affairs.
>
> (Oluniyi, 2006:95)

Onaiyekan's (2010: 1-35) article "Dividends of Religion in Nigeria" argues that religion plays an important role in the Nigerian environment and should be seen as providing important resources for the management of people. Onaiyekan substantiates the role of religion in many areas, including the provision of chaplains as well as places of worship and pilgrimage.

1. Chaplaincies: the government has a history of sponsoring chaplaincies within its institutions such as the military, police, university and college chaplaincies, which dates back to the colonial era. These chaplaincies represent the two dominant religions in contemporary

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[13] For example the polio controversy of 2003 in the northern part of Nigeria which broke out between the Islamic religious leaders and the government (although no such incident was reported within AKS). As part of a global polio eradication drive, the WHO quick started "to kick polio out of Africa" in 2003. In July 2003 the Supreme Council for Islamic Affairs (SCIA), an Islamic religious body in Nigeria, claimed that the said vaccines were contaminated with anti-fertility and AIDS-inducing agents. They therefore advised the Moslems not to participate in the exercise as it is a calculated attempt by the Western world to eradicate them. Following these statements, some northern governors embarked on a campaign to stop Muslims from participating in the event According to Obadare (2005:266,274), the claims should be seen in the background of the politics of suspicion of the colonialist conception of disease against the traditional beliefs and a suspicion of the Western world's attempt to depopulate Africa, on the one hand. On the other hand, it demonstrates the mistrust of the government by the people whom they suspect are tools of Western rulers for their selfish ends (Obadare, 2005:279). For Obadare (2005:274) the point is not whether the suspicion that the polio vaccines were contaminated was founded, but a particular history of politics and especially health politics that it invoked. Thus Obadare blames the WHO and the United Nations Children's Emergency Fund (UNICEF) for their disregard of the social embeddedness of medicine in Africa, which resulted in the crisis and the Nigerian state and the Ministry of Health, which failed to provide the socio-legal climate for an adequate operation by relating to the people in order to mitigate their distrust. It should also be noted that it was mostly the religious leaders who resolved the problem.

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Nigeria: Islam and Christianity. "They have been carrying out their duties in such a way that religion is properly integrated into the lives of those public institutions" (Onaiyekan, 2010:22). In the recent times, during President Obasanjo's administration (1999-2007), religious chaplains were assigned to Aso Rock (Presidential Residence) with Rev. William Okoye as the first chaplain to the president (Kunhiyop, 2008:173). These are laudable achievements. However, there is still an important sector that needs to be attended to by the government and health institutions. As will be further argued in (2.6), religions have played significant roles in the establishment of hospitals and health institutions as well as providing moral and ethical values that instil wholeness through places of worship.

2. Places of worship: the Nigerian federal government is known to have allocated land as well as financial resources for ecumenical centres for Muslims and Christians (Onaiyekan, 2010:24). Places of worship are also allocated to various religious bodies in educational institutions, market places, government offices and other public places.

3. Pilgrimage: the government sponsors both Muslims and Christians on pilgrimages to Mecca and Jerusalem respectively, although some Nigerians do not see the rationale for the government's spending on pilgrimages.[14] Many people say this money should rather be used for health care.

The above perspectives on the role of and relationship between religion and the socio-political wellbeing of Ibibios underscores the fact that religion, rather than merely being a personal and private affair, is a major determinant in the AKS/Nigerian public arena. Besides the government patronage and sponsorship of religious bodies, religious groups have collaborated with government in the provision of health services for Akwa Ibom State and other Nigerian communities in search of health and wellbeing. In other words, the religious institutions, rather than being mere recipients of support, are contributing tangibly to the holistic wellbeing of Nigerians in a number of areas including health.

In memoranda to the Federal Government religious organisations such as CAN, for instance, affirmed their commitment to ensuring that Nigerians have sound minds and bodies.

[14] Onaiyekan (2010: 23) observes that the government sponsorship on pilgrimage has become more political than religious. He therefore argues that pilgrimage should be left in the hands of the religious bodies, as he believes "that in no religion is pilgrimage an obligation that must be fulfilled". Some Nigerians like Onaiyekan are of the opinion that the funds spent on pilgrimage should rather be directed to more pressing areas of social welfare. This study contends that since religion is known to be an integral part of Nigerians' lives and a number of institutions in Nigeria, it should be given a place within the public health arena and other significant institutions where it could make significant contributions to the wellbeing of Nigerians and Nigerian institutions.

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Similarly the Islamic Network for Development (IND) has also pledged the same. The position of religious bodies on health is further strengthened by the realisation that some hospitals in AKS and Nigeria as a whole are owned and sponsored by Christian and Muslim organisations.

More specifically, HIV and AIDS is one of the diseases that is ravaging Nigeria's population currently;[15] this generates much concern among both the leaders and the citizenry, the poor and the rich. To this end religious groups, faith-based organisations, churches and Muslim organisations such as Islamic Network for Development are responding to the pandemic, through seminars and sensitisation of people within the state and in Nigeria as a whole.

Accordingly, the Muslim community has also been holding its own against the HIV and AIDS pandemic by holding workshops for youths and women in Nigeria. For instance, the IND has organised programmes on HIV and AIDS sensitisation (Ahonsi, 2008; Oshodi, 2008:2-4; Olurode, 2008:5-7). Lai Olurode (2008:5-7), in his seminar paper entitled "Leadership and Reproductive Health in Islam", argues that religious leaders have a stake in the promotion of the health of Nigerians through their privileged position of being in close and regular contact with the majority of Nigerians. According to them, all Nigerians profess Islam or Christianity and respect the opinion of their religious leaders; the Islamic leaders are thus able to shape the norms, morality and beliefs of their adherents through the teaching of their faith (Ahonso, 2008:19; Olurode, 2008:5). They argue that religious leaders are also easily able to mobilise volunteers to respond to HIV and AIDS. These responses include prevention, care and support, treatment and impact mitigation (Ahonsi, 2008:20-21). The issue of the important role of Islamic leaders in mitigation of health problems in Nigeria as raised by the Islamic leaders show agreement with the Christian and the traditional leaders. In this regard religious leaders (including CAN, faith-based organisations, and representatives of the Nigerian Supreme Council for Islamic Affairs and women Muslim organisations) in AKS have been called upon to partner with health institutions to curb the menace of various diseases (Akwa Ibom State Government 2011. Prevention and Control in AKS Churches Mosques Advocated as Channel of Information in Malaria).

In this regard, the religious bodies and FBOs could take advantage of the invitation to collaborate and complement their provision of health facilities with actual involvement in the

[15] According to the National HIV Seroprevalence Sentinel Survey, Federal Ministry of Health 2006, about 4.4% of youths aged 15-49 were infected with HIV and there were about 2 million maternal orphans in Nigeria in the same year. This age range is the reproductive age group in Nigeria (Federal Ministry of health Policy Project, 2005).

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health care of the sick and suffering in Nigerian hospitals in general and in AKS in particular. They should also create platforms for dialogue with the various health institutions on more appropriate and meaningful ways of harnessing both medical and religious/spiritual resources for the greater good of the people. But a more meaningful involvement of the religious organisations and institutions will involve an in-depth understanding of the worldview of Nigerians regarding illness and health. Without understanding the cultural context, providing care for Nigerian patients might be off target in terms of their expectations which are often culturally laden.[16] This endeavour is important because, as Thesnaar (s.a:10) has suggested, a lack of sensitivity (due to ignorance) can render the best intentions in intercultural caregiving ineffective. For this reason James Corkery (2005:27) argues that there is a reciprocal relationship between culture and religion/ spirituality. This is a mutual interconnectedness which involves reflecting, challenging, enhancing and transforming one another. Therefore both cultural and religious worldviews could be said to shape the illness and health-seeking behaviours of Nigerians. Hence As already indicated in 1.6.1, it is an imperative and not an optional extra to attend to issues of culture and worldview. At this point it might be pertinent to assess the Nigerian religio-cultural worldview to gain a better understanding of Nigerians through the lens of the Ibibios' perception of the illness-health continuum and the meaning it elicits for the sick in their context. It is religio-cultural in the sense that Dukor (2010:164) argues that the African cultural world view is essentially a religious one. Therefore everything is explained in terms of religion (Dukor, 2010:214).

2.3 The Ibibio religio-cultural worldview and sickness and health

A good number of scholars have accused Western missionaries and colonialists of a poor approach to health care, which undermined the African culture and worldview. Some of these scholars include Pobee (2002:60), Lwanda (2006:20), Obadare (2005), Hokkanen (2007), Schumaker, Jeater and Luedke (2007:713) and Kalu (2010b:67). For instance Obadare (2005:276) tell us that "the colonial administration basically denied the essential humanity of the people it dominated; it also could not bring itself to recognise the presence, to say nothing of the validity, of the medical knowledge at the disposal of the local cultures". Worldview is an aspect of culture which elicits the behavioural pattern and experience of a people. Kalu (2010b:66) provides a conception of worldview which is relevant to this study. According to him,

[16] Amagihionyeodiwe (2008:215) argues that patients judge the quality of care of an health institution based on societal and subcultural expectations of the role of the health care institutions as regards their illness, as well as on the basis of the perceptions formed through their previous use and experience of the health care facility.

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> [w]orld view is a picture which points to the deep-level assumption and values on the basis of which people generate surface-level behaviour; it provides the motivation for behaviour and gives meaning to the environment. Like the rest of culture, it is inherited unconsciously but deliberately transmitted. It could be encrusted in customs, myths, proverbs and folk-lore, music and dances
>
> (Kalu, 2010b:66).

Culture and religion/spirituality are intrinsic to the African worldview. In fact Oluwabamide and Umoh (2011:48) point out that "[r]eligion is a non-material aspect of culture" and a universal occurrence which is depicted by its universality, rituals, sacredness and persistence as well as offering answers to ultimate questions. Therefore, the cultural values and beliefs of a Nigerian patient are strong factors in her perception of illness (Pearce, 2000:4-8; maghionyeodiwe, 2008:215-216). A consideration of the self-understanding of the Ibibios, their environment and relationships in times of sickness and good health is paramount. In essence there is no worldview and culture without a people. Therefore engaging with the worldview of Ibibios entails a critical reflection on who they perceive themselves to be and on their understanding of the world around them. Understanding a people's worldview proceeds from who they understand themselves to be and what constitutes meaning to them. The people's worldview is embedded in their understanding, which could be gleaned through their proverbs, folklore, songs etc. In other words, it touches on their understanding of life (Esen, 1982:64; Nwachuku, 2012:517). Louw (2012:25-26,113) argues that an understanding of life is a search for meaning and a search for meaning is a quest for identity. However, the human search for identity directly influences their understanding of God. Therefore, a search for God as it is connected to the issue of health also raises the issue of the concept of God within one's belief system. In this regard the following section will deal with the anthropological dimension of Ibibio concept of personhood, followed by their concept of God and their view of good and evil. The question of ill-health and suffering raises a question of meaning which touches on the patient's understanding of the concept of good and evil as regards its nature and source.

2.3.*1* *The Ibibio understanding of personhood "owo" and its relationship to health*

Different theories of human personhood have been put forward from different fields and disciplines of enquiry to answer the question: what is human personhood? The medical theory, for instance, views human beings as distinct from things and animals. But psychological theory posits that it is not enough to merely distinguish humans from things and animals. Therefore psychology conceives humans as having self-awareness (Evans,

1999:861). The view of personhood will be discussed from the perspective of African spirituality as understood by the Ibibio/Nigerians. The Ibibio understanding of personhood is at least informed by psychology, Christianity or Islam and African Traditional Religion. In African anthropology the position of persons in the community is very important as Ibibios/Nigerians understand life in holistic terms (Esen, 1982:50-60; Bujo, 2001:112; Esema, 2002:111). As stated earlier in Chapter One, one's anthropology guides one's method of care. In other words, one's way of being with people and the method or therapy he/she engages to care for fellow humans depends on one's view of human beings, which in turn is affected by one's religious convictions, and one's beliefs regarding who human beings are and what makes one human (Louw, 2008:42). Therefore, it is pertinent that human beings are understood in the light of the religious traditions, which, as was mentioned, is one of the factors shaping the Ibibio understanding of personhood. The purpose of this section is therefore to explore the different understandings of the human person from the perspective of the Ibibios that can provide a deeper understanding of their worldview regarding illness and health. Several theologians have undertaken this task from different perspectives; Louw (2008:41-42; 2012:37), for instance, approaches it from the perspective of a relationship with God within a systemic network.[17]

Ahmad (1997:7-25) has written from the perspective of Islamic morality, Dukor (2010:149) from the perspective of community and Metuh (1999:113-116) from the perspective of personality. Anderson (2003:29) has written from the perspective of the human person in relationship to self, while Benner (1998:52) approaches the issue in terms of the composition of the human person as perceived by different theologians over the years. Although all argue from different perspectives, there is a common vision among them. This vision is that they all portray a holistic view of the human person and together they discard the compartmentalisation of human beings into body, brain, tissue, mind, and soul or spirit, which in turn affects the quality of care.

This is evident among the Christian theologians even though they do admit that the Bible mentions the different components of the body – as body, soul and spirit, and sometimes, heart. However, they are in agreement that these seeming demarcations should not be taken as contrasting parts functioning apart from the others, but should be seen as different aspects

[17] He argues that a person should be regarded as a social being acting within a cultural context. Therefore the human person should be understood as a qualitative concept determined by the circumstances of life and the quality of relationships which directs his/her attitude, aptitude, habitus and position within relationships (Louw, 2012:37).

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of one vital and integral wholeness of personality. In other words, the "components" (mentioned in the Bible) should be seen as different ways of describing the whole person (Louw, 2008; Benner, 1998:53). Benner argues that to ask how many parts there are to a person is asking the wrong question, as the quest for parts of personhood becomes frustrating and inconclusive, since the Bible's intention was *not* to analyse the human person.

Anderson's (2003:29) argument seems to be in agreement with Benner's position that the aspects are functional rather than hierarchical. According to Anderson (2003:29),

> the relations of body, soul and spirit denote a unified, yet differentiated, whole rather than a tri-partite view of the self…. The biblical terms *nephesh, psyche* (soul) and *ruach*, *pneuma* (spirit) are primarily functional rather than denoting discrete substances or entities. As such, while there are distinctive patterns of use, the words used by the Bible to denote aspects of human life are not analytical and precise in the philosophical or semantic sense.
>
> (Anderson, 2003:29)

A simple analogy to describe the different aspects as a whole person could be the names given to individuals. In all cultures of the world people are identified by names. One person could bear at least two or three names. The three names do not describe the different parts of the person but the whole person, even though the names are distinct and cannot be taken for another; neither do they mean the same.

Within the traditional African and Ibibio worldview the unity of the human person was never in question but taken for granted. In the contemporary Nigerian understanding, this has become blurred due to the fact that traditional concepts are not static but are constantly reinterpreted as the people interact with other cultures. Many Ibibio communities are no longer homogenous but exhibit cultural and religious diversity. Among the Ibibios their world view is juxtaposed with traditional beliefs, religious and Western ideologies of the human self as they interact with Western sources such as books, music, videos as well as persons. The Ibibio/Nigerian understanding of personhood could therefore be likened to a person with a double personality. Sometimes he/she takes on the Western worldview and another time it is his/her African view which takes precedence or combines both. As Metuh (1999:77) and Burinyuu (1988:45) observe, many Africans live in a dualistic world. The reason as Nwachukwu (1994:68-69) explains is because Africa is experiencing a force of social change factors that propels it towards modernism. Africans therefore become sandwiched between the two worlds. As a result "there is much Western influence of the Western trichotomy of person as consisting of soul, psyche, and the flesh…" (Berinyuu,

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1989:28). But Metuh (1999:115-117) contests that the African's (which also includes the Ibibios') concept of personhood does not accept the dualism characteristics of the western psychological and religious culture.

The fact that a preoccupation with the composition of the individualistic human person is a post-Christian engagement is substantiated by the fact that the Ibibio/Efik Bible does not have a word for "spirit", although they have *Ukpong* (soul). The English version "Spirit" is maintained (Udo, 1996:37). Berinyuu's suspicion could be substantiated in Metuh's (1999:115-117) and Dukor's (2010:214-215) doctrine of the human person in Igbo culture of Nigeria. According to Metuh (1999:115-117), Igbo conceives man in various terms such as Obi (heart, breath), chi (destiny), eke (ancestral guardian), *mmuuo* (spirit or shadow) as principles not parts. Likewise, Dukor's (2010:214-215) preoccupation with the concepts of body, shadow, heart, soul, brain, spirit, breath, god and blood in his attempt to conceptualise personhood in the African worldview. The preoccupation is premised on the fact that he tries to bring the Western philosophical perspective to correlate with his African philosophy. In the end he struggles to maintain a balance between the holistic understanding of persons in African thought and the above-mentioned categories person, man (sic) and destiny. However, Metuh acknowledges elsewhere (1999:77) that this view is juxtaposed with the Christian and traditional understanding. Thus it is not a pure traditional understanding of the human person because the Igbo culture (and also that of the Ibibios) is not static. However, Dukor (2010:214-215) makes important and valid points about African personhood worth consideration. They draw attention to the fact that conceptualising human personhood is a complex task that defies easy reductionism. Therefore, Evans' (1999:861) advises that such differing views should be regarded as complementary perspectives rather than rivals, since all these characteristics are significant elements of personhood that are important points to note.

As such, the question of how many parts a human being has becomes unnecessary. However, among the Ibibio as well as many Africans, the human person is believed to be a creation of God (Ukpong, 1982:162; Mbiti 1975:13; Ahmad 1997:7). The human person is not isolated but integrated into his/her world. Furthermore, from the Islamic point of view, human personhood is conceived from the perspective of morality. According to Hazrat Mirsa Ghulam Ahmad (1997:15), one is not considered a true person if one's true morals *(khulq)* are subject to natural impulse like animals, or if one lives more or less like an animal. Morality, according to Ahmad, signifies an inner birth which is different from *khalq* the physical birth. Therefore persons are understood by their inner moral quality. Such moral

quality could be courtesy, modesty, integrity, benevolence, jealousy, sympathy, generosity, endurance etc. Ahmad (1997:15) suggests that morals grow with time. That is a person attains true morals when he is mature, suggesting that persons grow in their moral quality by their relationship with God. The Islamic understanding of persons, according to Ahmad, may have some similarity with the psychological perspective of personhood which views human persons as self-aware and morally significant persons with rationality. However, the point where this Islamic understanding differs from the psychological understanding may be found in the source of morality. For Islam morality is derived from God, whereas the psychological conception of morality sees humans as ends in themselves with the potential for fulfilling rights and obligations (Evans, 1999:861).

From the perspective of communality, Maduabuchi Dukor (2010:149), speaking of the Igbo worldview, which is also representative of the views of most ethnic groups in Nigeria including Ibibio, argues that a person is understood not only as an individual but as a social being who interrelates with the community of relatives, ancestors, spirit and nature. Hence, a person is "identified with community of other beings, the living, the death and the unborn". His understanding may represent the general view of personhood in Africa, as Bujo (2001:117) asserts that the human person from Africa is a network of relationships that constitute his inalienable dignity. Therefore given the importance of community to Ibibio and Nigerians in general, life is embedded in the community. As such good life or health constitutes maintaining a good relationship with important relationships. In this regard Bujo (2001:117) and Dukor (2010:226-236) have argued that in Africa one becomes a person not through the ontological act of birth nor self-realisation, but personhood has already been established before one is born. Hence, human personhood is not about flesh and bones. Understandings of personhood in Ibibio are never that it is a static category or a finished state, but a process which continues even after death. However, the fact that personhood can be threatened, affected and could perish when the individual is denied a place in the community (*obio or idung*) "to become a person" is hardly in doubt in the African and Ibibio worldview (Bujo, 2001:119). Hence, the individual becomes a person through participation in the life of the community and this is a daily process (Esen, 1982:115-153; Bujo, 2001:115). There is therefore little wonder that being severed from the community for whatever reason poses a serious crisis of meaning and identity that threatens the identity of an Ibibio.

In the light of this background, sickness and hospitalisation could pose serious challenges not only on the physical, but on the emotional, psychological and spiritual perspective. However,

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Bujo and Udo (1988:144) argue that the individuality of persons is not denied, but persons can only become persons through community. Likewise, the community forms an important aspect through which Ibibios derive their identity. Thus the Ibibio proverb "*Eto isidaha ikpong ikapa akai*" (a tree does not stand alone to become a forest). A forest (*akai*) is equated with community. This is why Udo (1988:144) states: "There is no private self as such. It is always self in relations". He further argues that "this is not a devaluation of individual traits and talents", but that through "the process of belonging and the act of participating in social drama, the self becomes more aware of its potentials and responsibilities" (Udo, 1988:144). The far-reaching implication is that the health of an individual will affect the community and vice versa as is discussed in 2.3. It means that through community the person can receive the nurture, enrichment, solidarity and mutual help necessary to maintain a balance of wellbeing and good health or coping during trying times.

Therefore, in the Ibibio traditional understanding personhood is viewed from different perspectives. According to Turaki (1999:220), ATR sees humankind from three perspectives: one's human nature, one's network of relationships in the community and one's cosmic spiritual and mystical relationships. Therefore, the African understanding of human personhood is holistic, in that it maintains a balance between the personal, the moral, the social and the spiritual/mystical relationships. In other words, in the Ibibio/African traditional understanding, a person is integrated into his/her environment. Hence, Berinyuu (1989:28-34) later proposes a so-called unitary concept[18] of personhood. "A unitary person tries to recognise all aspects of humans or personhood as attempts to serve all dimensions in any one act" (1989:29). This means that the human person in Ibibios' view is an embodied soul created by God[19]. He/she is a person with moral values that are embedded in his religious, social and cultural world which yearns for acknowledgement and interconnectedness with the physical, spiritual and metaphysical realities in meaningful relationships. Therefore all these dimensions receive adequate attention in the traditional Ibibio/Nigerian practice of care and healing, as will be discussed in 2.4.

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[18] The unitary concept proposed by Berrinyuu is different from the concept of monism in Western psychology. The monists believe that a person is purely spiritual and thus deny that a person has two distinct substances of body and soul/mind/spirit. In monist interpretation the body (the physical material) is regarded as spiritual in some sense (Evans, 1999:862).

[19] The the Ibibio proverb *uyo owo edi uyo Abasi*, (the voice of man is the voice of God), carries the meaning that owo comes from Abasi Ibom. The purpose for which Abasi created owo is to enable him to participate in life (Udo, 1983:258). He participates in life as a response to the wishes of the gods under the supreme rule of God (Abasi Ibom) as they affect the human person.

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One of the significant relationships and an important component of the community as it concerns maintaining a balance in health are the spiritual beings. This includes the ancestors, spirits and the Supreme Being. Daisy Nwachuku (2012:517) reiterates that "the African worldview is grounded in a pervasive sense of God-consciousness". In this regard, Dukor (2010:214) rightly argues that any understanding of personhood in African worldview will never be complete without a discussion of the theistic and humanistic associations. The different expressions of African/Nigerian personhood within his/her environment are further discussed below, beginning with the Nigerian and indeed the Ibibio personhood in relationship with God.

2.3.2 The concept of God in Ibibio and its relationship to health

African concepts of God have received a lot of attention from scholars of African Traditional Religion such as Mbiti (1999), Udo (1988), Berinyuu (1988), Turaki (1999) and Munyika (2004). These scholars have approached the concept of God also from different perspectives depending on their methodologies and theological traditions. Common to all the scholars is that God is not a foreigner to Nigeria and Ibibioland in particular and Africa in general in the sense that God was not introduced to them by the missionaries. Dukor (2010:155) and Mbiti (1999:30) argue that African knowledge of God is expressed in proverbs, short statements, songs, prayers, names, proverbs, myths, stories and religious ceremonies. Hence, Dukor asserts that Nigerians have a clear conception of God which is usually reflected in the names they bear, proverbs, myths and folklore. God is the creator and controller of life (Dukor, 2010:155). The Ibibio name for God is "*Abasi*". Esen (1982:38), Ukpong (1982:162) and Esema (2002:98-111) state that there are many gods *"mme ndem*", which also include the ancestors *"ikaan"*; among the Ibibio the greatest being is *"Abasi Ibom*".

The simple expression of the Ibibios "*Abasi do*" (God is alive) attests to this view that God is the creator and controller of life and that there is a deep consciousness of His existence among the Ibibios. Such is also true among other Nigerian ethnic groups. This expression "*Abasi do*" is normally expressed in a situation where one feels cheated, threatened, oppressed or insecure. In this context, the person simply says that God who is more powerful than the threatening factor will act on his behalf. In other words; the expression "*Abasi do*" expresses resignation of one's fate to God. The existence of God is taken for granted without questions. As a result, it is held that there is no atheist among the Ibibios. What concerns Ibibios as Africans is how this God can become involved with them in their daily struggles against the tides and waves of life. That God is the creator and source of everything and

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therefore a great One is substantiated by his name "*Akwa Abasi Ibom*", meaning "Great and Mighty God" in Ibibio. The Ibibio believe that God is the benevolent giver who does not discriminate and is impartial. Ibibio names like *"Eno-Abasi"* (God's Gift), *"Mfon-Abasi"* (God's mercy), *Emem-Abasi* (God's Peace), *"Aniekan-Abasi"* (who is greater than God?) portray this idea. Esema (2002:99) argues that the Ibibios believe that God is great and has full knowledge of whatever befalls them. As such, whenever they could not explain any happening, they attributed it to God. Therefore, the question may be asked if this God image is of any meaning and significance to the Ibibios in particular and Nigerians in general.

Dukor has argued that the Nigerian and in particular Ibibio concept of God is a solace to the personhood of many Nigerians in the face of threats to life such as disease and illness and strife. God is seen as the source and controller of life. He is the giver of good health. This God is very much involved in their existential realities. Therefore the Ibibio like other Nigerians look up to God in times of sickness and health (Dukor, 2010:149). Thus God influences every aspect of their life through the activities of the lesser gods, called "*ndem*" in Ibibio; the Igbo call them *"amadioha"* and also known as "*orisha*" in Yoruba. Dukor believes that although many Africans believe in the remoteness of God, Africans and Nigerians also believe that God is ever present with them. According to some African scholars, His remoteness makes a space for the divinities, spirits and ancestors in African cosmology to be worshiped as gods in themselves or as means of getting to God as messengers or intermediaries[20] (Esema, 2002:98; Metuh, 1999:82). According to Metuh (1999:82), these intermediaries exist in the form of a hierarchy depending on the power they possess and their role in the cosmological order. Furthermore, these intermediaries are deemed to possess spiritual powers and forces (delegated to them by the Supreme Being) that give them such prominence in traditional religious practices to attend to the needs of humans. For Metuh (1999:61) the unicity of God which is evident in the belief in one God and many deities is not contradictory but indicates complementarity.

Accordingly, Dukor (2010:190-194) terms this God-concept "polymonothesim".[21] He argues that a monotheistic conception of God is only "useful in providing an explanation of the

[20] There are divergent views among African scholars as to whether the spirits and divinities are worshipped as a Supreme God or they are merely a means to reach out to the supreme God.

[21] Dukor (2010:190-192) seeks to reconcile the African belief in a supreme being as well as their belief in spirits, divinities and ancestors as "polymonotheism. As the term suggests, it is a combination of monotheism and polytheism. He argues that Africans believe in a supreme being who created all things to whom there is no equal. However, they also believe in the plurality of gods whom they worship during times of crisis.

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creation of the world", after which he is dismissed as meaningless to their existential realities. The polytheistic conception is an existential pragmatic approach, where the immanence of the gods who mingle with the life of the Ibibio as other Nigerians and Africans is an important aspect of their faith. Therefore, a polymonotheistic god-human relationship, according to Dukor (2010:149-196), is a symbiotic, reciprocal and mutual one, whereby humans feed the gods and the gods in turn provide health and fertility. Therefore during threats of illness an appeal is made to God directly or indirectly through the divinities. This understanding is so pervasive in the traditional Ibibio/Nigerian worldview that almost everything or action or occurrence is interpreted to have spiritual connotation. In other words, an appeal is made to God or gods in almost everything.

Thus beyond the rational and physical explanation of an event, they seek for a spiritual explanation (Esema, 2002:99). If Dukor's argument is taken seriously, it might provide an explanation of the health-seeking behaviour of Ibibio/Nigerians who will visit a pastor/imam, a traditional healer and medical doctor for the same problem (Abdalla, 1997:30). This pervasiveness shows an interplay between their God concept (God-image) and healthiness. At stake therefore is a quest for a God concept or God image that can hold meaning for them. Turaki (1999:149) gives a helpful hint that the understanding of God in Africa is a comprehensive one as it is a holistic/organic, spiritual, power-conscious and communal worldview. It means that the patient's image of God is vital to his recovery process. As Dukor (2010:233) further argues, the realisation of an individual (patient) goal and aspiration (e.g. health) and equilibrium depends on God. In the light of this research objective, providing care to the sick in the Nigerian context has to address the God image of the patient. It calls for an appropriate approach to caring for the Nigerian patient. Given this understanding, omitting this aspect might make care unsatisfactory to the patient. Therefore the Nigerian patient's search for wellbeing might not be unconnected to a search for a God who can be trusted to be pragmatically involved to restore health and wellbeing to him/her. It could be for this reason that Dukor (2010:187) asserts that the "African God is everywhere. He is omnipotent". However, the link of an all-powerful God-concept with health raises another set of problematic "why?", "what?" questions. What is the link between God and suffering and illness? Where did evil come from? In other words, how do Africans in general and Nigerians like the Ibibios in particular relate God with Good and evil?

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2.3.3 Ibibio view of good and evil

Good and evil as a theme is of universal concern to all human society. The question of how a world created by a good God could become infested with evil becomes a question of the goodness, the all-knowingness and all-powerfulness of God and the validity of such claims by all religions. This question becomes more pronounced in the face of suffering and adverse conditions of life. Thus, the understanding of God is a quest for meaning which is influenced culturally and contextually (Dau, 2000:6). Theodicy is a western theological construct and it attempts to explicate and justify the goodness of God in the mist of sin, suffering and evil. This implies that the question of good and evil is a question of the meaning and purpose of one's life in the created world. Although this is a universal concern within the various traditions, religions and cultures, their approaches vary according to their ideologies, cosmologies understanding and experience of God (Dukor, 2010:241). The problem of the existence of good and evil as frequently discussed in Western philosophy and Christian theology is not an issue in the African concept of God. In addition, many Africans including Ibibio, while recognising the existence of evil in the world, do not believe that it is inconsistent with the belief that God is omnipotent and good (Metuh, 1999:134). According to Metuh, God is not responsible for the presence of evil in the world, but He is given credit for all the good there is in the world. Dukor (2010: 149-196) further explains that the polymonotheistic belief of the African allows God to be exonerated from evil, while the blame is placed elsewhere, namely the divinities, spirits, ancestors etc.

Consequently, the balance of good and evil is linked to the account of creation. As mentioned earlier, the Ibibio/African cosmology life is organised into categories of God, gods, spirits, divinities and ancestors as well as living persons and inanimate objects. Constant harmony and balance is maintained among these categories that ensures the good and peaceful existence of all categories. Evil results when there is a disturbance in this natural order of harmony and balance. Thus, most Ibibio communities perceive good or evil to be caused by actions and activities of either of these cosmological categories. This implies that good and evil are not absolute, but are dual elements that are located within humans and non-humans who do good (i.e. good persons/spirit), humans, and non-humans who do evil (i.e. evil persons/spirit). These persons could be individuals who usurp powers to do evil, such as witches and sorcerers or evil spirits. Good in this sense could be conforming to the customs and norms of behaviour in the relationship, family and community. This does not mean that a person is inherently good or bad, but his goodness or evilness is determined by his/her moral

conduct (Ajibade, 2006:195). Consequently, Ibibio/Africans "perceive a causal link between disturbed social relations and disease or misfortune" (Dukor, 2010:198). For the Africans it is explained in terms of cause and effect. As such, something or somebody must always be responsible for his or her ill-health. Therefore, as it relates to this study, attending to issues of evil becomes a necessary imperative for the hospital care of patients. As such, suffering can be reduced through the loving and intentional act of caregiving. However, in the Nigerian worldview, such as among the Ibibio, witchcraft is often the embodiment of evil.

2.3.3.1 Witchcraft (*Ifut*)

Fiscarra's definition of evil resonates with what some African authors and scholars describe as witchcraft. The phenomenon of witchcraft is varied, complex and ambiguous. Various authors define it differently. Elias Bongmba (2007:113) defines it "as a special ability that some people possess and which enables them to accomplish certain things". Ter Haar (2007:8) and Akrong (2007:56) describe it as a concrete manifestation of evil that disrupts the life processes believed to come from a human source. The life processes disrupted are what Van Wyk (2009:23), Dovlo (2007:68) and Akrong (2007:56) call *inter alia* the breaking of accepted norms, destroying the normal and the good of the society, harming close relations, eating of human flesh, causing barrenness, exam failure, acting in secrecy, and displaying loathsome behaviours. This implies that witchcraft is linked to the social and communal relations of African people. Ter Haar (2007:11) believes that witchcraft and evil spirits are two different forms of evil. While witchcraft powers represent a type of evil that is considered inherent, voluntary and permanent, evil spirits are believed to be external forces that enter a person involuntarily and take up temporary residence in the person. Bongmba, Dovlo and Akrong remark that in Cameroon and Ghana the powers of witchcraft can sometimes be utilised for good, such as an ability to see things that happen in the future and protection of the community. Van Wyk (2009:23), Hinfelaar (2007:232), Nyaka (2007:258), Van Beek (2007:294) observe that desires and actions of witches and sorcerers are opposed to African social values such as helpfulness and solidarity. For this reason, they are the worst enemies of the society. They must not be tolerated but have to be cured, purged, beaten, exiled or killed. In other words, many African communities believe that whatever good witchcraft may bring to the community, its evil renders them insignificant, that is its evil surpasses its good, hence it is not desirable.

These views are representative of Ibibio traditional beliefs in witchcraft *(ifut)*. *Ifut* is one of the many and dangerous forms of evil. Among the Ibibios people refer to evil action as *Ifut*

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(witch or witchcraft). In contemporary Nigeria witchcraft is used both in a general and specific sense to refer to different ideas and practices of the manipulation of powers and people. Often in general communication among Christians, it is common to hear of "charismatic witchcraft" meaning that one manipulates the emotions or situation of another to ones' advantage. Statements such as "His anger burns like a witch" are common. Such usage is different from references to actual witchcraft, which is believed to be inherent in the person, who uses it to cause severe harm to the community or family and other relationships. This is the idea that Danfulani (2007:152) in his article "Anger as a metaphor of witchcraft" seeks to communicate when he writes, "*Sot*, (witchcraft) is a term used both popularly and loosely among the Mupun to describe all sorts of evil and secret employment of spiritual forces, mystical powers, or life-forces to destroy other persons' life force." Danfulani's linking of anger with witchcraft also expresses the general notion of witchcraft in Ibibio understanding.

The effect and consequence of witchcraft believed, imagined or experienced are inimical and debilitating to the wellbeing of the Ibibios. The pervasiveness of the belief in witchcraft operations in Nigeria is evidenced in the attention that the Nigerian Home Video industry gives to the phenomenon in many of its films as well as the attention it receives from the Pentecostal, AIC and some mission churches in the country. Therefore Kalu (2010a:72) observes that the major contribution of the Pentecostals "is how they address the continued reality of the forces expressed in African cultural forms". The quest for the solution is what has given rise to many prayer fellowships and pseudo-prayer houses in many Nigerian communities. In the light of the issue under discussion in this research, the prevalence of perceptions of witchcraft is of great importance. This pervasive belief in Nigeria in general and Ibibios in particular calls for all caregivers to devise an appropriate way of responding to it without either fostering or ignoring it in their vision of holistic wellbeing. The understanding of Ibibios and other Nigerians as well as many Africans regarding the origin of evil also influences the way they respond to situations that depict the presence of evil such as illness. As such, the concepts of good and evil make manifest the underlying theory of human suffering. In dealing with ailing Nigerians, including Ibibios, it is therefore important to understand this theory of sickness, because each theory of sickness suggests a distinct mode of healing practices. The belief in witchcraft as the source of some sickness will require a spiritual rather than a medical approach. The presence of evil in its varied forms also raises the question of its origin.

2.3.3.2 Origin of evil

As aspect of the concept of evil is the origin of evil. The concept of evil is central to the religious beliefs of most Africans and their understanding of the causes of ill health. Although many Nigerians are more concerned with the effect of evil on people's lives rather than its origin, a concern about its origin is gradually emerging. This may be because of interactions and the influence of Western worldviews. Thus in ATR evil is attributed to evil spirits and evil persons who are driven by envy, anger, jealousy and hatred, as in the case of witchcraft (Kgatla, 2007:269). According to Kgatla, witchcraft answers the 'why' of the mishap, not the 'how', but the 'how' is implicated in the 'why'. The 'why' is a question of causality, which means that nothing happens by chance or coincidence; it is caused by something. That something is located in the other – persons, spirit or God (2007:269). Mbiti asserts that in many African societies, God is never directly implicated in evil, but evil is understood to originate from other spiritual beings or their human agents whom they possess (Mbiti, 1999:199-200). He illustrates this with a Vugusu tribal myth, which tells of the existence of a divinity that God created to be good, but which later turned against God to become evil. The divinity, which became evil, is the source of evil. Contrary to Mbiti's view, Van Wyk (2009:25-26) argues that the notion of cosmic dualism such as implied by a devil that causes evil problems is strange to traditional African beliefs. According to him, witches and sorcerers are the source of evil. Nevertheless, he does not also deny that God or the ancestors may be responsible for some occurrences, but they are certainly not evil. It is for this reason that he asserts that

> [i]n ATR, evil can only be attributed to human beings. The origin of evil and the reason for its continued existence are human beings. The question about evil as such (as something that exists separate from human beings) is senseless to the traditional African. ATR is only interested in the practical fight against evil. To fight evil the cause must be known. The cause for evil in ATR is always the other one not God or the ancestors. The other responsible are the witches
>
> (Van Wyk, 2009:25-26).

Van Wyks's view resonates with most Ibibio/Nigerian views about the origin of evil. Humans not spirits are responsible, not an evil force, for people would not themselves have been available to be used by evil forces. Evil as such does not simply perpetuate itself, but it only happens through the action of human beings.

Thus Dau (2000:164) may be right when he concludes that in many African beliefs "God may be exonerated of the responsibility for evil and yet at the same time implicated. There is

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hardly any doubt that traditional Africans will never reject God because evil, suffering and misfortune afflict them, rather they will cling to God even more in spite of evil and suffering". Dau further asserts that "people may, however, complain to God and ancestors for the suffering or evil that befall them, but they will never accuse them of any moral or evil wrongdoing" (2000:164). Dau's observation summarises the experiences of most Ibibio communities about God and evil.

Good and evil are connected to the values and practices of persons within a culture. The notion of witchcraft in African cosmology implies a personalistic view of evil in that someone (witches, sorcerers, and evil spirits) will always be responsible for every misfortune. Hence, there is no such thing as a natural disaster or an accident, as someone will always be implicated in the crises. Superstition[22] abounds within the Ibibio/Nigerian environment to such an extent that chance plays little role in the occurrence of events. This makes it very difficult to differentiate between natural and unnatural events.

On the other hand, some Nigerians demand responsibility from those who are engaged in acts of evil without attributing them to something or someone else. A drunken person should not blame his violence on the alcohol, for the alcohol will only bring out that which is in him/her. Responsibility and control in Pastoral Care are issues of self-care and locus of control. In contemporary Ibibio/Nigerian society (especially among Christians and Muslims) there are social taboos such as "don't drink too much or don't drink at all" or "don't smoke" that if violated result in problems or evil. Evil can occur because one has not maintained a level of responsibility in self-care. Good and evil then are connected to the moral values and practices of the person within the culture. Therefore adhering to social taboos, customs, traditions, rituals and avoiding negative influences can help one to counteract the force of evil and enforce goodness and wholeness, health and healing, which are legitimate concerns of Ibibios. In the light of this research it is important to attend to the Ibibio understanding of health and wholeness.

2.4 Understanding the concepts of wholeness and health in Ibibio

Ibibios, like other Nigerians, are more concerned with life than anything else. God is the creator and source of life, as discussed earlier. Life for the Ibibios, as for many Nigerians, is a

[22] Superstition in the context of this study is understood as "beleifs and practices that presuppose a faulty understanding about cause and effect, usually by assuming notions of causality that have been rejected by modern science but may represent longstanding popular belief or practices" (Martin 2004:10).

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paradox of good and evil. Evil is a distortion of the good creation, which results in disharmony among the creations of God. Most Ibibios, rather apathetically accepting the inevitable, will engage with the forces against life to restore it to normal to sustain their perception of wholeness and health. In the light of the research hypothesis that Pastoral Care can contribute towards the holistic care of patients as well as improve the quality of care and patients' level of satisfaction, it is important to understand what wholeness and health really mean to Nigerians and especially the sick in the hospital. Therefore, this section addresses the understanding of the Nigerian concept of wholeness, health, sickness and healing in the light of the research objective.

Wholeness and health are rich and complicated concepts, which assume different meaning and understandings within a variety of contexts and fields of research. They are concepts that help us avoid the pitfalls of postmodern reductionism and compartmentalisation, which are evident in their simple answers to the complex issues of life. Nevertheless, the different understandings of wholeness and health open up channels for continuous engagement and reflection on life as a whole. Wholeness and health will be discussed first from the medical perspective, but also related to the Ibibio and Nigerian environment as to other places.

According to Winifred and Thomson (2001: 60), wholeness suggests comprehensiveness and integration. It suggests that the whole is more than the sum of its parts. Wholeness as "comprehensiveness" and "integration" assumes different understandings, connotations and meanings in medical, religious, political and traditional contexts. Hence, like many contemporary concepts, its meaning can only be understood within the context in which it is used. From the medical perspective, the term "integration" is more in fashion. It is mostly used to qualify a certain practice of medicine (integrative medicine) which is emerging within the medical field. Integrative suggests a combination of two or more different methods or views which are distinct from one another, in this case complementary and alternative medicine or therapy (CAM) and traditional therapy. CAM includes nutrition, spirituality (which includes prayer and meditation) and stress management (Koopsen & Young, 2009: xvi-xx). From the US context, Koopsen and Young (2009: xx) argue for a holistic and integrative approach to health care. They explain that 'integrative medicine' involves "the concept of communication among all health providers who share the responsibility in coordinating the best possible treatment plan for a client, including the client's choices of care providers' expertise in understanding and managing the complexities of conventional-complementing treatment interactions" (Koopsen & Young, 2009:xx). The overall goal of

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integrative medicine is the healing of the patient and the overall improvement of his/her health by charging him/her with responsibility over his/her situation while the carers/healers maintain a supportive role. The healers/carers are therefore intended to support the healing process and not to suppress it; they do this by removing the obstacles to health and wholeness (Van Wyk, 2009:1-2). Healing therefore means to make whole (Ballentine, 1999:4). Consequently, integrative medicine is holistic medicine and is concerned with healing as wholeness rather than with disease (Koopsen & Young, 2009: xx). Wholeness is related not only to a person's physical wellbeing as it is reflected in the actual wellness of the body, but also in the caring relationships and connectedness with oneself, others and the environment.

From the African religious point of view, Archbishop Desmond Tutu, the African icon and renowned theologian, and Mpho Tutu capture the concepts of health and healing very interestingly. They propose that "[i]n a life of wholeness we may face brokenness and endure woundedness, but our suffering will not be meaningless. Meaningless suffering is soul destroying" (Tutu & Tutu, 2010: 49). In their book *Made for Goodness* the Tutus provide a dimension of wholeness, which is paradoxical. For them wholeness is God's invitation to perfection. "Be perfect as your father in heaven is perfect". Godly perfection, according to them, is not flawlessness but an invitation to beauty that embodies a sense of wellbeing and wholeness irrespective of the circumstances that may confront one's life. Stressing the point further, they argue that

> [a] life of wholeness does not depend on what we experience. Wholeness depends on how we experience our life. In a life of wholeness we still confront the death grief, and pain that are part of human reality but they will not destroy us. A life of wholeness can accept, even embrace, death, grief and pain. They are essentially part of the human life. They lend texture to life
>
> (Tutu & Tutu, 2010: 43-48).

Besides the Tutus' connection of wholeness with perfection and beauty, they also interpret wholeness to include the life of community and interconnectedness with others represented in the concept of *ubuntu*: "I am because you are" (2010:43-48). Pobee (2002:60) agrees with this view of wholeness and health when he states that communal wellbeing is a result of mutual participation in community and ability to tap into the resources that give impetus to their values and sense of belonging as human beings. Pobee (2002:60) says that "a person's worth is measured in his or her social relationship, which assures him or her of success in life, good health, and potency of fertility. This means that we are whole when we connect to our community, family, friends and relations. This dimension of wholeness as reflected by

the Tutus mirrors the understanding of wholeness and health by most African communities in general and Ibibio in particular. That wholeness is beauty is well captured by the Ibibio saying that "*Nsong idem edi uyai*" meaning "Good health or wholeness is beauty". Thus, Nigerians experience wholeness as a quality (blessings and all that is positively valued in life) of daily living. The ultimate goal of many Ibibio/Nigerians is wholeness and health. Thus, they consult every avenue that is within their physical and spiritual reach to ensure that they are in good health. This idea is expressed in the Yoruba proverb *"Ilera loro"* (Ajibade, 2007:193-194) and the Ibibio's *"Nsong idem edi imo"* both meaning "health is wealth". Although Ibibios seek good health, they also understand that wholeness does not necessarily mean being well as being well is often associated with absence of illness. The Ibibio proverb "*Anana ibout anana udongo*" (it is only a headless person who has no sickness) is an expression of the understanding that there can be wellbeing in the midst of suffering and difficult situations of life.

The Islamic understanding of wholeness, according to Rassool (2000:1476), is connected to the 'oneness of Allah' as stipulated in the Qur'an. This implies the unity of God in all spheres of life, death and the hereafter, which suggests a holistic understanding in meeting the physical, psychological, psychosocial and spiritual needs of the care seeker. Consequently, Pulchalski, Dorff and Hendi (2004:694) remark that the Qur'an attempts to deal with the human being as a whole. Thus Johnson (2001:39) states that a contemporary Muslim understands health as a state of complete physical, psychological, social and spiritual wellbeing. Similarly, the World Council of Churches (WCC) suggests that 'wholeness' means the unity of body soul and spirit. The WCC's definition of wholeness suggests an intertwined connection between wholeness and health, and the two concepts could be used interchangeably and simultaneously. The earlier World Health Organisation (WHO, 1948) definition of health as "the perfect state of physical, psychological and social well-being" was widely criticised by scholars. For example, Louw (2008:43-48) views such a definition as incomplete because some significant aspects of the human person such as the spiritual category, which actually defines human personhood, is not included. Louw (2008:43-48) further remarks that healing should cover all seven perspectives that are crucial to the human person, namely the psychological, existential, functional/pragmatic, social, scientific, medical and spiritual. Any consideration of health in an African perspective must incorporate the spiritual dimension in addition to other dimensions (Igenosa, 1994: 126). Igenosa's observation is noteworthy and very relevant to this study, as health in the African spiritual

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perspective involves living in a sound relationship with God. In awareness of the complexity of the concept of health in different contexts, and in response to some criticisms as mentioned earlier, the WCC has reformulated a definition of health. According to the WCC, health is "a dynamic state of wellbeing of the individual in society: a physical, mental, spiritual, economic, political and social wellbeing, of being in harmony with each other, with the material environment and with God" (Benn & Senturias, 2002:20). From the WWC's point of view, health as a dynamic state implies that persons cannot possess all these dimensions at a given time, as a person is never completely sick nor completely healthy, but is always in a dynamic process of experiencing more or less health or disease (Benn & Senturias, 2002:20).

The introduction of this dynamic into the definition of health adds a unique dimension to the understanding of health, as it makes it more realistic. Secondly, it brings a shift from the individualistic focus on health to a community focus, which addresses individuals within the structure of society as they are impacted upon directly or indirectly, positively or negatively. It also provides for a holistic and/or comprehensive model of restoring one to wholeness and health, and mirrors the African concept of wholeness, health and healing. Nevertheless, does this view truly incorporate an African understanding of what it means to be sick and what is involved in restoring balance or healing? An assessment of the African understanding of sickness and healing through the lens of an African society such as the Ibibio might be necessary in order to gain an in-depth understanding of the sickness-health continuum within an Ibibio/African environment. Such an understanding might benefit an intercultural and contextual approach to health and wholeness which focuses on the meaning of health within cultures and religion as well as a mutual sharing within the space of the hospital that may empower the patient in caring relationships in hospital care (Cilliers, 2007:7; Thesnaar, s.a:6).

2.5 Understanding the concept of sickness in Ibibio

Karen Flint (2008:19) claims that disease, illness and sickness are concepts that depict crisis situations and are culturally constructed. They are informed by the experiences of a people as they perceive them within the period in which they live (2008:19). Generally Ibibios, as with many Nigerians irrespective of the religious inclination, perceive sickness as an abnormality and a disruption in the harmony that an individual enjoys with himself, others and the environment (Abdalla, 1997:117; Berinyuu, 1988). From traditional clichés, proverbs or sayings in Ibibio communities, it does appear that Ibibios worry more about sickness than death. For example, the Ibibio saying *"Kukere mkpa nte udongo"* (Do not be worried about death as you should be worried about sickness) vividly portrays the concern of the Ibibios

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and to some extent Nigerians about sickness above that which they have concerning death. Udo (1988) has argued that the reason why illness is so feared by Nigerians may be because of the debilitating and lingering effects of pain and suffering on the human body, mind and spirit, whereas death terminates the pain and suffering of humankind as it often follows a sigh of relief from the ill patient. Kalu (2010: 209) argues that for Africans disease is not restricted to this Western construct, but is culturally construed to be all that and above all it includes economic, social and spiritual aspects.

According to Kubukeli (1999:24) and Dukor (2010:198), sickness is consequential in African context. In other words, sickness does not just happen; something causes it to happen. Kubukeli (1999:24) argues that in African worldview and philosophy, identifying the cause or the source of the sickness is often more important than knowing or gaining insight into the nature of the sickness. Thus the question "Why am I sick?" is more important than "What is the nature of my sickness?" This implies that a detailed explanation of disease based on germ theory is not only foreign but also inadequate to African concept of illness. He concludes that "[to] understand the African traditional healer and the whole traditional process,[23] one needs to understand African religion. The whole African belief system is so fundamental that any form of healing process that ignores these beliefs is psychologically unsatisfactory and in some cases unaccountable" (Kubukeli, 1999:24). Pobee (2002:60) agrees with Kubukeli when he argues that in the African worldview sickness, whether physical or mental, beyond being understood as biological is more appropriately interpreted as psychosocial both in its cause and treatment.

The views above resonate with the Ibibio concept of sickness. In the traditional as well as contemporary Ibibio communities the causes of illness are known to be multifaceted (Abia-Williams, 1994:224-225). They can be personal, natural or supernatural/spiritual/religious in nature. Often the beginning points of diagnoses are in that order. When one is ill, he will first seek for the cause and solution in himself. For example when one experiences diarrhoea, one will ask: Have I eaten anything my stomach does not tolerate? If the person thinks it is food poisoning, he/she will take some herbs or medicine. If the problem does not go at the normal time it should go, he or she will seek the cause in the supernatural and thus will resort to the religious or spiritual approach. Ajibade (2006:195) substantiates this view which is common to Nigerian communities including Ibibios, using the Yoruba of Nigeria as a typical example:

[23] Contemporary African cultures are not homogenous but are alloys of traditional value system, beliefs and practices of new value system, assimilated from foreign cultures. This is because traditional African cultures and religion are not exclusive but accommodative of other religions, Christianity inclusive (Pobee, 2002:56).

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> Among the Yoruba, major illnesses and diseases are seen as religious experiences. Minor ailments are treated with medicine- herbs, charms and all forms of medicine but when they are chronic, the religious cause must be sought… [W]hen a sickness persists after the application of medicine prepared to cure such sickness, they inquire from Ifa priest or any other diviner to know the cause of the illness. At times, an individual, lineage or a whole community can suffer from a disease or epidemics due to their failure to perform certain religious rites or performing it wrongly.
>
> (Ajibade, 2006:195)

He further argues that in an instance that a person is afflicted with sickness from the "powerful people" (witches and wisards), the remedy lies in the spiritual or religious approach (Ajibade, 2006:197). Thus, sickness in the Ibibio culture is divided into three broad categories, namely natural, supernatural or religious or spiritual, and personal.

2.5.1 Natural cause

Ajibade (2006:197), Mulaudzi (2009:33) and Kalu (2010d: 207) report that many Africans also belief that ill-health is a "result of some 'natural' cause" such as infections, bad weather, flu, headache, and stomach ache, cold, excessive heat, dampness etc. In other words they acknowledge and subscribe to the germ theory, among other factors (Abia-Williams, 1994:225). For example, the Ibibio perceive certain sicknesses as seasonal or relating to certain weather conditions or changing weather. To suffer from catarrh or cold in the rainy season is normal and natural.

2.5.2 Supernatural/spiritual/religious cause

These are deemed to proceed from witchcraft, sorcery, wrath of ancestors, breaking of taboos and generational curses (Abia-Williams, 1994:225).

Witchcraft: Sickness and calamity are often attributed to evil spirits like witches. When this is the case, the patient's health can only be restored by identifying the witch or wizard by means of sorcery or divination.

Sorcery: Kalu (2010b: 69) defines sorcery as the employment of "magical incantations, implements, objects, medicine and their paraphernalia" to do evil. This may involve "the use of poisonous ingredients put into the food or drink of someone" (Mbiti, 1999:194). Persons who engage in such acts are called sorcerers. Stephen Nyaka (2007:258) explains that sorcerers are commonly associated with the misuse of mystical powers to cause death or adversity to fellow human beings. I. W. C. Van Wyk (2009: 22) states that, unlike witches who are mostly women and whose activities are often in the night, sorcerers are mostly men

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who carry out their intentional wicked acts during the day. However, some ethnic groups like the Ibibio in Nigeria do not restrict sorcery or witchcraft to a specific gender. Witches or sorcerers can be men, women or even children, and they are the cause of varied forms of sickness. Ajibade (2006:198) shares this view: "witches [and sorcerers] are also believed to cause sterility to women by turning their wombs upside-down; they can cause abortion by removing the child from a pregnant woman's womb, and taking it to their nocturnal meetings to feast upon. They can similarly cause impotence in men by removing their testicles". This is arguably the reason why many pregnant Nigerian women believe that during pregnancy they are more susceptible to the activities of wicked powers.

Wrath of ancestors: Disease is also attributed to the anger of the ancestors (Abia-Williams, 1994:225). For example, traditional Africans identify what is diagnosed as epilepsy by Western medicine as anger from the gods for refusing to carry out certain sacrifices (Mulaudzi, 2009:33) such as refusing to give one's father a second burial, as in the Ibo culture of Nigeria. It could also be as a result of refusing to heed to the call of ancestors to fulfil a particular role in the community such as a diviner. The symptoms may include body pains, severe headache or "an accident that defies all possible explanations" (Bojuwoye, 2005:65). In extreme situations the ancestors may punish the members of a whole family or community by epidemics. Ajibade (2006:201) draws attention to the usual precautions that should be maintained in order to avoid such wrath of the ancestors: "People must not disobey their deities. They must offer quality sacrifice at the appropriate time. Failure to adhere to this will incur the wrath of *Esu* – 'the trickster god', who will visit the victim with disease, sickness, affliction and untimely death". Where such afflictions occur, healing can only be effected by appeasing the gods through sacrifices or heeding to the call of the ancestors.

Breaking of taboos: Among the Ibibios there are many laws, customs and observances and regulations of behaviour of its people (Esema, 2002:109). Breaking of taboos *(Uduo obom)* relates to the contravening of the moral code of the society as well as those codes related to the worship of a deity. Taboos were meant to preserve peace, harmony, happiness and life. Hence Abia-Wiliams (1994:225) argues that a taboo in Ibibio traditional society "is more sensitive than other [causes of sickness] as it promotes abstention from food, occasions and streams unless carefully atoned for". To put this differently, taboos were meant to prevent misfortunes and a means of ensuring wellbeing. Within the varied ethnic groups of Nigeria taboos are common. The social, ethical and religious life of the people is safe-guarded by the institution of various forms of taboos. Turaki (1999:212) emphasises that "[a] taboo can be

seen as a moral tool for socio-cultural and religious conditioning, maintaining the social order, harmony and structures of meaning and worldviews”. However, in most cases no attempt is made to make a distinction between religious and moral law or taboo as with the Ibibios. Sometimes the social or moral law is not different from the religious law, as moral and religious values are the same as the Ibibios believe that some of the laws were established by the gods (Esema, 2002:109). The entire community is entrusted with the responsibility of instructing the younger people (Ajibade, 2006:199). For instance, Ajibade (2006:201) argues that the devotees of *Obatala* are forbidden to drink palm wine because of the effect it has on the deity. The breaking of such taboo may result in sickness. This taboo also corresponds with the prohibition from taking alcohol by some Nigerian Christian churches. In the case of *Obatala's* devotees, however, their action has a direct consequence on the deity. The breaking of the moral code in the case of the Christians has a direct consequence on the violator, not God. Such consequence may be intoxication, an accident, injury or pain. What Munyika says of the Owambo of Namibia is also valid for the Ibibio, namely that apart from safeguarding moral values and maintaining order in the community, taboos are meant to protect people from many manifestations of sacredness, spirits, witches, things, places, and deformity (Munyika, 1999:233).

Generational curse: Sickness could be a result of a curse handed down from generation to generation. For example, in Ibibio mental sickness is seen to be a general sickness as a result of the sin or wicked act of one member of the family in the past which was not mediated (Abia-Williams, 1994:225). Thus, members of that family are seen as cursed and anyone who associates with that family either by marriage or by birth inherits the sickness. Freedom from such curses and their effects can only be obtained by breaking the curse. For the African Christian the means of breaking the curse is prayer and deliverance, both of which are often accompanied with fasting, while the traditional African worshiper breaks the curse and acquires deliverance through spiritual sacrifices to the gods. Speaking on the African Christian response to his experience of evil, Asamoah-Gyadu (2004:389, states that “[t]hese are new ways of dealing with the challenges of life … through which supernatural evil is confronted in order that Christians may be freed to enjoy the abundant provisions of God in Christ”.

2.5.3 Personal sin

According to this view, ill health could be the result of the individual's violation of the society's norms and values. For example, Esema (2002:110-111) states that the Ibibio people

perceive illness to be associated with wrong living and choices. Wrongdoing can lead to sickness, calamity or even death. The popular Ibibio saying *"Owo odok se oto"* (a man/woman reaps what he or she sows) attests to the fact that some illnesses are connected to the deviation of an individual from socially accepted behaviour and character in the society; hence, sickness is associated with some personal sin. Esema (2002:110-111) argues that among the Ibibio sexual immorality was forbidden. Thus "[i]f a housewife committed adultery, the husband would be attacked by *ekpo nka owo* (that is the avenging spirit which was against adultery). He would fall sick until the appropriate cleansing was performed. The woman, even the children could also fall sick". In another instance, a woman in one of the churches where I was pastor was accused of having an affair with another man during pregnancy. She had a difficult delivery and eventually gave birth through a caesarean section. Unfortunately, the child died after few days. The people concluded that her misfortune was a result of her infidelity to her husband while pregnant. This belief is not only prevalent in the African traditional societies, but is also held by some contemporary African Christians. Doctors Michael Aziken, Lawrence Omo-Aghaja, and Friday Okonofua (2007:45), who conducted research on pregnant women in one of the teaching hospitals in Nigeria, wrote a paper entitled "Perceptions and Attitudes of Pregnant Women towards Caesarean Section (CS) in Urban Nigeria", in which they report a pervasive belief that women who undergo CS are accused of marital unfaithfulness to their husbands.

Although most Ibibios, like many Nigerians, recognise the multifaceted cause of sickness, the challenge is identifying or diagnosing the particular cause appropriately. Diagnosis is the process of identifying the cause of sickness. Understanding the underlying cause of sickness is important, because each assumption of sickness implies a different method of healing. It also explains why one method of healing may be preferred over another. However, identification and diagnosis do not mean compartmentalising the patient. It could be for this reason that Kalu (2010:209) has argued that Africans perceive sickness holistically. In other words, the different dimensions of sickness are interrelated. It means that a lack of physical health is understood as symptomatic of spiritual, emotional or moral sickness. Conversely, a person who has conflict with his family, neighbour or community is regarded as sick even though he may be physically well. Such a person, he argues, is termed a "working corpse" meaning that he is psychosocially and spiritually sick though he is physiologically well. The poor condition of the body also affects the soul and vice versa (Dukor, 2010:218). The point that this research is trying to emphasise is that sickness for the Nigerian patient is part of an

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interrelated whole. For this reason Louw (2008:42) has advised that all network of caregiving to patients must understand sickness in a systemic and holistic perspective. There can be no doubt that Louw's advice also applies to healing/cargiving in Nigeria.

2.6 The quest for healing/caregiving in the Ibibio sociocultural context

Thesnaar (s.a: 6) has argued that within the African context healing is the process of restoring harmony within the community. For Nigerians, healing is the process of becoming whole, through the process of connection and reconnection to significant relationships within the community. It is maintaining and/or restoring the balance of the cosmic world. This is a dynamic process of evolving into something new rather than returning to the old state before the onset of sickness (Kalu, 2010:208). Three major traditions of healing can be identified in both traditional Ibibio society and in the present-day Akwa Ibom state, as in many Nigerian communities. The three traditions are traditional healing, spiritual or faith healing, and biomedicine.

2. 6.1 Traditional caregiving (healing) in Ibibio

The traditional method of healing is the most pervasive and widely used by contemporary African societies. Particularly in most rural areas it is the main means of healing and therapy, as most people do not have access to hospitals and clinics (Kubukeli, 1999:24). Secondly, it is considerably cheaper than some other available healing methods. The traditional method, as the name implies, has its origin in the traditional societies' practice of healing before the advent of the Western method of healing. Traditional healing takes many forms in the Ibibio/Nigerian culture just as sicknesses take many forms. The method of healing chosen will depend on the causative agents as well as the nature of the illness as explained above. In other words, there are different types of traditional healing.

Within the traditional Ibibio environment traditional healing practices can be broadly grouped into traditional medicine, which consists of the utilisation of herbs, and traditional religious activities, which comprises such practices as confession, sacrifices, prayer, cult dances and music.

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2. 6.1.1 Herbal treatment/medication "*Ibok*"[24]

Kubukeli (1999:24) aptly states that "[t]he medicinal use of herbs is as old as mankind itself". This makes use of herbs, roots, leaves and animal substances associated with the curing of diseases and sicknesses as well as oral medicine, which makes use of divination and incantations. Although many forms of healing methods abound in contemporary African societies, this method enjoys a high level of patronage because Ibibios (especially in the rural areas) seem to have more confidence in its potency and positive healing results. This phenomenon is in fact not peculiar to African societies but also to other traditional societies. The WHO estimates that herbalism is three to four times more commonly practised worldwide than conventional medicine (Kubukeli, 1999:24).

Herbal or medicinal treatment (known as *"ibok"* in Ibibio) is utilised when the source of treatment is diagnosed to be physical or natural in nature (Esema, 2002:113). The medication takes the form of a concoction. Just as in Western medicine, a concoction is made by mixing the ingredients together with water or local gin to form a syrup, or by crushing the ingredients into a powdery form or paste. The method of application ranges from drinking to rubbing of the herbs on the body. However, this is where the similarities between Western medicine and traditional herbal medicine end. Herbal medicine has been criticised for its lack of precise dosage as a result of the difficulties in measurement (Hokkanen, 2007:748). Its validity has come under serious attack, first by the colonial masters and the missionaries, and subsequently by the Western-trained Nigerian physicians. Although some of the writers on African religion such as Hokkanen (2007:748), Obadare (2005:276) and Kalu (2010b:67) believe that some of the criticisms were based on a misunderstanding of African culture, religion and tradition, the major difficulty with traditional medicine is its secretive nature, which is largely responsible for its minimal contribution to research in the field of healing. However, this medication (*ibok*) is normally considered sufficient to cure the ailment, especially if supernatural forces are not implicated in the diagnosis. It must be said here that almost every family within Ibibio culture has knowledge of certain herbs for treatment of certain sicknesses such as *Dogonyaro*, "*mfang Awolowo*" (*Eupatorium Odoratum*) for malaria, *Mfang ntong* or *"mfang Awolowo*" for stoppage of bleeding of wounds and malaria.

[24] *Ibok* is the Ibibio word for medicine. It is often used to refer to all forms of medication, concoctions and charms.

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According to Ajibesin et al. (2008:388),[25] 75% of the people of Akwa Ibom State rely on traditional medicine and herbs for health care delivery; this covers ailments such as skin diseases, malaria, gonorrhoea, and haemorrhoids, which are mostly treated with the medicinal plants. Inyang (1994:230) states that the medicine man is held in high esteem in AKS. This is true of many tribes in Nigeria as some of these herbs are also used among them, though they may have different names. In the event that the sickness is not cured at the stipulated time, the sickness might be suspected to have a supernatural cause. If this is confirmed through divination, rituals in the form of sacrifices may be carried out. Here the family of the victim might seek the help of a traditional healer. This is where the openness and secrecy of traditional medicine ends and begins respectively. Traditional healing often will incorporate the ritual of sacrifices as its form of healing.

2. 6.1.2 Traditional religious [activities of] healing

Confession: According to Offiong (s.a: 121), confession is a vital process in Ibibio traditional healing practices. It involves the patient revealing any act of wrongdoing or evil against another person or community such as telling lies, or bearing false witness against another, or committing a taboo or abomination (adultery), stealing and so on. Where the patient is too ill to talk, the relative or friend or the closest person to the patient may be asked to confess on behalf of the patient. Offiong (s.a: 121-122) asserts that "once a patient is taken to a traditional healer, one of the first things done is to ask the person if he or she has ever tried to harm anybody in any way…. After the confession has been made, the traditional healer then seeks out those people named by the patient and assists in making peace with them". Offiong further states that healing through confession is concluded with some sacrifice and libation. In the traditional Ibibio belief confession is the bedrock on which other healing practices such as sacrifices may work, because if a person does not confess, the medicine employed may not be effective. Thus, it is important that hospital care practices do not ignore the need of patients to confess, as this relieves the patient from guilt and shame, which places an emotional burden on the patient that cannot be relieved by medication.

Sacrifices and offerings "Eno-Uwa": Turaki argues that offerings are believed to be gifts offered to the deity or spirit as a mark of hospitality without constraint from the offerer. Contrary to this assumed notion of what sacrifices are believed to be, sacrifices are rather

[25] Ajibesin et al. (2008) in their ethnobotanical survey of Akwa Ibom state identify 114 medicinal plants used among the Ibibio people in particular and Akwa Ibom people in general for the treatment of diseases and sickness known to have a natural cause.

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rituals required for atonement or propitiation for infractions, normally offered under constraint from the offerer (Turaki, 1999:206). Sacrifices show similarities and differences between the ATR and the Bible. The major difference is in the essence, purpose and meaning.

Sacrificial offerings or sacrifices in the Ibibio dialect are called "*Eno-uwa*", or "*uwa*" in short form. *Uwa* serves different purposes. *Uwa* forms part of the Ibibios' daily life activities. For example, the Ibibio people offer sacrifices to the ancestors to procure blessings from them and be saved from trouble. However, when trouble does come in the form of sickness because of personal or other evil, the sacrifices take a different tone. They vary according to the kind of disease, the cause, the victim's age and the social status of the sufferer (Munyika, 2004:192). Items of sacrifice in the Ibibio culture as well as some other tribes of Nigeria include yam, palm oil, palm kernel, salt, goats, sheep, chickens and cows. For the Yoruba almost all types of food and drinks and living things (even human beings) are used for sacrifices (Mbiti, 1999:60).

In the case of sickness arising from a spiritual or metaphysical cause as mentioned above, the victim will usually be required to carry out certain rituals apart from providing these items of sacrifice. This takes place after the traditional healer must have identified the cause of the sickness. Normally the victim is not left alone in this period; the family members may delegate a person or persons to be with him/her, or they may be accompanied by a friend who will stay with the patient until the end of the treatment or sacrifice. Implicit in sacrifice is the notion of projection of one's illness, cause and effect to another (the scapegoat). The animal is usually killed. While the blood is shed to appease the gods, the flesh is eaten by all present during the sacrifice. The fact of the family involvement in the process of healing underscores the importance of involving the patient's family in the treatment and healing, which many hospitals are incorporating to a certain extent.[26] Sacrifices in the Ibibio cultures are meaningless and worthless without the ritual of prayer.

Prayer: prayer is the essential part of the healing process. There can be no sacrifice without prayer, although prayer can be said without sacrifice. Prayers, like sacrifices, have different purposes. Prayers for healing will normally be directed to the spirit, ancestors or God, as the case may be. The name of the supernatural agent assumed to be responsible for the affliction is called and appeased through symbolic sacrifice. He is then asked to forgive the offender. The healer will normally face the direction where he/she believes is the abode of the spirit or

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[26] There are some hospitals in Nigeria that do not allow the family member, especially husbands, into the birthing room, which some women complain about.

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ancestor or God. In the case of God, they pray looking upwards; in the case of ancestors, they pray pouring the sacrifice to the ground. In the case of the spirits, they go to the shrine of that particular spirit. This is true of the Yoruba, Efik/Ibibio, etc. Mbiti (1999:60) asserts that for the Yoruba prayers are said at any time and at any place. Prayers in the Ibibio culture may also be followed by word-magic or incantations to exorcise the evil spirit that may be responsible for the illness. According to Dukor (2010:162), prayer could be mediated with a symbol such as kolanut[27] as a celebration of life invoking the will of God or the gods to be done. Unlike the Christian ritual of prayer, which is addressed only to God through Jesus Christ, the traditional prayer may be offered to God or the spirits. The relevance of prayer to this study is that to the Nigerian patient prayer would form one of the vital components of caregiving towards recovery, healing or the process of dying. Besides prayers, music and cult dances are also forms of traditional healing.

Cult dances and music: Apart from symbolising the act of worship to the Supreme Being, music and dances also have healing effects. It is for this reason that the traditional healer prescribes ritual and symbolic dances as part of the healing process. According to Vontress (2001:246), music and dance provide a form of group healing to draw psychological support for the illness through the collaboration of the healer, the patient's supporters and family members present. The healing effect stems from the mystical spiritual aspect of the ceremonies, which are often ecstatic in nature that engenders hope as well as providing the psychological support of the therapeutic community of healer and patient's family.

Healing of illness in the various cults depends on the supernatural being responsible for the illness as well as the religious group of the patient (Awanbor, 1982: 209). The duration of the cult ceremonies also varies. According to Awanbor, duration is given in symbolic numbers of three, seven and multiples of seven. Interestingly, Wing's (1998:145-50) analysis of the folk healing concepts theorises that regardless of geography, cultural origin or religious beliefs, there are certain healing concepts (such as symbols, colours, numbers, etc.) that traditional cultures share which are similar to many contemporary concepts. She notes that although the meanings attached to them may vary from one patient to the other, symbols, colours and numbers are universal and important sources of expression of meaning and healing for patients. Symbols, colours and numbers can also elicit fear. Therefore they deserve respect

[27] Kolanut is celebrated as a divine fruit that brings and sustains life among many tribes of Nigeria, including the Ibibio, Igbos, Yorubas, Hausa etc. There is even a saying among the Igbo that "he who brings kola brings life" (Dukor, 2010:162).

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and understanding to appreciate and appropriate their power to heal. It is interesting to observe that in most Nigerian cultures numbers have symbolic connotations of events, ideas and emotions. Some numbers like three and seven are associated with good luck and elicit a sense of comfort, while some numbers are rarely used in healing practice. Thus, it might be necessary for caregivers to use number symbols, which provides comfort, as symbols are very powerful representations of ideas and beliefs. Admittedly there is some evidence concerning the utilisation of traditional healing symbols by modern medicine;[28] however, a conscious, deliberate and sensitive approach ensures that the needs of the patient are responded to adequately and wholly.

Although different types of healing could be identified in ways which sharply differentiate one from the other, yet in practice these are often blurred. The diverse nature of traditional healing means that no one healer can adequately handle the various dimensions of illness. Different healers administer the healing process. They are known by different names according to their functions and roles in the different Nigerian communities.

2.6.1.3 Types of traditional caregivers (healing practitioners) in Ibibio

The classification of traditional healers in this study is done for the sake of clarity and precision. In actual practice there are no clear boundaries, as most of these groups overlap in terms of functions, roles and skills because of mutual influence and interactions among the practitioners. That is to say, there is a potential for diffusion, adoption and appropriation of other ideas, practices and artefacts (Flint, 2008:16). In most Nigerian languages there is only one general name for the different types and role functions of traditional healers. For instance, the Ibibio general name for traditional healers is "*Abia ibok*"; "*Obos*" in Edo; "*Babalawo*" in Yoruba; and "*Dibia*" in Igbo. The Ibibio know that "*Abia ibok*" are divided into categories and no two "*Abia ibok*" are the same. The type of illness and the skill of the healer are what determine their choice by the ill person when they do need a healer. Some traditional healers are skilled in more than one area of classification. Given that there are common trends that are identified with traditional healers, discussing the traditional healers in this way affords this study the opportunity to take into account the slight differences and

[28] Some hospitals in Nigeria make use of symbols like the cross, the crucifix as well as giving doses in numbers of 1, 2, 3, 4. However, no matter whether these practices are performed with sensitivity to the patient or are merely following the laid down Western procedures (as in the doses) which may accidentally coincide with the patient's symbolic meaning, it should be appreciated that numbers and objects are powerful symbols in the healing context of Africans.

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uniqueness of each healer that would have been lost if the study were to regard them in a general sense.

a) Herbalist/doctor (Abia Ibok): Arguably, almost every Ibibio is a herbalist in the general sense of the term. This is because most Ibibios know of herbs, roots and tree barks that can cure some common natural and physical sicknesses such as malaria, fever, stopping of haemorrhaging as well as healing of minor wounds. Many Ibibios/Nigerians will try to heal themselves first of their ailment with the herbs around them. If he/she has no idea of what herb or medicine to use, he/she will normally complain to a family member, neighbour or friend to seek advice on what to do. In this sense, the whole community acts as doctors for the ill. This attitude might resonate with what Koopman and Young (2009: xviii) enumerate as the key philosophy of CAM such as the emphasis on self-healing and the use of nutrition and natural products as essentials for health and wholeness (2.4). Hence Vontress's (2001:243) assertion that "Africans have a long history of using plants for almost every condition that ails them and that [e]ach home has its storeroom or special place for them" is very true of the Ibibios.[29] In spite of the fact that Western doctors sometimes frown at self-medication, because sicknesses which would have been easily treated may become complicated, many Nigerians are still steeped in the practice of self-medication. Beyond the dangers of self-medication, could this not also underscore the point that many Nigerians are ready to assume responsibility and a participatory role, given their inner resources for their health needs? N.C. Van Wyk's (2009:2) assertion that in holistic (integrative) health care "the responsibility remains with patients to address their needs while the healer fulfils a supporting role in order to reach shared health care goals" is of note to Nigerians.

However, many Ibibios seek professional advice when the ailment becomes severe or does not respond to the normal remedy. In traditional Ibibio society these professionals are the herbalists. They are the first port of call by the natives. Like Western doctors, traditional doctors have areas of specialisation; they are not all general practitioners (Mulaudzi, 2009:37). For example, in Ibibio some of the specialists are diviners, bone setters, traditional birth attendants etc. Herbalists in contemporary Nigeria are breaking with stereotypical practices and are practising in ways that makes them more acceptable than before. Some of their medicines are now bottled and put on shelves like Western medicines for anybody to walk in and buy. Many assume that such herbs are free from fetishism and ritual practices

[29] *The Ethnobotanical Survey of Akwa Ibom State of Nigeria* carried out by Ajibesina et al. (2008) in 930 homes attests to this claim.

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that Christianity is averse to, but more importantly they are more hygienic than those from especially the rural areas. A typical example of this group is *YEM-KEM* International and Ayodele, both in Lagos state of south-west Nigeria. Consequently Schumaker, Jeater and Luedke (2007:708) recognise the often open and adaptive nature of African healing and its ability to absorb and transform their practices and practitioners. While "herbalist" as a name implies mainly the use of herbs and an extensive knowledge of their use in the treatment of illness, they do not exclude spiritual resources especially when they diagnose the sickness as having a supernatural origin. Where there is a case that is beyond his expertise, he might refer the ill person to a diviner to uncover the cause of the illness.

b) Diviners ("Mbia Idiong"): According to Berinyuu (1988:37), "a diviner is a person who discloses the causes of misfortune or death" rather than foretells the future. Diviners are mediums who link human beings with the living dead and spirits. They act as intermediaries to those seeking help from the gods. The position of *"Mbia idiong*" is important for this study, first, because it reveals the traditional and religious Ibibio's attachment to the mediums through which they can access the spiritual realm to find solutions in moments of crisis such as illness. Secondly, it shows the interrelatedness of the spiritual and material, and the key roles of certain individuals in mediating these realms through symbols, objects and other materials for the benefit of individuals and the community. The functions of diviners are to diagnose illnesses, reveal the causes of illness and provide spiritually and socially acceptable solutions. They make use of fetishes for divining the cause of peoples' illnesses. A "fetish" is "any object, animate or inanimate, natural or artificial, thought to possess mysterious powers or to be the residence of a deity" (Vontress, 2001:243). In Ibibio the fetish objects are tombs, cowries, coins, stones, bones, lotions, beads etc. In addition, diviners make use of common sense, intuitive knowledge, insight and dreams. According to Mbiti, the role of diviners encompasses that of counsellor, judge, comforter, adviser, pastor, priest, solver of problems and revealer of secrets. Thus, Berinyuu (1988:37) likens the roles of the diviner to that of the PCG as mediator of God's presence and as spiritual healer. So on the surface one might conclude that the functions of the diviner are holistic and represent hope for the society as he/she tries to meet the needs of the people, especially the sick. It is in this respect that many Ibibios would consult an "*abia idiong*" (diviner) or spiritual healer or pastor especially in cases that Western medicine was unable to cure. Unfortunately, in some instances these hopes are dashed, especially when these persons who are consulted to mediate God's presence misuse the opportunity for selfish and wicked purposes.

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C) Spiritual healers: With the advent of Christianity many spiritual healers have emerged in prayer houses *(Ufok akam*). Spiritual healers are those who use prayer as their main healing method. Abia-Williams (1994:224) remarks that "they are trained to use spiritual powers, exorcism, supernatural forces, to treat all forms of ailments". Their activities resemble those of the traditional diviner in terms of the use of certain fetishes such as holy water, handkerchief etc. There are many healing homes in Ibibio, especially in the rural areas. In Ibibio land almost every community has these *ufok akam* which people visit in great numbers. The reasons are not far to seek. There are few psychiatrists in Nigeria relative to the population. It is also cheaper and easier to access spiritual healers than psychiatrists because of the usual hospital protocols and bottlenecks, which are not usually applicable to the spiritual healers. As long as people relate some illnesses such as mental illness and others to supernatural causation, spiritual healers will always be patronised. In this sense, Vontress (2001:244) notes that "[a]lthough modern hospitals deal effectively with the physical side of disease, they are usually unable to do much to relieve spiritually related suffering". The logic of many of such patients, their close associates and a number of Ibibios is that what is spiritual cannot be healed by physical means. Hence the need for health care in the Nigerian hospital context to meet these spiritual needs of Nigerians. Spiritual healers, especially from the Christian and Islamic perspective, will receive more attention in 2.6.2 below.

d) Traditional surgeons: Mulaudzi (2009:38), drawing from the South African Traditional Health Practitioners Act 22 of 2007, defines a traditional surgeon as "a traditional healer or traditional health practitioner who performs circumcisions as part of a cultural initiation process and includes any person who has been trained to perform such circumcisions and meets with the requirements for performing circumcision". Circumcision is the removal of a section of a male or female sex organ. Going by Mulaudzi's definition of a traditional surgeon with reference to circumcision, many Nigerian communities have these groups of people, especially in the rural communities, where health centres are few and are often far removed from the people. Yet many of these traditional surgeons perform their role not as part of cultural initiation or rite of adulthood, but also as a cultural and medical necessity for babies. The Ibibio and many other Nigerian communities carry out the circumcision of their male babies on the eighth day after birth, while the female circumcision is carried out at puberty. While circumcision is known to be beneficial to males, female circumcision in Nigeria today is widely criticised because it constitutes a health hazard for females. Although traditional surgeons are losing relevance in urban areas because the hospitals are handling

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these aspects more satisfactorily, traditional surgeons are strongly present in the rural areas. As long as these healers are fulfilling the health needs of Nigerians in some ways, they will continue to exist.

e) Traditional bone setters (TBS) ("Abia Okpo"): TBS in Ibibio language is known as *abia okpo* (singular) or *mbia okpo* (plural). TBS as the name implies are traditional healers who specialise in the treatment of broken bones (fractures). In contemporary Ibibio this set of traditional healers is still valued and respected in most cases above the Western medical form of healing bone fractures by orthopaedic surgeons. Some Nigerians who have bone fractures are usually advised by family and friends to utilise a TBS for fast and satisfactory results (Inyang, 1994:232). Udoh (1988:101) also records similar experiences in his work *Guest Christology*. Although for some observers, their means of healing completely shattered bones with mere leaves or herbs is difficult to grasp, yet the relevance of TBS grows by the day as people are finding their services efficient and effective.

f) Traditional birth attendants (TBA) "Abia uman": In Ibibio TBAs[30] are found in almost every community including the cities. Bassey et al. (2007:355) report that over 60% of pregnant women in Nigeria utilise TBAs. While TBAs are usually women, a few men have also been known to perform this role among the Ibibio. Bassey et al. (2007) in their research on TBAs in Cross River State of Nigeria also report 19 males out of 140 TBAs in five rural areas of Cross River State. TBA's role and functions are similar to those of an obstetrician or birthing nurse in the hospitals or clinics. While most of them are not formally trained and have no form of education[31] at all, like the hospital medical staff they are knowledgeable about women physiology and some clinical conditions of women and children. They could detect a pregnant woman whom they have never met by merely looking at her physical appearance. Their functions include educating pregnant women on issues of health, nutrition and family planning (Bassey et al., 2007:355 & Apantaku, 2005:257). For example, they advise on the kind of food or drink to take or abstain from during pregnancy.[32]

[30] According to Mulaudzi (2009:38), "traditional birth attendants (usually women) assist other women during antenatal care, labour and afterbirth. Traditional birth attendants do not have formal training. They learn the skills from their elders through observation and mentoring… [T]he conditions for becoming a traditional birth attendant include having had at least two babies of your own and an apprenticeship lasting up to 20 years".

[31] Bassey, Elemuwa and Anukam (2007: 354-358) in their research carried out on TBAs in rural communities of CRS of Nigeria reports that out of 140 TBAs interviewed 62 (44%) were illiterate, while 19 only had secondary education as the highest level of education attained.

[32] For example, in Ibibio land they advise women not to eat too many oily and fatty foods and to periodically take a shot of "ufofop" (local gin) to prevent the child from becoming big. They routinely check on them to

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Some TBAs also double as traditional surgeons who also carry out circumcisions on male children. The community-based approach[33] offered by TBAs makes some Ibibios revere them. However, the TBAs are limited and handicapped when labour becomes complicated and a Caesarean section (CS) needs to be carried out by the more professionally trained hospital personnel. Yet it will seem that this skill in handling complications like CS, which would have underscored the importance of professional medical personnel above the TBAs, instead reinforces the admiration of the locals for the TBAs because of cultural mores that teach that CS is unnatural birth and therefore abnormal and unacceptable. Aziken et al. (2007:42-47) in their research reports state that some Nigerian women would not accept CS under any circumstances, because their culture and traditions are averse to it. Secondly, it leaves scars on their abdomen, which would not allow them to tie their abdomen to ensure a flat abdomen as they would traditionally do. Thirdly, women who consult faith healers for prayers or rituals to be performed will have normal delivery. For these women when there are complications in labour, "reliance on faith and the supernatural is the solution not CS". For this category of women, the TBAs will combine these resources to address the situation. Aziken et al. (2007:46) therefore recommend the "need for specific health education of women and the community to reduce the level of beliefs and superstition as causes of adverse pregnancy and labour outcomes". Such recommendation requires collaborative service from all helping professions, including PCG.

In all, the question of why traditional healing and healers continue to gain popularity; about 80% of patients in Africa utilise traditional healing methods (Mulaudzi, 2009:31) despite the shortcomings and criticisms first from the colonialists, missionaries, and now from the medical profession and some medical groups in Nigeria. Several reasons have been advanced to explain the persistent patronage of traditional healing and healers. Vontress (2001:243) finds the reasons in a shortage of trained physicians, poor access to rural areas by modern hospitals, and the relation of sickness to spiritual causes. Akinyemi (2006:287-288) suggests the cultural belief practices of the people and the popularity that is given to them in the media are responsible for the trend. These answers may provide some reasons for the phenomenon,

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monitor their progress. They also assist in the delivery of babies. They advise the mother and family on what to eat and how to care for their body, such as drinking hot water for 2 to 3 months, hot drinks, pepper soup (a kind of watery soup that has much pepper in it). Every morning and evening hot water will be used on the birthing passage as well as abdomen to heal any laceration and to assist the womb to return to normal respectively.

[33] Some TBAs may have a room or rooms provided by the community or their own home where they attend to women and families who seek their services, or they may attend to the women at their homes, in which case a particular room is set apart for such services for the period.

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but they do not necessarily represent the entire situation. According to Apia-Kubi (1975:237), a close scrutiny of healers reveals that not all herbs users are rural dwellers, neither is traditional medicine given more prominence in the media than modern medicine. What is responsible for the trend is the traditional healer's holistic approach to healing, which gives dignity and identity to the users, and the readiness of the healers to adapt to the changing socio-cultural and religious context. Second, they give the sense of treating the whole person. In this regard Apia-Kubi (1975:237) notes that "[o]ne of the chief complaints in modern church hospitals is that the doctors speak about them, look at their charts and take their temperature but do not touch them as persons". Bujo (2001:163) laments that the medical model of health has tended to reduce many African practices of healing to the biological and medical dimension, overlooking the elements that made them socially and psychologically meaningful. This means that the healing model of traditional healers possesses resources which can be engaged with and possibly transformed to meet the needs of the patients in the hospital. Nevertheless, it would seem that the traditional approach to sickness and healing is conceived in terms of the cause and effect paradigm. This approach, which might provide pragmatic relief to the patient, may not be helpful in some instance, such as in a case of the patient blaming himself or herself for the illness. Furthermore, it might result in the desire to cure at all cost, and the failure to do so disappoints the patient. In this regard Louw (2008:24) has argued that patients need to be helped to shift from a cause-and-effect attitude and disposition towards dealing with illness. He argues that such change depends on, among other things, reframing their normative frame of reference, the support system as well as the networking that exist among the caregivers. It would therefore be necessary in the light of the concern of this study to look at the training of the traditional caregivers.

2.6.1.4 Selection and training of traditional caregivers (healers)

Traditional caregivers are popularly known as healers, but in this study they will be referred to as caregivers. This is to avoid the misconception that attends the concept of healing, especially in Nigerian society. In Ibibioland, traditional caregivers assume their role by calling and training. The training differs from one community to another and from one cult group to another. The call can come to a family that has been chosen by the ancestors to produce traditional healers. This means that at any point in time somebody from that family might be chosen to fulfil the role of the diviner. Alternatively, he or she might simply assume the role of his/her father's (or mother's) trade by choice of association. According to Udoh

(1988:95), "[a]mong the Ibibio of Nigeria, prolonged sickness, incessant accidents, unusual luck as well as the presence of vultures, certain insects or bees in a home may be interpreted as signs that one of its members might be endowed". Other signs of a calling could include severe psychotic behaviours and a change in mood. Apart from the calling by affliction, some may receive their calling through visions and dreams. "However, the final verdict has to come from an expert '*abia*' who declares whether or not a candidate is eligible" (1988:95). The confirmation is the first step in the series of training.

The training of the caregiver varies according to the field he/she wishes to engage in and the community's requirements of the caregiver. Most significantly, it depends on the wealth of knowledge, intelligence, disposition, age, psychological maturity and spiritual awareness of the apprentice before the call. For example, the Yoruba diviners train from 3 to 7 years, although the training tends towards informal practice by observation and mimicking rather than formal schooling (Mbiti, 1999:173). Vontress (2001:247) asserts that the components of the training include:

- Knowledge in medicinal value, quality and use of herbs, leaves, roots etc.;
- The causes, cures, and prevention of disease and other forms of suffering;
- Magic, witchcraft and sorcery and how to combat them;
- Techniques of communication with spirits;
- Various secrets some of which cannot be divulged to outsiders;
- A vast body of literature, mythology and associated rituals;
- Specific healing procedures and the language of healing;
- Interview techniques and the method of divination.

Berinyuu (1988:40) and Udoh (1988:98) stress the necessity of the trainer to maintain a personal quality of uprightness, friendliness, trustworthiness and readiness to serve, as there may be dire consequences if this is violated. In other words improper training and misconduct can turn trainees "into '*Ifut uduag*' or 'destructive witches' because they lack the will power which goes with a call" and because they violated the rules governing the practice. Among the Ibibio the period of training culminates in ritual burial and cleansing (Udoh, 1988:96). There is also a social celebration during which the trainee is ushered into the market place to present himself to the community as a qualified healer. "The purpose is to avail oneself to public examination that he has successfully completed his training and that he is alright. It also means he is not a quack. As a friend, he is qualified to listen to any problems and to help.

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It is a way of soliciting trust, respect and social approval" (Udoh, 1988:97). This insistence on proficiency and professionalism signals a warning against mediocrity in his practice.

So far there is evidence of a correlation between culture, religion, and health and healing. Many medical professionals and researchers agree that religion, and most specifically faith or spirituality, plays a significant role in the understanding of concepts of sickness, health and healing, and the processes of healing (Koopsen & Young, 2009:39, Van Wyk, 2009:28, Maier-Lorentz, 2004:24, Piderman & Johnson, 2009). Religion also influences the diagnosis and the process of healing. Van Wyk's conclusion with reference to South Africa, namely that "Christianity may be the dominant religion, but the influence of ATR is unquestionably strong" (Van Wyk, 2009:28), is also true of Nigeria and AKS in particular. The African Independent/Pentecostal churches and Islamic prophetic healing could provide a window through which the role of religion can be viewed more fully, with particular reference to African spirituality and faith healing and their influence on the Ibibio and Nigerian health care delivery system. Such observation could also reflect on questions such as: Is there an incorporation of traditional African spirituality into the healing practices of African Independent and Pentecostal churches? Does such inclusion not benefit the Nigerian patient and may it not be a pointer to the need for the incorporation of spiritual care in healing contexts such as the hospital? We now turn to religion and faith healing in Akwa Ibom state as practised in African Independent/ Pentecostal churches and how they reflect the Ibibio and Nigerian perception of healing.

2.6.2 Faith healing in Akwa Ibom State: The African Initiatives in Christianity (AICs) and the Islamic prophetic healing

Faith healing is a popular concept in contemporary Nigeria. In the popular and scientific sources the term *faith healing* is applied in a diversity of contexts. Psychic healing, chiropractic, folk medicine and shamanism, as well as religious or sacramental healing, have all been referred to as faith healing. However, the common perception of faith healing is associated with miracles and religion (Van Bragt, 1999:429). Faith healing as used in this study refers more specifically to religious healing and less generally to non-medical healing. Although there are divergent views on what constitutes faith healing and the validity of faith healing, what cannot be denied is that faith healing is real and works (Inyang, 1994:230; Van Bragt, 1999:429). The belief in faith healing is fast gaining ground in Nigeria, including AKS, partly as a result of the factors we highlighted in the socio-political and religious situation in Nigeria (2.2). The African traditional religious worldview is also impinging on

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the citizen's understanding of sickness and negotiation of their healing, including Christianity and medicine (2.3).

In AKS traditional medicine exists side by side with modern biomedicine and religion[34] (Inyang, 1994:229-234). The three are complementary to one another with the sick selecting eclectically whichever is available and necessary to them.[35] However, the negative perception of traditional healing by the Christian missionaries and the Islamic Jihadists and their teaching that traditional healing is tantamount to heathenism, as well as the prohibition of church members by the missionaries from utilising them (in the case of Christianity), created a new identity challenge. This meant that the new converts who were not totally convinced of the position of the missionaries or Jihadhists would evolve new ways of dealing with their problems so as not to lose their new Christian or Islamic identity and a part of their culture (cf. Inyang, 1994:230; Abdalla, 1997:20-22). The incorporation of some of the ritual and spiritual practices, which had similarities with biblical symbols (in the case of Christianity) and practices would form their new vision of spiritual healing. Thus, this approach seems to be appealing to many Akwa Ibomites in their search for meaning. It is therefore not surprising that American magazine tell of some African priests, religious and lay Catholics resorting to becoming diviner-healers to call on the ancestors for faith healing (African Priest Told to Stop Traditional Healing (2006). However, the preoccupation of these African priests is regarded as unacceptable practices by some Christian groups. Kalu (2010d: 201) writes that there is a contention against faith healing or divine healing or spiritual healing on three levels. First is the suspicion and negative stance adopted by medical science towards faith healing that is rooted in their naturalistic orientation. The second level arises from the disciplines of psychology and psychiatry, which are embedded in their Enlightenment worldview; and thirdly the rejection of faith healing by some Christian groups is grounded in the

[34] Medical practitioners in Nigeria often report that some of their patients see either a traditional healer or spiritual leader or both before consulting them. For instance, Unuhu, Ebiti, Oju and Aremu (2009:24) note with seeming disapproval that their anorexic patients had visited both before consulting them. Orji, Dare, Makinde and Fasuba (2001:483) also report similar practices. These reports reinforce what has become the popular approach among many Nigerians, and of addressing their existential problems especially in the matters of health and life.

[35] It appears that this way by which some patients deal with their illness was not peculiar to Nigerians as Davids (1997:436) also describes the same thing occurring in the ancient Mediterranean Greek and Jewish worlds, which belies the Old and New Testament writings in respect of healing. "In the ancient world there were various means of seeking healing. There were the healing cults (involving the gods) like Asclepsis and Isis, magical means such as spells, amulets special oils and sacred inscriptions as well as various physicians trained to a certain degree in combination of healing arts of Greek (Hypocrate) or Roman (Celcus De Medicina). In other words 3 types of healing existed involving the gods (miracle), Magic and Medicine. The lines were blurred with practitioners using a variety of means and ill individuals selecting eclectically from whatever practitioners were available..."

Enlightenment worldview. Despite such contention, there is a growing impact of sects and prayer houses because of some existential needs that arise as the negative impacts of globalisation and industrialisation weigh on the daily lives of Ibibios. Like many other African scholars, Kalu argues that health and healing are important concepts and central themes in Nigeria (2010d: 201). These scholars therefore state that healing is important to Africans because they are conscious of the fact that hospitals are concerned with disease and not their person or value, and they are therefore alienated. The AIC becomes an avenue to recreate African life where the human person is of supreme worth (Kruss, 1985:233).

Given the factors as enumerated above, spiritual healing constitutes an important dimension of restoration to wholeness in the Nigerian worldview regarding healing. In contemporary Ibibio society faith healing is strongly represented by the church's model of healing in the case of Christianity and to a lesser extent Islamic prophetic medicine. Therefore this section of healing practices will first of all consider the African Independent Churches and secondly Islamic prophetic medicine or healing.

2.6.2.1 The African Initiatives in Christianity (AICs), Pentecostals and prayer houses

This section explores the health and healing concepts of AICs, Pentecostals and prayer houses so as to ascertain if the AICs, Pentecostals and other African Christian healing groups' practices are holistic, sensitive to the Nigerian patient's worldview and relevant to the caregiving of the Nigerian patient. They have been chosen over and above other religious or Christian denominational traditions, because they are regarded as the vanguard of African traditional religious practices (Kruss, 1985:28, Majoga, 2000:193; Kalu, 2010:70). An encyclopaedia of missions and missionaries defines African independent churches as churches "founded in Africa, by Africans for Africans" (Bonk, 2007:7). However, this simplistic definition is problematic as AICs are found not only in Africa and membership of contemporary AICs goes beyond Africans. Hence some have tended to talk about an African International Church or African Instituted Churches or better still African Initiatives in Christianity[36]. The contemporary form of AICs in Nigeria are better known as Pentecostals and Charismatic movements, although some older forms of AICs, e.g. the Aladuras and prayer houses, still exist. The AICs emerged during the times of acute health crises in

[36] In this study, "African Initiatives in Christianity" is prefered to "African Indepent Churches" because the nomenclature "African Initiatives in christianity"allows for the different variants of the churches established by Africans irrespective of the context of worship or composition of its membership. Thus the name emphasises the point that these churches are founded mainly by Africans in response to the contextual need of the people.

Nigeria, when the existing missionary churches were either ignorant or passive, and hence could not rise to meet the existential challenges of the people. "Healing and protection from evil are the most prominent practices in the liturgy of many African independent churches and are probably the most important elements in their evangelism and church recruitment" (Jenkin, 2008:60).

The AICs' great emphasis is on prayer, spiritual experience, prophecy, visions and healing. "With their strict focus on healing , the believers received an enormous boost during the great epidemics that swept West Africa during and after World War 1" (Jenkin, 2008:60). The AICs maintain a theology and belief of sickness as having three forms of causality, but they place greater emphasis on sin, punishment from God, a test of faith and the work of the devil as the causes. Therefore for the AICs sickness could be physical, psychological and socio-economic, political and spiritual. In this regard, they also perceive a causal link between sin, either personal or of the fathers (ancestors), and the health of the patient's family and community. Consequently, health is not merely physical but incorporates inner peace, contentment and social relationships. Hence, AICs share the same conception of health and healing with the African indigenous worldview and cosmologies, while utilising Christian resources to address health and healing issues (Kalu, 2010d: 201-223; Ayegboyin, 2005:238). Asamoah-Gyadu (2004:390), in his article "Mission to 'Set the Captives Free': Healing, Deliverance, and Generational Curses in Ghanaian Pentecostalism" comments that

> [c]entral to the healing ministry of the church in Africa [are] the causal factors involved in evil and suffering, and how they are interpreted. In addition to the recognition of natural causes, African traditions also generally acknowledge that personal sin, curses, demons, and other forms of supernatural evil could be responsible for illness or misfortune…. [The] effects of suffering, whether caused naturally or supernaturally, can be dealt with through the power of the Holy Spirit often working through the specially anointed people of God.
>
> (Asamoah-Gyadu 2004:390)

The major emphasis of the AIC is on faith, although others like the Aladura may incorporate herbs. Music and dances form part of their approach to healing (Owoeye, 2007:294,298, Isichie, 2003:38; Adedeji, 2008:145). Kalu (2010d: 209) further argues that the AICs' theology of healing is not simply a physical cure, but is holistic in orientation. Their diagnosis and healing methods place the emphasis on spirituality, deliverance and prayers, and utilise the diagnostic tools of gifts of knowledge and discernment, tongues and prophesy. This is commonly called faith healing. Healing is therefore an act of the Holy Spirit through the faith of the patient or others. This faith is not merely believing but acting on the word of

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God, which premises a manifestation in the physical realm. Healing for the AICs is a sign of the kingdom that announces the reign and power of God to the patient to save and to deliver. In response to the problem of evil perceived to be perpetuated by these forces, the Pentecostals carry out deliverances and healing rituals which have to be preceded by confession, repentance and salvation (Asamoah-Gyadu, 2004:392). Thus, the AICs take seriously into account the African worldview of sickness, diseases and the reality of demons and witchcraft.

Although the practices are sometimes not successful, as with all human endeavours, because of poor discernment, denial of limitations and timely referrals (cf. Orji et al., 2001), their view of illness is considered by many Ibibios, as with many Nigerians, to be much broader than the medical model, which maintains a mainly pathological view.

While Pentecostals have received much criticism from some quarters of the Ibibio/Nigerian church and society in terms of their materialism, radical positions on some doctrinal issues and lack of theological training (Materialism, Heresy, 1999; Fatokun, 2009:51), their role in the political, socio-economic and religious contexts in Nigerian society is phenomenal. This is evident in the millions of people who turn out to attend their miracle, deliverance and healing services. Testimonies of the attendees at each service tend to attract even greater crowds. Their teachings of abstinence from drugs, alcohol, cigarettes and premarital sex have helped to foster more responsible living and better health among youths and other age categories in Nigerian society. Their message of hope and possibility in the mist of impossibilities, suffering and difficulty in life is probably what has contributed most to Nigerians being viewed as among the happiest people in the world. Their message of assurance of a restored relationship in Christ, protection from robbery and accident and a prolonged life addresses the contextual reality of suffering, joblessness, poverty and incurable sicknesses, including HIV and AIDS and cancer, in Nigeria. In addition, their model of healing which takes into account the totality of the patient is very much associated with the popular African belief that “the whole person is ill” during illness or other challenges of life. Similarly, Islamic prophetic healing has also impacted on the Muslim community.

2.6.2.2 Islamic prophetic medicine

According to Abdalla, faith healing receives a lot of attention from Muslim adherents. He asserts that the form of medicine that was brought to the Muslim community (*Umar*) was the prophetic or Islamic faith healing. It is so-called prophetic medicine or medicine of the

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prophet because the Muslims believe that the prophet Mohammed was a great physician (Abdalla, 1997:96). The Islamic faith healers also stressed the importance of prayer as a means of cure. Prayer is combined with the recitation of Quranic verses and the name of Allah. Thus Abdalla (1997:104) concludes that "whether it be the recitation of the verses of the Quran, as the prophet did, or the names of Allah and other mystical formulae… prayer is considered adequate for the achievement of whatever goal man desires". Accordingly Syed (2003:48) writes that most prayers and amulets contain verses from the Quran, which has curative power. The only reason why this healing approach will not work, according to the faith healers, is because the people lack faith when they pray (1997:106). Thus Abdalla (1997:29) and Senger (2003:56) assert that though the Muslims recognise the natural causes of sickness, Allah or his agents are still believed to be the cause of major illnesses and misfortunes. Therefore at the core of Islamic faith healing is prayer and its efficacy is unparalleled. Consequently, Islamic prophetic healing relies on two sources as its authority: the hadith (the sayings of the prophet Mohammed) and the Quran.

Islamic prophetic healing differs a great deal from Christian faith healing. However, the common denominator for both healing practices is the emphasis on belief (faith) and an appeal to authoritative writing of the community (Quran and hadith) as well as the emphasis on prayer as the sole means of treating sickness, helping realise various goals or alleviating hardship (Abdalla,1997:103). Abdalla (1997:104) argues that

> [i]n the Sufis [Muslim] worldview all health and illness depend on Allah alone and the right prayer done in the proper fashion always achieves results no matter what obstacle stand in the way. In this respect they are not dissimilar from the Aladura prophets who appeared in Nigeria after the 1918 influenza epidemic and who emphasised prayer for healing, which is also the case one may add, among many independent African churches.
>
> (Abdalla, 1997:104)

Abdalla (1997:94) identified three Hausa Muslims as Muhammed Bello, Muhammed Tukor and Abdullahi dan Fodio. Their medical treatise touches on different aspects such as medical hygiene and related topics (1997:94). Abdalla (1997:95) also asserts that many Nigerian Muslims rely on the medicine of the prophet. They are constantly exhorted to accept the efficacy of the medicine of the prophet and its religious value.

In conclusion, the faith healing traditions of the Ibibios as with many Nigerians, have contributed to the sense of healing and wholeness as they take into consideration their worldview on sickness and healing. This approach by prophet-healers (both of Christians and

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Muslims) to sickness is viewed by some persons (Aygboyin, 2005:243 & Abdalla, 1997:17) to be superior to that of the traditional healers and medical practitioners as they often heal sicknesses that traditional healers and Western medicine consider to be hopeless or incurable. In arguing for faith healing (in the case of AICs), Ayegboyin (2005:243) states that traditional medicine and Western medicine cannot heal demonic cases by incantation (if the power involved is stronger than that of the traditional healer) or drug administration respectively. Therefore, Hunt (2002: 188) may be right when he remarked that the AICs "mark a response to the ever-changing difficulties, demands, and constraints of everyday existence not only those engendered by political state but the broader economic and social restrictions of everyday urban life". "It follows that the recent movement in Pentecostalism involves theology and practices that address issues related to the family, sexuality, health, wealth, and justice, as well as the economy, government and the entrenchment of powerful social and political elite" (Ayegboyin, 2005: 243).

As such faith healers represent a holistic and transformative group in their concept of healing. It might be necessary to note that many writings on AICs come not from these groups themselves but from outsiders who observe their lived practices. This confirms Apia Kubi's (1975:237) assertion that "in many African countries religion is not merely talked about but lived". Thus Nwachuku (2012:517) asserts that to understand the African religious inclination is to focus on the rites rather than on the belief. The AICs' and Islamic prophetic healing practices reflect a holistic standpoint that demonstrates sensitivity to the context in which they operate. These strengths could account for their resilience and growth (especially of AICs) despite criticisms of some of their practices. Admittedly, some of their practices fall short of being professional and sometimes their healing homes do not live up to the ideal. These limitations draw attention to the essence of acknowledging boundaries of competence and creating space for collaborative practices. As Ayegboyin (2005:244) rightly remarks, "shared concern calls for welding of combined skills of physicians, psychologists and pastors/prophets. All these professions with their different competences can serve as God's healing team". However, AICs and Islamic prophetic healing represent the volume of evidence on the significant role of religion in negotiating the wholeness, health and healing of the Nigerian people and the Ibibios in particular. Among other resources, the hospital can stand to benefit through the inclusion of religious and spiritual care in hospital care based on the great trust and confidence that Nigerians have in religious leaders as the bearers of hope, despite some of their weaknesses. Weaknesses are part of the human endeavour as fallible

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beings, just as it relates to the practitioners of biomedicine. The third healing tradition that is worth the attention of this study is modern medical care in Nigeria and especially AKS.

2.6.3 Modern medical care in AKS

The study of the modern medical care tradition in AKS is aimed at understanding the origin, strengths and possible gaps as they relate to mediating healing to the Nigerian patient and sensitivity to the socio-cultural and religious contexts of the patient. As already evident from our discussion, Ibibios had ways of dealing with their health needs and challenges before the advent of modern health care practice. Although their approaches were not without flaws, they nevertheless satisfied their health needs. The coming of the missionaries ushered in another era of health management in Akwa Ibom State by their introduction of education and modern hospitals. This section will consider the history of the development of hospitals. In assessing their development, the different types of hospitals will be discussed to assess the structural development of hospitals since their first introduction into Nigeria. This will be followed by a discussion on the health care professionals. The goal of the medical profession will be discussed as well as health care policies and limitations of medicine.

2.6.3.1 The development of hospitals in AKS

According to R. Schram (1971), the foundation for medical care in Nigeria was laid by the European navy surgeons and the army medical officers. According to Obadare (2005:276), “the earliest medical interventions by the colonisers were targeted, not at their newly conquered territories and ‘subjects’, but the bureaucracy that was to supervise the process of imperial domination”. However, it was the missionary doctors who brought medical services to the natives, including the Ibibios who were not in immediate contact with the colonial government centres. Some of the pioneering missionaries were Dr Hitchcock, Hope Masterton Waddell, Mary Slessor and others in the southern part of the nation (Schram, 1971; Owoeye, 2007:291). The first medical centre was established at Badagery in 1845. In 1886 the first true missionary hospital was established at Abeokuta. This was followed by Illesha hospital in 1912 and Uburu Hospital in 1915. By 1940 there were only 62 trained Nigerian doctors, many of whom were given basic training and thus were considered inferior to the missionary doctors.

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In addition, the missionaries established leper colonies at Itu, Obubra, Ozuakoli and other places. The missionaries also encouraged and assisted the government to establish and to run hospitals and medical centres in Nigeria.

Table 2 AKS Early Hospitals and Founding Agencies

Location	Date Founded	Founding Organisation
Itu Hospital	1906	Presbyterian Mission
Opobo General Hospital	1906	Government
Ikot Ekepene Hospital	1926-59	Methodist
Ituk Mbang	1922	Methodist Mission
Etinan General Hospital	1927	Qua Iboe Mission
Itu Leper Settlement	1928	Presbyterian Mission
Ekpene Obom Leper settlement	1928	Qua Iboe Mission
Oron (Iquita) Hospital	1934	Methodist Mission
Anua Hospital	1937	Roman Catholic
Eket General Hospital	1951	Lutheran
Urua Akpan Hospital	1952	Roman Catholic
Ikot Okoro	1958	Qua Iboe Mission
Uyo	1963	Mennonite/Presbyterian

Source: Priorities for the Development of AKS (1991:30)

The table above shows that modern medical care in many parts of Akwa Ibom State owes its presence to the Christian missionaries who established many hospitals in the region. Being an establishment of the colonial and missionary era, hospital care in Akwa Ibom State is modelled after the Western model of healing. This model follows an empirical and scientific yardstick for determining what is abnormal and the process of restoring what is abnormal to normalcy (Inyang, 1994:230-231). In other words, it is based on facts that must be verified. Hence, healing must be quantified in one form or the other, otherwise it is not healing. Louw

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(2008:36) remarks that the medical model relies on advanced knowledge of the functionality of the human body in relation to disease and factors both internal and external that influences the course of the disease. Thus the medical model emphasises skills and accuracy, and applies analytical and diagnostic principles. As a result, it makes use of relevant apparatus, instruments and medication. Subsequently, they prefer the terms "cure" and "treatment" to "healing" since healing relates more to metaphysical and spiritual categories.

Several reasons led the Christian missionaries to engage in health care. First, the health of the missionaries themselves as they were being attacked by the tropical diseases (Benn & Senturias, 2002:8). Second, hospitals were established as a form of Christian charity and social action to help people in need. Third, "Western Christian missionaries were faithful to Jesus Christ's compassion to preach the Good News, teach and heal the sick. The Commission was fulfilled through the establishment of missions. The success of Christianity in Africa just as in the ancient world was in part due to the preaching of a Healer-Saviour who redeemed humankind from sin and other dehumanising conditions" (Mwaura, 2000: 80-81).

Although it seems that the early missionaries' practice of medical care did not separate care of the body from cure of the soul/life. They combined preaching with social responsibilities such as education, skill acquisition and medicine as well as sports (Aye, 1987: 169-170). In the missionary team were doctors as well as preachers. For instance, the Hope Waddell-led team of Presbyterian missionaries, which operated from Calabar, also included doctors and clergy. The missionaries' approach to care was holistic at least in principle. They integrated Pastoral Care with medical care. Most of the missionary pastors had basic training in community medicine and first aid. For instance, Rev. Samuel Edgerly opened a clinic and dispensary at Creek Town. Another missionary, Rev. Baillie, also opened a dispensary at Duke Town with government approval (Ecoma, 1996: 170). The doctors combined preaching with medical practice. This practice attained great results. "Diseases such as small pox, dysentery, malaria, hookworm, yaws, jaundice, hernia and many more yielded to the missionary doctor" (1987:117).

However, the missionaries, whose personal health concerns motivated the medical care practice in AKS and other parts of Nigeria, did not hide their rejection of African healing practices and worldview on sickness in its totality, and so their motivation to build a healthy Christian community based on modern Western medicine soon fell short of meeting their goal of reaching the totality of the patient in reality. In other words, although these doctors

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could be said to have adequately understood that the religious as well as the physical dimension of sickness and its importance to the understanding of Nigerians and Ibibios in particular in the treatment of their illnesses through their incorporation of pastors into their team of medical practice, in fact they failed to do so. Consequently, the jettisoning of the important aspect of African healing became the bane of medicine in Nigeria. Hence, scientific medicine eventually took the centre stage and religious practices of healing fell to the domain of the church and traditional healing; the two categories would become "strange bed- fellows" and operated in separate spheres (Aye, 1987:143). Consequently, the vision of a holistic healing of the human person began to drift into oblivion. Contemporary theories and practice of medical care became almost confined to the dictates of scientific and technological advancement.

However, in contemporary Akwa Ibom society the medical model is steadily gaining much popularity and acceptance because of its accuracy in diagnosis and sophistication in the method of healing and/or treatment and cure. This seems to make contemporary medical theory and praxis proceed in such a way that it seems to ignore the need to respond to the religio-social worldview and challenges of Ibibios in the condition of illness and healing in the hospital context. Ugeux (2006:133) argues that the medical model assumes the "illusion of omnipotence" that has led medical staff to believe in their ability to cure all sicknesses to the exclusion of other perspectives. For instance, in a number of research projects carried out by the Nigerian medical personnel on the perception and attitude of Nigerians towards certain illnesses and diseases, a significant percentage mentioned the spiritual and supernatural dimensions as the cause of and remedy for those sicknesses by both patients and medical personnel. Yet such ratios are merely acknowledged without concrete steps being taken to incorporate such areas in health care delivery (cf. Akinyemi, et al., 2009; Ibrahim & Odusanya, 2009; Obiechina, Diwe & Ikpeze, 2002; Aziken, Omo-Aghoja & Okonofua, 2007; Orji, Dare, Makinde & Fasubaa, 2001; Adewuya & Oguntade, 2007).[37]

[37] In research carried out among hospitals on knowledge of risk factors, belief and practices by Ibrahim et al., half of the participant indicated prayer as the cure for cancer. Orji et al. mention that mission house delivery "should be seriously addressed. They help people cope with the stresses of everyday life but they drive women away from orthodox maternity care by encouraging unsafe delivery in mission houses" (Orji et al. 2001:483). Aziken et al. report that 13.8% of 370 participants identified evil spirits and witchcraft as the cause of strokes among hospital staff. Obiechina, Diwe and Ikpeze (2002) report that 175 of 983 participants or 17.8% believed that poison or witchcraft caused STD in the research on knowledge and perceptions of STDs among Nigerian adolescent girls. Adewuya and Oguntade (2007:933) reveal that 53.8% (168) of doctors believed that mental sickness was caused by evil spirits, witches and wizards. The researchers, rather than acknowledge this spiritual dimension as a concrete reality, berated these doctors as superstitious and inadequately trained (in Western psychiatry).

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Interestingly, Ibrahim (2007:901-905),[38] has a lot to say about the inadequacy of medical practice and training in Nigeria.[39] Poor training will inadvertently affect the quality of patient care in this enormous country. It also reveals the need to educate Nigerian citizens on the importance of religious and spiritual care, their role and distinctiveness from other forms of care such as medical care.

However, a recent study from Oluwabamide and Umoh (2011:49) shows that medical personnel in AKS are beginning to show a positive attitude to religious representatives and faith healing. According to Oluwabamide and Umoh, “some doctors and nurses … said that illnesses, especially those without hope of any cure by orthodox medicine, would need God’s intervention. According to them, such conditions require words of encouragement, exhortation and prayers”. Some of the doctors would even refer patients to churches for prayers (Oluwabamide & Umoh, 2011:49).

It should be stressed again that an African holistic concept of religion and life makes no distinction between the sacred and the secular. In this light, the contemporary practice of medical care-giving needs to reflect on the African spirituality and religiosity which takes into consideration all dimensions of human and cosmic life. Such caregiving should factor in spiritual, social, economic and political concerns, if health and wholeness are to be achieved. Contemporary health challenges in the state (as already discussed above) make it indispensable for the practice of health care to retrieve its religio-cultural and social responsibility in order to acquire significant meaning within the Nigerian and indeed AKS context.

2.6.3.2 Modern health care structure in AKS

The health care system in AKS in 2001 had about 479 hospitals and clinics of different categories (The Development Framework of AKS, 2005:106).[40] These health care services are provided by the federal, state and local government as well as private non-governmental

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[38] Muuta Ibrahim is a medical doctor at Bayero University, kano, Nigeria.

[39] Some of the problems of medical training outlined by Ibrahim are: curriculum overload, curriculum atrophy, absence of staff training programmes, lack of awareness of global change, lack of exposure to current trends in medical education with little or no opportunity to travel and learn, inertia and reluctance to accept changes by leadership in the Nigerian medical schools etc.

[40] However, the recent website of the Ministry of Health AKS stipulates that AKS has 42 health institutions, meaning that between 2001 and 2012 the number of health institutions had significantly decreased instead of increasing. Although the reason for this is not apparent, it could be assumed that some of these institutions have ceased operations, or merged or metamorphosed into another health institution as in the case of the medical center that is now the University of Uyo Teaching Hospital.

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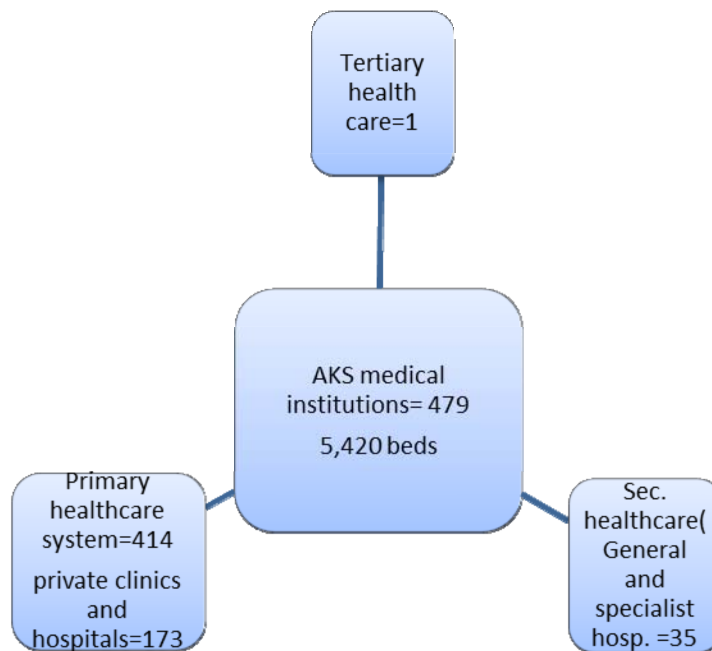
institutions (profit and non-profit) (The Development Framework of AKS, 2005:106; Amaghionyeodiwe, 2008:215-216). Therefore, the Nigerian modern health care system can be classified into primary health care, secondary health care and tertiary health care. Most of the health facilities, including the private ones, are located in the urban centres with a total bed capacity of 5,420. It is clear that the health care facilities in AKS are not evenly distributed (NSHDP 2010-2015 (2010:38).

Figure 2 AKS Modern Health care System



Source of Data: The Development Framework of AKS (2005:106)

The primary health care system: The primary health care delivery system is made up of the community health centres, dispensaries, maternity clinics and clinics. The Nigerian Code of Medical Ethics 2004 Part A, No. 12, under the section classification and nomenclature, refers to primary health centres as institutions where only consultation and out-patient treatment are carried out. They also include such programmes as health education, maternal and child health, family planning, nutrition education, immunisation, diagnosis and treatment of common ailments etc. These clinics have wider coverage into remote areas and villages (about 65% of all existing hospitals) and serve about 70% of the Nigerian population (NSHDP 2010:39). Conversely, the personnel are mostly nurses and some of whose qualifications are lower than the standard of registered nurses, with little or no presence of a physician (Adebayo & Oladeji, 2006:389). These services are mostly funded by the local government, which explains the inadequate provision of health care services at this level

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(Adebayo & Oladeji, 2006:389; Amaghionyeodiwe, 2008:215-216). AKS has a total of 414 of these institutions, as indicated in Figure 2.

The secondary health care system: The Nigerian Code of Medical Ethics 2004 Part A, No. 12, under the section on classification and nomenclature, defines a secondary health care centre as "an institution in which a full complement of curative care is provided" (2004:23). According to the code of medical ethics, such institution should include units such as an accident and emergency unit, a diagnostic unit, out-patient consultation, wards (surgical, medical, pediatric, ante-natal, labour, post-natal) and treatment facilities (consisting of operating theatre, pharmacy department, physiotherapy and diet kitchen). The Code of Medical Ethics (2004:23) also stipulates that there should be at least three doctors who should be able to offer surgical, medical, gynaecological and pediatric care. The secondary health system consists of the general hospitals. According to the Developmental Framework of Akwa Ibom State, there were 35 general hospitals in 2001. While this figure is more than a decade old, it is worth noting that there may have been an increase in the number of hospitals since the last recorded statistics; thus this figure might have changed significantly as more hospitals (mostly privately and religiously owned hospitals) have been established, including the recent establishment of a specialist hospital in the state capital by the state governor (Giant stride in the health sub-sector by the Akwa Ibom State government, *Health News*, 2007: 27). Most of the hospitals in the state, including the private hospitals, are found in the urban centres. Also the distribution of the health staff is greater in the secondary health care system than in the primary health care system, and there are better facilities and funding. General hospitals had 102 out of 137 doctors in the state in 2001. Most of the general hospitals are state owned and funded (The Development Framework of Akwa Ibom State, 2005:107-108; Adebayo & Oladeji, 2006:387).

The tertiary health care system: The tertiary health care delivery system is comprised of the teaching hospitals. These hospitals have medical schools attached to them, although some general hospitals in Nigeria offer some training opportunities especially to nurses and other disciplines at a range of levels. Teaching hospitals are specialist hospitals in the tertiary category which concentrate their practice on one or more specific disciplines such as psychiatry, orthopaedics etc. (Nigerian Code of Medical Ethics, 1990:23-24). These hospitals are very few in number compared to the other two levels of hospitals. At present there is only one teaching hospital in Akwa Ibom State. These hospitals are the best funded and have the highest numbers of health care personnel and specialisations. They also have the highest

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number of specialist physicians and professionals. In addition, this level of hospital has a referral facility where patients are referred from the general hospitals to have access to special technical skills and equipment of the expert professionals for their treatment (Nigerian Code of Medical Ethics, 2004:24). However, in practice some patients and family members make it their first port of call for any suspected illness without any referrals. For example, Akande (2004:130-133), in his research on the referral system of a tertiary health facility in Nigeria, reports that about 93% of patients report directly to the hospital without referral from doctors. Thus, it appears that the tertiary hospitals enjoy more patronage from Nigerian patients. Akande (2004:133) reasoned that the phenomenon persists because "people have little confidence in the care they would receive outside of the hospital". Such usage may be due the fact that they are mostly staffed with specialist health care professionals and so enjoy patients' confidence in their quality of service. As a result, the facilities and staff of these hospitals often experience intense pressure and stress from the patients and vice versa, as there are often long queues and frustratingly long hours of waiting before they can be diagnosed. This situation may also indirectly affect the quality of services provided in this sector. The Development Framework of Akwa Ibom State mentions that the only teaching hospital in the state "is yet to provide a full complement of the services expected of a hospital of that nature" (2005:107). Against this background Aluko (2006:234) and Gesler (1984:26) argue that the health care system in Nigeria (including AKS) is not well developed according to international standards and cannot truly be called a system, because there is no proper coordination among the various levels of hospitals and their practitioners.

Consequently, it can be concluded that religious/spiritual care is not the only field that is still under-developed; medical care as well as clinical pharmacy in Nigeria have not achieved an international standard (Augustus, 2006:262). Yet a good professional standard is the goal which all professions in health care and helping professions strive to attain. Consequently Amaghionyeodiwe (2008:215) and NSHDP 2010-2015 (2010:10-11) argues that the quality of health services provided in Nigeria as a whole is poor. He argues that quality of care is one of the determinants of health care choice in addition to cost, distance, income and technical facilities.[41] It could therefore be argued that pastoral care could add to the health resources of

[41] Amaghionyeodiwe's research utilized quantitative closed-ended questionnaires that do not allow room for participants to give their views. His result showed that the factor of distance was the highest percentile of 33% followed by better treatment (quality of service) 30.8%; the third was price of treatment 14.2%, time factor was 4.2% and the least significant factor was income at 3.2%. His findings also indicated that the private hospitals (which in his categorization included the mission hospitals) were more preferred to the government hospital (39.6% to 32.6% of the government facilities), traditional medicine (13.6%) and no response (2.3%). It is worth

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the hospital, thereby improving the quality of care in such a health care facility. Therefore, creating a space for PCGs who have the potential and capability to contribute to the spiritual needs of patients could contribute to quality of health care in the hospital. The classification of Akwa Ibom State hospitals and some challenges in their functionality as it relates to hospital care offered to the patients that patronise those hospitals have implications for Pastoral Care in the Nigerian hospital context. It suggests the need for Pastoral Caregiving in this space that could provide some form of cushioning, especially as it relates to religious/spiritual care for the patient, family and staff, as indicated in the previous chapter, as well as to the pattern of involvement of the PCG in such a scenario. The aspect of pastoral care in the Nigerian health care system could form part of the policy revision of the health care system related to the structure and quality delivery of care in the hospital.

2.6.3.3 AKS health care policy

The health care delivery system in Akwa Ibom State is somewhere between that of Europe's centralised system of control and funding (e.g. England) and the North American decentralised system of multiple players (D'Emilia 2001:178; National Policy on Public Private Partnership for Health in Nigeria 2005) (cf. 4.6). Thus health care policies of Akwa Ibom state are geared towards provision of health care services, infrastructure, practice of medicine to its citizens with the goal to save or prolong lives and improve the general wellness of the people. These services include hospital services and provision of health infrastructure (Akwa Ibom State Government, 2011). Hence, the AKS health care system is funded by the government and managed by the Ministry of Health, in addition to privately owned for-profit and the not-for-profit hospitals owned by religious institutions. The three tiers of government (federal, state and local) fund the hospitals at the three levels (Amaghionyeodiwe, 2008:215). Such sponsorship has implications for the Nigerian health care delivery system, which includes poor funding. Aluko (2006:234) remarks that funding by the government is inadequate, as the government allocates only 0.2% of its GDP to the health sector. He further remarks: "As a result of underfunding, health institutions are unable to pay the salaries of workers regularly. The consequence of this is the incessant strikes often witnessed in the health sector. Shortage of funds also results in an acute shortage of equipment and inability to maintain the existing facilities". According to Adebayo and

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noting that Amaghionyeodiwe's reasons or factors of choice of health care facility omitted the religious factor. This is inconsistent with the Nigerian worldview, which is religiously loaded in all aspects and situations of life as discussed in Chapter Two. This study argues that religious affiliation or provision of religious care in a hospital could also affect the choice of the hospital.

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Oladeji (2006:390), statistics of government budgeting on health from 1990-2001 seems significantly higher, i.e. between 2.2% and 12.2%, with the actual spending being 1.4%. This, they explain, is because health care services are grouped with social and community services. In 2006 the statistics of government expenditure on health as compared to the total government expenditure was 3.5%, of which only 30% was expended (Reading, 2010:374-375).

However, in its efforts towards the provision of health care services, the federal government of Nigeria had implemented some policies[42] with some level of success in some respects and total failure in others. One of the unsuccessful policies was the introduction of Structural Adjustment Programme (SAP) in 1986, whereby the government reduced spending on several sectors including the ill-funded health sector (Pearce, 2000:18-19). With regard to health care delivery, SAP took the shape of the introduction of user-fee charges (Uzochukwu & Onwujekwe, 2005:1-8). Adebayo and Oladeji (2006:390) explain that the fee was intended for cost recovery in part or whole of government spending on health. Such user fees were charged on consultation, drugs and medical consumables. It was also hoped that the introduction of fees would improve the level of health care delivery, augment the government spending and increase the availability of drugs in the hospitals and other health care centres (Adebayo & Oladeji, 2006:389-390). Adebayo and Oladeji (2006:390) have analysed the policy and comment as follows:

> Assessment of the introduction of the user fee charges on health delivery service in Ghana, Uganda and Nigeria appears to show that the policy is being pursued beyond reasonable expectation. In the case of Nigeria, CASSAD indicates that fees were introduced for various health services, including consultation, drugs and medical consumables. Consequently, irrespective of the condition of patients (whether emergency or outpatient) health facilities had to demand fees from users for any service to be performed or consumables to be used to obtain attention. Due to the high rate of poverty, the development reduced the utilisation of the PHC, general hospitals and teaching Hospitals. It however substantially increased the patronage of private hospitals, mission clinics, NGO health care centres and traditional healers, which are less equipped for proper management of health problems than government-owned facilities.
>
> Adebayo and Oladeji, 2006:390)

Similarly, Uzochukwu and Onwujekwe (2005:5), from their empirical studies carried out in the primary health centres in one of the states in Nigeria, report that the failure of this policy

[42] Some of the policies include the National Policy on Public Private Partnership (2005), Draft Health Promotion Policy (2005), National Strategic Health Development Plan (NSHDP) 2010-2015; Draft National Health Equipment Policy for Nigeria (2005), etc.

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(user fee charges) was a result of patients' discouragement from using the facilities. Thus, Adebayo and Oladeji's assertion as to why the policy of user fee charges failed and the attendant consequence is an age-old sentiment raised by concerned Nigerians in the health sector that the high cost of hospital fees have become an important deterrent to hospital use among the poor (Pearce, 2000:20).

The Akwa Ibom State government has made an attempt to reverse the situation and improve funding on health by introducing other policies. Such policies include free health care, universal access to primary care, building and strengthening the existing hospitals etc. (www.aksgonline.com). There was an improvement in the budgetary allocation to the health sector in Akwa Ibom State and Nigeria in general. Adebayo and Oladeji (2006:391) argue that in the year 2002, in Nigeria generally, there were more health care reforms, which included the intensified campaigns and immunisation against polio and deadly diseases. There was also the intensified effort of the National Agency for Food, Drug Administration and Control (NAFDAC) to fight against fake, subs-standard and expired drugs and other consumable products. Most striking was the introduction of the National Health Insurance Scheme (NHIS) in 2007 in Akwa Ibom State that covered in- and outpatient care, provision of certain categories of drugs and maternity care for four live births for every member under the insurance scheme (*Health News*, 2007:30; Adebayo & Oladeji, 2006:391). However, more recent research carried out by Amaghionyeodiwe (2008:215-227) reveals cost is not the only problem; other factors such as distance and better treatment play a role, as discussed in the previous section. This means that even with the government's eventual cushioning of the user fees problem and the provision of free medical service, there is still the greater challenge of how the patients can have access to the facilities as most of the facilities are located in the urban centres (Ukpe, 2007:4). For those who can eventually access the facility, how would they perceive the quality of health care delivery and treatment in the various clinics and hospitals? Pearce (2000:5-70) locates the challenge in the biomedical model as adopted by the Nigerian health care system, including in Akwa Ibom State, which ignores the category of religion. She laments that the status quo has not changed when she remarks that

> European medicine incorporated science, but African medicine was religious and perceived as non-scientific. The Nigerian government's adoption of biomedicine as the official system encouraged those responsible for developing the health care system to pay attention to structures and technology rather than people and relationships. An approach to health that places life within the context of group dynamics begins its discourse on health and illness with analyses of social relations.
>
> (Pearce, 2000:5-7)

Examining the recent policies of the Nigerian government on health reforms such as the NSHDP 2010-2015 (2010)[43] may confirm Pearce's suspicion. Drawing from Pearce's argument and the published government policy documents (cf. www.fmh.gov.ng), it would be fair to conclude that the government policy, which focuses on structure, equipment, science and technology (not that these are bad in themselves) and ignores the personal and relational aspect, is hardly adequate. In essence, religious and spiritual care, which focuses on the relational aspect of personal and religious/spiritual nature, receives no attention in the Nigerian national health care policy development, including AKS. This in turn has affected the development of a working pastoral care department or the desire to do so in most government-sponsored hospitals and clinics. Although inadequate funds in the Nigerian health care system is worth noting, yet it will be a laudable venture should the AKS health care system policy makers show a commitment to holistic and patient-centred care in their Development Framework and reforms. This can be done by providing for spiritual/religious care as a means of upholding human dignity as its goal, giving regard to patient religious and spirituality needs and the role of spiritual care in the Nigerian health care setting such as the hospital. Therefore, Pearce's observation has implication for this study's goal of advocating for space for Pastoral Care in the AKS and Nigerian hospitals in general. It reveals the inadequacy of a purely technological approach to hospital care despite its acclaimed successes. Hill and Smith (2010: 175) concur with Pearce and argue that despite the benefits of science and rational analysis, they frequently fail to fulfil people's need for meaning. The question is why is religious care not part of the AKS and Nigerian health care policy? Why is religious care not considered as a regular part of patient care, because all patients have problems of ultimate concern that affect the success of the healing process? Why is spiritual/religious care considered as adjunct intervention at the convenience of patients who need religious ministrations instead of being an integral department or component of hospital care? The reason for this may be, as Ashley and O'Rourke (1989:391) have observed, the secularisation of the medical profession which the health care professionals believe is neutral to religious concerns. Who are the health care professionals?

[43] The NSHDP 2010-2015 (2010) serves as the overarching framework for health development in Nigeria. It draws on the 36 states and FCT health development plan. This policy has not articulated the place of beliefs and values such as religion and spirituality. The place of relationships is not clearly articulated. Neither is there any drafted policy on spirituality and religious provision in health care institutions among all the drafted policies.

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2.6.3.4 AKS health care professionals

There are various health care professionals, namely the doctor, nurse, pharmacist, physiotherapist, psychologist and social worker. In addition to the above health care workers there are also administrative staff such as administrators, bursars and receptionists. Each of these staff members is important for the effective management, treatment and care of patients in the hospital (Dzurgba, 2005:13). Therefore, hospitals organise themselves into manageable units for effective utilisation of health care workers, infrastructure and health care delivery. Ellis and Hartley (2008:19-25) assert that the organisation of health care staff into units is commonly known as a team. All members of the team have a common goal of seeing to the wellbeing of patients in their care. Cobb (2005:38) identifies various forms of health care teams such as the nursing teams and the clinical teams. The composition of the health care team differs according to the type of hospital or the health facility. However, irrespective of the type of hospital, two health care workers are generic – the doctor and the nurse. Apart from physicians and nurses, there are many other health care professionals that are involved in patient care. They are: dentists, social workers, physiotherapists, pharmacists, occupational therapists etc. Ozumba (2003:92) observes that to a common person, all health workers in the hospital are either doctors or nurses, whether they are surgeons, dentists, ophthalmologists, pharmacists etc., even though these health workers are distinct from each other, because they see these areas as related areas of the medical profession. The literature identifies nurses as the central professionals in hospital medicine, while the other range of health care professionals is commonly referred to as allied health care workers(Cobb 2005:19; Ellis and Hartley (2008:147). For the purposes of this thesis two generic medical professionals shall be discussed, the doctor (who may be a physician, surgeon, psychiatrist, psychologist etc.) and the nurse.

a) The doctor

Ozumba (2003:92) defines a doctor as a person who has undergone training in the art of medicine and has been licensed by an authority which may be a state or a school, to provide a prognosis, diagnose and treat diseases or undertake all forms of curative and healing processes. The doctor's role focuses on the diagnosis and treatment of pathological conditions of God's creation, especially human beings. He/she is also concerned with the necessary approach to the prevention of diseases. Doctors are trained to give an accurate diagnosis of a problem. The strength of the doctor lies in his/her timely response to the problem at hand (Louw, 2008: 12). Hence they are trained for competence in delivering.

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They are also expected to be compassionate. Contemporary doctors' attitudes to patients, as Schiedermayer remarks, must stress that "compassion without competence is a moral fraud and a betrayal of the patients' trust" (1994: 99). It simply demonstrates what happens when there is competence without compassion. Secondly, doctors are bound by their principles to protect life. Schiedermayer, echoing L. Kass, puts it succinctly: "[T]o protect life, to maintain and support it, to restore it to wholeness and certainly not to destroy it is the common principle [in medicine]. To be sure this principle gets outside support from religious teachings … but one sees it can be derived from the inner meaning of medicine itself" (Schiedermayer, 1994: 101). The implication of this is that their profession demands that doctors as well as nurses be committed to saving life.

b) Nurses

Ellis and Hartley (2008:146-147) assert that nursing is a difficult concept to define because of the confusion of nursing with medicine and the diverse roles expected of a nurse in contemporary times; therefore nursing theorists have developed definitions based on their conceptual framework. The result is numerous definitions of a nurse or nursing (Ellis & Hartley, 2008:148). As Ellis and Hartley explain, the difference can be found in the purpose and goal of both professions (i.e. medicine and nursing). Therefore, nursing differs from medicine in the sense that "nursing is concerned with caring for the person from a holistic perspective in a variety of health-related situations". Medicine, on the other hand, is "concerned with diagnosis and treatment". Hence Pera and Van Tonder (2005:3) argue that nurses are concerned with caring for and having continuous contact with the patient. According to Pera and Van Tonder (2005:3), primary care is therefore the nurses' responsibility. Professional nursing trains students to care for the wellbeing of patients and their families with compassion, commitment, confidence and a deep sense of moral awareness. They are also trained to respect the dignity of human life. A professionally trained nurse also maintains a person-centred approach. Pera and van Tonder (2005: 3) remark that nurses by profession have closer contact with patients and their families. How they are able to embody these virtues is of great importance to the medical profession.

2.6.3.4 The goals of the medical profession

The Draft Health Promotion Policy of the Federal Ministry of Health (2005) states as its vision the reduction of morbidity and mortality rates resulting from communicable diseases to the lowest indices as well as to "meet the global goal on the elimination and eradication of diseases, and significantly increase the life expectancy and quality of life of Nigerians".

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Similarly, the Nigerian Code of Medical Ethics and Conduct (2004:23-24) states that the goal of the medical profession is the promotion of the health of patients and the general health of the community. The ultimate goal of contemporary medicine and medical practice focuses on alleviation of the suffering of persons and their communities. In line with this goal the Akwa Ibom State ministry of health stipulates its goal as being to

> support healthy living for sound bodies and minds as well as combating of diseases through the operation of an accessible, affordable, and efficient and integrated health care delivery system that is structured around a two prolonged integrated primary health care services and secondary care strategies administered through health institutions by skilled care providers
>
> (http://www.aksgonline.com/articlepage.aspx?qrID=925).

Implicit in the above goals of medicine as articulated by Nigerian policy documents as shown above is the fact that currently there are some limitations and challenges in the provision of health care to the people of Akwa Ibom State in particular and Nigeria in general. The following can be identified as limitations of medicine in the Nigerian hospital setting.

2.6.3.5 Limitations of medicine

According to the WHO: (2010) "a well functioning health system responds in a balanced way to a population's needs and expectations by improving the health status of individuals, families and communities, defending the population against what threatens its health, protecting people against the financial consequences of ill-health, providing equitable access to people-centred care and making it possible for people to participate in decisions affecting their health and health system". However, the National Policy on Public Private Partnership (2005) laments: "Health care delivery in the public sector is currently highly bureaucratised, undermining effective delivery of services, professional ethics, job performance, and morale. The cost of care is unaffordable for large percentage of people and very high for those who could even afford such services". This situation shows gross limitations in terms of the WHO's criteria for a well-functioning system. Ashley and O'Rourke (1989: 126-127) argue that the modern medical care has produced as much poor health as healing. This limitation of medicine has three dimensions. First is the dimension which Ashley and O'Rourke (1989: 126-127) call clinical iatrogenesis, a situation in which physicians and health care services dispense drugs, unnecessary surgery and harmful procedures to patients. The second is social iatrogenesis, a situation by which people are helped to consume doubtful medical remedies rather than changing the unfavourable social structures that cause their illnesses. Thirdly is cultural iatrogenesis which takes the form of symbolic, psychological effects on the way

persons' parts are treated as something meaningless rather than as part of their person that has to live, grow, die and be transcended. In the same vein, Chattopadhyay (2007: 265) has argued that "[t]he strength of modern Western medicine has also been its weakness, in the sense that it has achieved remarkable success in diagnosis and treatment of disease, but neglected the existential questions and spiritual issues that accompany serious illness". This shows that the issue is a global challenge.

More pragmatically, Uduigwomen (2003:175-180) identifies several limitations in Nigerian medical practice. The limitations include the following: shortage of health care givers, especially doctors, lack of medical facilities/equipment, lack of drugs, poor remuneration, lack of a sense of duty and lack of research. In addition, the Development Framework of AKS (2005:109) identifies major limitations of the AKS health care system as insufficient and poor spatial distribution of health infrastructure and facilities, limited access to public health services, and a high rate of infant, child and maternal mortality. There is also inadequate financing, which constrains the delivery of efficient health services as well as incomplete implementation and supervision of health projects, among other limitations. Therefore, from the above challenges facing the medical service in AKS/Nigeria, this study categorises the limitations of medical practice as follows: highly technological medical practice, incurability of some diseases and high mortality rate, poor infrastructure, poor remuneration, fake and substandard drugs and/or non-availability of drugs, shortage of medical professionals and lack of a sense of duty.

a) High-techonology medical practice

In the contemporary world high-technology medicine is almost displacing the human dignity of patients. It tends to place heavier emphasis on the status of the machinery and disease rather than the patients and their human dignity. Louw (2008), for instance, laments that in the past hospitals used to be a safe place for the sick and suffering. Such distressed persons received an abundance of compassion, care and attention from medical personnel. Presently it has become a nightmare (Louw, 2008: 209). In a related view, Schiedermayer also remarks: "Field studies of physicians' behavior in the intensive care unit (ICU) reveal a focus on laboratory evaluation rather than on patients, a lack of expression of personal feelings, and an excessive dependence on invasive technology" (Schiedermayer, 1994: 69). This is the bane of medical practice in AKS. Professional medical personnel will have to learn to provide comfort alongside technology. This approach tends to subject and reduce all illness to the level of its pharmaceutical treatments. It also breeds and sustains the incurability of some

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sickness/diseases and eventual high mortality rates, especially for ailments of which the roots transcend the natural or scientific categories.

b) Incurability of disease and high mortality rate

Contemporary medicine and its practices are still limited in the treatment of some diseases, particularly those of which the causes transcend science. Medicine, as Callahan remarks, is yet to rediscover "ways of dealing with more than a fraction of the whole range of physical disease; campaigns, after all, are being mounted against cancer, [HIV and AIDS] and heart disease" (Callahan, 1998:256). Callahan argues that "people will continue to die of diseases for a long time to come, probably forever" (Callahan, 1998:256). Therefore the National Policy on Public Private Partnership for Health in Nigeria (2005) decries the deplorable national health profile as evidenced by high infant and maternal mortality rates and low life expectancy in Nigeria generally. Thus AKS has identified high mortality of infants, children and mothers in their health facility as a particular challenge for health care in the state. This challenge, as Ukpe (2007:4) has argued, is partially the result of inadequate or complete lack of well-equipped health facilities in the area.

c) Poor infrastructure

The Draft National Health Equipment Policy for Nigeria (2005:6) states that the state of medical devices in Nigeria, including at all teaching and specialist hospitals, raises problems such as lack of competent maintenance, and obsolete and broken-down equipment. Therefore infrastructure constitutes the bane of health care delivery in AKS in particular and Nigeria in general as well other underdeveloped and developing nations. As already stated in the previous section, health care facilities remain inadequate. Health infrastructure remains insufficient and unevenly distributed. This is evident in the majority of the general hospitals, including the only teaching hospital being situated in the city. The 90% of the people who live in the villages have difficulties accessing the facilities because of the poor road network. Most of the clinics' infrastructure in the villages, such as buildings, beds, and equipment, is in very poor condition. This is as a result of poor financing (Development Framework of AKS, 2005:109; Ukpe 2007:4). The poor financing would inadvertently affect the health staff, who may seek other ways to make ends meet.

d) Inordinate ambition of health workers

There is a common saying in some indigenous societies that contemporary medical personnel have a special love for gold. This view can help to shed light on some aspects of the Nigerian medical system. Some of the clinics in AKS and Nigeria generally are established for financial gain rather than concern for the suffering. According to Uduigwomen (2003:179),

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"most of our medical staff are now more concerned with material wealth than the well-being of our patients. Some shuttle between the governments hospitals in which they are permanent staff and their private clinic(s). Some promptly issue medical certificates to 'healthy patients' on production of some cash…" This ought not to be. Schiedermayer, citing Hippocrates, remarks that for doctors, as for pastors and all who devote their lives to the service of others, "no fee, not even a large one, is adequate for the physician, but it is with God Almighty that his remuneration rests – and what he may receive should be reckoned as a gift, a present" (Schiedermayer, 1994: 142). Furthermore, some medical personnel, being driven by the desire to make it at all costs, create an enabling environment for fake and substandard drugs to flourish in Nigeria.

e) Fake and sub-standard drugs and the non-availability of drugs

Fake and substandard drugs have become a global phenomenon as they are found in almost all countries of the world, although some countries are more affected than others (Akunyili, 2004: 21). A fake drug, according to the World Health Organisation's (WHO) definition, is "one, which is deliberately and fraudulently mislabelled with respect to identity and/or source". The NAFDAC identifies various forms of fake and sub-standard drugs *inter alia*:

- Drugs with no active ingredient;
- Drugs with insufficient active ingredient;
- Drugs with active ingredients different from what is stated on the package;
- Drugs without full name and address of the manufacturers;
- Expired drugs or drugs without expiry date or expired and with the intention of extending their shelf life (Akunyili, 2004: 21).

The impact and implications of fake and sub-standard drugs range from poor prognosis, drug resistance to death in severe cases. For instance, deaths that are related to fake drugs abound, but because of a poor reporting system few of these cases are reported and thus there are few statistics to support them. Some of these few cases include the 1999 "paracetamol syrup disaster" which claimed 109 lives at Ibadan and Jos (Akunyili, 2004: 22). On 27 November 2007 *This Day* newspaper reported the death of 25 children at different locations of the country resulting from consumption of a contaminated drug (My Pikin Teething Mixture) (www.allafrica.com/stories/200811270357.html.).

Besides the issue of fake and sub-standard drugs is the challenge of non-availability of drugs in many Nigerian hospitals, which "has given birth to the now accepted societal syndrome of 'out of stock (OS)" (Uduigwomen, 2003:177). Such non-availability of drugs exposes

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patients to the risk of purchasing sub-standard drugs from unreliable sources. These conditions are fuelled by some factors such as irrational use of drugs, corruption and conflicts of interest, insecure and unfriendly environments as well as shortage of medical professionals.

f) Shortage of medical professionals

Uduigwuomen (2003:176) identifies the shortage of manpower as one of the gravest limitations facing the Nigerian medical profession, which also applies to AKS. Health care ranks top of the list of many Nigerians' crucial needs. However, this concern is inadequately met, as they do not get the desired attention from the health services because of the shortage of medical professionals. It is a common sight in many Nigerian hospitals to see long queues and patients spending the whole day in out-patient departments to be attended to for a maximum of 15 minutes. This is the result of so few professionals being available to treat patients. In some instances, one physician and nurse may attend to 500 patients waiting to receive medical attention. Those who cannot bear the frustration of waiting a whole day have to resort to private services, which are exorbitantly expensive and often beyond the reach of poor citizens. This situation has also contributed to the challenge of limited access to public service as is identified by the AKS government (The Development Framework of AKS, 2005:109).

g) Poor remuneration and lack of a sense of duty

The shortage of manpower invariably leads to poor-quality service as many medical professionals work under stressful conditions as a result of work overload or poor/non-payment of salaries. High-quality service demands that patients' health care professionals understand and respond to patients' needs, attitude and concerns. However, Uduigwomen (2003:179) remarks that in Nigeria "it is not uncommon to see medical practitioners treat patients with all amounts of indifference and reckless abandon". According to Uzochukwu and Onwujekwe (2005:4), the non-payment of the health care staff salaries de-motivates and demoralises them with result that they experience themselves as being rude, unfair and inattentive to the patient. In their research a health care worker's confession reflected on this matter: "The non-payment of salaries does not really allow us to think of our patients as we should, although we do not deserve the kind of embarrassing reward for all our efforts considering our quality and quantity of work". Consequently, patients have to bear the brunt of the transference of negative emotions and attitudes of some of these medical practitioners, in which case their emotional and spiritual needs are often neglected. Poor remuneration also

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breeds non-commitment to duty, which in turn affects the motivation of the health professionals to embark on research.

h) Lack of Research
Uduigwomen (2003:178) laments the scarcity of research in the field of medicine. Uduigwuomen argues that medical practitioners in Nigeria are often at the receiving end of medical theories and practices that originated in and researched for the Western context, without attempts to contextualise such theories and practices. However, in recent years Uneke, Ezeoha, Ndukwe, Oyibo and Onwe (2010: 110-126) have argued that health policy research is a new phenomenon (initiated in 2008) which is presently taking place in two states of the federation – Bauchi and Cross River state. Furthermore, such research takes place only at the tertiary health institutions, i.e. the teaching hospitals (Uneke et al., 2010:113). According to Uneke et al. (2010:111), evidence from research has the potential to generate reliable findings that can assist in informing health policy development. They also argue that factors that have been militating against sound health policies and system research are poor incentives for health staff and researchers by government, poor budgetary allocations for research, and the communication gap and poor networking between the policy makers and researchers (Uneke, 2010:110). In addition to the above mentioned limitations as identified by the medical scholars and government policy documents, this study identifies the non-inclusion of the religious components into the medical model (Inyang, 1994:230) as a grave limitation of medical practice as it denies the care seekers their human dignity. Given these limitations of medical practice in AKS, there is need to shift the paradigm of health care delivery towards a multidimensional collaborative approach which should include the services of the religious and spiritual care.

2.7 Conclusion

This chapter addressed the descriptive empirical task of practical theological interpretation, as described by Osmer (2008). It focused on what is going on in the AKS as regard health and health care. It noted that, although AKS is one of the fast growing states in Nigeria, it is also struggling with poverty, sickness and crises of identity. The tough times are causing Nigerians, including the Ibibios, to re-evaluate their roots and find significant ways of responding to their search for meaning, wholeness and purpose. Examining the historical context of AKS revealed that sickness is keeping more and more Ibibio/Nigerians in poverty just as poverty creates favourable conditions for diseases such as malaria, cholera, HIV and AIDS etc., revealing a poverty-sickness nexus. It further discovered that the challenge of

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sickness and health care is influenced by Ibibio cultural and religious traditions as well as the broader political and economic realities (2.2).

Therefore, this chapter argued that understanding the Ibibio background implies understanding their worldview. The Ibibio worldview implies their understanding of life and their understanding of life entails a search for meaning, and a search for meaning is a search for identity. Embedded in their search for meaning are cultural values and beliefs which constitute strong factors in their perception of illness and the healing approach. Therefore, the Ibibio religio-cultural worldview of life was explored, beginning with a consideration of their self-understanding, their environment and relationships in times of sickness and health. It noted that the Ibibio understanding of their personhood stems from at least three perspectives: religious morality, community and personality (body and spirit/soul). It indicates that the Ibibio hold a holistic view of the human person. This holistic personhood is also intrinsically connected with their God concept, without which such understanding will be incomplete. Thus at the core of the Ibibio understanding of who they are and their relationship with God is a quest for a God concept that holds meaning for them. What this means is that the patient's image of God is an essential part of their recovery process. Therefore the Nigerian patient's search for wellbeing is also a search for God, who can be trusted to be pragmatically concerned about their wellbeing. Thus, the Ibibio context indicates a worldview that implies a holistic cosmological understanding of the material and spiritual world (2.3).

The chapter consequently explored the concept of wholeness and health as well as sickness and healing from an Ibibio cultural perspective and indicates how the religious worldview of the Ibibio impacts on their understanding of health and health care. It revealed that the Ibibio concept of wholeness and health has a social, psychological, existential, pragmatic, medical and physical dimension. Above all it involves a spiritual dimension which involves a sound relationship with God (2.4). On the other hand, sickness was indicated to be understood in terms of the natural supernatural and personal category (2.5). Given this holistic understanding of wholeness, health and sickness, this chapter, in seeking further verification of "what is going on", went on to analyse the healing traditions in both traditional and contemporary Ibibio society.

This study's analysis of the three healing traditions in contemporary Akwa Ibom State – traditional healing, faith healing and medical care – has revealed that Ibibios, like many Nigerians, choose any of them based on availability and the perceived cause of affliction, and sometimes use all three healing traditions eclectically (2.6). Most of the healing methods are

not practised in fixed categories but were dynamic and developed in distinctive ways under the influence of the changing social, cultural and religious context. In this light, the African traditional healers and religious faith healers, as this study discovered, attempt to incorporate the Ibibio cultural values and beliefs into their healing approach. Therefore their approach attempts to address the whole person according to the Ibibios' understandings of personhood.

On the other hand, the analysis of the modern medical system revealed the adoption of a mainly biomedical model, which was very limited. An examination of the Akwa Ibom State modern medical system through its structure, policies, goals and limitations revealed an inadequate, low-quality and less than satisfactory system that is hardly able to cater for the health needs of its people (2.6.3). This situation has arisen despite the technological advancement in medicine and the good efforts of the government. However, a major limitation was a negligible or complete absence of pastoral care. The absence of significant pastoral caregiving in the hospital care system in contemporary Akwa Ibom State, as in many Nigerian hospitals, has a negative impact on the Akwa Ibom State health care delivery system, in the sense that it does not significantly take care of the religious/spiritual and sometimes cultural background and aspirations of the patients. However, the multiple aetiologies of sickness and human suffering as perceived by the Ibibios imply different methods of enacting healing based on perceived causes. It reveals that combating sickness is a complex exercise that may require a collaborative effort and all resources necessary within a holistic framework that are available in Nigeria. This assumed collaborative effort would necessarily include religious experts as represented by PCG in order to be termed holistic.

Therefore, this chapter has revealed that the Ibibio, as typical Africans, cannot let go of their spirituality and religiosity in the face of technological advancements in medicine and in other fields. They will therefore unfailingly seek for spiritual and religious answers in times of crisis. Kalu (2010c:59) has rightly remarked that "[r]eligions have always forced people to re-examine their spiritual roots"; therefore "Religions are supposed to serve as balm in different times and answer ontic questions about existence". Religion and spirituality play a huge role and could contribute significantly to health care, especially when a cure is not possible and people question the meaning of life. Implicit in the discovery of limitedness or absence of religious and spiritual care is the question: Can Pastoral Care adequately attends to the religious and spiritual needs of Nigerian patients as part of holistic hospital care? Given the hypothesis that PCGs can contribute to the quality of health care and patient satisfaction in Nigerian hospitals, the question will be investigated through the exploration of the

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meaning and nature of Pastoral Care as a theory that guides the practice of PCGs. This will be our focus in the next chapter.

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CHAPTER THREE

THE MEANING AND NATURE OF PASTORAL CARE

3.1 Introduction

This chapter focuses on the theology and distinctive nature of Pastoral Care. It is guided by the fact that the National Policy on Public Private Partnership for Health in Nigeria (NPPPPHN) (2005) states that "alternative health providers whose practices are of proven value, shall be encouraged and supported as the frontline of health care provision for many people". However, in the previous chapter the context of the Nigerian society and healthcare system with reference to Akwa Ibom State was explored in order to reflect the Nigerian approaches to health care from the Ibibio perspective. From this exploration it was evident that the Ibibios, like other Nigerians and Africans, have a holistic approach to sickness and to the realisation of wholeness, as embodied by the traditional and religious caregivers. It also revealed that religion and spirituality are means through which Nigerians and Ibibios in particular negotiate their significance, identity and purpose daily. In this light religious beliefs and values were seen as an integral part of Nigerian spirituality that also controlled their illness-health behaviour. These religious beliefs, practices and values are pointers to some theological reflections that unavoidably accompany such beliefs, values and spirituality. Consequently, the Akwa Ibom State modern healthcare system was analysed and the conclusion was reached that the concept and practice of healthcare as guided by the medical model is not only limited in terms of the provision of healthcare to majority of Nigerians in the Ibibio context, but is also lacking in the fundamental spiritual and religious dimensions of care. It further down plays the significance of this to many Ibibio/Nigerians in healing. Also, the religious/spiritual care through the church, mosque or ATR as discussed in Chapter Two may have limitations in meeting the spiritual needs of patients in the hospital. Therefore this study contends that the religious and spiritual needs of patients in the hospital could be professionally and adequately addressed through Pastoral Care.

This chapter consequently seeks to explore the theories of Pastoral Care with regard to healthcare in the hospital context. The purpose of the exploration of theories, practices and methods is to provide an understanding of the development of Pastoral Care as it constructs and reconstructs its identity. Such an understanding could assist in the appreciation of religious opportunities embodied in Pastoral Care for multidisciplinary practice for holistic

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and quality healthcare. Thus the chapter will provide an awareness of the religious and spiritual model of healthcare from the perspective of Pastoral Care. Hence, the discussion on the meaning and nature of pastoral care will be underpinned in the first instance by an overview of Pastoral Care by exploring its understandings and praxis. Praxis as conceptualised in 1.8.6 refers to Pastoral Care practice by their beliefs and values as informed by intentions, attitude and aptitude which have consequences for life and the quality of care given in times of sickness. Such awareness will be revealed by an overview of Pastoral Care. It also aims to delineate the meaning and understanding of Pastoral Care as understood by pastoral theologians across contexts. The assumption of this study is that a single meaning is neither possible nor appropriate in a pluralistic context of beliefs and cultures. Osmer (2008:83) states that there is "no one perspective to capture the fullness of truth … often many perspectives are needed to understand complex and multidimensional phenomena". The study opens up the possibility of PCGs engaging in the hospital context as post-foundational methodology allows beliefs to be explored across disciplines and contexts, as well as social and cultural categories as the common grounds (cf. I.6.2).

In the second instance the chapter will attend to paradigm shifts in Pastoral Care. Pastoral Care identity as implied in 1.6 is dynamic as a discipline in terms of its forms of practice; its theories (as embedded in perspectives, beliefs, and values), role and practice therefore differ from context to context and in concert with societal and changing needs of the care seekers. Such changes of Pastoral Care role identity,[44] which are by no means simple and easy to capture, will be investigated through the lens of paradigm shifts in Pastoral Care. This is underpinned by the fact that achieving quality healthcare – which is one of the objectives of this study – is to constantly reflect on the quality of care rendered. Such reflections should demonstrate reasonable, effective and substantively responsible practice that is sensible to the care seeker's needs (1.8.3). Paradigm shifts become a useful means of examining such changes and reconstruction of Pastoral Care praxis which impinge on role identity.

Thirdly, quality healthcare also suggests that there should be a baseline assessment for good practice. In this regard, exploring the meaning and nature of Pastoral Care will also take into consideration the basic elements of good Pastoral Care practice. The plurality of definitions and meanings of Pastoral Care does not mean that Pastoral Care falls into some form of

[44] See 4.2 for definitions of identity and roles as they have been discussed from the social and anthropological perspective of role theory.

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relativistic nihilism, where every kind of care is Pastoral Care and consequently it relates to no care at all. Thus the next section will attend to essential elements in Pastoral Care

In the fourth instance, Pastoral Care is presumed to be a unique approach to healthcare that could contribute to the quality of hospital care. Such uniqueness this study assumes is to be located in the foundation, goals and functions of Pastoral Care within a defined context (space or place) (cf. 1.8.6). These unique (i.e. foundational) values influence Pastoral Care theories, method and practices as evident in the various models. The models provide a lens to viewing the richness of the practices of Pastoral Care generally that can be applied within the healthcare context in particular. Thus this study will attend to the uniqueness of Pastoral Care from the perspective of its foundation, contexts, models, goal and function. Finally, the possibility of Pastoral Care as holistic care is explored, not in the sense that Pastoral Care alone can attend to all the needs of Ibibio/Nigerians, but in the sense of attending to the whole person.

In pursuing the concerns of this study, this chapter will engage the interpretive tasks of drawing from the theories and practices of Pastoral Care to aid the understanding of the resources of Pastoral Care that may be useful in the mediation of spiritual and religious care in the Nigerian hospital context. It adopts Osmer's (2008:12) interpretive task of Practical Theology in line with a post-foundationalist framework as presented in Chapter 1.6. An overview of Pastoral Care will first be provided.

3.2 Pastoral Care - an overview

Calvert (2009:267), Lartey (2002:22), Louw (2004:21) and Benner (1998:23-25) argue that Pastoral Care has often been erroneously associated with that aspect of ministry exclusively carried out by the representatives (mostly pastors) of the Christian church. According to these scholars, Pastoral Care is not an exclusive term that belongs to the domain of the church. Likewise the term "pastoral" does not necessarily refer to pastors or the work of pastors; although they have been used extensively by the church, they have also been used in other areas such as education traditions, cultures and religions like Judaism and Islam. In the case of Islam, Johnson (2001:40-41), Isgandorova (2005:85) and Gilliat-Ray (2010:145) argue that that there is no clergy in Islam because Islam's religious specialists exercise no sacramental and/or priestly functions. Pastoral Care therefore rests on the shoulders of family members and also depended on the interpersonal relationship with the Imam. But using the Imam as an equivalent of pastor or chaplain (PCG) is strongly rejected by Isgandorova (2005:85), who

observes that the Imam belongs to the male folk as a woman cannot be an Imam. As such she suggests that the correct word should be *ruhani khadim* (spiritual caregiver). These arguments are in the spirit of this study, which agrees with the broadening of the concept of Pastoral Care beyond the work done by ordained pastors in the case of Christianity or Imams as it relates to Islam, to include those who might not be ordained but who work within their community of faith, and are directed and motivated to carry out such functions. It should be noted at this point that Pastoral Care in Islam is not well developed theologically in Eurocentric literature as in Christianity, though it is not absent (Gilliat-Ray, 2010: 145). Similarly ATR as a religion without a book is infused into the Christian and Islamic practices of care as many ATR practitioners adherent either of Islam or Christianity.

The proverbial story of the six blind men who describe an elephant in some way reflects the multifaceted nature of Pastoral Care. Since these blind men could not see, they could rely only on their sense of touch of the elephant and based their imaginative conclusions based their experiences. They each touched a different part of the elephant. One touched the ear and concluded, “The elephant is like a fan”. The other touched the leg and concluded that the elephant is like a stick. Still the other touched the trunk and concluded that the elephant is like a fat man. Yet another touched the tusk and concluded that the elephant is like a long wooden cup. They all had differing opinions of what they thought the elephant looks like, based on the part each person touched. They could all vow that this is what an elephant looks like and their description was the authentic one. However, their understanding was only a part of the whole. The truth is all of them had one perspective on the elephant and not a comprehensive understanding; not even their combined experiences could be said to be comprehensive enough, because there were parts of the elephant that none of them touched like the eyes. Pastoral Care could be said to be like this “proverbial elephant” and those who engage in it “blind men”.

The above illustration demonstrates that Pastoral Care has a complex character by virtue of its being associated with the concern of human beings for one another and an attempt to respond to their needs (Gerkin, 1996: 21-22). Hawkes (1991:52) observes that Pastoral Care is concerned with human life, human behaviour and human experience. The complex character of Pastoral Care is further evident in the different definitions and understanding as perceived by different groups, cultures and ideologies of people who are engaged in it, especially as they are challenged by postmodern influences (Hawkes, 1991:53; Ramsey, 2004:12). Such definitions and understanding are based on the lived experiences, norms and

values of each person (Louw, 2008: 268-269). What this means is that individuals' understanding of what it means to be human and what they perceive to be the appropriate behaviour, motivation and quality of life as well as their personal stories, their relationship with and their understanding of God's involvement with humans will influence their definition. These categories are dynamic and in constant change. What seemed to have been an accepted approach and elicited meaning in time becomes inappropriate as people acquire more insight into and knowledge of the human condition. For instance, Campbell (1981:13) has observed that the priestly authority which people accepted in the past is now viewed as paternalistic and judgmental, and hence they "want a style which acknowledges the ambiguity of every care we offer in a situation of mutual responsibility and mutual need". Ramsey (2004: 6) refers to "critical post-modernity sensibilities" in describing this situation in which the postmodern human values, human rights and justice clash with the pre-modern claims of authority of religious traditions, both competing for authenticity in Pastoral Care and theology. With particular reference to Pastoral Care and counselling in Africa, Berinyuu (1989:1) observes that the difficulty in defining Pastoral Care is because of its multipurpose and multidimensional nature. Consequently, Pastoral Care is a dynamic concept that is in constant engagement with and reflected on these concerned groups as they strive for new and better ways of expressing their intrinsic qualities as their ethical responsibility to their fellow human beings.

The plethora of works on Pastoral Care such as *Rediscovering Pastoral Care*, by Alastair Campbell (1981), *What is Pastoral about Pastoral Counseling. Reconstructing Pastoral Theology*, *Theology and Pastoral Counseling: A New Interdisciplinary Approach* by Deborah Hungsinger (1985) and many other works by various scholars are all pointers to the dynamism of Pastoral Care and the conscious efforts of pastoral caregivers to articulate what they do on the basis of their understanding and practice of Pastoral Care. In essence, the definitions are neither uniform nor final, but are still ongoing and will still undergo definition and redefinition until the end of time. Thus, the observation of many theologians that Pastoral Care expresses what it is to be human is very significant and a good point to keep in mind. Humans are assumed to be complex and constantly in a state of change and transformation. This places them within a continuous process of understanding themselves as persons. Fowler (1995:4) captures the nature of Pastoral Care succinctly when he argues that Practical Theology (an aspect of Pastoral Care)

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> is a critical and constructive reflection by communities of faith carried on consistently in the contexts of their praxis, drawing on their interpretations of the normative sources from scriptures and traditions in response to their interpretations of the emergent challenges and situations they face, and leading to ongoing modifications and transformations of their practices in order to be more adequately responsive to their interpretations of the shape of God's call to partnership.
>
> (Fowler, 1995:4)

However, Pastoral Care was grounded mostly in the Western and Judeo-Christian understanding of healthcare until the 1970s, when it started incorporating diverse faith perspectives (Johnson, 2001:40-41; Gilliat-Ray, 2010:145). Therefore, the understanding of Pastoral Care has always been embedded in the Christian understanding known as the cure of souls (Johnson, 2001:40-41; Anderson, 2003:14). The Hebrew *nephesh* and the Greek *psyche*, which are often translated as 'soul', is understood by scholars of African, Judeo-Christian and Islamic traditions as a person's whole self. It embodies a wholesome personality and engagement with life which includes the spiritual, ethical and social dimensions (Igenosa, 1994:128; Johnson, 2001:39; Louw, 2005:15-17). 'Cure', on the other hand, suggests an action that is intended to restore a lost wellbeing.

There is an increasing interest among theologians in distinguishing 'cure' from 'care'. Anderson warns that to understand Pastoral Care as cure rather than care could prove to be dangerous. It is in this light that he asserts that "to speak of curing rather than caring can be not only presumptuous but also dangerous. One can all too easily think of some purported cures which have been far more destructive, even demonic, than the original state" (Anderson, 2003:14). Although Anderson is rather extreme in his criticism of Pastoral Care as cure, there may still be some value in his view in the sense that cure will not always be possible in all situations. An amputee, for instance, can never recover his/her limbs, and AIDS, cancer etc. have no cure, but they can be given loving care. Koopman (2006:38) therefore argues that care does not exclude the search for cure. His vision of care embodies being present to those in sickness, brokenness and suffering as well as taking the risk to address forms of evil and the restoration of justice. His understanding of care is also similar to Rassool's (2000:1481) Islamic understanding of caring. Similarly, care and cure have also received attention in the nursing literature (cf. Younger, 2001:328). For Koopman (2006:38) caring is healing. He contends that caring as healing might help the suffering person to experience health as the strength for human life, the strength to live a life of humanness, dignity, worth, value, wholeness and shalom. He further argues that caring leads to healing, which does not necessarily mean curing an ailment but a restoration of the whole that

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connects with the spiritual dimension (Koopman, 2006:40). It could be argued that Koopman's attempt at connecting caring and healing is an implicit identification with both the physical/human dimension and the spiritual dimension involved in Pastoral Care. To care implies the being and the doing component. Koopman's argument points in the direction of this study. Care is not cure, although in its comprehensive consideration care should include cure where possible. Care and cure could therefore be held in creative tension as this has consequences for Pastoral Care for the sick in the Nigerian hospital context.

From the Islamic perspective, Rassool's (2000: 1481) view of caring is also in agreement with that of Koopman. Johnson (2001:41) also states that Pastoral Care has a similar history in Islam, being understood as divinely inspired, as people who engage in it receive divine blessings. He further implies that Pastoral Care stems from the understanding that care is a service to God. This caring is expressed in intentions, thoughts and actions (Rassool, 2000:1481). According to Rassool (2000:1481), caring "means the will to be responsible, sensitive, concerned with the motivation and commitment to act in the right order to achieve perfection". This motivation for caring, he asserts, can be received by studying the attributes of Allah. Caring for Rassool is a natural outcome of having a love for Allah and the prophet, which means caring lovingly and compassionately for the weak and suffering of the society. Rassool (2000:1484) thus argues that the concept of caring is embedded in the theological framework of Islam as a caring and comprehensive belief system. Wuruta (1995:20) also argues from the African Christian perspective that all ways and means to achieve human restoration to wholeness and wellbeing come from God, the ultimate giver and sustainer of life. Pastoral Care can thus be perceived as the communication of God's love in ways that can assist patients to realise the meaning and purpose of their existence in their daily living. Consequently, Louw (2004:8, 2012:15-19) contends that Pastoral Care is a theological discipline and its unique identity should be sought in the God-human relationship.

However, it might be tempting to conclude that Pastoral Care is just about care and cure. This is not the case in all instances. McClure (2008:189-210) brings another perspective to the understanding of Pastoral Care and argues that pastoral theology should be broadened to include care of the environment and promotion of justice in view of the contextual issues that impact on individuals. Ramsay (2004:3) believes that Pastoral Care is both restorative and transformative because it includes formation, support, advocacy, preaching, liturgy, theology and ethics. These dimensions provide Pastoral Care with constructive reflective engagements.

Consequently, Pastoral Care becomes an open-ended process rather than a conclusive engagement and reflection.

Gerkin (1996:21) maintains that central to the tradition of care is the notion that Pastoral Care involves a response to human experience. In other words it is an exploration of the meaning of life in which Pastoral Care directs those who are in crisis and those who have lost a sense of the purpose and significance of their life's existence (Nauta, 2008:585). This response is not apart from God and his graceful involvement in human joys and pains. Traditionally, the imagery of the shepherd has been used by many pastoral theologians as capturing the meaning and nature of Pastoral Care (Campbell, 1981:36-45; Berinyuu, 1989:3-4; Johnson, 2001:40-41). According to McClure (2008:189), "[p]astoral theology [Pastoral Care in particular] derives its name from the image of the shepherd and can be understood as the theology [and activity] of shepherding". The metaphor[45] of the Shepherd is synonymous with the one who cares (Johnson, 2001:41). Pastoral theologians such as Purves (2004:xxvi-xxx) are not particularly satisfied with the shepherd metaphor as represented in Pastoral Care. This metaphor of the shepherd, he argues, is insufficient for Pastoral Care practice in the community of faith partly because many people have never seen a sheep. However, he agrees that it is an appropriate metaphor for the God-human relationship. Berinyuu (1989:3-4) is not oblivious of the limitation of the shepherding metaphor, but contends that it is most appropriate for Pastoral Care and counselling in Africa. Berinyuu's sentiments may be right, because as evident in 2.2.1 many Nigerian communities are still subsistence agrarian in nature, which means they are familiar with sheep and the roles of a shepherd. In addition, many Hausa Muslims, including those who reside in Ibibio land, are predominantly cattle and sheep farmers or merchants. Therefore, the shepherd metaphor connects Pastoral Care to the compassionate and loving concern of God in a way which appeals to the Christian and Muslim patient.

According to Rassool (2000:1481), the Islamic "concept of caring for the sick grew predominantly from an understanding of care as service to God, a vocation that was the fulfilment of God's covenant purpose and a freely given mutual service within society",

[45] Metaphors indicate a hermeneutical relational paradigm which connects God's purpose to human existence in real-life situations. Metaphors are linked to God images and thus attempt to convey the connection between faith and our lives. God images are symbols or metaphors which people use to relate to their relationship and understanding of God. There are a number of God images usually used by patients: loving God, father, friend, etc. The appropriateness of a patient's God images determines the patient's ability to live meaningfully with hope in the face of sickness.

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which distinguishes it from other caring as exemplified in the Prophet Muhammad. Similarly, for the Christian tradition God identifies with human suffering through the death and resurrection of Christ in his sacrificial and redeeming love for humankind. To mediate God's care to people requires some level of skills on the part of the PCG, who utilises such skills to guide, nurture, heal the wounded and bring back the lost (Berinyuu, 1989:3-4; Rassool, 2000:1481). Pastoral Care is in essence a theology rooted in the praxis of God and the participation of the community of faith in God's plan through reflection in theology, theory and the practice of care. These theological reflections are guided by the fact that Pastoral Care is dynamic and constantly seeks to reconstruct its identity as it constantly reviews its approaches to religious and spiritual care to meet the needs of the care seekers at each given time. Such identity reconstruction and review of approaches suggest an open theological method that can be incorporated into hospital care at various levels for holistic and improved quality hospital care. Paradigms become a useful framework for viewing the theology, theory and practice which underpins the identity of Pastoral Care as it responds to the changing social context.

3.3 Paradigm shifts in Pastoral Care

The field of Pastoral Care and theology is characterised by shifts in definitions, practices, methods, sources, authority and self-understanding in concert with the cultural, spiritual, political economic and global changes (Ramsey, 2004: 7) that impact on their identity. From a social scientific perspective (identity theory) Ramsey's view is explicated by Chreim, Williams and Hinnings (2007:1517) and Kram, Wasserman and Yip (2012:305), who in line with him understand identity as a natural phenomenon that professional disciplines must experience as part of their "identity work" in which values and beliefs are evaluated and retained, rejected or revised (cf. 4.2.2). Thus identity involves a continuous construction and reconstruction of theory and practice as inherent in their beliefs and values as propelled by the discipline's social context and the personal attributes of its members. The discussion on roles and identity will receive further attention in Chapter Four. The focus of this chapter is on the nature of Pastoral Care; Louw (1998:13), Ramsey (2004: 7) and others are of the opinion that these changes in Pastoral Care are most prominent in paradigms. Therefore, paradigm shifts provide a useful framework for this chapter's exploration of the theoretical conception of the meaning and nature of Pastoral Care in the institutional context of the hospital.

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A paradigm is a dynamic concept. According to Bosch (1991:185), it is a slippery concept which different scholars use differently. Thomas Kuhn (in Bosch, 1991:185) defines a paradigm as "the entire constellation of beliefs, values, and techniques and so on shared by members of a given community". Whereas Hans Kung refers to paradigms as "models of interpretations", T. F. Torrance (in Bosch, 1991:185) prefers to call them "frames of knowledge". In Burton's (1988:9) view, a paradigm is "a theoretical and working model of a world view according to which a person, group or institution understands and operates in a normative way". Although Ramsey never gives a definition of a paradigm, Burton's perception of paradigms seems to be implicit in her writing. This study aligns itself with Louw's (1998:13) understanding of paradigms as a dynamic concept which is subject to shifts as informed by cultural, spiritual, political, economic and global changes for the purpose of making a particular concept meaningful to the context in which it serves.

The idea of a paradigm shift was first employed by the philosopher Kuhn and adopted into theology by Kung (Bosch, 1991:183). Bosch applies it to the area of missions. In utilising paradigms in theology, Bosch (1991:186) warns that the use of paradigms in theology should not be regarded as definite and irreversible in the same way as paradigms in the natural sciences where the new replaces the old. "In theology … old paradigms can live on. Sometimes one may even have a revival of a former, almost forgotten paradigm." Bosch's statement is valid for our discussion. What this means is that paradigms need not be taken as absolutes and linear in each timeline. Elements of all three paradigms that will be discussed in this study could be present in one particular paradigm, although it may not be the primary focus. Burton's (1988:9) pastoral paradigm is theoretical and narrowed in its application to pastoral care practices of the ministry in congregations, which is not the focus of this study. Whereas Burton's Pastoral Care paradigm is important to Pastoral Care, it does not apply to this study, which concern itself with Pastoral Care within the hospital context. John Patton (1993), however, applies paradigms to Pastoral Care and theology in a sustained way, which Ramsey (2004:1-44) and McClure (2012:275-276) and many others also employ to discuss the changes in modern Pastoral Care. Patton identifies three great paradigms for interpreting the changes in Pastoral Care; *the classical*, *the clinical pastoral* and *the communal contextual* paradigms. Patton's three paradigms are not entirely new, what is new[46] is his attempt to

[46] Patton borrows from Peter Hodgeson's classification of the changes in Christian theology (classical, modern and postmodern) to construct his paradigms. The terms classical and clinical Pastoral have been utilised by many pastoral theologians in the literature such as Thomas Oden (1984) and the *Dictionary of Pasdtoral Care and Counselling*. The term clinical pastoral is not Patton's invention.

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apply these paradigms to Pastoral Care comprehensively.[47] Patton's paradigms provide a simplified structure for this study to discuss the complex changes that have occurred in Pastoral Care. It assumes that the ministry of Pastoral Care and the changes that have taken place therein can be related to these three paradigms namely: the classical, the clinical pastoral and the communal contextual paradigms of Pastoral Care. This study also adopts these three Pastoral Care paradigms because it appears that much literature related to Pastoral Care and theology make use of at least one of these three paradigms (or traditions, as some scholars prefer to call them).

The notion of a paradigm shift has a direct bearing on this study because in professional disciplines such as Pastoral Care and theology strongly institutionalised beliefs and values define professionalism, which impacts on their professional definitions of role function and practices. It is worth noting that professional Pastoral Care has been dominated and influenced by Christianity; however, in recent years other faiths such as Islam have started to make their presence felt in pastoral literature (e.g. Van Buuren, Kaya and ten Broek, 2009:291-305). But this study focuses more on Christianity than other religions. A discussion on the paradigms will commence with the classical paradigm.

3.3.1 Classical paradigm

The classical paradigm is considered by some in the pastoral literature to expend from the beginnings of the Christian era to the middle of the 20th century (Oden, 1984). According to Patton (1993:4), the classical paradigm "extends from the beginning of Christendom beyond the Reformation to the advent of modern psychology's impact on ministry". Therefore Pastoral Care in the classical paradigm is understood to be a practice mainly within a homogenous context of the church for the Christian tradition or the mosque in Islamic tradition. The hospitals were mainly a place of evangelism for lost souls. Thus McClure (2012:273) asserts that Pastoral Care during this period emphasised sin as the cause of all human problems. Therefore the role of pastoral care focused on the reconciliation of sinners to God. The mode was preaching and the sacraments. The content of the message was confession, repentance, forgiveness and reconciliation (McClure, 2012:271-272). These tasks (preaching and sacraments) placed Pastoral Care primarily as the function of ordained clergy

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[47] Lartey later adds the intercultural paradigm, which may be considered as a forth paradigm, but which is very similar to Patton's communal contextual paradigm. Other paradigms within the wider field of practical paradigm such as the "clerical paradigm" and the "academic paradigm" (Miller-McLemore, 2007:19-37) are worthy of note; however, this research limits its focus to the paradigms prevalent in the practice of Pastoral Care to the sick, suffering and challenged individuals in the hospital.

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to be practised within the confines of the church, as in Christianity. There was emphasis on seminary training and ordination as a prerequisite for the practice of Pastoral Care (Townsend, 2009). In consequence, there is emphasis on the message of Jesus Christ as the incarnate word of God. The major pastoral theologians within this paradigm are the Church fathers, Thomas Oden (1984), Jay Adams (1976) and Andrew Purves (2004). Oden (1984: 24) and Adams (1976:75) believe that within the classical paradigm lies the distinctive character and identity of Pastoral Care because of the centrality of Scripture and prayer in the paradigm. Adams (1976) considered the influence of psychology and psychiatric resources as negative and unhealthy influences on the theory and practice of Pastoral Care and counselling.

Similarly, Purves (2004: 22) asserts that "[t]here is no faithful content to speaking forth and living out the gospel pastorally apart from knowing and sharing in the mission of God who acts in and through Jesus Christ and the Spirit precisely in and as a man for all people". Consequently, the major distinction between the classical paradigm and other paradigms of Pastoral Care could be located in its emphasis on the theological content, Scripture and biblical message (kerygma). According to Polhill (1997:626), kerygma refers to an act of proclamation of a message or the message being proclaimed. It demonstrates both the act and the content of proclamation (Friedrich III, 1985:435). The content of kerygma was Christ crucified, the word of faith, messiah, the son of God and the kingdom of God. Polhill (1997:626), however, argues that the content of the kerygma differed according to context. He identifies six components of kerygma, which he draws from Dodd. Nevertheless, Polhill (1997:626) summarises the content into three basic elements, which include Christ, scriptural proof and exhortation to repentance. He further argues that although the content of preaching (such as salvation in Christ, Scripture and exhortation to repentance) varied in the early Christian usage, the gospel of Jesus Christ was central to the content of the message being proclaimed or taught. Related to kerygma is *didache* (teaching). Scholars such as Dodd argue that *didache* was distinct from kerygma in that *didache* was an ethical teaching carried out subsequent to the believer's response to the kerygmatic message. This meant that the major focus of pastoral care was teaching and preaching. However, Polhill maintains that there was no such distinct category, but that kerygma (preaching or proclamation) and *didache* were regarded together (Polhill, 1997:627-628).

The kerygmatic approach of the classical Pastoral Care paradigm presupposes that sin is the core of human suffering. Gerkin (1996: 31) consequently identifies *metanoia* (repentance)

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and *exomologesis* (confession) within *koinonia* (faith community) as the dominant model of Pastoral Care. Gerkin (1996:24) claims that Pastoral Care in this tradition (the classical paradigm) communicated God's care to God's people in the richness of ritual practices as well as the biblical wisdom tradition in wise counsel and guidance. Therefore, as Gerkin observes, the classical paradigm also gives attention to counselling, although preaching was the main focus. This meant that the biblical message or text is central to pastoral engagement for the purpose rather than the human condition. Adams (1976:65) has also stated that in the classical paradigm of Pastoral Care "any counselling worthy of the name Christian must include a place for evangelism". Purves (2004: 162) also states that Pastoral Care "can be concerned with nothing else than the proclamation of forgiveness and the sanctification of man for man [sic]". Adams and Purves have argued that in the classical paradigm Pastoral Care was mainly carried out in the context of the congregation. Whereas this understanding and practice were relevant and effective within the context of Pastoral Care in the faith community, it raises a question of how effective and appropriate it would be in a space outside the homogenous community of faith such as the hospital. What in effect will be the role of Pastoral Care practice of preaching, evangelism, repentance, forgiveness and reconciliation in the hospital? Thus the shifting of Pastoral Care from congregation to hospital demands a revision of the practice.

Good Pastoral Care practice is that which encourages persons and communities to acknowledge their fallenness and take responsibilities for wrong actions (especially if they are guilty), seek forgiveness and reconciliation to the relationships affected as a regular or even daily practice. But when sin is stressed in the situation of illness and other sufferings, the issue becomes more complicated. It reveals the tendency of the classical approach to degenerate into what Louw (1998:26) calls a "homiletical event", which presupposes that the problem always lies in the care seeker. In other words, all sufferings are assumed to be as a result of sin. Stone (1996:39) contends that although Pastoral Care must retain its kerygmatic element, there is danger of relating all human problems to a sinful nature. Thus a simplistic answer to a complex problem which borders on the human quest for meaning in a situation of intense suffering raises a question about the effectiveness of such a theological theory that guides Pastoral Care in contemporary practice. Hence the classical paradigm is called into question by some theologians such as Louw (1998:26) and Berinyuu (1989). These theologians believe that such a theology (that underpins the classical paradigm) is victim blaming, stigmatising, discriminating and isolating. The African understanding of human

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beings (2.3.1) challenges such a reductionist stance. It leaves a lot to be desired when placed in a concrete situation and context such as Nigeria, where conflicts resulting from unwholesome proselytising leave innocent people dead and the more lucky ones finding themselves in the hospital. It offers no consolation either for the Ibibio patient, whose religious worldview is embedded in causality, in which the experience of sickness looms large, despite all the sacrifices and rituals to the gods (2.3.3, 2.5). It also raises the pertinent question when the illness persists of why has the sickness not gone despite my confession and repentance? Is God that unforgiving that he cannot show mercy? For instance, HIV and AIDs, poverty and structural injustice could also challenge such a theology of Pastoral Care. This is because a number of these challenges, which often call for Pastoral Care, do not always emanate from the sins of those afflicted by these diseases or challenges.

A purely classical approach further reveals a tendency of such care to collude with persons who believe, for instance, that people living with HIV and AIDS are being punished by God for their sinful behaviour. The danger of kerygmatic reductionism in the classical paradigm is also described by Berinyuu (1989: 3) as dogmatic ruling, arbitration, moralism, outright judgment and condemnation. The result, according to Berinyuu (1989:3), is less preference for such PCGs, not because the patients do not value religion, but because the Pastor or Imam tends towards what Louw (1998:27) calls "*kerygmatic* enforcement and manipulation".

Louw (1998: 26) further identifies another problem with the classical paradigm as a tendency to be directive and advisory, which ignores the existential and experiential elements of the patient. Thus what could guide the application of the classical approach is how the message should be applied to the patient. What would be healing and good news to them? A judgmental God image could have the danger of reaffirming the Ibibio/Nigerian belief in ancestors, as God the creator is far removed from their problems. Therefore, Pamela Cooper-White (2012:24) insists that Pastoral Care that is meaningful to the suffering person is that which recognises the experience of the person who suffers. "[T]he human experience is an authoritative source of theology" in which all categories of scriptural exegesis and doctrinal formulation are open for ongoing consideration and critique". In this understanding, good theology must be relevant to healing and liberation in shaping the individual and the community's response to suffering.

Similarly, Townsend (2009: 9) has rightly remarked that Pastoral Care should ensure that its theologies are thick enough to support ministry in the public arena. These views have implications for the pastoral care of patients in the AKS/Nigerian hospital. The religious

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support should be appropriate, adequate, sensitive and meaningful for the patient's quest for meaning, if pastoral care is to provide more meaningful and quality care to patients than can be offered in ATR. In essence, the context and the situation in which Pastoral Care is located should determine the way in which the message should be communicated. In other words, the word (Scripture and kerygma) and the person are important and as such should be taken into consideration in the mediation of care. But keeping the balance between the theological content and the empirical dimension of the human experience is not devoid of challenges. According to Louw (2008:154), it requires a critical dialogue without losing the tension between the continuity and discontinuity of the Christian faith.

In summary, the approach of pastoral care in the classical paradigm focused on the communication of the gospel, confession, repentance, forgiveness and prayer. Thus the emphasis is on the communication of the word. In the classical paradigm Scripture and prayer are central and unique resources for the mediation of healing, transformation and growth rather than the person's need. The concern raised against this paradigm is in its deductive application of Scripture rather than an inductive approach to human problems in caregiving. Despite this concern, this model of Pastoral Care is still considered to have relevance for pastoral caregiving in terms of Scripture and prayer as unique resources of pastoral care. What it needs to do is to pay attention to the human experience and need. Therefore, pastoral and practical theologians such as Cooper-White (2010:24) and Louw (2008:154) insist that the empirical resources of human experience, reason and tradition could be coupled with the resources of the faith community for personal and communal reflection and the praxis of caregiving. Such criticism of the weaknesses of the classical paradigm led to the emergence of the clinical pastoral paradigm, which was intended to close the gaps in the classical paradigm.

3.3.2 Clinical pastoral paradigm

The clinical pastoral paradigm, as the name suggests, was developed within the clinical context of the hospital. The clinical pastoral paradigm has been in existence in its developed form since the middle of the 20th century (Patton, 1993:4; Ramsey, 2004:26). Pastoral Care in the classical paradigm is viewed by some scholars with ambivalence. Such scholars include Oden (1984:24), Adams (1976:75), Purves (2004) Pattison (2000:106), Thornton (2002:55), and in more recent times Carson (2010:340-341). Unlike the classical paradigm, contemporary Pastoral Care literature (Marshall, 2004:133-153, Miller-McLemore 2007,

Townsend 2009:1-10) relates Pastoral Care positively to the clinical pastoral paradigm. Pastoral care in the clinical pastoral paradigm assumes that good relationships are at the heart of good care and that relationship is the beginning of theory. McClure (2012:273) argues that good Pastoral Care has always attended first to the person and relationships and then reflected on the meaning of the encounter. This approach to Pastoral Care, which is sometimes called a client-centred approach, insists that the emphasis in care should not be on the word but on the human need. This does not imply that the word is not important. Therefore appropriate pastoral caregiving depends on the interpersonal relationship fostered by good communication skill (Louw, 1998:27).

Patton (1993:5) believes that the clinical pastoral paradigm is beneficial in at least three ways. First, it demonstrates the interaction between quality care and the character of the caregiver. "The way one cares for others is inescapably related to the way one cares for oneself". Second, "[p]astoral caring always involves *being* someone as well as *doing* something". Third, "[o]ne can best learn about oneself and how to care for others through experiential and reflective participation in caring relationships" (Patton, 1993:5).

The distinguishing feature of the clinical pastoral paradigm, unlike the classical pastoral paradigm, is its emphasis on specialisation and training in addition to drawing on classical resources such as rituals and symbols in order to respond effectively to the human predicament in the technical setting of the hospital. Meanwhile, Townsend remarks that at its inception the clinical pastoral paradigm emphasised ordination and regarded the congregation as the context of Pastoral Care. However, recent decades have seen changes in the clinical paradigm with regard to ordination and sometimes the ecclesiastical connection is no longer held as the norm as a result of structural changes in government policy within the context in which Pastoral Care operates, such as the hospital. Townsend notes that the changes that ensued decentralised this pastoral paradigm into several smaller, discrete narratives. Consequently, the changes led to some shifts in the location of the identity and role of the PCG (cf. Chapter Four). Townsend (2009:1-10) perceives this paradigm as the most liberal and volatile with its changes in models, methods and approaches to the extent that its expression is dependent on the context of practice and training where Pastoral Care is located.

Such changes demanded the licensing of pastoral counsellors (caregivers) by the state in accordance with the demands of professionalisation. Ramsey (2004:27), in her article "A

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Time of Ferment and Redefinition", describes the various changes within the structures and organisations of Pastoral Care:

> Professional identity for chaplains and pastoral counsellors has been complicated both within their organisations and as each has needed to represent their interest with the health care industry and secular accrediting organisations in an attempt to secure financial and professional survival… The history of both organisations includes …. members who prefer a rather marginal relationship with their largely Christian communions usually because of a preference for less traditional theology and religious practice. Ironically, in the present context, it is precisely their ability to hear and respond to person's faith and spiritual journey that is the added value most promising for marketing and professional recognition.
>
> (Ramsey, 2004:27)

The demand for specialisation and licensing decentralised ordination, which grounded Pastoral Care within a specific and exclusive ecclesiology (the church). It raised questions of the place of the sacraments, which it was the function of the clergy to administer, as well as of ordination. The shift meant that ordination depended on the PCG's preferred identity. McClure (2012:272) comments that the development elicited mixed feelings from scholars. Therefore, the professional identity of the pastoral caregiver as identified (in ordination) in the classical paradigm is sometimes perceived by theologian such as Oden (1984:24), Adams (1976:75), Pattison (2000:106), Thornton (2002:55), and Carson (2010:340-341) as unclear and even questionable within the clinical paradigm. Some theologians have referred to this state of affairs as an "identity crisis" (Thesnaar, 2010:267). They fear that accountability for behavioural practice is compromised by the playing down of ordination (Townsend, 2004:124). McClure (2012:272) has also remarked that the playing down of ordination as an integral identity of the PCG amounts to secularisation. McClure (2012:272) argues that this was why a psychological interpretation of the human experience was perceived as being given the major attention in the theory and practice of Pastoral Care. Nevertheless, the majority saw it as an effective response to the need of the person to be known and accepted personally and deeply.

Another criticism of the clinical paradigm has to do with its specialisation with a tendency to emphasise psychology and its pragmatic focus on the "hints and helps of pastoralia" (Miller-McLemore, 2007:19), which is inclined to separate Pastoral Care and counselling from public life (Thesnaar, 2010:267), and as such promoting the psychological reduction of Pastoral Care to communication skills and attention to human needs. Purves (2004:xix), who is one of these critics of the clinical paradigm that now dominates contemporary Pastoral Care

practice, contends that under this paradigm Pastoral Care has been largely framed by interrelated, ethical symbolic and functional dimensions. As a result, its views of human wholeness and competent functioning tend to prevail, which in effect suppresses the Christian doctrine of God. He worries that Pastoral Care has "become concerned with questions of meaning rather than truth" (2004: xix). Purves's observation reflects Pastoral Care as the model of an exclusively Christian ministry, which is valid only to the Pastoral Caregiving in the Church. Within a pluralistic context such as the hospital, his criticism is open to debate.

Miller-McLemore (2007:19-38) responds to the likes of Purves in their criticisms of the clinical Pastoral Care paradigm that an impoverished understanding of practice of Pastoral Care and theology may be responsible for such criticisms. Miller-McLemore explains that Pastoral Care is propelled by *habitus*, which she defines as "the profound, life-orienting, identity-shaping participation in the constitutive practice of [spiritual] life" (Miller-McLemore, 2007:19-38). In that sense *habitus* "not only requires insight and understanding but also a kind of judgment, skill, commitment, and character that full participation in practices both requires and nurtures" (Miller-McLemore, 2007:29). She refutes the negative view of specialisation as equal to fragmentation and asserts that pastoral theology (and Pastoral Care) rightly understood is a "performative discipline" where the focus is right practice or "authentic transformatory action" rather than right belief (2007:29). From an Islamic background, Rassool (2001:1481) argues similarly that Pastoral Care at the practice level is related to knowledge, skills and resources. From Islamic perspective Pastoral Care embraces technical skills as well as human interaction. Consequently, Townsend admonishes that contemporary theologies of Pastoral Care should be constructed to take in diverse narratives and practices (Townsend, 2009: 9).

Consequently, the clinical pastoral paradigm approaches Pastoral Care from an interdisciplinary and interfaith perspective driven by the desire for good practice. This implies the widening of the Pastoral Care space to include other religious expressions (like Islam) as well as persons who may have been excluded by ordination (like women) to be part of the continuum of care for care seekers, liberating it from an exclusively Christian model as embodied in the classical paradigm. This has led to the development of Muslim chaplains who had been excluded and ignored in the classical paradigm (cf. Rassool, 2000:1476-1484; Gilliat-Ray, 2010:145-157; Johnson, 2001). It further meant giving attention to improving professional practice as well as interacting with psychological and healthcare resources. Townsend (2004: 118) observes that the interfaith focus as embodied in CPE liberates

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Pastoral Care from denominationalism and opens up the space for an inclusive religious care that acknowledges religious pluralism, which gives Pastoral Care an institutionally definable task. Consequentially, it radically diversifies theories that guide Pastoral Care engagement. He observes that the Pastoral Care that focuses on the classical paradigm has declined or disappeared from training, but the interdisciplinary approach which he calls a "bridge discipline" is flourishing (Townsend, 2004:121).

However, the interdisciplinary engagement is understood variously by theologians. Louw (1998:61) proposes a convergence model of interdisciplinary engagement, while Hunsinger (1996) proposes bilingual competence as in the Chalcedonian model. On the other hand, Osmer prefers a communicative model of rationality as a cross- or inter-disciplinary[48] perspective of relating theology with other disciplines such as psychology (Osmer, 2008:163). These perspectives are useful ideas which could illuminate this study.

McClure (2012:272) writes that no other person was more influential in redirecting Pastoral Care towards an interdisciplinary focus than the pastor, psychiatric patient and founder of Clinical Pastoral Education (CPE), Anton Boison. CPE forms one of the many approaches within the Clinical pastoral paradigm. This approach deserves more attention in this study because it evolved from the hospital context of care and can be related explicitly to the goal of this study. Jones (2006:128) believes that the uniqueness of CPE lies in its approach to theological problems, which concentrates on the study of the human situation, or what Boison called "the living human document" (Jones, 2006:128). The implication of Boison's view is that CPE approaches theological problems that relate to human situations not through books and traditions, but in practical life situations. CPE in its developed form has come to be known as a professional theological education for ministry through which the student learns

[48] Osmer (2008: 163) defines interdisciplinary dialogue as a special form of rational communication in which the perspectives of two fields are brought into conversation. Osmer proposes three ways in which Pastoral Care can engage in interdisciplinary dialogue namely: correlational, transformational and transversal models.
Correlational model: This model undertakes the dialogue between theology and other fields as one of mutual influence. Correlation implies that both fields have something to contribute to the discussion and listen to one another respectfully, which also involves a critique and even a revision of the traditional beliefs or practices in the light of new insights gained.
Transformational model involves a dialogue between theology and other fields that speak different languages (e.g. between two different cultures). Therefore the transformational model involves different language games.
Transversal model is similar to the correlational method but engages at the micro-level of specific individual participants with a specific view point while the correlational operates at the general level of the participating discipline. It views the relationship of Pastoral Care and psychology as an interacting network of different fields, which is strengthened by rational communication between them. They may share the same goal or resources on a general level, but their values or ways of achieving it might differ.

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the skills of Pastoral Care through supervision[49] by a certified supervisor. The key feature in CPE is supervision. This approach is historically attributed to Boison. This issue will receive more attention in Chapter 6. However, suffice it to state here that in this study the clinical pastoral paradigm is also an interfaith paradigm, which brings theological students and ministers of all faiths e.g. pastors, priests, rabbis, imams and others, into supervised encounters with persons in crisis (www.acpe.edu/studentsFAQ.html).

As is evident, the clinical Pastoral Care paradigm was an attempt to address the weaknesses of the dominant approaches to Pastoral Care within the classical paradigm. But the clinical pastoral paradigm is also open to some criticism. The clinical pastoral paradigm is a human construct (Osmer, 2008:103) and as such it is fallible, and must be subject to criticism and open to reconsideration to achieve closer approximation to the truth. Hence, there is virtual consensus among theologians that the major weakness of the clinical Pastoral Care paradigm is its individualistic focus, particularly in the sense of the relational and developmental dimensions of individuals (Gerkin, 1996:65). Therefore, the clinical pastoral paradigm's tendency to neglect group and community care is also inconsistent with the Ibibio worldview (2.3.1), as the community plays a key role in the life of an individual. Therefore, the criticism of the clinical pastoral paradigm as focusing on the individual person and ignoring the context of community led to a review of its practice of focusing on the individual client to develop a group and community focus in what scholars call the communal contextual and intercultural paradigm. The communal contextual and intercultural Pastoral Care paradigm is thus another shift in the theory and practice of Pastoral Care.

3.3.3 Communal contextual and intercultural paradigm

The communal contextual and intercultural paradigm of Pastoral Care shifts Pastoral Care theory and praxis from the care-cure of individuals to a focus on community, which devotes attention to matters of development, gender and justice to mention a few. Pastoral Care within the intercultural paradigm with its focus on community also widens the horizon of Pastoral Care beyond the focus on patients and family in the hospital context to engage with institutional structures of healthcare, which means the patients as well as the staff and institutions as a whole become the focus of Pastoral Care. Patton's proposal of the communal

[49] While O'Connor acknowledges the varied interpretations of clinical pastoral supervision (CPS), he defines it "as an educational process that involves a pastoral relationship between a qualified supervisor and a group of supervisees for the purpose of developing skills for ministry integrated within the pastoral identity". Clinical pastoral supervision seeks to address two issues, namely the person and the work of the PCG – in O'Connor's exact words: "what I do as a minister and who I am as a minister" (O'Connor, 1998:7-8).

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contextual paradigm of care was a response of the faith community emanating from his ecumenical concern. Patton proposed a model of care that could hold together the old and new concerns of the faith community as they relate to its existence and functioning in care giving. In this understanding of Pastoral Care Paton was not attempting to negate the classical or clinical pastoral paradigms, but instead he aims at integrating both forms of Pastoral Care into what he calls the communal contextual paradigm.

Thus, in attempting to affirm both paradigms, his intention is to preserve the most valuable features of the two paradigms. It is in this sense that Patton argues that the communal contextual paradigm is old and new at the same time. It "is old in that it is based on the biblical tradition's presentation of a God who cares and who forms those who have been claimed as God's own into a community celebrating that care and extending it to others. It is new in that it emphasises the caring community and the various contexts for care rather than focusing on Pastoral Care as the work of the ordained pastor" (Paton, 1993: 5). In proposing this paradigm Paton shows his sensitivity to the relevant issues in his context. From this particularly Christian perspective, Paton was therefore proposing a model that could accommodate the spirit of Christian ecumenicity, thereby shifting ecclesiastical authority away from the churches' clerical hierarchy toward particular Christian communities. But Patton's communal contextual paradigm, though relevant in terms of its focus on faith community, is limited in its location within an exclusively Christian community and is not thick enough to include perspectives outside the confines of the church.

Emmanuel Lartey (1987) the Ghanian pastoral theologian has proposed the intercultural paradigm of Pastoral Care. Lartey uses the term intercultural "to describe an approach to care and counselling that responds to a dynamic complexity of cultural pluralism around the world. Intercultural care also seeks to correct the problematic consequences of Eurocentric cultural, political and hegemony. It values the rich dynamic, interpretive complexity of interactive cultures and rejects typologies that reduce such complexity" (Lartey, 1989). Lartey's view is particularly significant to this study as it emphasises "contextuality, multiple perspectives, and authentic participation" (Ramsey, 2004:12) that privileges interdisciplinary and cross-disciplinary interaction (1.6.1 and 1.6.2). Besides aligning with the communal contextual paradigm, Lartey's approach to Pastoral Care explores new grounds that could be said to be relevant to the postmodern context. In this understanding of Pastoral Care, the space in which Pastoral Care can function in line with this paradigm includes a pluralistic religious context, pluralistic and complex cultures such as the Nigerian public space, which

could include the hospital, political and socio-economic settings. Lending his voice to the contextual pastoral paradigm, Vivian Msomsi (2008) in his work *Ubuntu Contextual African Pastoral Care and Counselling* argues that "it is appropriate for Pastoral Care and counselling as a discipline to continually take seriously the cultural, social, religious and political factors in the context of its operation. Msomi (2008:206) states that

> [t]his is a time for pastoral theologians to claim the unique vantage point offered by the integrative stance and multidisciplinary training and vision. It is the crucial position for contributing to the central agenda of our age and it must begin with a shift in the way we define the essential nature of pastoral counselling and a broader model of the pastoral counsellor as person, as professional and as a culturally capable therapist.
>
> (Msomi, 2008:206)

In Msomi's view and in line with the intercultural paradigm, Pastoral Care is concerned with ministering to the person within the context he/she finds him/herself. Stressing further the significance of the intercultural approach to Pastoral Care, Berinyuu (1989: 9) argues that "the cultural dimension influencing individuals' concept of illness and behaviour responses to crises should be taken seriously so that sociology and culture, which play a significant role in the development of personality, can become part of therapy". As such Africans do not need to rely on Western interpretations of healing. The task of African Pastoral Care and counselling is therefore to help individuals and groups of human beings to utilise the strength located in the core of their group, personality and culture (Berinyuu, 1989:10). Lartey's (2006) intercultural paradigm emphasises the community as comprising multiple cultures that should be recognised and incorporated into care. The intercultural paradigm directs the attention of Pastoral Care to focus on the larger community beyond the faith community. Theological viewpoint, gender, race, sexual orientation and economic class are some of the contextual issues caregivers encounter as they try to understand and adequately respond to problems within the care-giving relationship (Gorsuch, 2001:66). In line with this view, Louw (2005:22-26) advises that Pastoral Care should shift from care of isolated individuals to care of individuals within the community. Such community could be located within the hospital, church and larger society.

This requires the search for and understanding of worldviews and practices by which Pastoral Care could mediate care to people and individuals to care for one another by way of contextual analysis (Lartey, 2006:46). According to Lartey (2006:42, 50), contextual analysis is a way of discerning the mind of God in the varied conditions of human experiences in

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different contexts. He observes that contextual understanding of care "arises as a result of the individualistic, rationalistic, emotional expressive, with the focus on the promotion of the development of self-fulfilment (ego) above all else of the Western context" (Lartey, 2006:42, 50). The awareness raised by this fact is what has led to the expansion of "the living human document" to "the living human web" by pastoral theologians, as discussed earlier (3.3.2). One could assume that "web" carries the idea of the whole community as the client of Pastoral Care. It also means that Pastoral Care should not be the exclusive task of religious leaders (although such Pastoral Care has its own place and should not be taken for granted), but a task carried out by the whole community. In this sense, the nuclear and extended family, friends, neighbourly support, and lay counselling play special roles and have their unique place in Pastoral Care, especially in Nigeria. The broadening perspective of Pastoral Care and theology on community also means that Pastoral Care will be confronted with normative and ethical issues such as violence, racism, women and child abuse, gender inequality and issues of justice etc. (Van Arkel, 2000:146), which demands greater cooperation with all healthcare and helping professionals

The focus on communality in Pastoral Care paradigm is currently at the heart of feminist and womanist theology.[50] Their aim is to reduce violence, patriarchal hierarchy, impositions and cultural indifference. In the current pastoral theological dispensation referred to by Gerkin (1996:65) as "a time of transition, conflicts and search for new approaches" to pastoral and theological work, feminism is currently having a great influence on pastoral theories and practice (Moore, 2002; Gorsuch, 2001; Van Arkel, 2000). Van Arkel (2000:1470) may be right when he observes that feminist and womanist theology has made Pastoral Care and theology more aware of the wider social, political and religious contexts of care. Thus, "they have made a considerable contribution to the increased attention being given to caring communities and the impact of context on human experience and on care" (Van Arkel, 2000:1470). Indeed the work of feminist and womanist theology and theologians in the current paradigm is bearing fruit, as is evidenced in the increasing attention of the subjugated and marginalised as authentic and important sources of knowledge. These "voices from the margins", as they are sometimes termed, have generated a perspective of pastoral sensitivity to communal being and experience. This is what Lartey (2006:42-50) refers to as interculturality. Interculturality according to Lartey urges pastoral theologians and caregivers

[50] Bennette Moore (2002:28) borrowing Bell Hooks's definition, defines feminism as "a struggle to end sexist oppression. Its aim is not to benefit solely any specific group of women, any particular race or class of women. It does not privilege women over men. It has the power to transform in a meaningful way all our lives".

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to be sensitive to the context in which they engage and interpret the experiences of the people they care for as well as their context.

Within the communal contextual paradigm is yet the issue of cultural diversities within and among communities and therefore the intercultural method of care is proposed as a way out. The proponents of the intercultural paradigm call for a jettisoning of cultural stereotypes and generalisation of people and groups in providing care. The major voice from the African continent who is an advocate of this paradigm is Emmanuel Lartey. Lartey (2006:43-47) talks about three processes in the communal contextual paradigm:

- *Globalisation:* This is a process whereby the worldview, lifestyle, values, theology, anthropology paradigms and forms of practices are transported from the developed world in the different cultures and context;
- *Internationalisation:* The Western and the non-Western interact in search of pastoral practices that are more compatible with the social and cultural norms of the particular context in this dialogical engagement. The fact of difference between individual and community care should awaken Pastoral Care givers to the need to always deal with the individual within the context of their community's structure as it relates to their problem;
- *Indigenisation:* This is a process which occurs when practices of indigenous cultures are re-evaluated, re-adopted and utilised in Pastoral Care.

Whereas the message is the main emphasis of the classical paradigm, the person is the concern of the clinical pastoral paradigm, while the context is pivotal to the communal contextual and intercultural paradigms. The changing nature of Pastoral Care, as indicated by the various paradigms, indicates that Pastoral Care is a discipline that hermeneutically discerns what particular practice truly suits each situation at a given time and context (1.6.1).

The discourse on paradigm shifts highlights salient points for this study to the effect that, first, Pastoral Care having started within a specific faith group has enlarged to include other religious voices. Second, it has continued to improve its methods and practices by reflecting interdisciplinary conversation partners (Marshall, 2004:146). Third, the interdisciplinary focus diversifies Pastoral Care as a professionally viable practice to include many voices (Townsend, 2004:131). In this regard Pastoral Care has been reshaped as practitioners and theologians continue to respond to the cultural and sociopolitical context. As the social psychologists argue, social structures and roles arising from human agencies are not fixed but

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undergo mutual exchange (Still, 1998:93; Chreim, Williams & Hinnings, 2007:1515; Ibarra & Barbulescu, 2010:145). Therefore, to ask which is the most appropriate paradigm for good Pastoral Care is to ask the wrong question. Rather the question is: how should the respective paradigms with their different emphases be applied for the good practice of Pastoral Care? It could be for this reason that Louw (2012) argues for a hermeneutical systemic approach, which incorporates useful elements in Pastoral Care Practice.

The implication of the paradigm shifts for creating a space for pastoral caregivers in the Nigerian hospital context is that the hospital is not a homogenous unit; therefore the models of care should be liberal enough to accommodate diversity and changes. The different perspectives of Pastoral Care enrich the diversity of care to patients in the hospital that could benefit hospital care as a whole. They align well with Ellis and Hartley's (2008:119-120) (cf. 1.3) suggestion that an alternative practices to the medical model should not be ignored, but they should be assessed for safety and effectiveness as well as the expertise of the practitioners (a point which will be expanded in Chapter Four). As discussed in 1.8.3 and as evident in Chapter Two, hospital care can only be effective and efficient through the adoption of a continuum of care that integrates the perspectives of practice and disciplines in different settings. Pastoral Care as demonstrated by these paradigms is a useful alternative and complementary healthcare model in the care continuum because of its attention to improved professional practices by revising its models to meet the expectations of the care seekers that can create a *heimat* for both the care seekers and givers of such care. The attention to quality of care in healthcare policies and the concern to seek the review of such policies to include the PCG into the hospital environment, which is one of the objectives of this study, also implies that the quality of a Pastoral Care model as it concerns healthcare should further receive attention in this study by assessing the basic elements of Pastoral Care's good practice.

3.4 The essential elements of Pastoral Care

In view of the shifts in Pastoral Care practices as discussed above (3.3.1, 3.3.2 and 3.3.3), McClure (2012:273-274), Patton (2005:852) and Lartey (2003:25-31), among others, have argued that there should be basic elements or persistent themes in Pastoral Care for good practice. Therefore, the question of what constitutes the essential aspects of Pastoral Care practice is important. In other words, what should be the unifying features of Pastoral Care

irrespective of the context, paradigm, dispensation of the care receiver, the person or the problem involved for an authentic care across cultures and contexts?

John Patton (2005:852) in *Dictionary of Pastoral Care* identifies the basics of Pastoral Care and counselling as initial structuring and evaluation, pastoral relationship, pastoral counselling process and termination. Recently McClure (2012: 273-274) has identified three important components as elements of Pastoral Care, namely careful attention, theologically informed diagnosis and compassionate support or intervention. On the other hand, Lartey (2003: 25-31) enumerates five essential elements of Pastoral Care: expression of the human predicament, the recognition of transcendence, love, multivariate forms of communication, prevention and fostering. These elements as put forward by these scholars are perceived in this study to fall under three major perspectives, namely the pastoral relationship, the pastoral process and the content of the pastoral praxis. Therefore the essential elements of Pastoral Care discussed in this study are the pastoral relationship, the pastoral process and pastoral content.

3.4.1 The pastoral relationship

Scholars are unanimous that the pastoral relationship, or what can be identified as an interpersonal relationship in sociological and psychological terms, is one of the most essential elements in Pastoral Care. The quality of relationship is also given prime position in healthcare (e.g. nursing and medicine) and all helping professions (Gooch, 2006:20). The reason for this emphasis is that good quality relationships with care seekers in turn enhance the effectiveness of the caregiver and the quality of care rendered (1.8.2). Patton (2005:852-853) argues that the most important ability of the PCG is his or her ability to care in a disciplined and honest way that offers the care seeker an opportunity to share his or her concerns. He further notes that more often than not the care seeker has enough knowledge to deal with the problem at hand, but what the care seeker needs is a context of an emotionally and spiritually mature and caring relationship within which the resources can be utilised. The pastoral relationship is very important, because it provides the care seeker an understanding of and personal connection with the values of the religious community directly and personal connection to the religious community through the person of the PCG (Patton, 2005:853) and the values the PCG represent. Lartey (2003:26) refers to this religious connection as awareness of transcendence. Lartey demands that an essential element of Pastoral Care is that it should attend to this transcendence, which although intangible and difficult to verify, is

nevertheless real.[51] Hence, pastoral caregivers should understand the importance of recognising and validating the experiential and religious dimension of human life as real without minimising it. This quality is what is commonly referred to in some nursing literature as "emotional intelligence" (Goosh, 2006:20; Stuttard, 2007:68; Ellis & Hartley, 2008: 483-486) (cf. 4.3.2.2). Such recognition could enhance the pastoral relationship. Consequently, scholars believe that Pastoral Care concerns itself with this non-tangible and spiritual dimension of the whole person as persons relate with God and the tangible world (Louw, 1998:3, Rassool, 2000: 1481; Johnson, 2001:40-41; Louw, 2008:62-63). The ultimate is therefore about God and His connectedness to ultimate life. Pastoral relationship is therefore about God and His connectedness to purposefulness in which the care seekers can trust. Hence, Pastoral Care as relationship and as an activity of human concern to others has at its core communication of God's covenantal care and love.

God's love and care can be communicated various ways and mediums (Lartey, 2003:27) (cf. 3.5). In line with this view, McClure (2012:273) states that "the field of Pastoral Care assumes that good relationships are at the heart of good care", fostered by the motive of love at its core (Lartey, 2003:27; Ramsey, 2004:10; McClure, 2012:273). Love, according to Ramsey (2004:10), is enlivened by attention to issues of justice and power, which strengthens the operation of love. Wright (2005:2), inspired by Alastair Campbell, clearly underscores a point in his brief and simple definition of Pastoral Care when he states that "[p]astoral care is in essence surprisingly simple. It has one fundamental aim: to help people to know love, both as something to be received and as something to give". Love operates within the moral context, which gives guidance in the way or manner we care. Thesnaar (2010:268) clearly underscores the point of love's centrality to caring relationships when he said that a well-meaning act of care can become brutal without sensitivity to the person or group in all respects. Intercultural pastoral caregiving to persons different from oneself should have a wellspring of love to be able to move through the unfamiliar terrain of the other's beliefs, norms and values. Anderson (2003:142) clearly makes sense when he says that "[t]he one who enters into this therapeutic relationship must do so in such a way that he or she is perceived essentially as a fellow human being not merely a professional clinician [or pastoral caregiver]". This implies that compassionate support and intervention, as McClure

[51] In theological anthropology human beings are the only creatures of God that have the ability to transcend themselves. This places humans in a unique position, which differentiates them from other creatures. Many scholars acknowledge that beyond the physical and tangible body of humans lies the intangible self, mind, soul, spirit, heart, psychic energy, life force, inner being, inner nature or whatever name we might choose to give to this intangible dimension of humans.

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(2012:273) terms it, are core activities because Pastoral Care as she perceives it has always focused on person-to-person intervention as central. However, Pastoral Care as an activity of human concern (Lartey, 2003:29) has also attended to congregational activities, such as fellowship, suppers and meetings, preaching, liturgy and ritual, worship and prayer, laying on of hands, anointing with oil etc. (2012:273-274). Communication is generally divided into verbal and non-verbal communication (Lartey, 2003:29). A good pastoral relationship is also fostered by attending to the element of the pastoral process.

3.4.2 The pastoral process

John Patton (2005:852) has identified the pastoral process as one of the basic elements of Pastoral Care. He argues that what happens in the pastoral relationship is a telling of stories, which requires genuine understanding and interpretation in the light of the religious community's stories. Such a process requires structuring and evaluation. Structuring and evaluation are what McClure terms as "careful attention" and "theologically informed diagnosis" (2012:273). Thus McClure (2012:273) states emphatically that all good pastoral caregiving needs to take very seriously issues of concern to people by careful listening and observation. She emphasises that every effective PCG has to know how to give attention by observing and listening to care seekers as well as the context. Attention, she asserts, is the basis of a good relationship, which in turn is at the heart of good Pastoral Care. Therefore every PCG needs to devote attention to careful listening and observation as a prerequisite for making a pastoral diagnosis.

Making diagnoses, according to McClure, is the ability to interpret theologically the cause of suffering and to perceive what is essential. Contemporary Pastoral Care, she says, takes the human and religious experience seriously, often allowing the human experience to challenge and inform theological understanding. Precise assessment of what is going on and why it is going on requires the "practice of strategic knowledge" (2012:273) as a critical skill in Pastoral Care intervention. This is important because all PCGs engage in assessing situations, whether consciously or not (2012:273). "Being clear about one's tools of analysis makes more explicit the resources one brings to bear on efforts to care". Theological diagnosis can be enhanced through structuring. According to Patton (2005:853), the essence of structuring is to enable PCG to develop the context in which the relationship takes place; therefore it should be done early in the process. This implies that pastoral care as a formal relationship involves a well-planned process for an optimum outcome. Patton 2005:853) identifies three

components of structuring that can enhance assessment and evaluation: intake and referrals, magic questions and unit of care. Intake and referrals is to help evaluate the care seeker's concern to determine who can best handle the issues. The magic questions as a structuring tool helps determine what is required, whereas the unit of care is to determine whether care should be focused on the individual care seeker or involve others connected to the presenting problem of the care seeker. As Patton perceives it, having the right person involved is often more important than what is said in the pastoral encounter.

3.4.3 Pastoral content

The third essential element of Pastoral Care is the pastoral content. The essential components of this element in the view of many scholars who agree explicitly or implicitly is pastoral concern for what is variously referred to as human concern (Gerkin, 1996) or the human predicament (Louw, 2008; Msomi, 2008:26), context (Patton 1993), problem and situation (Dunlap, 2012:34). The focus on content is of particular significance to this study, because content will direct the process and influence the skills needed. Focusing on content as one of the basic elements of Pastoral Care demonstrates the uniqueness of Pastoral Care in the mist of other caring acts.

Scholars identify the human predicament either in terms of the ultimate origin of sin and evil, or the consequence of suffering. Pastoral Care recognises sin and suffering as a basic human predicament. Pastoral Care therefore makes meaning of suffering. Suffering is a lived reality, a reality that cannot be denied. It is an integral part of life, a part of our humanness. Cooper-white (2012:25) makes an effort to distinguish suffering from other related terms such as pain, anguish, distress, misery, torment and affliction, which are a group of words that signifies a deep wound or disease. However, in Cooper-White's understanding suffering expresses a deeper meaning of "ongoingness" and a "bearing with" (2012:25) related to the passage of time as the other terms are not. It also conveys a level of symbolism that pain, for instance, does not. Pain may be mental, physical or emotional, but it does not convey any meaning in itself, because it is not registered in the thinking part of the brain. It is mute, but suffering speaks. Suffering seeks expression and recognition. When pain cannot be recognised or expressed, it degenerates into trauma and thus prevents pain from becoming suffering. Therefore suffering is the meaning one makes, or attempts to make, of one's pain (Cooper-White, 2012:25). Every human being will eventually suffer from one sort of predicament or the other, because of sin and evil in the world (Gen. 3:16-23).

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Vermeer, Van der Ven and Vossen (1996:63), on the other hand, make connection between evil and suffering. They define suffering as an emotional response to an evil situation. According to them, evil is not the same as suffering, although in most cases evil induces suffering. Accordingly to them, "evil refers to an event or situation of mischief which causes suffering as soon as it is experienced by man" (Vermeer, Van der Ven & Vossen, 1996:63). Such event or situation could be death, illness, loss of job, disaster etc. This experience is existential as well as religious or spiritual. The basic spiritual and existential sufferings of persons could take the form of anxiety, fear of rejection, isolation, despair, guilt, unfulfilled needs, helplessness, hopelessness and shame (Louw, 2008:62-63, 2012:19). When an individual is confronted with an evil predicament, it raises existential questions such as "Why me?" According to Louw (2012:113-197), many of these life issues cannot be solved; rather, they demand a lifelong process of learning. Such demands will challenge one in search of transcendence or ultimate meaning of one's life, which is a spiritual journey, a journey of faith. Existential life issues such as suffering often call to mind questions related to the identity of the sufferer. This question is a search for the meaning of suffering.

Meaning refers to an individual cognitive disposition as regards his/her concerns and is related to goals, objectives, achievements, values, motives and expectation in life (Louw, 2005:1; Vermeer, Van der Ven & Vossen, 1996:63). Nauta (2008: 586) believes that beyond the various prepositions of what gives meaning to life, such as seeking union with God, living a productive life, spiritual perfection, love, pursuing the task of giving meaning to life, "[i]t is the ordinary that gives meaning to life, the habit that breeds security, the feeling of being safe at home".

Suffering evokes the question of meaning and the purpose and direction of one's life. This search for meaning can be secular or religious (Vermeer, Vander Ven, & Vossen, 1996:67), but more often than not it takes a religious character. Suffering can be an opportunity for growth or crisis for the individual or community, depending on the resources available to engender coping. Louw (2000:9) has rightly observed that suffering affects our human as well as our spiritual identity when he asserts that "suffering is not so much about the pain, afflictions and tragic events which befalls us on our journey through life, but the quality of our reaction to the threatening and traumatic events". An aspect of Pastoral Care as it relates to the element of Pastoral Care content is generating meaning by transforming through people's resources their goals, values and commitments which are of ultimate concern as a means of coping.

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Stone (1996:126) states that no vocation faces the direct question of the meaning of suffering more frequently than does the ministry of Pastoral Care. This is because the quest for meaning is often a theological issue and always raises the question of God's involvement in and connection with the human predicament (Louw, 1998:4; Fukuyama & Sevig, 1999:106-7). Pastoral Care guides individuals to overcome suffering and they search for peace and comfort. The task of Pastoral Care is to assist people towards a realistic view of humans and their predicament regarding suffering (from a theological and biblical stance) and to orient them towards an appropriate response to God's love and justice to engender growth and maturity. Therefore Pastoral Care must help people to express their suffering, making meaning, incorporating values, spiritual beliefs, hope, fears, anger, sorrow and a narrative sense of what has happened for healing to take place (Louw, 2012:25). This is done by expression of concern in Pastoral Care through its various activities. Such engagement should be geared towards transformation of individuals and communities.

Lartey (2003) has argued that, unlike the assumption that has tended to relate Pastoral Care to something similar to rescue operation, or a remedy for people in an ugly and devastating situation, Pastoral Care is an opportunity to prevent an ugly incident from taking place by engaging proactively, or an opportunity to foster the growth of individuals in a crisis. Besides offering relief in times of suffering, Pastoral Care should include equipping, informing and educating people to live responsibly. This way suffering could be avoided or minimised. There are situations, however, that cannot be changed. In such a case the afflicted person should be equipped with coping skills. Such preventive and fostering activities and other necessary Pastoral Care engagements entail a number of forms of communication.

The above elements of Pastoral Care could be said to summarise the basic components of Pastoral Care as understood by different scholars and theologians of Pastoral Care. The understanding of the essential elements of Pastoral Care has also evolved over time. The basic elements of Pastoral Care reveal it as a professional discipline which adheres to the core principles of health care that constitutes quality health care as discussed in 1.8.3. However, arguing for a role position (or space) in the hospital context necessitates articulation of values, norms and beliefs inherent in Pastoral Care that direct its practices. These include: its foundation, goals, functions and understanding of practices (models) and operational boundaries (context). These unique principles guide Pastoral Care practice. Therefore this study attends to the foundation, context, models, goals and function.

3.5 The foundation of Pastoral Care

Purves (2004: xiv) has argued that there is a need for an adequate theological foundation for Pastoral Care, otherwise Pastoral Care might be distracted or hijacked by secular goals or techniques of care. Purves's statement implies that a foundation is linked to goals, direction and meaning whether as it relates to human existence and practices, structures, institutions or organisations. Most importantly, Purves's assertion suggests that Pastoral Care is tied to God's purpose for humanity and that special connection has to be discovered and sustained. As Purves (2004: xxix) further argues, having an appropriate foundation is important because it gives the ground, basic content and specific identity to Pastoral Care. Having such a foundation therefore helps the PCG's self-understanding. Purves's concept of the foundation is consistent with Kileen's (2001:52) understanding from the nursing perspective that a profession's values and ethical grounding directly affects the quality of care given as values direct members, give meaning as well as guide behaviours and affects assessments. Discussing the foundation therefore becomes important for this study, because not having the right foundation can lead Pastoral Care to posing the wrong question and thereby engaging in inappropriate choices and actions. This foundation gives credibility and sustainability to a project. In other words, a good foundation could ensure good Pastoral Care practice.

Some theologians have located the foundation of Pastoral Care in two theological concepts: *Missio Dei* (Waruta & Kinoti, 2000:6), and Christology (Purves, 2004). For Waruta and Kinoti (2000: 6) the foundation of Pastoral Care is based on God the creator. Scholars such as Waruta and Kinoti (2000:6) explain that the motive of God's mission (*Missio Dei*) on earth is propelled by His eternal love, which led to the creation of human beings in His image (*Imago Dei*). *Imago Dei* therefore expresses the sanctity of human life as worthy of preservation, support and protection. The *Missio Dei* reveals a compassionate and loving God whose interest in humankind as being in his own image (*imago Dei*) is to be identified in their human situation. Fubara-Manuel (2007: 126) thinks that "the compassionate nature of God is important to underscore as it reveals something of the heart of God that is crucial for the mission [of Pastoral Care]". Similarly Rassool (2000:1481), from the perspective of Pastoral Care in Islam, expresses the same understanding when he states that Islamic Pastoral Care is founded on the love for Allah and his prophet Muhammad. This compassionate attribute reveals the basis on which Pastoral Care to the sick in the hospital should be engaged. Pastoral Care engages in the task of caring as an obligation, which demonstrates the love, recognition and affirmation of God to fellow human beings. It engages in the task of restoring

the wholeness of human life as co-workers with God in the primary task of perfecting the divine creation as an act of God's calling. This further implies that the foundation of Pastoral Care is based on God's command to "tend my sheep" (John 21:15-17). Similarly, Islamic belief also grounds its Pastoral Care on the divine injunction to care for others, especially during periods of illness and suffering, which is a cultural, social as well as religious obligation (Johnson, 2001:40; Puchalski, Dorff & Hendi, 2004:696; Wehbe-Alamah, 2008:87).

However, Purves (2004:22), arguing from a specifically Christian foundation, contends that grounding Pastoral Care on the *Missio Dei* threatens the unique identity of Pastoral Care and may place Pastoral Care on the same level as others such as the philanthropist, who also appeals to God as the basis of his/her philanthropic activities (Purves, 2004:22). A foundation based on creation makes the person and the work of Christ irrelevant. In the light of the above, Purves (2004:22) has developed the concept of the *Missio Dei* further for Pastoral Care, which is very important to note. He argues that Jesus Christ as the mission of God to and for us is the ground of and the basis for the involvement of Pastoral Care with caring for all people. He contends that Jesus Christ as the mission of God goes beyond the understanding that he carried out the mission of God, for that will mean separating his person from the mission, which places him on a par with other figures or movements such as Muhammad, Buddha or labour movements. Thus Jesus "is in his own person the mission of God to and for the world, and any sense in which some person or movement might subsequently become identified with the mission of God is possible only on the basis of sharing in Christ's mission" (Purves, 2004:22). This understanding makes Jesus neither a messenger of God nor a prophet, but God in human flesh.

This Christian understanding is at variance with Muslims' understanding, according to which Muhammad is merely seen as a messenger and prophet of God, never to be equated with God (Rassool, 2000:1481; Schirrmacher 2008:19). According to Islam, God's purpose for his people is not mediated through the person of Muhammad but through the Qur'an (Johnson, 2001:39). However, Purves insists that the understanding of Pastoral Care in the sense of Jesus being the mission of God to and for the world through whom persons or movements can identify with the mission of God reflects the ecumenical, catholic and evangelical theology of the church. As it stands, it can be deduced that Purves's Christological theological foundation of Pastoral Care is grounded on the concept of *Missio Dei* as God's mission in the world as an extension of the kingdom, which other theological scholars hardly

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dispute.[52] Neither does this study dispute this position. This means that Pastoral Care has no mission of its own, but participates in the mission of God (through Jesus Christ for the Christians) to the world. It further means that Pastoral Care engages in its ministry of care within the hospital environment and beyond as a sign of the kingdom of God. Pastoral Care's involvement in any context including the hospital should be in tune with what God wants for humankind and other expressions of God's kingdom. Pastoral Care relies on God's grace to carry out its functions with the goal of spiritual transformation and growth to mediate love, peace and hope to those suffering in the hospital environment and in other places where care is required. However, this study is not merely seeking for systematic and doctrinal statements about Pastoral Care (i.e. the being of God or the person of Christ), but it is concerned with how the knowledge of God or of Christ could generate meaning and hope for the sick and suffering in the hospital. Therefore it posits the following questions: What embodies the Kingdom? And in what ways can such activities that mediate the kingdom be carried out? In what ways does God care for His creation? Magezi (2005:192) has argued that "the task of Pastoral Care and counselling [which could be termed activities that embody and mediate God's kingdom and further reflect how God cares for his creation] is to link the abstract God to existential situation". By undertaking such task, metaphorical language has been employed to transcend the gap between revelation and experience.

Theologically many Christian Pastoral theologians have grounded Pastoral Care engagement in the world in the person and work of Jesus Christ, expressed while on earth as means of God's identification with human suffering. For Laurenti Megasa (2000:219) Jesus promises his presence to accompany, guide and correct all who seek him. Thus, Pastoral Care in the same way seeks to encourage and give direction in a complex world. Accordingly Berinyuu (1989:3) asserts that these promises of Jesus also emphasise the caring and protecting aspect of Pastoral Care. In this sense, Pastoral Care is popularly denoted by the metaphor of shepherding of the flock, by which Jesus is acclaimed as a Good Shepherd. The Shepherd metaphor "implies sensitive and compassionate caring, to heal, sustain, guide, reconcile, nurture and empower. God's instruction to humans corresponds with the way that He takes

[52] Fubura-Manuel in this book *In the Missio Dei: Reflections on the being and calling of the Church in the Sovereign Mission of God* contends that the Trinitarian God is in mission in which he sends his son through the Holy Spirit, who also calls and sends the church to the world. Therefore the church has no mission of its own, but participates in the mission of God to the world (Fubara-Manuel, 2007:6). This study identifies with Fubara-Manuel only to this extent. The way that Fubara-Manuel unfolds his argument is in dissonance with the African world view and understanding and is at best colonial in its theological approach. This study agrees with Bosch's articulation of the concept of *Missio Dei* in his work *Transforming Missions: Paradigm shift in the Theology of Mission.* The concept of *Missio Dei* was well articulated by Karl Barth in contemporary times.

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care of the creation". According to Louw (1998:41), the importance of the shepherd metaphor lies in its connection of Pastoral Care's compassionate and loving charity to Jesus Christ's sacrificial and redeeming love for humankind. "This means that the concern of Pastoral Care is not limited to human sympathy alone, but also includes the compassion of God Himself" (Louw, 1998:41).

However, basing Pastoral Care on cosmology or Christology is limited, as it does not explain the means by which God participates in the human predicament and how Pastoral Care engages in its work with suffering people. In other words, establishing Pastoral Care on these two concepts could only illustrate the content without indicating the mode or style of Pastoral Care participation. Louw (1998:41) believes that the concept *parakalein* best describes and reflects both the content (Christology) and style (pneumatology) of pastoral comfort and care. *Paraclesis* links Christology and Pneumatology. Hence Louw argues that Pastoral Care should not only be based on Christology. This study will now shift to the eschatological dimension which completes the continuum of the Trinitarian perspective and foundation of Pastoral Care.

According to Louw (1998:166-168), Pastoral Care is also based on the standpoint of eschatology. He believes that eschatology and pneumatology provide the framework within which Pastoral Care interprets the human interaction between God, the person and the environment. This pneumatic perspective depicts a complete submission, transformation and a focus upon God. One now lives from God's grace and promises (Louw, 1998: 166-168). This means that Pastoral Care engages in care not as perfect humans but as persons dependent on God's grace. This presupposes that people should be assessed in terms of their relationship with and dependence on God (Louw, 1998: 140). As stewards of God, the pastoral caregiver engages in the divine programme to influence, change, renew, comfort, support, sustain and heal fellow human beings towards physical, spiritual and mental wellbeing. The comforting effect of God's grace, compassion, presence and identification with human suffering is mediated by the PCG through the enabling power of the Holy Spirit. A theological anthropology that takes seriously the question about those qualities that determine our human dignity and the sanctity of life (Waruta & Kinoti, 2000) as people engage in care for one another is very valid (cf. 4.3.2).

In summary, the foundation of Pastoral Care is based on the mission of God (in Christ), as empowered by the Holy Spirit (*parakletos*) to identify with human suffering, pain and joy for the sake of the Kingdom of God. The essence of Pastoral Care as premised on its foundation

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is to glorify God, not to seek cheap popularity or praise neither from men nor even to increase the numerical strength of churches or mosques. The mission of God is the "mission of life" (John10:10 "I have come that you may have life and have it more abundantly") (Moltman, 1997:19). Pastoral Care in the hospital context should therefore derive its authority first and foremost from God through Christ as empowered by the Holy Spirit, not from human authority. Consequently, the foundation helps to reveal the underlying assumptions within contexts, models, goals and functions of Pastoral Care within a specific context. In other words, the foundation seeks to guide the theological orientation that gives uniqueness to Pastoral Care as it relates to the focus of this study. Hence Purves (2004: xiv) and Thesnaar (2010:268-269) argue that Pastoral Care needs to be uniquely founded, otherwise it could risk being eclipsed by other fields. Therefore, the practice of Pastoral Care is envisioned from within the context of the kingdom of God.

3.6 The kingdom of God as context of Pastoral Care

The issue of the context in which Pastoral Care can function has become a matter of debate for pastoral theologians. There are two dominant views in relation to what extent Pastoral Care can authentically carry out the work of Pastoral Care giving. To some pastoral theologians like Seward Hiltner and Wayne Oates (quoted in Townsend, 2009:2), Pastoral Care in the form of counselling "outside the walls of the church made no sense; it was a violation of the ministry and was probably unethical". Unlike Hiltner and Oates, Frederick Kuesther (2009:2) argues that Pastoral Care and counselling were "not about an institution, [they were] about caring for the inner lives of individuals and family". The discussion on the context of Pastoral Care is important for this study because the understanding of the context determines the modes, methods and approaches that Pastoral Care may utilise in the ministry of care. In addition to determining the modes, methods and approaches of care, the context could also direct the goal for such practice of care. With particular reference to this study, the issue of context raises a salient question: can the Nigerian hospital environment suffice for consideration as a context in which Pastoral Care can be practised?

Ecclesiologically, Louw (1998:70) locates the context of pastoral encounter within the congregation as the embodiment of the *koinonia* of believers. A similar idea is also expressed in Islam (Johnson, 2001:39). Nevertheless, by locating Pastoral Care primarily within the church or mosque (congregation of the people of God), which arguably by extension includes the congregation of the people of God beyond a formal ecclesiastical structure to include wherever God's people are such as gatherings of believers both in the hospital and elsewhere

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provides a unique context for fellowshipping. Louw's assertion has implications for Pastoral Care to the sick in the Nigerian hospital. This means that there is a crucial need for Pastoral Care in the Nigerian hospital context for at least the people of God who have gone to the hospital to seek medical attention and those that have gone there to care for their family members. There is no doubt that although these believers have not gone to the hospital for the purpose of worship and fellowship, they nevertheless fellowship and worship God, desiring his intervention in facing their challenges beyond the services that modern medicine can offer. This is undoubtedly the African and Nigerian attitude, which is inseparable from their world view in every situation, not only the context of affliction (cf. 2.3).

In Louw's terms *koinonia* imparts a role of loving service amongst believers (1998:81) even in the hospital environment. The koinonic context, although it is invaluable for caring for the *laos* "people of God" and believing community where mutual care is envisioned, becomes problematic as it leads to the inevitable questions: What happens to those who do not belong to the church? Are they not deserving of Pastoral Care? Louw adds as an afterthought that care should be extended to everybody wherever they are found, which seems to make Pastoral Care to the non-believer a secondary issue. Louw's assertion presupposes that Pastoral Care is the "children's bread". Others that do not belong can only eat the "crumbs that fall from the table", which may often be too little or nothing at all. The far-reaching implication for Louw's position as well as Islam's is that Pastoral Care belongs to and is for believers. The unbeliever may receive Pastoral Care out of the pastoral caregiver's benevolence as a privilege not as an obligation. Many churches and mosques in fact organise their Pastoral Care visitation around this theology – the pastor or member goes to visit his parishioner or fellow member. This approach falls short of the ideal which this study envisions – Pastoral Care for all who may desire it.

Arguing from a Christian perspective, Wright (1996: 8) rejects this self-preserving posture which confines Pastoral Care to believers and argues that "the Church is only the church when it exists for the sake of others". The church, he argues, is the only one body which exists (or rather should exist) for the sake of those who do not yet belong. Gerkin (1996:126-128) argues that the church as a Christian community is called to care for one another and for the greater world of human needs. This means that mutual care for one another should not be the goal but the means to the goal. It further means that authentic Pastoral Care in the hospital must seek ways that lead "from religion to the kingdom of God, from the Church to the world, from concern about our own selves to hope for the whole" (Moltman, 1997: 20).

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Louw's location of the context of Pastoral Care in the congregation as the body is valid and should be taken seriously, as the congregation provides community for both the caregiver and the care receiver. However, such understanding should be informed by the fact that such care should proceed from the church (or mosque), but should go beyond the church (or mosque) to the wider society for the good of humankind not just believers. Anderson appears to have proffered a solution for the narrow focus of such scholars who limit Pastoral Care for the benefit of believers. In his view of Pastoral Care the believer is not privileged over the unbeliever in Pastoral Care to the sick in hospital, as his location of Pastoral Care is not the context of the church but the kingdom of God.

Anderson (2001:234-235), in his book *The Shape of Practical Theology*, argues that the therapeutic context of Pastoral Care is the kingdom of God. The kingdom of God is the central theme in Jesus' message and ministry as a whole (Mark1:4, Matthew 4:23). According to Anderson (2001: 233-234), "[i]t is the social reality over which and through which God exercises His power and presence, rather than merely a realm over which he reigns. The Kingdom of God is a culture with its own social and religious life that takes form in existing world cultures". This notion of the kingdom of God breaks boundaries and offers the caregiver the opportunity to carry out his/her care obligation without discriminating between believers and non-believers. The vision of the kingdom of God allows each person to be attended to as bearer of the image of God and as an object of God's love and care. This vision of the Kingdom of God as the context of Pastoral Care is a departure from the popular view of the church as the context of Pastoral Care.

The Kingdom of God as the context of Pastoral Care envisions a broad-based or holistic practice of Pastoral Care that is concerned with both public and private lives. It holds that the understanding of the church as the called-out community of believers is relevant. As a sign of the kingdom, the community of believers "forms the unique context in which the [care] can be mediated and realised" (Louw, 1998:70). The faith community as a fellowshipping community supplies the caregiver with significant resources for rituals and practices. Such resources are necessary in sustaining care for people who are suffering. Thus, if there is anything that applies to Nigerians, it is their community consciousness, the desire to gather in groups to give support to one another. For the Christian church, life is organised around fellowship in small groups of men, women, youths and children, home cells and prayer cells. Fortunately, the understanding that the Kingdom of God is the context of Pastoral Care lends strength to Townsend's (2009: 9) contention that Pastoral Care theologies of ministry practice

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should be thick enough to support ministry in the public space. Townsend's position from this specific kingdom mentality also legitimatises the engagement of Pastoral Care in the hospital, not as a privilege but as an obligation of Pastoral Caregivers and the faith community and as such strengthens the thesis of this study. Engaging the dimension of the religious and spiritual in hospital care takes seriously the world view of Nigerians as typical Africans regarding conditions such as sickness and general wellbeing. It also commits to the need to render quality service by being sensitive to the needs of the care seeker (1.8.3). Townsend's recommendation could therefore be said to align with Anderson's position, which envisions a broader engagement for Pastoral Care practice in the public arena such as the Nigerian hospital.

In summary, the context of Pastoral Care as community brings back the overarching importance of engaging in Pastoral Care to the hospitalised in Nigeria from a contextual communal and intercultural paradigm, beyond individuals or even exclusive groups (church or mosque). In the next section the models of Pastoral Care will be examined to understand the influences of the foundation on the method and practices of Pastoral Care within the context of the Nigerian hospital as a unique practice.

3.7 The character of Pastoral Care in an African environment: models of Pastoral Care in Nigeria

The exploration of Pastoral Care literature reveals varying practices and methods of Pastoral Care which embody the nature of Pastoral Care. Models of Pastoral Care may well be explained by the assertion that the "expectation that religious communities might provide both service and values has increased pressure on theologians to reconsider religion's public role" (Miller- McLemore, 2004:47) Miller-McLemore (2004:50) insists that the reconception of pastoral theology as public theology was driven by liberation theology, which focuses on forms of social oppression such as poverty, racism, sexism, interreligious conflicts and colonialism as problems of not just the weakness and moral turpitude of individuals, but as the consequences of unjust patriarchal, political structures and ideologies (Miller-McLemore, 2004:50). In the same vein, African theologians such as Oduyoye (1986), Udo (1988), Berinyuu (1988, 1989), Mapolo (1994, 1991), Mbiti (1999), Nyamiti (2006), Lartey (2006), Msomi (2008), Kalu (2010a-h) and others have been at the forefront of the contextualisation of theology as content and form of the African theological response to the religious and public concerns of Africans. These developments to some extents concerns the manner in

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which Pastoral Care is mediated generally which may be applied to hospitals both in African and Nigerian contexts.

In the *Dictionary of Pastoral Care and Counselling* (2005) scholars have identified models, activities and practices that are associated with Pastoiral Care such as: preaching (Purves, 2004 & Oates, 2005:833-836), social service (Hunter, 2005:1193) and visitation (Jackson, 2005:115-116). Also the moves of theologians towards addressing social issues have led to the review of the concerns of Pastoral Care beyond the traditional domains of sacraments and rituals, counselling, preaching and teaching, and pastoral visitation to include broader practices of advocacy, empowerment, social action and development. Additionally, this study also considers dialogue as a necessary form of Pastoral Care, especially in the Nigerian hospital context. Therefore the models of Pastoral Care will be discussed in the following order: Pastoral Care as counselling, Pastoral Care as ministry of service, Pastoral Care as social action, Pastoral Care as empowerment, Pastoral Care as visitation, Pastoral Care as preaching, and Pastoral Care as dialogue.

3.7.1 Pastoral Care as counselling

Many African pastoral theologians and practitioners have variously mentioned Pastoral Care as counselling. For example, Lartey (2003:81-82) argues that “[c]ounselling is a skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully”. This means that counselling is a structured relationship of trust which relies on communication. According to Louw (1998:101), this communication which involves verbal quality is based on the skilful use of relationship to enable the expression of thoughts, feelings and emotions and the exploration of behavioural patterns, which may be the cause of the worry. The question that may arise is how does pastoral counselling differ from counselling generally? Louw (1998:101) explains that far from being mere communication, pastoral counselling relies on the language of faith seeking a way of understanding (*fides quarens intellectum*) and ways of conversing (*fides quaerens verbum*) (Louw 1998:101). Louw (1998:259) further explains that

> Communication is not merely a process in which people communicate by means of words, gestures and symbols (although symbols, signs and images are very important in Pastoral Care to the Nigerian patient). It also involves the fellowship that exists between two or more people when they focus on understanding each other which is

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> aimed at compassion, consolation and empowerment. The quality of this process of understanding is determined by attitudes, dispositions, values systems, perception of life (philosophy) and faith convictions.
>
> (Louw, 1998:259)

Louw (1998:247) describes pastoral counselling as a trialogue, because God becomes the third partner in the pastoral encounter. He believes that "it is not the person and his/her communication and counselling skills who is the third factor in the pastoral conversation but God, in dialogue and operating via Scripture and creation" (1998:247). Louw's emphasis on God and scripture is not an attempt to play down on the importance of skill but rather eliciting the uniqueness of pastoral counselling. From Louw's explanation above, there could be a temptation to assume that all forms of pastoral conversation is counselling. Therefore, Vaughan (1987:18) warns that pastoral counselling is not a general conversation which the pastoral visitor engages in, but conversation which is aimed at spiritual healing and wellbeing.

In support of Lartey (2003:81-82) and Louw (1998: 94), Berinyuu (1988:94) likens the task of pastoral counselling the patient to divination and the task of peeling off the layers of the palm kernel.[53] Berinyuu (1988:94) argues that divining is like reaching to the delicate part of the palm fruit. Divining calls for sensitivity, knowledge and skill to carry out the arduous task of peeling off the layers until the seed is reached to find out what is hampering the life of the nut (the core, delicate and edible part of the kernel). Berinyuu (1988:95) concurs that healing in pastoral care begins with the initiation of the relationship between the patient and the diviner healer and continues through the relationship. He may use word magic, amulets and other symbols in this process. In pastoral counselling, the goal of which is to bring healing and process, is the same. Healing presupposes that something has gone wrong from its normal or usual manner of performance. This abnormal functioning causes pain, discomfort and suffering, and could be understood in medical parlance as sickness or illness or pathology and in theological usage sin (Lartey, 2003:55). Louw (1998:249) calls this healing conversation "therapy".

Theologically, therapy is derived from the Greek word *therapeuo* which means "to heal" (Baltz & Schneider, 1991:143). In the secular Greek usage *therapeuo* had three meanings: to serve, to care for the sick, and to treat and to cure both body and soul (Beyer, III: 128). The

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[53] Berinyuu's (1988:94) choice of the palm kernel shows his sensitivity to communicate the intricacies of pastoral counseling vividly to his West African audience, who are very familiar with this fruit. The palm tree from which the palm kernel emanates is a common and economically viable tree that thrives in all seasons of the year. Every part of the tree is useful for different purposes within the culture.

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explanation of Davids shows that the purpose of counselling was in essence to heal. According to Davids (1997:436), there were various means of seeking healing such as healing cults, magical healing using spells and amulets, special oils as well as physicians trained in the healing art of the Greeks and Romans. In Davids' opinion, the lines between these healing practitioners were blurred as the patients selected from whatever practitioners were available. In other words, healing was understood in terms of the medical, the magical and the spiritual.

The same understanding was also applicable in the Judaic world (Beyer, III: 331; Davids, 1997:436), where the healers draw from the Old Testament traditions of Elijah and Elisha and Solomon's wisdom. Others used mainly prayers, while some combined medicine with magic and prayers. Their understanding, according to Davids, was that the effectiveness of both was due to the action of God. These healers were mostly sages and prophets.

In the New Testament *therapeuo* carried the sense of healing – not just of medical treatment but of the spiritual healing that Jesus brings (Beyer, III: 331). Healing was carried out through words of commands and prayer. There was a strong connection between healing and signs and wonders and the Holy Spirit. This was based on their understanding of divine or spiritual causation of illness (Acts 5:1-11, 12:20-23). Thus some sicknesses were traced to sin (Davids, 1997:437), which laid more emphasis on spiritual healing. Hence, the whole community was admonished to confess and pray for one another using anointing oil. Davids explains that the healing did not come through the oil, but through the Holy Spirit in the name of the Lord. Thus, the use of oil was symbolic and sacramental in the spiritual healing. Subsequently there was the belief that spiritual healing would result in physical healing (James 5:16-18). Nevertheless, they also acknowledged physical causation such as the fall of Eutychus (Acts 20:9) to be responsible for illness. The presence of magicians in the New Testament world made it necessary for the disciples to explain that it was done in the name of Jesus, through the power of the Holy Spirit. The sole purpose of the healing was to point them to Jesus and his message. Thus in the New Testament *therapeuo* carried more of a spiritual sense which incorporated physical healing. While in care there was an emphasis on mutual relationships within the whole community, there was also some specific authority vested in the leaders of the whole community. It is therefore important to note in the light of the above that the understanding of healing was holistic both in the Old and New Testaments.

From the time of the Church Fathers to the Reformation the belief that spiritual healing will result in physical healing continued. Thus the connection between sin and sickness also

continued. The strong sacramental use of oil and Holy Communion is evident. The physicians and the priests shared the practice of a holistic approach to healing, but there was also a clear distinction between medical and spiritual healing. Hence the famous quotation of the Lateran council: "When physicians of the body are called to the bedside of the sick, before all else, they admonish them to call for the physician of souls, so that after spiritual health has been restored to them, the application of bodily medicine maybe of greater benefit" (Berinyuu, 1988:69). This holistic approach seems to have given way later to separation of body and spirit. Berinyuu (1988:69) suspects that in time caring for the sick was left in the hands of the physicians with little visitation and prayers for them from the community of believers through the priest or minister. The Enlightenment brought the enthronement of science and the playing down of spiritual care for the sick. The physician and the priest grew apart. Healing in contemporary times has taken on a different meaning and was defined in terms of the personality function of the individual. It should be noted at this point that the understanding of healing and its practices over the centuries at each stage has implications for this study as it shows that healing had always required a spiritual and physical or scientific component to make it holistic. The priest, minister, pastor or pastoral caregiver and the physician were collaborative partners in the healing ministry. Different modes of healing have prevailed from time. Healing has been the concern of the sick and the sick have always sought to use the best of healing methods available to them. Where integration is not possible, there must at least be a collaboration of the healer of soul, mind and body.

By the turn of the 19th century a psychological understanding of healing had an influence on the Pastoral Care to the sick. The connection between the physical and spiritual sickness which had been the norm before now was hardly made. 'Therapy' was hijacked by psychologists as their exclusive term to describe their work with patients. However, Louw (1998:443) insists on using the word therapy, but in doing so he distinguishes between pastoral therapy (counselling for healing) in a theological context and psychotherapy in the psychological context. According to Louw (1998:444), "[p]sychotherapy concerns a person's personality functions and problems on an intra-psychic, inter-personal and contextual level. Pastoral therapy is primarily concerned with problems on a spiritual level: it focuses on people's functions of faith and their relationship with God". The goal is to foster a mature faith. Pastoral therapy is promissiotherapy. Promissiotherapy is offered by the pastoral caregiver in koinonic relationship motivated by God's faithfulness to his promises and the

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healing dimension of salvation in Christ (Louw, 1998:444). In this vein, Berinyuu (1988:98) argues that the Christian diviner (pastoral counsellor) must point people beyond themselves to God's Love in Christ and elicit gratitude and commitment to a sense of stewardship in life and creation. Therefore at the heart of Pastoral Care is the question of who Christ is to the patient, and it therefore demands a Christological response. "Beneath these questions are how the sick person understands and believes Jesus as 'Son of Man' and 'Son of God' as his/her 'Lord and Saviour', as his/her 'healer and redeemer'" (1988:101). Berinyuu (1988:98) therefore concludes that in times of sickness the humanity of Jesus is most helpful to the sick.

Nyamiti (2006:144) argues that Africans are preoccupied with counselling as a healing ministry just as it was a major preoccupation of Jesus. He asserts that there are obvious similarities between Jesus' healing function and that of the African ancestor. Ghunney 1993:96 asserts that pastoral counselling which is a part of Pastoral Care is a participation in the ministry of Jesus Christ, who is the unique presence of God and who brings salvation and healing. Salvation, according to the African, carries with it the idea of empowerment as well as deliverance. The implication of Pastoral Care as counselling for this study is that Pastoral Care to the sick in the Nigerian context should embody a sensitive and attentive presence borne out of skilful training, so as to convey the message of Christ and the love of God to patient.

Counselling has been in use within the African and Nigerian traditional family setting where elders, friends and peers offer words of wisdom to their fellow troubled persons (Ghunney, 1993:93). In contemporary Nigerian society much of this counselling is undertaken by families, friends, religious leaders and the religious bodies. However, the family structures are gradually eroding as a result of some impacts of globalisation and migration of people from their original place of affiliation in search of work, school and a better life. The impact of globalisation on the Nigerian cultural milieu means human problems are increasingly becoming more complex than ever (Offiong 2010:121; Kalu, 2010b:57-62). The increased complexity of human problems demands that traditional counselling be supported by more skilled and professional pastoral counselling, where these problems can be referred to for better results (Keane, 1993:73; Ghunney, 1993:97). Gastongauy (1993:54), a Malawian practising pastoral counsellor, accordingly comments that "there is space and real need for a new generation advisor, a counsellor. The Alangizi (traditional advisors) had an important traditional role, laying a foundation upon which a sensitive pastoral counsellor can build". She fears a difficult future for counselling unless more skilled pastoral counsellors are present

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or trained to carry out the task. Gastonguay's plea is equally applicable to the Nigerian context and speaks in the direction of this study.

Counselling in Nigeria should move from "amateur" counselling to purposeful, skilful, and structured engagement of Pastoral Care and counselling with its faith character. In like manner, Ghunney (1993:96), a practising pastoral counsellor in Ghana, echoes the Nigerian scholar Imasogie and advises that pastoral counselling with African patients should emphasise the place of the Holy Spirit as Africans have more faith in spiritual guidance than in psychological guidance. His statement confirms this study's hypothesis that Pastoral Care and counselling could be urgently needed in Nigerian hospitals, where people are struggling with organic, functional and mental diseases. This is not because Nigerian patients do not value psychological or psychiatric care, but also want the spiritual component to be present.

Treatment raises ethical and moral dilemmas that have a religious undertone. Ghunney (1993:104), speaking of the Akans but his point can also be applied to the Nigerian patient, comments: Pastoral counselling with the Akan is incomplete without moral or ethical counselling. There are a lot of 'do's' and 'don'ts' in the Akan [Nigerian] society, the breaking of which bring psychological distress to many people". This requires that pastoral counselling and faith must be combined with our work (skills) in Pastoral Care to become more meaningful to Nigerians who are plagued with various relational, cultural, systemic and political problems. James (2:14-17) rightly asks, "What good is it, my brothers if someone says he has faith but does not have works? Can that faith save him?" He concludes that a faith without works is dead and useless. That is, counselling must adopt an interdisciplinary approach in order to be useful to contemporary Nigeria in the hospital and society at large to combat the ongoing and emerging challenges for healing. Another form through which Pastoral Care is expressed in Nigeria is as a ministry of service.

3.7.2 Pastoral Care as ministry of service

Ministry is constitutive of roles played by individuals or groups as they give their services within a religious community and the society at large (Rassool, 2000:1481; Wehrli, 2005:730). From a Christian perspective, it describes the various gifts which God bestows on humanity (1Corinthians 12:5). Ministry, according to Wehrli (2005:731), also refers to such acts as offering (2 Corinthians 8:19-20) and the help offered to one in prison (Philemon13). Hence, all members of the church have gifts of grace to exercise in the service to others. Such ministries derive their authority from Christ (Wehrli, 2005:731). Similarly in the Islamic

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tradition, “the Prophet Muhammad states ‘no one will be allowed to move from his position on the day of judgment until he has been asked how he spent his life, how he used his knowledge, how he earned and spent his money and in what pursuit he used his health’” (Johnson, 2001:39). Therefore Pulchalski et al. (2004:696) argue that Islam encourages Muslims to help the needy.

According to Lartey (2003: 56), Pastoral Care as ministry of service is construed as “the operation or activity of particular persons, viewed as agents or intermediaries”. They may operate as individuals or as teams and may utilise counselling skills and other religious rituals and symbols to promote growth, wellbeing and spiritual direction for persons in need. This suggests that Pastoral Care involves a general act of caring by all members of the religious community (3.5.1). This model emphasises availability, compassion and presence to the weak and vulnerable from all members of the faith community. The parable of the Good Samaritan in which all believers are called to engage in the ministry of care fits into this model (Luke10:25-37). Johnson (2001:39) claims that a similar story is recorded in the Qur’an.

Pembroke (2006: 32-41) terms this type of Pastoral Care by availability “hospitality”. According to him, “hospitality involves the practicalities of preparing a space and of offering food and drink. But it also involves something deeper, namely the giving of oneself”. Thus giving oneself becomes more important than carrying out a task. In this way, believers demonstrate God’s hospitality as is manifested in Jesus Christ, the ultimate expression of the hospitality of God. Pembroke’s (2006: 32-41) conviction is that hospitality is central to the ministry of Pastoral Care. For him the metaphor of the wounded healer relates more to hospitality. Emily Choge (2006:390) believes that service as hospitality is engrained in African societies, which have both a personal and communal perspective. It was a service offered not only to friends and family but to strangers as well. She argues that hospitality as practised in biblical times also had similarities to African practices with guidelines to check abuses. Heeding the guidelines, she says, helps to keep boundaries and also checks abuses by host or guest. What Choge’s argument illuminates for this study is the need for Pastoral Care to practise hospitality in an ethically informed way to be meaningful to the patient. Pastoral and practical theologians such as Lartey (2003:56) and Louw (2008:73) have identified five classic activities associated with Pastoral Care as ministry of the church.

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- Proclamation (*kerygma*) involves communication of God's word. This "word" which gives Pastoral Care its unique character must not be exchanged for an empirical or phenomenological approach.
- Teaching (*didache)* conveys knowledge about the revelation of God in the scripture and laid down traditions, their interpretations and understanding by the community of faith as it relates to divine direction in their relationship with God in their daily living.
- Service (*diakonia*) is a sacrificial service of the community of faith such as visiting the sick providing food and shelter to the needy. This affirms God's (*paraklesis)* caring and comforting presence.
- Fellowship (*koinonia*) is a gathering of the hopeful for the purpose of providing mutual support and encouragement and edification within the community of faith. Koinonia may take the form of games, celebrations, burials and memorial services. This affirms the social need of human for community and connectedness.
- Worship (*eucharistia*) involves giving praise to God in response to His love and care. It also offers the community of faith the opportunity to give their time, possession where possible in honour of God, their ultimate source of existence. In many communities of faith all actions and engagements in life are interpreted as acts of worship, although most devout the first part of the fellowship for prayer, thanksgiving, dance and praise of God which is specially called "praise and Worship" in their liturgy which most often takes up a greater part of the programme for the day. Many churches in Nigeria take the form of this type of worship.

Schweitzer (2009:45-53), in her article "Worship as Pastoral Care across the generations" links Pastoral Care as ministry of service to "worship". Locating her article within the context of the church, she contends that in worship (wedding, celebrations, funeral, times of crisis etc.) the faithful interconnect with the past, present and future of the Christian church. Although she warns that the focus of worship is not on the individual or even the faith community but God, yet authentic worship should exhibit a pastoral sensitivity, which takes into consideration both the person of the worship leader and those who participate in the worship. "Pastoral sensitivity considers seriously both the gifts and the limits of those who attend worship as well as those who lead in it. Pastoral sensitivity that stretches across generational boundaries is willing to consider how all members of the congregation are included in corporate worship" (Schweitzer, 2009:47). She calls this sensitivity the "pastoral

norm" (Schweitzer, 2009:47). At stake also is the theological norm, which asks the basic question of how the worship maintains a focus on God. "The theological norm does not impede the community's focus on addressing concerns to God, but rather ensures that the concerns will be addressed to God appropriately and allow a broader participation within the whole congregation" (Schweitzer, 2009:48). Meaningful worship, she argues, will have to consider the "historical norm" (Schweitzer, 2009:49) of the congregation. The historical norm, she explains, takes into account where the community has been in order to arrive at where they presently desire to be. "Attending to the significance of the historical norm in worship as a form of Pastoral Care helps us to remain connected with past and future because what matters is not the *how* but the *who*" (Schweitzer, 2009:49).

Schweitzer's assertions are important for this study. Worship in Pastoral Care within the [Ibibio/Nigerian religious] society is embedded in rituals in which the worshippers stand in solidarity with one another, past, present and future (Lekwata, 2003:183). But Schweitzer seems to restrict worship to the congregation and as such limits it to the confines of the congregation. In so doing, he does not seem to be sensitive to African solidarity and communion which transcends a particular place, and is usually carried out everywhere- in the shrine, home, market place etc. as was discussed in Chapter Two. Worship that is sensitive to the religio-cultural worldview of Ibibio/Nigerians must break the boundaries of place and time.

According to Lekwata (2003:183), worship, as a "'paradigm of faith-liturgy and life', bridges the sanctuary and the market place". He laments that traditional values of solidarity and communion are being threatened by the denominationalism and individualism of the West. Lekwata could be said to agree with the aim of this study, which advocates for spiritual/religious care which celebrates the life of people in worship beyond the confines of the church (congregation). A service of worship extends to the hospital space as an authentic expression of worship, especially for the Nigerian patient in the hospital environment. Worship within an ecumenical setting must have an even higher sensitivity to the diversity of people from different denominational and religious backgrounds in their celebration of worship. Therefore, liturgies and rituals could play such role in their worship service which also resonates with African religious values of symbols and rituals (Uzokwu, 1997:41-50) for quality care of patient. Pastoral Care that seeks to enrich the sick and suffering therefore should be sensitive, hospitable and make use of religious symbols which the patient can connect with for healing. The renowned Nigerian and African Liturgist Uzukwu (1997:43)

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contends that rituals and most specifically religious rituals provide active liberative expression for the oppressed and are a possible means of social transformation. The practical theologian Edward Foley (2012:143-152) suggests that ritual as a pervasive human activity in practical theology is not confined to a certain religion (although each one has specific way of performance). As such it is a fruitful way of deepening the experiences of individuals in meaning making. In summary, the ministry of service in intercultural Pastoral Care incorporates worship (which involves religious rituals) to foster meaning for patients.

Added to the manifestation of communal solidarity, hospitality and worship as a form of Pastoral Care in Ibibio/Nigeria, another model of Pastoral Care is social action and advocacy.

3.7.3 Pastoral Care as social action and advocacy

Leas and Kittlaus (1981:3) assert that, historically pastoral counselling and social action were understood as mutually exclusive, operating on parallel lines with no possible interface. While pastoral counselling is focused on individual personal motivation to create an environment of change, social action was directed towards policies and focused on the environment, and is concerned with power and influence to create environmental change that impinges on human wellness. Leas and Kittlaus (1981:9) argue that pastoral counselling and social action are necessary aspects of Pastoral Care. They therefore advocate for a holistic Pastoral Care practice that does not divorce pastoral counselling from social action and vice versa. Peter Wagner (in Paredis, 2008:71) makes a distinction between social service and social action. He defines social service as a "kind of ministry geared to meet the needs of individuals and groups of persons in a direct immediate way" such as the examples mentioned above under service. But "social action is the kind of social ministry geared towards changing social structures…. It involves socio-political change … the end goal of social action is to substitute just (or more just) for unjust (or less unjust) political structures" (Paredis, 2008:71). In this regard, social action differs from hospitality in the sense that the former focuses on the care receiver while the latter focuses on justice and advocacy. Although Wagner acknowledges the importance of social action, he prefers social service to social action, because social service focuses on increasing the numerical growth of the community of faith. Wagner's view is myopic in terms of the overall mission of God as His mission is not necessarily to increase churches but to expand His kingdom (3.5.1 and 3.5.2). Such motivation as Wagner's might be detrimental to Pastoral Care's practices as such a posture might generate competition for church membership among denominations and could generate tension in a multi-religious setting among the various religions.

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However, there are notable scholars and practitioners who have transcended such denominational boundaries. For example, Onwunta (2008:52-132) has advocated for more participation and inclusion of women in leadership positions in the Nigerian church and the Nigerian society. Most notable are the works of the circles of African women theologians with outstanding figures like Mercy Oduyoye, Musa Dube, Tola Pearce as well as their male counterparts. Such works of advocacy include but are not limited to the campaign against HIV and AIDS, violence against women and children, and advocacy for better health and greater accessibility to health facilities and a better health policy. Pastoral Care as social action and advocacy could also be viewed as the prophetic dimension of the pastoral caregiver's engagement in the hospital context. It implies that quality care includes issues of justice as such care also addresses the structures that militate against people's health. As observed in (2.2), the scourge of poverty and underdevelopment, which is keeping many Africans including Nigerians in their deplorable conditions, is largely attributed to the unjust global, national and local socio-political and economic structures. Tito Paredes (2008:67) argues that social action is imperative, as social structures are not amoral. "In this world there is much injustice, discrimination, indiscriminate exploitation of the environment and exploitation of human lives. Sin and evil are concretely expressed not only in individuals but also in structures" (2008:67). Similarly, Hunter (2005: 1194) recognises the complexities of social problems and warns that transforming social challenges cannot be successfully engaged by individuals but should be addressed inter-professionally to achieve greater results. Pastoral Care seekers who desire spiritual direction might have social, emotional, legal and economic needs beyond the normal anticipation of the Pastoral Caregiver. The above statement underscores an important implication for pastoral caregivers in the medical or hospital context that their role may stretch beyond religious/spiritual parameters. For this reason Hunter (2005: 1194) encourages collaborative efforts of Pastoral Care with other professionals through referrals and consultancy with appropriate agencies to meet the needs of Pastoral Care seekers.

J.D. Crichton (2005:189) has argued that "pastoral care which deals only with the distress of individuals but ignores or condones social forces which cause the distress can be regarded as worse than useless, or a tacit acceptance of injustice inimical to love. Thus, the prophetic and the pastoral must be viewed as two aspects of a single ministry of love, and caring must include both a critique of the structures of the church and society". Another model of pastoral caregiving is empowerment and social action.

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3.7.4 Pastoral Care as empowerment and development

Empowerment connotes a proactive ministry of care. Clinebell (1984:34) has argued that Pastoral Care is fundamentally the development of persons and groups towards maturity in character and faith. Likewise Obaji Agbiji (2012: 28-31) highlights the essence of Nigerian development in its various forms which are geared towards responsible wellbeing, social empowerment and transformation of its people. Such is evidenced in the ability of individuals to take up responsibility for their lives by living rightly. The underlying assumption is the belief that people are capable of changing positively towards growth no matter how debilitating the circumstances might be, even if they might not be aware of their potential (Clinebell, 1984: 34). This underscores the fact that humans have an inherent worth and value that transcend many situations. To empower them is to help them see possibilities. Pastoral Care equips people with skills to be imaginative, creative and anticipatory towards life and its attendant challenges (Louw, 2008:76). Thornton (2002:149) relates guiding and sustaining to empowerment from a pastoral theological framework of the cross. This means that the goal of sustaining and guidance should be geared towards empowerment. The implication for Pastoral Care in the hospital context is that the practice of empowerment through reconciliation helps to transform the powerless or the sufferers for a better life by making them agents of change and not merely victims. Therefore, empowerment in the form of guidance draws from the inner resources of the people to help them respond to the challenging situation and enables them to take decisions. Jones (2009: 641-654), in his article "A pastoral Model for Caring for People with Diminished Hope", has observed that a Pastoral Care that intends to empower must take cognisance of the fact that some persons may not have the will power to take the initiative to use their own resources. Therefore, he advocates that Pastoral Care can, and should, reach out to hurting people such as people with diminished hope.[54] Empowerment in the hospital context may entail equipping patients with the necessary life skill to pose the right question, take the right decision and adopt an approach that can assist them along the journey towards more meaningful and quality care. According to Lartey (2003:58-59),

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[54] Basing his model on Jesus' healing of the man at the pool (Jn. 5:1-17), Jones (2009: 641-654) believes that our pastoral model of empowering people with diminished hope should include: pastoral perceptiveness – trusting one's spiritual intuition; pastoral compassion – caring from the heart; pastoral initiative – reaching out to hurting persons; clinical clarification – asking great questions; engaging the will – helping people tap their inner resources; embracing action – helping people get unstuck; encouraging connectedness – helping people embrace their faith community.

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> Empowerment implies not weakness but rather some pre-existing strength upon which one builds. The task of pastoral care under this model is the 'drawing out and building up' of the unnoticed strengths and resources within and around people and communities….[P]astoral caregivers who work with an empowerment model seek to assist in the 'conscientisation' of the oppressed and marginalised through enabling them to ask questions about life situation. Conscientisation is the process within which people become aware of their situation and the resources they possess to respond and change things.
>
> (Lartey, 2003:58-59)

To assist people to ask questions about their life situation, J.D. Crichton (2005:189) believes that a "developmental approach could help as it recognises that different needs arise and different questions must be faced according to the stage of the person's life." Such stages of life could be job seeking, marriage, childbearing, loss of loved ones or job, the adolescent stage, old age, sickness etc. Many of these stages could present enormous crises to individuals if they lack insight about what is going on and this could prevent them from growing through the stages. With particular reference to adolescence, Kiriswa (2002:65-80) has argued that Pastoral Care in Africa could assist troubled youths with the rich spiritual resources to overcome the temptations of drug abuse and issues of self-identity and an inferiority complex, rebellious and aggressive behaviour. He describes the adolescent stage as the most confusing, challenging, frustrating and fascinating phase of human development, but one that is beclouded with uncertainties. This also affects their physical, sexual, emotional, intellectual and social development, which might manifest in their desire for personal autonomy, self-identity, self-esteem, sense of belonging and affirmation. Their inability to handle these issues leads to complicated problems. Kiriswa notes these problems are common among youths, but these challenges can also be extended to adults and might become accentuated during illness.

Daisey Nwachuku (1994:67-83) also identifies childlessness as one of the developmental crises that may impinge on the African women that Pastoral Care in Africa should address towards the empowerment and development of such women who might regularly visit the hospital for help. Such empowerment, she believes, can be carried out through enrichment programmes and strong collaboration with other health professionals through a strong referral network. Attending to issues of development also makes evident that not all people who visits the hospital are medically sick, but may be there for other reasons, such as regular check-ups. In this regard, youths, the childless, people with HIV and AIDS, and alcoholics, for instance, need to be empowered to realise that they can live a truly meaningful life despite

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disfigurement. Pastoral Care in Nigeria should understand and incorporate this dimension into its theory and practice of care by providing small growth groups, peer support groups, alcoholics' support groups and insight counselling in the hospital as well as strengthen the already existing groups in churches, mosques and other institutions to encourage and strengthen them towards self-acceptance and spiritual maturity (Mpolo, 1994:29; Kiriswa, 2002:71). Developmental or growth or empowerment counselling seeks to assist people discover and utilise the special features of their particular life stage (Clinebell, 1984:128).

Again, despite the ongoing efforts of some churches and other religious bodies, more measures on development could be undertaken for the empowerment of its members and communities. Such development could go beyond mere charity and relief to include issues of justice. For an effective vision of justice, conscientisation is indispensable to awaken people's awareness to structures that impinge on their process of growth and development of their inner potential. The practice of Pastoral Care as visitation assists the empowerment and development process as those in crisis feel affirmed as relevant and vital to the community of faith and the larger society.

3.7.5 Pastoral Care as visitation

Jackson (2005:115) in *The Dictionary of Pastoral Care and Counselling* identifies visitation as one of the traditional roles of the minister of the congregation to take the initiative to visit persons in need at their home or in the hospital for the purpose of nurturing, evangelism, discipline, organisation and caring. Jackson describes visitation as the unique Pastoral Care engagement, privilege and responsibility in the sense that the pastoral caregiver can call on the individual or family without prior invitation, unlike other professionals who may only act on special invitation and appointment. According to Jackson, the advantage of pastoral visitation lies in the fact that it affords the pastoral caregiver an opportunity to interact and observe the person or family in an informal way. Similarly, Rassool (2000:1481), Johnson (2001:39), Pulchalski et al (2004:696) and Wehbe-Alamah (2008:87) identify visitation as the core religious practice of Islam.

Pastoral Care as visitation resonates well in Nigerian society and has a strong bearing on this study. Given the above understanding of the practice, it could be said that one of the greatest strengths of Pastoral Care in Nigeria is its ability to lend support to people in distress. This aspect of care is often seen as an obligation to the community as it requires standing in

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solidarity and showing neighbourly love by visiting the person in distress.[55] Life is built around community and relationships within the community are greatly cherished. For many Nigerians, as was represented by the Ibibios, their sense of worth and importance is judged by how many people respond to them or identify with them in their time of crises or celebration. Kalu (2010f:183) makes this point clear when he asserts that in the Nigerian context any individual who lacked a social support system is considered as a poor or evil person. Thus, love for an individual is interpreted in terms of physical presence and interactions during special moments of life such as moments of suffering or celebration.

Pastoral Care as personal interaction or visitation, as Benner (1998: 34) puts it, "is not something we do to people, rather it something we do with them" within a context of relationship. This model of Pastoral Care should not be limited to the select professional few, but it should involve the whole community of faith as their religious responsibility. Stone (1996: 112) calls this form of care "lay pastoral care" in which the whole community participates in mutual sharing in the priesthood of all believers. Although Lartey (2003:59) identifies Pastoral Care as personal interaction with a process where relational skills are employed to assist people explore, clarify and change unwanted thoughts, feelings and behaviour, thereby placing the emphasis on professional skills, Pastoral Care as visitation needs just basic interpersonal skills and does not require special skills in many cases. Therefore, professional skills, although needful and of added advantage, are not considered to be a precondition in the engagement of this model of care, as such a requirement may hinder many who would otherwise visit because "they do not know what to say" or do not have the skills to offer care. Pastoral visitors sometimes do not need to say anything but merely to be with the person who is experiencing challenges. Gerkin (1996:103) argues that Pastoral Care should give adequate attention to the place of rituals and liturgical practices that can elicit ultimate meaning. However, when visiting within a highly technical institution such as a hospital, pastoral visitors may need to be given some basic skills and education about the ethical codes of conduct governing such institutions to avoid contraventions and unnecessary tensions. This means that although skills are not the foremost prerequisites, a basic training for religious lay people and family members may be necessary to equip them to care for one another as a caring community. This aspect of Pastoral Care is given attention in 6.8.2 and 6.8.3 of this study.

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[55] In Nigeria and many African societies visiting someone does not require an invitation from the person being visited. In fact, finding out from someone you want to visit if you are welcome to do so might be interpreted as reluctance on the part of the visitor to visit, which might be offensive to the host.

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Pastoral Care as visitation bridges professional Pastoral Care and counselling as pastoral visitors could help through personal interaction with the individual to seek professional help for the situation. Jackson (2005:116) has observed that Pastoral Care as visitation makes it possible for caregivers to observe stressful situations and needs. "Emerging problems may be dealt with before they become critical" (Jackson, 2005:116). Pastoral Care as visitation has vital implications for Pastoral Care in the hospital context that this study advocates for. The nurse, doctor, friends, church members etc. could act as the frontline for professional Pastoral Care by attending to the basic spiritual needs and referring the complex spiritual issues to the professional PCG. This is in line with the remark by Pulchalski et al. (2004:711) that spiritual care is an interdisciplinary engagement that should involve the healthcare professional for basic spiritual assessment. This model of care could be said to be the foundation upon which all other models rest. Pastoral Care as preaching is also a model of Pastorl Care being used in Nigeria as in other places.

3.7.6 Pastoral Care as preaching

As was evident in 3.3.1, the classical understanding of Pastoral Care considers preaching or proclamation of the word, admonition, discipline and conversion as the basic task of Pastoral Care. In this sense, Pastoral Care was word care. Stone (1996:47) postulates that communication of God's word is the essence of Pastoral Care. "The word" according to Stone has six different meanings; the Old Testament law, a particular Old Testament passage, God's revealed will, the word proclaimed by Jesus, the Christian message and the incarnate Christ. Therefore, an authentic Pastoral Care giving must proclaim this message. Similarly, Islamic tradition believes that all that one needs to know about God is in the Qur'an and the sayings of the prophet Muhammad (Rassool, 2000:1481).

The centrality of the word in Pastoral Care as enunciated coheres with Pastoral Care practice in Nigeria, as the word takes primacy in the Pastoral Care ministry in Nigeria. This is evidenced by the particular attention that preaching receives in most Nigerian and African churches and mosques. Hilary Mijoga (2000) devotes his research to the assessment of African preaching in both missionary and AICs churches. In most churches preaching is regarded as the climax of the worship (Kalu, 2010d:218).[56] In the Christian tradition, while

[56] According to Kalu (2010 Vol. 3: 217-221) an analysis of the Pentecostal churches in Africa showed that the word takes a central position in their healing practices. The word is regarded as the final authority to which many Pentecostals make all appeals in the midst of tradition and other sources for reconstructing their reality. He further states that preaching is the model which they employ to engage with the excruciating pains of the human condition. He notes that these churches affirm their position on the authority of the word preached or

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Pastoral Care is still understood as the function of the ordained pastors, which is carried out from the pulpit, it is also perceived as the function of the whole community of saints who must engage in prayers, mutual support and preaching to unbelievers. Therefore, the laity are also involved in preaching in conformity to the belief in the priesthood of all believers. However, the laity are not engaged until they are adequately trained to competently carry out the assignment (Lekwata, 2003:58). In contrast, Islamic preaching is only carried out by Islamic scholars (Gilliat-Ray, 2010:145). Hence, the religious communities in Nigeria consider their primary task of ministry as preaching, teaching and deliverance from evil forces by which confession is sometimes a precondition. Consequently, the objective of such an engagement is to evangelise and win souls for the Lord. Evangelism includes preaching in all its forms, conversion, the distribution of the Scriptures, religious literature distribution, crusades, morning cries, church planting etc. The vibrancy of preaching and the gifting of the religious leader in deliverance and exorcism often measure the viability and spirituality of a particular ministry. For some, good preaching or teaching spiced with miracles takes care of problems in minutes that counselling and therapy may take hours, days or months to address. Rassool (2000:1481) states that the Qur'an is a means for providing guidance and cures for diseases. Preaching therefore is a form of group therapy that coheres with the African world view of problem solving.

Uka (1994:151), affirming the relevance and authenticity of preaching and teaching, recommends that fasting, prayers and deliverance services should be regular features in the churches services as much as preaching and teachings. This has implication for Pastoral Care and counselling in the hospitals. Certainly, the vital place of preaching as a form of Pastoral Care practice is in no doubt, as preaching in the context of cooperate worship can open great opportunities for people to reflect on the issues of their lives in a meaningful way. It can even be a means through which people become aware of their need for counselling. However, Pastoral Care in Nigeria must endeavour to engage the two modes of conveying the word, namely preaching, teaching and Scripture, and the visible word through ministry of presence and mutual listening and attending (Stone, 1996:49). Pastoral Care could also be engaged through dialogue.

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confessed in the often used expression: "This is the word of God I believe and it is final" (Kalu, 2010:218). Repentance and responding to altar calls become the climax through which people are invited to respond to God's invitation to wholesome care and healing. Kalu's observation, although referring generally to Africa and particularly to Pentecostals, could be taken as representing the practices of many Nigerian churches specifically. Kalu, being a Nigerian himself, could be assumed to have made these assertions based on his personal experience of Pentecostalism in Nigeria and other African countries.

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3.7.7 Pastoral Care as dialogue

The reality of a pluralistic world stares us in the face. Gone are the days when people believed that everybody will believe the same way, act the same way, feel the same way about things, and belong to the same group. Pluralism is a phenomenon of the post-modern world which should accordingly be acknowledged by anyone living in this era. It does appear that each individual's uniqueness causes a degree of tension which ultimately raises the question of how one can live together with one's fellow humans despite the differences without undermining the other's "otherness". Many scholars have long proposed dialogue to be the reasonable and responsible approach to life.

In the Christian tradition and theology, many theologians over the centuries have wrestled with the issue of dialogue. Dialogue takes many forms. Much of what fills the plethora of theological literature is inter-religious dialogue as form of ecumenical engagement. From these materials have evolved what Volker Kuester (2004:74) calls a "theology of dialogue". Many of these works derive from the discipline of missiology and scarcely any from pastoral theologians. In my view, it might be that a number of persons are yet to perceive Pastoral Care as dialogue and not merely conversation. According to Basil Singh (2002:215-226), Cornelius Omonokhua (2010:1-6) and Onaiyekan (2010:1-35), dialogue concerns communication to elicit insight about "the other". Singh posits that during dialogue, as a communicative relationship, one can be caught up, get carried away or get changed. Hence, Singh (2002: 217) emphasises the need to be consistent and congruent to one's own position. Singh (2002:216) asserts that fruitful dialogue would require what he calls "communication virtues", which he enumerates as comprising, but not limited to, dispositions, emotions, cognitions, patience, tolerance and willingness to give and take. Onayikan (2010:14) stresses that the reason to engage in dialogue should border on understanding rather than tolerance, for tolerance presupposes a negative feeling about someone for whom one can do nothing about. In the same vein, Harold Netland (s.a.: 121-122) argues that dialogue which aims at genuine willingness to listen to the other, learn from the other, and respect for his or her person is part of the missionary obligation of the church. It follows that dialogue has often been more associated with mission work and less associated with Pastoral Care. Indeed, Pastoral Care as dialogue has a different focus from what is traditionally understood as the goal of dialogue.

Owing to Omonokhua's (2010:1-6) discourse on the forms of dialogue, Pastoral Care in the opinion of this research is more concerned with *dialogue of life*, which goes on daily, as

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people live and interact with one another and the environment in the sharing of ideas and common concerns. Another form of dialogue is the *dialogue of social engagement*, where people meet together in varying situations and contexts to pursue a common goal. There is also the *dialogue of religious experience*, where people meet to share their peculiar experiences and life stories that concerns their religious experiences (Omonokhua, 2010:1-6). Pastoral Care is seldom a *dialogue of theological exchange* that seeks to establish what is "truth" or concepts about God or salvation (2010:1-6), except in relation to how it is helping or obstructing the care receiver's quest for meaning, growth and development.

However, considering the growing conflict and tension among Christians and Muslims in Nigeria, inter-religious dialogue becomes imperative as part of Pastoral Care in the hospital setting for the purpose of reconciliation, peace, justice and promotion of the dignity of the human person (Hall, 2010:38). This is in consonance with the biblical injunction: "Make every effort to live in peace with all men and be holy; without holiness no one will see God" (Hebrews 12:14). Therefore, the purpose of dialogue here is to sustain, affirm and stand in solidarity with the other in the face of his/her challenges. In Pastoral Care dialogue is primarily intended for the benefit of the care seeker not the caregiver. However, in view of the communal dimension of Pastoral Care, Pastoral Care as dialogue should benefit both the pastoral caregiver as a member of such community as well as the whole community in dialogue.

From the Christian perspective, Christian Association of Nigeria (CAN) and her constituent bodies mostly carry out Pastoral Care as an inter-religious faith dialogue within the Nigerian context. They have worked in this direction to the extent of forming formal structures of dialogue such as the Nigerian Inter-religious Council (NIREC) (Onaiyekan, 2010:10-16). Pastoral Care as dialogue has relevance for this study in the light of advocating for religion and spirituality as a component of holistic care in the hospital. Pastoral Care in the hospital with a plurality of religions cannot afford not to maintain an ecumenical and inter-faith dialogical stance. Such a stance offers a unique opportunity to foster understanding and acceptance of others' differences. In order to be able to adequately respond to the challenge of disease such as HIV and AIDS, Chitando and Gabaite (2008) has argued that it is imperative for the church to transcend denominational and religious boundaries to establish collaborative efforts with the necessary individuals and groups. In the same vein Kalu (2010g: 288) argues that the Nigerian public space should be guided by an inter-faith religious culture in order to ameliorate violence and improve peaceful co-existence. Although

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Christianity and Islam are missionary in nature and evangelism plays a vital role, such engagement should be carried out with wisdom, sensitivity and understanding as the end does not always justify the means. Wright (1996:8) has "condemned a church concerned primarily for its own self-preservation rather than its self-giving". The church's motive should shift from what it stands to benefit to be more concerned about the plight of the other by employing more ways of dealing lovingly with the world. Such selfless engagement would create a greater platform for witnessing faith to the world and peaceful co-existence. Pastoral Care in the hospital cannot be holistic in its care without incorporating the dimension of inter-faith relations and ecumenism which are inevitable components for meaningful dialogue.

It is evident that the Pastoral Care models discussed above present a variety of perspectives for the application of Pastoral Care practice. The utilisation of these models can guide a Pastoral Care approach to healthcare in the hospital context in an organised manner. Therefore it could guide this study's critical thinking process and reasoning in the search for an appropriate model for Pastoral Care practice in the hospital context. The models suggest that Pastoral Care practice is guided by certain goals. Therefore the models as guided by the foundation of Pastoral Care are also directed by its goal and functions.

3.8 Goal and functions of Pastoral Care

The goal and functions of Pastoral Care are formulated according to the specific situation, context, nature and the purpose they are to serve. The goal gives insight into the nature and meaning of what Pastoral Care is about. Understanding the goal of Pastoral Care is important for this study because it explicates the uniqueness of Pastoral Care and its relevance to the healing process of the sick in the Nigerian hospital context in particular and the African environment in general. To formulate the goal of Pastoral Care in general and in a specific situation or context, the Pastoral caregiver must first understand the needs of the care receiver for whom his/her care is intended. The caregiver does not determine the needs of the care receiver no matter how well intentioned the caregiver may be. Hence the crucial question: "What are the needs and expectations of care receivers in the Nigerian hospital context?".

According to Mbiti (1999:2), to be human in the African (and the Nigerian) context is to belong to the whole community and to do so involves participating in the beliefs, ceremonies, rituals and festivals of that community. "A person cannot detach himself from the religion of his group, for to do so is to be severed from his roots, his foundation, his context of security, his kinships and the entire group of those who make him aware of his own existence. To be

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without one of these cooperate elements in life is to be out of the whole picture". Mbiti's view is well supported by this study's findings as shown in Chapter Two. In this regard, it has been established that the Ibibio/Nigerians are religious and communal. They have a holistic perspective on life in which the person, religion and the community come together in a unified whole. According to this holistic theory of the manner of existence of Ibibio/Nigerians and who they are, a healthy Nigerian is a person whose total system of relationships is in dynamic equilibrium. A Nigerian patient who has been taken from his/her usual community (family, compound, village or clan) for the sake of dealing with his illness needs religious/spiritual support, among other forms of support, to be able to cope with the unfamiliar environment of the hospital while he remains there and to be able to adequately grapple with the challenges. Louw (2012:37) is in consonance with the African worldview and vision of health and wholeness when he argues that Pastoral Care is concerned about people in the totality of their existence within their systems. This view is supported by Browning (1983:19) and Larry Graham (1996), who affirm that the system in which a care receiver is located is central, because individual identity and behaviour are largely shaped by the identity and action patterns of the institutional systems of which persons are a part. It is for this reason that Graham (1996) in his book *Care of Persons Care of Worlds* suggests a psycho-systematic approach to care.

Therefore, Mbiti's statement cited above implies two basic needs of Africans/Nigerians, namely religion/spirituality and a community that engenders hope without which his/her dignity is impaired. However, Nyamiti (2006:144) – and as discussed in Chapter Two (2.3-2.6) – showed that health, protection from malignant spiritual agents and forces, and the restoration of relationships within the community are the primary concerns of Nigerians and other Africans (Nyamiti, 2006:144).

Given this understanding, the goal of Pastoral Care in Africa/Nigeria as it relates to the sick in Nigerian hospitals could be articulated as mediation of religious and spiritual care alongside other forms of care for more holistic care in the hospital. Mpolo (1994:28-29) highlights that spiritual needs as undercurrents of illnesses may be triggered by the stress caused by social change, marital conflict, female circumcision, childlessness, fear of being bewitched, menopause, fear of becoming sexually impotent, guilt, poverty, heavy pressure for financial performance from the extended family, and political instability. Hence Pastoral Care must necessarily incorporate acts of liberation in moving towards healing and wholeness. Therefore, the faith community as a preventive and healing community should mediate

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prayers, anointing with oil, invoke the Holy Spirit, partake of the Eucharist and participate in the baptismal service, which should be celebrated as religious/spiritual resources that point towards healing and wholeness. Berrinyuu (1989:10) supports Mpolo when he suggests that "the task of African Pastoral Care is to help individuals, groups of human beings, and families to utilise the strength located in the core of their individual and group personality and culture". This goal coheres with the goal of nursing care, according to Lois White (2005:32), which is to help the client attain the highest level of their wellbeing. This wellness in line with holistic care includes spiritual wellness. This means that, although nurses may attend to some spiritual needs of patients to some extent, attending to these needs does not become the main goal of the nursing profession (2005:38). The concern of nursing as it relates to spirituality differs considerably from that of Pastoral Care, whose major goal is the fostering of spirituality for meaning and significance.

Bruinsma-de Beer (2006:171) locates the unique work of Pastoral Care in the search for meaning and ultimate concerns. This underpins the assumption that Pastoral Care concerns itself with the patient's attitude towards suffering, and assists him or her in making meaning and to be restored to wholeness. Thus, a number of pastoral theologians agree that fostering wholeness is a major concern of Pastoral Care. However, the question still remains as to how this goal can be achieved? Is it a once-off event or is it a process?

According to Clinebell (1984:2), achieving wholeness as a goal with a liberative and healing vision aimed at assisting people to overcome "their prisons of unlived life, unused assets and wasted strength" in all dimensions is a process or journey rather than a fixed goal. Clinebell's understanding of the goal of Pastoral Care is drawn from a therapeutic psychological paradigm of Pastoral Care (Creasia, 2001:115-140). That achieving wholeness is a process presupposes that human beings have an innate capacity and potential to transcend their problems towards achieving self-actualisation. Carl Rogers (in Ramsay, 1999:18-20) describes this self-actualisation as a characteristic of a "[p]sychologically mature person". The pastoral caregiver's relations of trust, respect and positive regard help in the attainment of this goal.

However, Megazi (2005:157) is particularly wary about this hedonistic pursuit and wonders if it is possible to attain happiness or self-fulfilment in this way, or whether it is just a utopian wish. The goal of Pastoral Care and counselling should not be happiness (as psychology may claim), but to respond biblically by putting the Lord first. Put in a different way, self-actualisation might be the beginning point towards achieving the ultimate goal of spiritual

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growth and maturity. Meeting physical needs might open the door for the realisation of spiritual needs which foster growth. Thus Clinebell's understanding of the goal of Pastoral Care seems to be more of a function of Pastoral Care rather than its goal, especially within the African context.

From a theological perspective scholars such as Louw ((2005:9) understand the process of wholeness in the sense of maturity in faith. This means that Pastoral Care is not only restorative but also developmentally focused and transformative (3.2). In any case, the context of Pastoral Care also determines the goal of Pastoral Care. Pastoral Care that is holistic must bear in mind the physical, psychological and spiritual wellbeing of the people. From the Christian theological perspective of faith care, Louw (2005:9) locates the goal of Pastoral Care to the sick as cultivating a mature faith. He argues that the inner resources of the patient are strengthened by the content of faith empowered by the Holy Spirit and kept alive by hope. Louw (2005:9) argues that this character of hope is well expressed in Paul's words to the Romans (5: 2b-5): "And we rejoice in the hope of the glory of God..." Hope therefore enables the sick to continue to move on and not give up when the process of healing or recovery is slow or even truncated. From this perspective, Pastoral Care's vision of wholeness as a goal is to generate hope. Wholeness and hope in Pastoral Care are dialectically related. Thus, the goal of Pastoral Care to foster wholeness is also the goal to foster hope. Wholeness care is hope care. Pastoral Care is hope care. Hope reveals the transforming power of God as an expression of the faithfulness of God despite suffering. From the perspective of the cross and resurrection, wholeness includes reconciliation as a component of healing and the basis for hope in history (Louw, 2002:168). Louw (2005:9) emphasises that:

> Wholeness in the Christian tradition implies more than healing and a condition of wellbeing. Wholeness refers to a new condition of being, to a radical transformation of our existence. It refers to a new direction, to life as determined by God's grace and defined by justification in Christ. Wholeness refers to God's unqualified "yes" in Christ and implies the renewal of one's relationship with God, one self, one's body, with other human beings and with creation. It represents a recreation in terms of forgiveness. Wholeness is the outcome of salvation (healing = heil) and indicates healing in the sense that the past (guilt) is wiped out and a new future begins. The "already" of justification (indicative of salvation) determines the "not yet" of sanctification (imperative, growth of salvation).
>
> (Louw, 2002:168)

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The basis of this hope-motivated wholeness is the faithfulness of God. Wholeness is the concern of Nigerians and Africans. Consequently, the goal of their religiousness is to experience life in all its fullness. Pastoral Care in the Nigerian hospital context seeks to address the basic human problems of human existence – sin, guilt, worry, suffering and death. It seeks the physical, mental and social restoration of persons and their reconciliation to God, to each other and to life. Such a holistic (healing) dimension of Pastoral Care can transform into life-care. A true vision of Pastoral Care seeks growth in faith, i.e. trusting in God and His promises. It enables us to position the ministry of care prominently among wider social and political interpretations of the pastoral situation without losing focus on the healing, sustaining and guiding, empowering needs of the individual (Graham, 1992: 12-13).

In the light of the above discussion, the ultimate goal of Pastoral Care within the Nigerian and African hospital context is therefore the mediation of spiritual and religious care within the Nigerian hospital towards the realisation of meaning and growth or maturity in faith and the life of the patient for the purpose of attaining wholeness and hope. The pastoral caregiver engages in this divine programme of care to influence, change, renew, comfort, support, sustain and heal fellow human beings to physical, spiritual and mental wellbeing and this way he/she also brings to bear the function of Pastoral Care. The table below summarises the functions of Pastoral Care.

Table 3 Functions of Pastoral Care

Functions of Pastoral Care	Healing
	Sustaining
	Guiding
	Reconciling
	Nurturing
	Compassionate Resistance
	Empowerment
	Liberation
	Interpreting

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Source: Compiled by the Researcher

The functions of Pastoral Care as shown in the table above define boundaries and give clarity to the purpose and goals of Pastoral Care. Functions in a sense move goals from the realm of theory to the practical realm. In other words, functions translate goals to concrete actions. But the questions remain: How can the goal be attained? How is it useful to patients and staff in the Nigerian hospital? Discussing the functions of Pastoral Care is imperative for this study because Pastoral Care needs to state in practical and unambiguous terms what its task is and how it could be useful to hospital care in Nigeria as it is increasingly appearing to be necessary to that context. Discussing functions in a sense could assist in outlining the possible unique contributions of Pastoral Care to patients and staff in the hospital environment.

Clebsch and Jaekle (1975:32-66) in their ground-breaking work *Pastoral Care in Historical Perspective* have categorised the functions of Pastoral Care in which pastoral ministry through the ages has perceived, organised and carried out the ministry of care into four themes: healing, sustaining, guiding and reconciling. These four themes have become the classic statements of the functions of Pastoral Care through which many pastoral caregivers have viewed their central task of ministry and involvement, and influenced their praxis of Pastoral Care. In many pastoral literatures these functions have undergone revision and expansion to meet the changing cultural, psychological, religious, political and social contexts in which Pastoral Care operates as well as how pastoral engagements are understood. As Thornton (2002:56) notes, Pastoral Care should be in dialogue with the contemporary period and with our faith's tradition. In its practice, it should take into consideration contemporary times and worldviews. "We cannot simply appropriate traditions or knowledge from one context and transfer them to another without examining their inherited worldviews and cultural biases" (2002:56).

In view of his sensitivity to the times and the contexts of care, Clinebell (1984:41-43) adds *nurturing* to the existing four classic functions of Pastoral Care. Again, the rise of feminist and womanist pastoral theology has made the expansion of the functions of Pastoral Care inevitable. To this end, Miller-McLemore (1999:80) has incorporated into the four classical functions the following: compassionate resistance, empowerment, nurturance and liberation

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in line with their prophetic goal of transforming the oppressive conditions of the mostly marginalised women and children (Moore, 2002:28). Louw (2008:75-77) subscribes to Miller-McLemore's expanded version only to the exclusion of resistance and inclusion of interpretation. The uniqueness of Pastoral Care and counselling can therefore be summed up in the foundation, context, models, goals and functions of Pastoral Care. The models of Pastoral Care which have evolved from the paradigms suggest a holistic care to which we now turn for a broader understanding of what this kind of care entails.

3.9 Pastoral Care as holistic care

At this point this study can assert that Pastoral Care embodies a vision of wholeness. The reoccurrence of the theme of wholeness in this study indicates its centrality and significance to Pastoral Care in various contexts and especially the Nigerian hospital context. Pastoral Care starts with questions that relate to the life, fears and hopes of the whole person (Bruinsma de-Beer, 2006:172). This implies that Pastoral Care deals with the entirety of the human person: physically, psychologically, spiritually, socially, politically and morally. That Africans generally and Nigerians in particular view life relationships and the environment in an interconnected whole has been established. Louw (2008:180) proposes that Pastoral Care in an African context must be seen as an approach to the human being as a unity within his/her social system of relation and community. Such a stance necessitates harmony between self, others and the environment. This underscores Msomi's (2008:125) view that Pastoral Care and counselling which could be useful is care that understands the person in the context of life and culture, and his or her own creative attempt to make meaning of life even in a crisis situation. The holistic view of life is a positive response which must be encouraged in every positive way (Msomi, 2008:125). It appears to be in line with this thinking that Berinyuu (1988:95) claims that

> In pastoral care the goal and process are one. The treatment in pastoral care begins with the initiation of the relationship between patient and healer and continues through the relationship. Thus, in a desirable African approach, the eliciting of information by healer is itself part of healing process especially when it is carried out empathetically.
>
> (Berinyuu, 1988:95)

Thus, insisting that Pastoral Care adopts a holistic approach which does not ignore the interrelatedness of the other dimensions in dealing with issues of ultimate concerns and meaning is well attested. The Pastoral Care stance of addressing the whole person resonates with the African and Nigerian holistic view of life beyond compartmentalisation. This is why

the patient or care receiver can seek healing from a Western medical practitioner while at the same time trusting religious healing and applying traditional healing. It is for this reason that Uka (1994:150) advocates for holistic healing in line with the African notion of sickness, wholeness and healing. Uka therefore contends that Pastoral Care addresses the whole person in distress. Drawing his conclusion from Jesus' model of Pastoral Care and counselling, Uka claims that "This … establishes beyond doubt the need for Pastoral Care and counselling which enables the sick not only to cope with physiological problems but also with inner conflicts and emotional disturbances. Pastoral Care and counselling provide encouragement and guidance for facing losses and disappointments and whose life patterns may become self-defeating and self-destroying due to illness" (1994:150).

The holistic approach in Pastoral Care gives primacy to the dignity of the care receiver, which nurtures his/her identity to develop a responsible and accountable self within the community. As already discussed, the community forms an important aspect through which Nigerians derive their identity. In other words, fostering dignity in a care receiver conveys the value and quality of the human person as an outcome of the unconditional love *(agape)* of God mediated by the pastoral caregiver. Clinebell's (1984:26) identification of wholeness as the central theme and motivation for Pastoral Care for specific stages of people's life (as in times of sickness) has implications for this study. Illness and hospitalisation constitute one of the developmental or crisis stages in a person's life. Therefore, "pastoral care and counseling must be holistic, seeking to enable healing and growth in all dimensions of human wholeness" (Clinebell, 1984:26). It is a view of reality; it sees the whole that is greater than its parts. It goes beyond mere the combination of methods of therapies or healing. Wholeness in Pastoral Care is related to the care receiver's wellbeing in the sense that it touches all aspects of the care receiver's personhood and existence. For Christian Pastoral Care, wholeness is a quality generated by the knowledge that all things become new (whole) in Christ (2 Corinthians 5:17). Understood in this way, wholeness is a gift. Although wholeness is a gift, it takes an effort, intentionality and often painful struggles to develop our potential (Clinebell, 19984b:59).

Wholeness in Pastoral Care derives from an important biblical concept. In the Old Testament, for instance, wholeness is denoted by the Hebrew word *shalom.* Shalom is a comprehensive word, which embodies far more than the common English translation of the word as "peace". It is constitutive in a vision of wholeness, fulfilment, harmony and peace, which brings healing to all creation. The offering of salvation through the forgiveness of sin by Jesus

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brought not only physical healing but spiritual healing as well. Consequently, one could argue that salvation is a comprehensive dimension of wholeness. Wholeness is (embodies) salvation (Igenosa, 1994:127). The concept of salvation becomes an all-important and very relevant one for most Nigerians. In Udo's opinion African Christians cling more to the concept of salvation than any other metaphor; this is because "Africans are all too familiar with the innumerable forces causing misfortune, sickness and death" (Udo, 1988:144). The themes of sickness, sin and witchcraft are an integral part of their world view and ethos. Berinyuu (1988:110) concurs that "the notion of sickness as a punishment frequently pervades the thoughts of the sick". Rassool's (2000:1481) remark that a "sick person should remember that his sickness is a test from Allah which carries tidings of forgiveness and mercy for him" implies the same concern for the Muslims. According to Udo (1988:146), salvation as the Ibibio of Nigeria perceive it "refers specifically to concrete situations occurring in everyday life … salvation is understood in relation to physical and immediate danger". Salvation (which is unlimited from the Pastoral Care standpoint) through Jesus goes beyond the African understanding of salvation limited to earthly wellbeing. Salvation in Pastoral Care includes dimensions of divine salvation of the soul which brings total healing.

Louw makes an interesting association between healing and salvation. According to him, salvation and healing are asymmetrical terms, which although distinct from one another occur together. Salvation (*jeschuach* in Hebrew) means to open, to make room. Therefore, he defines salvation as the liberating, renewing and justifying dimension of the kingdom of God, while healing is the restoring, reconciling, anti-destructive and anti-chaotic dynamic kingdom of God (Louw, 1998:55). Salvation therefore implies a new state of peace and reconciliation as was understood by the Israelites. Since both salvation and healing have elements of forgiveness, reconciliation, deliverance and peace, and are therefore transformative, it suggests that salvation is a comprehensive term, which includes the dimension of healing. Salvation as healing makes room for the sick and hospitalised to pour out their heart to God, confess their guilt whether real or imagined, and open doors for forgiveness, reconciliation and peace to estranged relationships. Healing is also a sign of the kingdom of God. Thus, a holistic understanding of healing does not lose sight of the dimension of salvation.

Most certainly wholeness as a Pastoral Care issue concerns itself with the following dimensions: conception of the absolute or God, meaning, connectedness, mystery, sense of freedom, ritual practice, forgiveness, hope, knowledge learning and present centeredness (Fukuyama & Sevig, 1999:86). Wholeness entails a dynamic and continuous process. This

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statement means that "wholeness is not to aim at who the person was, but to aim at who the person will be … human wholeness is not in the past (Garden of Eden) but in the future (kingdom of God)" (Lee, 2005:430).

3.10 Conclusion

The goal of this chapter was to explore the meaning and nature of Pastoral Care. The purpose of this exercise was to explore the theories, practices and methods of Pastoral Care so as to ascertain its value as a frontline approach for alternative health provision. This goal was pursued through delineating the meaning of Pastoral Care as understood by pastoral theologians across contexts as well as understanding the development of Pastoral Care. It envisioned that such understanding could assist in the appreciation of religious and spiritual opportunities and resources embodied in Pastoral Care for multidisciplinary practice in achieving holistic and quality healthcare. It provided an awareness of the religious model of healthcare from the perspective of Pastoral Care. This chapter's investigation was guided by The National Policy on Public Private Partnership for Health in Nigeria (NPPPPHN) (2005) statement that proven alternative health care practices shall be encouraged and supported as the frontline of health care provision for many Nigerians.

This chapter has established that although pastoral care has many definitions across contexts, it has been traditionally understood as care of the souls. It was noted that pastoral care has a multipurpose and multidimensional nature. The varied definitions illustrated that pastoral care is embedded in the caregiver's understanding of personhood, quality of life, God concept and understanding of God's involvement in human situation. Consequently Pastoral care was conceptualised as the critical constructive reflection of faith communities undertaken consistently in the context of the caregivers' praxis, This praxis draws on the caregivers' interpretations of normative sources in response to their interpretations of the situations and challenges they face and lead to ongoing modifications and transformation of their practices in order to be more adequately responsive to God's calling.

The chapter also explored paradigm shifts in pastoral care (3.3). Paradigms in pastoral care highlighted different points of emphasis in pastoral care to improve good practice. Three major paradigms of pastoral care were identified. These paradigms included the classical, clinical pastoral and communal contextual and intercultural paradigms. The discussion on paradigms established four important issues. First, pastoral care started with particular faith group (Christianity) and has broadened its practice to include other religious voices.

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Secondly, pastoral care has continued to improve its practices and methods through reflection with interdisciplinary conversation partners. Thirdly, the interdisciplinary perspective diversifies pastoral care as a professionally viable practice. Therefore pastoral care is understood to reflect reasonable, effective and substantively responsible practice that is sensitive to the care seekers needs. Lastly pastoral care has been reshaped as practitioners and theologians continue to respond to the cultural and socio-political context. Paradigms therefore demonstrated that models of care in healthcare should embody diversity.

Disclosed in the paradigm shifts was the notion that Pastoral Care embodies good practice. Pastoral care as good practice was reflected by means of elements in pastoral care. Such practice was identified in the pastoral relationship, the pastoral process and pastoral content. These basic elements of pastoral care affirmed pastoral care as a professional discipline which adheres to the core principles of healthcare that also constitute quality healthcare. It is also at the same time a unique practice. These unique principles were articulated as foundation, context, models, goals and functions.

This chapter established that pastoral care is founded on reliance on God's love and identification with human suffering and calls on Pastoral Care to participate in providing loving care for all humanity as created in the image of God within the context of community as an embodiment of the kingdom of God. Pastoral Care carries out its functions of healing, guiding, sustaining, reconciliation, nurturing, empowerment, liberation and compassionate resistance. The goal is to mediate love, peace and hope for spiritual transformation and growth of the care seekers. The kingdom of God as context of pastoral care envisions a community in broad-based practice in both private and public places such as the hospital. The context of pastoral care also established the importance of engaging in Pastoral Care within a contextual intercultural paradigm beyond individuals or exclusive groups. It affirms the NSHDP principle that "community is one of the most important settings [and resources] for health promotion" (NSHDP 2010-2015, 2010:64), most especially the Pastoral Care community.

Finally Pastoral Care was established as a holistic practice of soul care that nurtures and sustains a wholesome personality and wholesome life engagement in the Nigerian patient in the hospital. It is a practice of healthcare that embodies models such counselling, worship, advocacy, empowerment, visitation, preaching and dialogue as illustrated in 3.7. Pastoral Care is therefore in dialogue with the contemporary period and with faith traditions. Pastoral Care as soul care describes the core of Pastoral Care ministry, which is directed towards the

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care of the whole person. The Pastoral Care stance of addressing the whole person resonates with the holistic Nigerian view of life.

Pastoral Care promises to be a useful and valuable alternative and complementary model of healthcare that could be part of the continuum of care. In this sense, effective pastoral caregiving can authenticate the ministry and identity of the pastoral caregiver to all and sundry within the Nigerian hospital environment. However, in what ways can the resources of Pastoral Care be useful to the sick in the hospital environment? This raises the question of the role of the pastoral caregiver in the Nigerian hospital context; this will be the focus of the next chapter (Chapter 4).

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CHAPTER FOUR
THE ROLE OF THE PASTORAL CAREGIVER IN THE HOSPITAL CONTEXT

4.1 Introduction

In the previous chapter it was established that Pastoral Care as a religious and spiritual engagement is interdisciplinary, synergises with other healthcare models, could be a viable vehicle for providing spiritual care within the hospital, and as such could satisfy the religious and spiritual needs of patients and hospital staff within the Nigerian hospital environment. The discussion on the nature and meanings of Pastoral Care was based on the conviction that the understanding of the nature of Pastoral Care and its role within the faith community and the wider society including the hospital environment could help illuminate the content and resources of Pastoral Care as a discipline and the possible contributions it could bring to the Nigerian healthcare system in general and hospital care in particular through the PCG. Additionally, it was based on the National Policy on Public Private Partnership for Health in Nigeria (NPPPHN) (2005) statement that "alternative health providers, whose practices are of proven value, shall be encouraged and supported as the frontline of health care provision for many people".

This chapter will seek to explore the PCG's role and significance in contemporary hospitals in USA and Europe. It is hoped that such exploration could assist in the articulation of the role of PCGs in the Nigerian hospital context through which the resources of Pastoral Care can be mediated to the patients. The chapter will also argue for a meaningful participation of the pastoral caregiver within the Nigerian hospital context so as to enable the pastoral caregiver to contribute to the Nigerian healthcare system towards achieving more holistic hospital care and healing.

This chapter will employ Osmer's (2008:152) normative task to present its argument. The task has three dimensions: theological interpretation, ethical norm and good practice. Whereas the previous chapter made use of the task of theological interpretation, this chapter will engage the normative task of good practice. The notion of good practice fits perfectly with the purpose of this chapter in determining what ought to be going on in the Nigerian hospital environment concerning the provision of religious and spiritual care for hospitalised patients – that is, the role of the pastoral caregiver in relation to the patients in hospital care as well as to the staff. In view of the fact that Pastoral Care (in hospitals) as a professional discipline is not well developed in Nigeria, exploring good practice in different contexts

where Pastoral Care has been practised within the hospital context could assist in the articulation of the role of the pastoral caregiver in the Nigerian hospital. In addition to this practical theological framework, this chapter will also utilise a social scientific theory, role theory, to further deepen the understanding of the interplay of the role and identity of PCGs. Role theory, as social theorists, Gordon (1966:21), Biddle (1979:12), and Kreindler, Dowd, Star and Gottschalk (2012:347-374) have argued, is a major framework for explicating human behaviour in an interdisciplinary manner. Biddle (1979:11) a leading scholar in role theory, notes that role theory is an eclectic mix of sociology, anthropology and psychology. Therefore, role theory plays a fundamental role in the helping professions (Biddle, 1979:12).

Brookes, Davidson, Daly and Halcomb (2007:153) concur that role theory is a plausible and useful framework to facilitate an understanding of the role perceptions of community nurses [and PCGs] in the contemporary health care system. They argue that factors such as an ageing population and the increasing burden of chronic disease mean that models of care need to be developed with an interdisciplinary foundation. As such traditional professional roles as well as healthcare consumers' roles are also challenged to be interdisciplinary. Role theory provides valuable insights into viewing and understanding the dynamics involved in the behaviours, characteristics, norms and values of the [PCG's professional role identity] (Thomas & Biddle, 1966:3-19). The interdisciplinary frame of this study means that the principle of good practice and role theory will complement each other in determining the role of the PCG in the Nigerian hospital context.

The goal of this Chapter is to provide an understanding of the dynamics involved in the professional roles and identity of the PCG in the hospital context. This chapter aligns with the research goal of seeking a space for Pastoral Care and the PCG in the Nigerian hospital context and proposing a model through which the PCG can collaborate with medical personnel in a team approach to hospital care in Nigeria. In this endeavour this chapter attends to the questions: What is role theory and how does it help to validate the role of the pastoral caregiver in the hospital context? Who is a pastoral caregiver and what is his/her identity in the hospital setting? What are the role expectations of the PCG in healthcare settings such as the hospital? These questions will be explored through the lens of the PCG in the Western context from the perspective of best practice and will ultimately assist in answering the question: What could be the role and the resources of the pastoral caregiver within the Nigerian hospital setting? In the light of the first question, the foundation of the concept of role theory will first be addressed. This will provide the theoretical framework for

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the discussion of the identity of the pastoral caregiver. To attend to the third question, different contexts in which PC is already accepted within the hospital context will be explored.

4.2 The concept of role theory

Biddle (1979:11) describes role theory as a science concerned with behaviours that are characteristics of persons within a context with various processes that explain or are affected by this said behaviour. In a nutshell, role theory stipulates that *role* describes people's behaviours, norms or beliefs. These behaviours are determined by the social positions of persons in a context. Biddle (1979:11) defines a social position as an identity of a group of persons who are widely known and who behave in a characteristic way (e.g. PCGs). These roles are stimulated by certain expectations guided by certain norms, values, feelings or thoughts that people anticipate of the individual or group, or the individual or group anticipate of themselves, known as *role expectation*, which may be reflective of a personal, social or occupational domain (Creasia, 2001:73). However these roles are directed by the *context* that determines what behaviour is expected.

Context defines the space in which the role is enacted and may be referred to as setting (Creasia, 2001:74). Therefore roles have effects or consequences on the context or a social system known as *role functions*. This means that people need to be socialised into roles in order to develop a self-concept which is comprised of, among other things, a set of role expectations (or role set) as they assume various identities and enter different contexts. Biddle (1997:11) states that this process of socialisation can be sometimes problematic, because sometimes social positions are not governed by the abilities or desires of the people but by the customs of the society. Consequently problems may be encountered with the roles a person assumes because of the difficulty of performing some roles, because the roles are difficult in themselves or the roles are incompatible with the role expectations of the person, resulting in *role conflict*. Sometimes he or she may be required to do things that cannot all be done by one person, resulting in *role overload*. At the other times the person is asked to play a role inconsistent with his or her basic needs, resulting in *role ambiguity*. Sometimes roles may have great generality and are likely to appear regardless of context, resulting in *role overlap* (Biddle, 1979:66). Consequently "role function needs to be guided by the concept of *role clarity* in order to know which role is in relation to others so that one can act according to role expectations" (Creasia, 2001:74) to avoid unnecessary *role blurring*.

An evaluation of role theory has revealed at least two theoretical perspectives that can be used to analyse roles: the structural functional and the symbolic interaction perspectives. The third perspective, which is the dramaturgical perspective as identified by Hardy and Conway (1988), is an extension of the symbolic interactionist perspective. The structural functional perspective posits that roles are linked with social position or structure, where the person takes on multiple roles associated with that position (Brookes et al., 2007:148). The assumption of the structural functional perspective is that the social position embodies norms and values that are passed on from generation to generation, "but as the social structure changes over the years the value and norms of a given position adapt to the change" (Creasia, 2001:74; Berger & Luckman, 1966) because of mutual influences.

The structural functional perspective, for instance, includes formal prescriptions for action that result in appropriate behaviour as a code of conduct. On the other hand, the symbolic interaction perspective is developed from a psychological perspective and focuses on the interaction between persons in a social system who created their environment through self-reflective communicative processes (Creasia, 2001:75; Brookes et al., 2007:149). Thus in the symbolic intractionist perspective communication plays a central role in the relationship. For such communication to be effective, symbols must have the same meaning for each person in the interaction.

In applying the role concepts to the PCGs, the expected role of the PCGs is guided by the PCG's social position and the context in which Pastoral Care is delivered. PCGs enact roles according to their personal expectation of the role, the behaviour modelling they have witnessed, the set of expectations of others relating with the role, and the social structure in which the role is being performed (cf. 3.3). Pastoral Care involves role behaviours on the part of PCGs as they interact with clients. Therefore, it is possible to consider much of Pastoral Care within the role framework, because Pastoral Care goes on within the context of demands and beliefs. Rudduck (1966:4) notes that a role includes not only what is to be done but how it is to be done. The contextual nature of a role and its association with norms, beliefs and values of a social group relate a role to culture.

4.2.1 Roles and culture

Biddle (1979:66) states that roles are related to culture in that role concepts include all those behaviours characteristic of a society. In that sense the role concept of a society often translates to the behavioural aspects of the culture. However, he explains that roles are

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smaller units of behaviour than behavioural culture. Culture has been defined as a total way of life (Ruddock, 1966:19) of people. "It is an all-embracing term and includes the language, knowledge, techniques, moral feelings, and art forms of many people as well as religious, economic and educational institutions and of course the family pattern".

Thus the use of the role concept in connection with society is usually within an institutional or functional context. One may read of the religious role of the PCG in the hospital context in this sense. The societal role then is associated with positions which are called *positional roles*. Positional roles may be "defined as behaviours or characteristics of those sharing a commonly recognised identity or social position" (Biddle, 1979:66). Roles vary for those having different occupations, cast memberships or kinship designations. In a given profession like Pastoral Care patterns and role types become distinct. Biddle (1979:66) states that it is possible to expand the role concept so that it becomes equivalent to that of behavioural culture. Just so, it is also possible to restrict the scope of role so that role becomes equivalent to identity (Biddle, 1979:66).

4.2.2 Role and identity

Biddle (1979:9) states that role is a function assumed by an individual or structure which reflects a personal, social or occupational expectation or character which might be descriptive, prescriptive or evaluative, hence might be considered as identity (Biddle 1979:9). According to Ibarra and Barbulescu (2010:135), identity is "the internalised and evolving story that results from a person's selective appropriation of the past, present and the future. Chreim, Williams and Hinnings (2007:1517) add that "identities are reflexively applied cognitions in the form of answers to the question who am I? These answers refer to internalised positional designations that represent the person's participation in structured role relationships". As such, people internalise group norms and use them to guide behaviour as part of their identity (Kreindler, Dowd & Gottschalk, 2012:350).   This means that, like roles, identities are socially constructed. Therefore, using a social identity approach, Kreindler, Dowd, Star and Gottschalk (2012: 349) have identified key dimensions of identity such as social identity, social structure, identity content, strength of identification and context.[57]

[57] Social identity occurs when people (e.g. PCGs) typify themselves as members of an in-group because such belonging enhances self-esteem. As such, persons also try to maximize their positive distinctiveness by comparing themselves with other groups. On the other hand, social structure refers to structural relations among groups which determine the level of conflict or peaceful coexistence among groups. Identity content refers to internalized group norms that are used by members of the group to guide behaviours. They also mobilise in support of, or to combat threats to, these shared norms. Concerning strength of identification, individuals belong

Therefore, social scientists Chreim, Williams and Hinnings (2007:1517) state that role and identity are two sides of the same coin. "While role looks outwards to the interaction structure in a setting, identities look inward to the self-definition associated with role enactment". This means that enacting a particular role gives rise to role identity. "Role identity is the individual's interpretation of role expectation according to position specific norms, attitudes, behaviours and cognitions" required for the individual (Brookes, Daly, Davidson & Halcomb, 2007:151). Hence, there is an intimate relationship between role and identity. Research indicates that role and identity evolve interactively and that there is no simple causal directionality between social structures, roles and identity (Chreim, Williams & Hennings, 2007:1517), which apart from being personal can also have a professional dimension.

Scholars have defined the concept and components of identity variously as comprised of four perspectives.[58] What is common in all is that identity consists of a personal and social dimension. This study is concerned more with the social dimension of identity, although it does not preclude consideration of the personal dimension. This identity is viewed in the sense of what Augbuger (1986:87) calls interdependence. Professional identity is a subcategory of the social identity, which is the focus in this section of this study. From the perspective of social work, Banks (2004:137) articulates professional identity to mean quality or attributes, values and culture that individuals belonging to the same membership share with one another.

Professional identity is an individual's self-definition as a member of a profession. It is associated with the process of enactment of a professional role (Chreim, Williams & Hennings, 2007: 1517). According to Chreim, Williams and Hennings (2007:1516), professional role identity, like the personal role identity, is never static; rather it changes according to prevailing circumstances exerting their influence on the professional identity, causing individuals to reconstruct their identity according to changing times. According to socialisation research theory, changes in identity are associated with role transition, "because

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to many groups and their sense of identification could either be strong or weak. Strong identification encourages positive actions towards group goals and seeks to protect the group from perceived threats to its status, distinctiveness or norms. Context refers to the notion which stipulates that group social identities are not fixed but change with the social context. Therefore modifying the context changes the group behaviour.

[58] Writing from a cross-cultural perspective, Augburger (1986:81-86) lists a person's identity as comprised of tribal, communal, village and individual identities. Erikson (in Clark, 2006:301) names the four categories of Augsburger's as a conscious sense of being a unique and a separate individual, a feeling of inner sameness and continuity over time, a synthesizing function of the ego and solidarity with a group that affirms a person's own identity. Banks (2004:137) simply reduces the categories to three: personal, social and ego identity.

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new roles require new skills, behaviours, attitudes and patterns of interpersonal interactions, they may produce fundamental changes in an individual's self-definitions" (Ibarra & Barbulescu, 2010:138). Ibarra and Barbulescu (2010:137) refer to this process as identity work. He defines identity work as "people's engagement in forming, repairing, maintaining, strengthening or revising their identities". For instance, the PCGs in the hospital traditionally provided prayers and sacraments for the patient, but as time went on they embodied other tasks like administrator, counsellor and patient's advocates etc. as will be explained below in (4.6) the role of chaplains in the Western context.

Chreim et al. further explain that professional role reconstruction (i.e. identity work) is influenced by institutional forces such as professional associations that define what constitutes professionalism and government regulations that specify what a professional can or should do impacts on how professional role identities are constructed. On a practical level, attending to institutional forces allows professionals who envision changing role enactments to understand the extent and the boundaries of their agencies and the extra organisational influences on their roles. On a theoretical level, ignoring the institutional forces can result in a professional role identity that is contained within organisational boundaries, when in fact the construction is highly influenced by extra-organisational forces (2007:1516). More so, the institutional environment impacts on changing professional organisation and boundaries as well as on individual professional role identities. Therefore there is an interdependence between institutions and individual identity and roles. In other words, reconstructions of role identity are influenced by institutional, organisational and individual dynamics as well as the institutional environment.

From a theological perspective and practical point of view, Townsend's (2009:10) narration of the changing role of PCG in the past decades validates the theoretical claims of Chreim et al. According to Townsend, the changing role of Pastoral Care is influenced by the changing times, changing government policies and professional policies of the various Pastoral Care organisations (2009:10). Townsend's findings (cf. 3.3.2) indicate that the institutional environment of PCGs is a source of interpretive, legitimating and material resources that both enabled and constrained the reconstruction of professional role identity, as explained by these role theorists (Chreim, Williams and Hennings (2007:1516). These influences are seen from two perspectives – directly and indirectly: directly in the sense that PCGs adopt and adapt resources; indirectly as institutional dynamics affect organisation-level arrangements that further influence micro-level agency. Thus, Chreim, Williams and Hinnings (2007:1517)

indicate that groups may proactively seek changes in a role so that the role change may engender personal and professional development as groups absorb the change by altering identity-related values and attributes. This means that dissatisfaction with a role (i.e. norms and values) can lead professionals to redefine it by changing the mission associated with the role (as was evident in the paradigms in 3.3). In this regard, Townsend's (2009:10) observation on the changing roles of Pastoral Care could be explicated from the social theoretical framework of role theory, validating and legitimising the process.

Based on a narrative perspective, Ibarra and Barbulescu (2010:135) argue that conceptualising identity from the narrative orientation is critical for understanding identity dynamics during macro work role transitions, "defined as passages between sequentially held organisational, occupational, or professional roles" (Ibarra & Barbulescu, 2010:136). In addition, they argue that people make use of narrative [story] during transition to instate (establish) a sense of continuity between who they have been and who they are becoming, as well as to obtain validation from the relevant parties" (Ibarra & Barbulescu, 2010:136). Furthermore, they postulate that self-narrations are powerful ways people use to build a "transition bridge" across old and new roles and across identities claimed and granted in transition-related social interactions. "Stories help people articulate provisional selves, link the past and future into a harmonious, continuous sense of self, and enlist others to lend social reality to the desired changes" (Ibarra & Barbulescu, 2010:138). Hence people will draw on their personal repertoire of narratives in their social interaction to achieve their identity goals that are part and parcel of macro role transition processes (Ibarra & Barbulescu, 2010:136). For example, Huh (2011:356) uses his bicultural background to understand his professional identity as a pastoral theologian.

The motive for the engagement in narrative identity work is authenticity and social validation. Authenticity and validation correspond with identity challenges that arise in the macro work role transition. PCGs have sought to obtain validation from relevant parties as part of identity recreation as they reconstruct, alter and revise their work identities. From this work role transition and narrative theoretical perspective one then understands why PCGs are engaged and concerned about their identity. The recent revision of their role function from pastoral care to spiritual care (Townsend, 2004 & Schipanni, 2009) (cf. 1.8.4) and the

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production of the white paper[59] are all indicative of the importance of authenticity and validation.

Thus role theory helps to explain and underscore the current role identity dynamics that characterise contemporary PCGs in the hospital context. This perspective thickens the plot of the discussion of PCG in the hospital context and further enriches the theological explanation of the current pastoral paradigms and takes it beyond the scope of theological explanation of PCGs simply adopting the social scientific paradigms and allowing them to influence their theories and practice. Hence from the role theory concept, the PCG's identity in a hospital setting can be considered from multiple perspectives.

4.3 The Pastoral Caregiver's identity within a hospital setting

The question relating to the identity of the pastoral caregiver in the Nigerian hospital context is important to this study in view of its quest to find an authentic place and space for the pastoral caregiver in hospital care. Identity is generally a contested subject because it is related to the very essence of our humanness. Building on Oglesby's (1980) biblical themes for Pastoral Care, Clark (2006:299-302) explores "naming" as one vital aspect of identity for Hebraic culture, which resonates with many cultures including Nigeria's. He argues that identity in a way is tied to the way in which a person views and names his/her self in relation to others. Name conveys to an extent a sense of self-image, power and authenticity of one's being; although one's identity is more than the name, the name is nevertheless a window to understanding oneself and one's roles. When one choses one's own name, it becomes even more significant and a lens through which persons or groups see themselves. Apart from searching for an appropriate name that represents their role,[60] the PCG's quest for such identity is the quest for legitimisation, purpose, values and recognition (Ibarra & Barbulescu, 2010:138). Kreindler, Dowd, Star and Gottschalk (2012:347-374) refer to this quest as a

[59] The white Paper is a position paper edited by Larry VandeCreek and Laurel Burton representing the five major professional chaplaincy bodies in North America which includes: the association of professional chaplains (APC), the Association for Clinical Pastoral Education (ACPE), the Canadian Association for Pastoral Practice and Education (CAPPE), and the National Association of Catholic Chaplains (NACC) representing about 10,000 members as at 2001.(VandeCreek and Burton (2001:81-97).

[60] There is a gradual shift from the use of the term Pastoral Care to spiritual care by a number of Pastoral theologians such as is found in *Interfaith spiritual caregiving*[60], and the professional chaplaincy "white paper". Most of these Scholars define their practice as spiritual caregiving and themselves as spiritual caregivers. In a later article for the above mentioned bodies "Defining and Advocating for Spiritual care in the Hospital" VandeCreek (2010:1-10) argues that defining chaplains as spiritual caregivers could assist them to attend to plurality of the hospital as well as strengthen the position of chaplains (Pastoral Care/spiritual caregivers) in health care institutions.

search for a social identity. As scholars argue, the search for such identity is a necessary and legitimate engagement to gain control over one's stories. In this understanding, Rushdie (1992:432) states that "[t]hose who do not have power over the stories that dominate their lives, power to retell them, rethink them, deconstruct them, joke about them, and change them, truly are powerless because they cannot think new thoughts". De la Port (2013:21) refers to this story telling as a "hermeneutical circle of understanding". The story telling that elicits understanding and eventual altering is informed by the principles of hermeneutics and the hermeneutical circle of understanding that lead to the transformation of the pastoral encounter, role and identity. Such identity creates a sense of power and confidence and authenticity for the unique role of the pastoral caregiver in the hospital space. "Authenticity implies an awareness of the tacit value, beliefs, assumptions and frameworks that guide practice and behaviour and that distinguishes different approaches to chaplaincy [pastoral care giving in hospital]" (Cobb, 2005:86). In other words, authenticity refers to the integrity of the person of the PCG in any situation (Ibarra & Barbulescu, 2010:140). Thus, the professional self-understanding of pastoral caregivers, of their image and identity, will influence their calling, vocation and ministry with people at the borderline (the sick and suffering). Thus naming in a sense conveys the role of a person or group. When there is identity confusion, the chances are that there may also be role confusion or crisis (Biddle, 1979:9, Clark, 2006:301) by virtue of the interrelatedness between the two concepts. Role identity offers the possibility of unique resources for growth through the different stages of sickness, injury and pain, and subsequently fosters insights for meaning making for patient and staff in the hospital space.

The identity of pastoral caregivers in the contemporary context of care has become ambivalent with regards to their roles and values. Some have viewed the identity of the pastoral caregiver as being in a crisis in view of its relationship with psychology and other social sciences. The identity of the PCG has therefore been understood and explained variously. For Hollifield (1983:202) the identity problem arises as a result of "the application of psychological principle to the problem of religion", which meant that psychology offered scientific success and wisdom to Pastoral Care. Eventually their roles were compromised and thrown into confusion as they could not be what they were not trained to be. However, John Huh (2011:356) argues that rather than terming it a crisis, it should rather be perceived as a

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bicultural or in-between identity, like that of the bat,[61] in the sense that the pastoral caregiver draws from the field of theology and psychology. Just how much they draw from one another is a debate that is ongoing. Huh (2011:356) contends that PCGs should see their nature as that which can be helpful and beneficial and not always problematic or challenging. Therefore should PCGs embrace their identity without denying the complexities or be forced to lose one side of their identity? PCGs bring a unique perspective to patients' care. Huh's bicultural identity is a valid explanation taken from a narrative perspective.[62] All the same, the question that Huh has to answer is which field does his profession primarily belong to – psychology or theology? While Huh prefers to embody the image of the in-between, this image although helpful in some senses as Huh states, in other ways might not be as helpful as he had himself pointed out earlier. The wisdom then lies in using it when and where it can be helpful. As it relates to this study, the image of the in-between is certainly not what might help the PCG who seeks to be integrated into the space of hospital caregiving.

Nevertheless, Megazi (2005: 139) has acknowledged from within the African context that Pasoral Care in the mode of counselling is increasingly being influenced by psychology and, as part of the global village, Africa is not left out. In her opinion, the development is not negative and should be embraced. Consequently, as said before, there appears to be an ambiguous understanding and misconception of Pastoral Care roles in comparison with those of psychology, psychiatry and social work. One reason for the blurred role identity of PCGs, as argued by Briunsma de-Beer, (2010:168), is because during the colonial and missionary era, some missionary clergy who possessed dual professional identities as clergy and medical practitioners performed both roles in the hospital context. In the second instance, Pretorius-Heuchert and Ahmed (2007: 17) argue from the psychological perspective about the blurring roles in the helping professions. According to them, identity and role blurring has become a phenomenon in most helping professions, including psychiatry, psychology and social work. This situation is informed by globalisation and modernisation as well as the development of specialised care such as social work, psychology and psychiatry. Maintaining a clear

[61] Using cultural identity as his defining base, Huh defines bicultural identity as the identity of a person who identifies with two distinct cultures which might include race, gender, place, history, nationality, religious belief and/or ethnicity. In a comical way he uses the bat who is neither a bird nor a beast or both a bird and a beast and relates it to the Asian American identity and draws inference from both to make a case for the in-between identity of the PCG or pastoral theologian, as he chooses to call himself and which he sometimes found helpful (2011:355-361).

[62] Ibarra and Barbulescu (2010: 136) have argued that people make use of narrative in their role transition to "instate a sense of continuity between who they have been and who they are becoming, as well as to obtain validation from relevant parties". Huh's articulation of his professional identity reinforces Ibarra and Barbulescu's assertion.

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distinction becomes very difficult. Likewise, the question of the identity of PCGs has come under scrutiny in view of the phenomenon as explained by Pretorius-Heuchert and Ahmed (2007: 17). It has also been informed by the fact that the field of caring is claimed by many professions but not owned by any (Pretorius-Heuchert & Ahmed, 2007: 17). All of these caring professions claim a willingness to take action to improve the quality of life of the individual, group and community, and there is often very little distinction between what each claims to do. These interactions raise the question of disciplinary boundaries.

From the perspective of social work, Crisp (2011:667) observes that much of what is being done by these fields was under the jurisdiction of the church through the diaconate ministry of the church, which carried out works of charity, welfare, education, medical work, counselling and prayers (Crisp, 2011:667). A similar development has also arisen in the Islamic religion in the Islamic world (Nagamia, 2003:23). As such, it is arguable that psychology, psychiatry and social work have their roots in religion. As noted by Beth Crisp (2011:667), social work (welfare service) was provided by religious organisations. Thus the impact of secularisation may as well have impacted on the thinking and views of other helping professions as it relates to their relationship with Pastoral Care. It is therefore worth noting that the questioning of the pastoral caregiver's identity in the hospital context is not peculiar to PCGs, but it also applies to other helping professions in view of the seemingly overlapping roles between Pastoral Care and other caring professions (cf Bruinsma de-Beer, 2010:168). At this point, this study will also attempt to use role theory from a scientific perspective to understand the identity issue of PCGs in the hospital context.

The social identity theory and role theory offer an added perspective on understanding the so-called "identity crisis" of the PCG. Crisis is conceptualised as a form of role strain which may arise from role conflict, ambiguity and incongruity. These are the common role strains of PCGs, which result in what is frequently referred to as identity confusion or an identity crisis. Role stress arises when "social conditions in which the obligations of the adopted or expected roles are poorly defined, conflicting or difficult to meet" (Brookes, Daly, Davidson & Halcomb, 2007:152). Role theory also posits that the way the professional perceives his or her role is fundamental to how they interpret and act in a work situation (Chreim et al., 2007:1515). The PCG's identity in the hospital context, from a role theory perspective, is an attempt at identity work development (as explained by role theorists) and engagement as a necessary stage in their professional life that they must attend to in order to legitimise and validate their place as professionals of value; in the words of De Vries, Berlinger and Cadge

(2008:24), they are seeking to "stake a claim" in the healthcare terrain. Seen from the point of view of role theory, this is a natural process. De Veries, Belinger and Cadge (2008:24) argue that it is a "predictable stage in the natural history of an occupational group", therefore unavoidable for PCGs. The changing context of the hospital itself provides the driving force, among other agents such as their interaction with members of new role set such as health care professionals and individual motivation to explore new options and stay useful by reconstructing their roles and identities (Ibarra & Barbulescu, 2010:138-39). Chreim, Williams and Hinnings (2007: 1515) point to the necessity of professional role change. According to them, people actively engage in identity processes to claim, revise and alter their various identities. The question that is pertinent therefore is why does the crisis occur? Creasia, explaining this from the perspective of the nursing profession, argues that the stressors are the result of the uncertainty associated with professional practice which is impacted by the changing healthcare environment in which professional roles are enacted (2001: 78-79). According to Kreindeler et al. (2012:350), a social identity approach provides a general theory of group processes and intergroup relations and transfer of insights across inter-professional and inter-organisational domains, which this study could utilise to explain the PCG's identity dynamics. In other words, social identity theory contributes to role identity including leadership, motivation and commitment, communication, group performance, intergroup negotiation etc. They argue that a social identity approach enables consideration of multiple influences on groups and inter-group dynamics.

Consequently, the role identity dynamics of the PCG could be explained from the structural functionalist and interactionist perspectives of role theory. From the functionalist perspective, as explained earlier, roles are created by the society (i.e. institution, culture, policy etc.) and more or less universally agreed upon in which the individual or group acts according to expectations guided by norms and values of the social institution which are often conceptualised as inflexible and difficult to combine (Lynch, 2007:382). This implies that "the degree of clarity and consensus determine the degree to which a role enactment is considered convincing, proper and appropriate" (Lynch, 2007:382). This in turn means that visibility of roles is important for role clarity and consensus to be possible. Biddle (1979:75) describes role visibility as "the degree to which a role is performed in the presence of an audience". He explains that visible roles encourage direct feedback from others, and thus fostering reciprocity with other roles. As such roles and identity are more likely to be understood and endorsed when visible, because of a greater tendency to familiarise others

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with the role. On the other hand, roles which are low in visibility are less subject to feedback from others and are more likely to be misunderstood, which increases the importance of internalised controls within their performers. This is why professional associations enforce a code of ethics on their members. At the moment, in a number of contexts, the roles of PCGs in the hospital context are low in visibility, which increases unfamiliarity and the tendency to be misunderstood. Often these roles are performed only in privacy with the patient, family and staff. PCGs perform their roles in a highly structured healthcare setting, where they are directed by policies, procedures, job descriptions and evaluative procedures alongside other healthcare professionals such as the nurses, where the structural demands exert an influence on the healthcare professionals as well as PCGs.

From the interactionist perspective, the interaction of PCGs with other professionals implies that the role identity of PCGs cannot be fixed or prescribed but are constantly negotiated in creative ways (Lynch, 2007:383). Thus role norms and values, rather than being fixed and stable, are changeable, continually readjusting to the social processes (Lynch, 2007:383). Hence, the bridge between the social structure and the role identity behaviour is the reciprocal relationship. Therefore besides the structural pull, the interaction of PCGs with the healthcare professionals contributes to their changing role and identity. As shown above, many Pastoral Care theologians who deal with the PCG's role identity (and possible crisis) in the hospital context seem to focus on this interactionist theory as an explanation of the influence of the social sciences on the PCG. They sometimes overlook the structural perspective in the PCG's identity dynamics. Understanding these dynamics in the PCG's professional role changes involves taking into consideration the social identity, social structure, identity content, strength of identification and context in which PCGs are located. These dynamics could provide informed and meaningful strategies for overcoming the ambiguity or resolving the role stress that may impact negatively on the identity of the PCG. However, the above dynamics imply that to gain legitimacy and authenticity and validation outcomes from others, it is necessary for the PCG to have a clear picture of who and what he/she is and stands for. As earlier observed by Thesnaar (2010:268-269) in (3.8), PCGs need to be well grounded in their identity. This is necessary, because when role identities are vague, ambiguous and incongruent, they can become difficult, conflicting, irritating or even impossible to attain, which in turn may lead to frustration, tension and uncertainty. This may well be the experiences of some PCGs. A definition of the PCG could assist in revealing the identity of the PCG.

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4.3.1 Pastoral Caregiver (PCG) – a definition

A definition is necessary because it provides the foundation and guidelines for education and could elicit insight into the scope of practice and, when necessary, may assist in the evaluation of the quality and type of care offered. Swift offers a concise definition of the person of the PCG in the hospital which is illuminating. According to him, PCGs

> [a]re representatives of their faith communities, which require them to live out the commitment of those communities to the wider world, in this case in a healthcare context. They must therefore be learned in the ways of the faith group and knowledgeable about the basis for its decisions and guidance. In this role, Chaplains are accountable to the faith group for embodying its ethos and teaching appropriately. A regular checking-back and refreshment of this role is necessary
>
> (Swift, 2009:150).

Swift's definition implies that the PCG is a religious person who provides care in a crisis situation. Such situations include times when life becomes impossible, when relationships have been distorted, if not destroyed, and when faith fails. Hence, the PCG could be a pastor or rabbi or imam or a lay person representing the religious faith in caring for the spiritual needs of the patients and staff in the hospital. However, Swift's definition may suggest that PCGs (hospital chaplains) are for the exclusive concern and benefit of those who belong to that particular faith community, as is often the case with most hospital chaplains. This traditional understanding and practice is currently receiving some attention in research and reconsideration by pastoral theologians and practising PCGs in various healthcare settings.

Some PCGs are beginning to widen their circle of spiritual care to include care receivers of different faiths. Some examples include the works of Vitti (2009), Bueckert (2009), Schipani (2009), Peterson (2009), Rempel (2009), Griffith (2009), Driedger (2009), Farris (2009) and Weiss (2009), among others. This is because, as stated in the previous section (4.3), the changing healthcare context driven by changing policies exerts a pull on the identity of PCGs in such contexts, causing them to constantly redefine their role and identity to meet the demands of the current healthcare context. The redefinition of PCGs in the hospital context as spiritual caregivers implies that PCGs are concerned with providing spiritual care to patients (cf. 1.8.4). In consequence, Kirkwood's definition of the Pastoral Care becomes more acceptable in respect of the current role of PCGs in a hospital context. According to Kirkwood, a PCG is "a person who supports people who are experiencing the familiar trials that characterise life in this world, such as illness, surgery, incapacitation, death and bereavement" (1995:13). This definition embraces all events though PCGs may represent a

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faith community; their role in the hospital context goes beyond visitation of congregational or denominational or even religious members. It is worth noting that the PCG in the hospital setting and other public institutions is generically referred to as the chaplain.[63] However, this study adopts the term "PCGs" for the sake of consistency. This term attempts to avoid any misunderstanding that may be misleading in the Nigerian context, as Nigerians associate chaplains with ordained pastors who minister to their faith group.

The PCG refers to the person rendering pastoral care to persons who go through the doors of the hospital. Therefore, the term is intended to avoid limitation to a particular religious group. The term PCG is more neutral and yet retains a useful correspondence with the religious and spiritual activities or roles of specific persons in the hospital. In this study, the PCG cover a wider understanding of pastoral care to all patients irrespective of religious views. While this study maintains the use of PCG, the term "chaplain" will be used if it appears in the source materials consulted. It follows that in this study "chaplain" and "PCG" mean one and the same thing. There are three different categories of PCGs operational in the hospital context that are identified in this study. While the three categories of PCGs will be discussed in 4.3.3, the section below deals with the qualities of the PCG.

4.3.2 Qualities of the PCG

From the church fathers in the classical tradition (3.3.1) to the contemporary PCGs, the necessity of PCGs having good virtues for adequate pastoral caregiving has been emphasised (Oden, 1989; Uka, 1994:138-153; Kiriswa, 2002; Abdalla, 1997:105). Many scholars share this opinion and have constantly emphasised the fact that good pastoral caregiving lies in the PCG's attitudes or virtues, and is thus dependent largely on the personality of the caregiver in the field of spiritual practice. Accordingly, the church fathers recognised that "some guides [PCGs] are more competent than the others. Therefore, it behoves a reasonable person to choose a soul guide well" (Oden, 1989: 63). How then can a good PCG be distinguished from an incompetent one?

Oglesby (1980: 18) has argued that "Right Knowing", "Right Being" and "Right Doing" inform the process of Pastoral Care and by implication a good PCG. Oglesby's understanding has implications for this study's quest for a space for Pastoral Care in the hospital. It means that good pastoral caregiving is dependent on the person, skills and function of the PCG.

[63] Nigerians are familiar with the term "chaplain" and would most likely associate the term with military or tertiary education as almost all tertiary educational institutions, military cantonments and most recently the police force and presidency have chaplains.

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However, Louw (2012:24) argues that more fundamental in pastoral caregiving are the being functions (right being), because the decisions, motivation, norms and values and sense of responsibility are drawn from our being nature and influence the quality of caregiving within networks of relationships. Several scholars have therefore approached what they deem as the necessary elements, skills or qualities of good PCGs from different perspectives informed by their goal, context and foundation or motivation in temr of Oglesby's (1980: 18) categories of knowing, being and doing. For instance, St Basil (in Oden, 1989:62), arguing from the perspective of the classical tradition, has emphasised the virtues of love of God and the poor, knowledge of Scripture, spiritual growth, freedom from avarice, forgiving, humble and not given to indecision. Ignatius of Antioch (quoted in Oden, 1989: 76, 109,160) emphasised relationships of trust, wisdom and guidance by the Holy Spirit as the requisite qualities for good pastoral caregiving.

Contemporary pastoral theologians such as Gerkin (1986:107) mention such qualities as being a good listener and interpretive guide. For Louw (1998:263-298) effective pastoral caregiving requires six psycho-pastoral skills: probing, comfort, discernment (wisdom), interpretation, empathy (listening and unconditional acceptance) and edification. Kirkwood (1995:117-133) mentions acceptance, availability, accountability, compassion, concern and empathy, sensitivity, obedience, witness, servanthood, love, confrontation and renewal, which he suggests are from Jesus' model of care to emphasise the vital qualities of a good PCG. Kiriswa's (2002:57-73) view of a good PCG is claimed to be drawn from an African perspective of Pastoral Care and counselling. The qualities he upholds in this regard are personal maturity, empathy, unconditional acceptance, genuine involvement, Christ-like attitude, and prudence as a moral and spiritual quality. Benner (1998:208-213) mentions trust, spiritual and psychological maturity, genuineness, experiential knowledge of God, wisdom and humility.

For the purpose of this study, the requisite qualities of a good PCG which could be termed the essential qualities, which will be derived from the different views of scholars and deemed relevant to the Nigerian context and hospital environment. Moreover, the different qualities of the PCG as presented in the literature on pastoral care as well as sources of African origin in this study could be synthesised into key qualities which embody all the perspectives of the different scholars irrespective of context and goal. This is because the character and the values of PCGs in the Nigerian hospital should be in consonance with the African and professional values of care. Furthermore, the qualities to be discussed are those which would

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with different religious traditions as is typical of the Nigerian hospital context where PCG is required. The qualities to be discussed are as follows: love, compassion, good listening, trust and confidentiality, wisdom, spiritual sensitivity to the Holy Spirit, personal maturity and community consciousness.

4.3.2.1 Love

Love has been identified as central to pastoral caregiving by Africans, pastoral theologians and caregivers of Christian background (Herbert Anderson, 2012:61-69) as well as African (Kiriswa, 2002:60) and Islamic scholars (Abdalla, 1997:105; Jun 2008:195; Schirrmacher, 2008:31). The virtue of love occupies a special place in both Christian and Islamic scriptures. Some Islamic scholars such as Al-Ghasali conceptualise love as a religious obligation (Jun 2008:223). African society also extols love as the virtue that unifies a community. Likewise, in the Christian Scriptures love is signified in the New Testament by the Greek word *agape*, which means self-giving or self-sacrificing. Love is an attribute of God. The Bible in 1 John 4:8 makes it clear that God is love. Thus, Christians who undertake to communicate this love must imitate Christ. The Lord demonstrated divine love by his sacrificial life and ministry. Unlike human love, divine love often expects nothing in return. This love takes the initiative in reaching out to patients in spiritual need (Kiriswa, 2002:60). Accordingly, the Islamic prophets also prescribe that the caregiver must not wait until he/she is invited to go and see a patient, but rather must go as soon as he hears about the sickness (Abdalla, 1997:111). Divine love treats a person as the carrier of God's image and recipient of divine care and love. It cares in spite of and not because of. Therefore, love is a means of grace and the motivation that urges PCGs to be involved in other people's suffering and pain.

That love is a means of grace entails "an economy of gift" (Morrison, 2005:436) a gift expressed in various ways such as unconditional mercy and tough love freely given for service. It suggests an attitude of unconditional acceptance and positive regard, affirmation and guidance. The word "unconditional" is significant in Pastoral Care. It is a guide to PCG not to react negatively to our human fallenness and distortions, but to act in such a way as to heal not to condemn, as stated in Christian Scripture. In John 3:17 "God did not send his son into the world to condemn the world, but to save the world through him". The attitude of non-condemnation, or unconditional acceptance, does not mean that PCG colludes with sinful behaviour in theological language, or destructive attitudes in psychological language, or prevents persons from taking responsibility. Guiding people to take responsibility for the consequence of their actions is exactly what tough love implies. Emphasis on love as a

quality of a PCG in Nigerian hospital care implies that PCGs must embody the unconditional and sacrificial love of God to all patients irrespective of faith affiliation, ethnic group and social status. As Benner (1998:207) rightly comments, "caring for people also means caring for them as they are". Genuine love is what a lot of counselling and psychological literature may refer to as respect and unconditional acceptance. The PCG, Kiriswa (2002:60) argues, must reach out to the care seeker without judgment, prejudice or discrimination. Anderson (2001: 230) also posits that the PCG must be willing to give affirmation to the one who is vulnerable to the demands of the law and powerless in the face of God's judgment on sin. This is a test of our having received the grace of God (1John.3:14) and of our having known God. Substitution, unconditional acceptance and complete forgiveness are three principles involved in Christian love (Louw, 1998: 283-284). Closely linked with love is compassion.

4.3.2.2 Compassion: having a "heart" for the people

The metaphor of the "heart" *esit* is used by the Ibibios to express qualities such as love, compassion, courage, sympathy. *Esit* expresses the sensitivity of the caregiver. According to Louw (2008: 283), compassion involves the art of listening and unconditional acceptance. It is defined as the transfer of one person into the situation of another by means of emotional communication. Compassion bespeaks of empathy, which means the ability to understand and reflect on a patient's thoughts and emotional experience (Anderson, Ogles, Patterson, Lambert & Vermeech, 2009:757; Thesnaar, 2010:271).

Theologically the Hebrew word for compassion is derived from the root word *rhm*, which means to have sympathy, and from *hnn,* which means to have mercy (Louw, 2004: 52). This character imparts a sense of solidarity and consolation. It enables the caregiver to identify with the sick in their situation. Compassion obligates us to assume the role of a servant in order to share and absorb human hurt, as Jesus taught us in the Bible (John.13:5), i.e. sharing in the sicknesses and weaknesses of human life. Compassion inspires the caregiver to enter into the suffering of others and convey the love of God. Abdalla (1997:105) mentions that one of the attributes of God in Islam is mercy and compassion; some Islamic prophets claim that if a believer embodies compassion, this can bring about wonders and healing. Similarly Demissie (2008:8-9) argues from the African Christian perspective that compassion is a fundamental virtue that directs all caring acts into spiritual and moral significance which enhances healing. Compassion energises the caregiver to go the extra mile in providing care. Compassion in a way imparts comfort and support during counselling. Louw (1998: 273) asserts that supportive counselling focuses more on the nature of the person's present

relationship than on the causes of the problem or the event. Compassion needs to be shown to the patient with wisdom.

It may appear that looking at compassion in this way might suggest that we are trying to shield the patient from every pain, even when the pain is necessary for healing. Compassion can therefore be confused with sentimentalism, over-involvement, over-protectiveness or shielding the patient from taking responsibility, and even denial. The consequence of such a display of compassion is compassion fatigue and other related forms of stress. From a clinical perspective, translating compassion into a practical manifestation without losing its import is an art that comes from emotionally intelligent and mature caregivers. According to Gooch (2009:21), emotional intelligence involves understanding one's self, goals, intentions, responses and behaviour as well as understanding others and their feelings. Therefore, the key to genuine and appropriate compassion lies in ones' self-awareness and an understanding of others. The implication of Gooch's statement for pastoral caregiving lies in the fact that the PCG should be able to draw the boundary line between compassion and over-protection of patients. However, genuine compassion from the caregiver enables him/her to be available to the patient. Availability in this sense enables the PCG to embody compassionate identification with human suffering. Stuttard (2007:68) states categorically that "dealing with emotions in an appropriate way is the key when relating with others". Emotional maturity such as self-confidence can direct the PCG on the appropriate compassionate response such as not being afraid to break bad news, not denying the reality, and not confusing compassion with paternalism that shield patients from taking responsibility and making informed decisions for themselves (Goosh, 2006:20). Therefore, compassion as an emotional component and a Christian virtue is dependent on emotional maturity. The virtue of compassion could enable the PCG to be a good listener.

4.3.2.3 Good listening

Berinyuu (1988:95) has noted that a PCG must be a good listener to stories if he is to be an effective caregiver, as sick Africans bring their everyday stories to the caregiver. In the same vein McClure (2012:273) emphasises that every good pastoral caregiver needs to know how to give attention by listening. Good listening indicates availability and presence. Most people in situations of suffering need a listening ear to listen to their story. Such story telling by care receivers is usually therapeutic and healing emotionally and spiritually, because in so doing they release themselves of the tensions and anxieties and are able to hear themselves talk about their situation. Long (2007:55) remarks that "there are times when just listening meets

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the need because what is chiefly needed is not dialogue or advice but simply presence". This itself directs the suffering to a sense of purpose and meaning. Nevertheless, good listening does not come easily; only very few people are naturally disposed to listening to people without the temptation to talk or to give advice. Good listening also involves the skills of empathy, the ability to understand and reflect back ones' feeling (both verbally and non-verbally) in such a way that the care seeker can gain understanding of and perspective on him/herself and the circumstance. Gerkin (1986:107) speaks of the PCG as an interpretive guide to patients' stories. Listening requires patience, non-judgmental and undivided attention (Chauke, 2003:142) and an enduring attitude. Good listening is even more pertinent for patients whose speech and voice level may be impaired by physical sickness. Flohr (2009:147, 157) uses a "dance metaphor" to describe her Pastoral Care practice with people of diverse religious backgrounds. According to her, listening could be likened to learning a dance; one becomes a good dancer only through commitment, interest, constant practice and reflection. To be a good listener therefore requires, among other things, constant practice and reflection. What is heard through good listening should also be held in confidence.

4.3.2.4 Confidentiality and trust

Confidentiality is a core concept in the helping professions. As it relates to the PCG in the medical context, it suggests that under normal circumstances information shared between the patient and the PCG cannot be transmitted to a third party without the patient's knowledge and express permission. Elger (2009:517) remarks that within the medical setting a patient's right to confidentiality extends beyond death and thus is a cornerstone of medical ethics. This is because a breach of such confidentiality has moral and legal implications for hospital care. According to Elger (2009:518), "a violation of confidentiality takes place if the patient is identifiable and has not consented to the transmission of his personal data".

Confidentiality raises the question of trust. The patient-PCG relationship is based on trust as the information shared within that relationship is often personal, intimate and may reveal the patient's vulnerability such as shame, guilt, helplessness etc. The ability of the PCG to keep such secrets enhances trust, the alliance sense of and security of the patient. Sometimes the patient may not have shared such information with any other person, not even their closest family member. Such information, if disclosed to another person, can damage the helping relationship. However, there are some instances where confidentiality can and should be broken. Confidentiality which is not broken when it should be could result in collusion of the PCG with the patient and has a moral and even legal implication (Kiriswa, 2002:67). Keeping

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the boundaries of confidentiality requires pastoral sensitivity to the risks to the patient. This requires knowledge of the medical policies of the particular context and situation regarding confidentiality as well as wisdom.

4.3.2.5 Wisdom

The centrality of wisdom in Pastoral Care is extolled by all traditions of pastoral caregiving (McClure, 2012:274; Louw, 2012:23; Kiriswa, 2002:30). Oden (1989:48) argues that in the Old Testament proverbs wisdom is personified as a woman and extoled as the principal thing to acquire (Proverbs 4:5-13). In the New Testament Christ is extolled as wisdom per excellence. To have wisdom is to represent Christ, who is the source of *wisdom per excellence*. Wisdom implies the ability to discern right from wrong. Wisdom can mean good counsel *etsah, yaat* (Hebrew) *eubolia* (Greek) (Oden, 1989:48). Thomas Aquinas (in Oden, 1989:48) defined *eubolia* as “the gift of counsel”. Therefore Wisdom is a gift of the Holy Spirit. The necessity of the PCG to possess wisdom is emphasised by Gregory of Naziazen (quoted in Oden, 1989:48) in the following words: “The right medicine must be applied for the right occasion as the temper of the patient allows and as the time and circumstance and disposition of the individual indicate. This of course, is the most difficult aspect of pastoral wisdom, to know how to distinguish which counsel is needed in which situation with a precise judgment so as to administer appropriate remedies for different temperaments” (Gregory Nazianzen, Oration II.28-33, in Oden, 1989:110). Gregory underscores the point that care giving is a dynamic process in which the PCG is presented with a lot of resources, techniques as well as dealing with people of varied personality, background and so on. Therefore the PCG must be able to utilise approaches suitable to the particular resources and problems, strengths and limitations of each person (Kiriswa, 2002:34). Biblical wisdom is concerned with daily living and is learned in the daily experiences of life. Wisdom enables the caregiver to make good choices in ambivalent situations and circumstances. Therefore, McClure (2012:274) states that practical wisdom (*phronesis*) is important to the formation of the pastoral caregiver. This is because wisdom is connected to basic skills such as empathy, self-awareness and interpersonal sensitivity, which are fundamental to the effectiveness of the pastoral caregiver. For instance, wisdom received as grace enables the caregiver to select from the rich pastoral resources that are available to him or her. The caregiver needs wisdom to handle Scripture wisely. Christian counselling can turn into an irresponsible act when unhealthy and selective use of Bible passages is applied to the patient or client during the exercise.

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In African traditional understanding wisdom is seen as a product of age and experience in life. Therefore wisdom was associated with grey-haired elders; children and young people were not considered as competent to counsel. Elders were considered as having a repertoire of wisdom because they were seen to be emotionally mature, of good integrity and morally upright (Kiriswa, 2002:29-30). From the humanistic and psychological point of view, such wisdom comes from emotionally mature minds that are self-aware, self-motivated, empathetic and interpersonally motivated, which directs the quality of patient care (Gooch, 2006:20-22; Anbu, 2008:52). A hospital PCG requires wisdom that comes from his/her emotionally mature mind to actively listen, comfort and empathise without the danger of colluding or patronising the patient, and maintaining a professional boundary. Wisdom is a prerequisite for PCGs and in a sense it is one of the determinants of pastoral effectiveness in the clinical setting if they must engage people and situations rightly with a view to effect change, transform life and nurture maturity in faith. Pastoral Care effectiveness in related to the PCG's success in performing his/her given task (McKenna & Eckard, 2009:303-204). The PCG's spiritual sensitivity is crucial to effective Pastoral Care.

4.3.2.6 Spiritual sensitivity

Louw (2008: 268) states that the quality of our spiritual dimension influences our decision, determines the quality of healing change and growth. This implies that Pastoral Care and counselling are a spiritual engagement. Pastoral Care and counselling involve ambiguities to which human experience alone may not offer the necessary way forward. Matters of the spirit are hardly discerned with a carnal mind. They are interpreted by faith, which the Holy Spirit enables, enhances and sustains. Hence, Louw (1998:281) argues that the pastoral encounter is a "trialogue" in which God is the third conversation partner. In other words, an approach to pastoral caregiving requires conversion experience, a calling and an equipping by the Holy Spirit for an effective ministry of care. The PCG must therefore be sensitive to the guidance of the Holy Spirit in order to facilitate the therapeutic process in a way that is meaningful to the patient. Mbiti (1975: 38) has argued that even the traditional healers recognise that God is the ultimate healer, that they do not have the final power, skill or knowledge, and in that way they confess their limitation and humility before God. Islamic medicine also alludes to the Islamic healers' dependence on God through prayers and the study of their Qur'an as the guiding spirit (Nagamia, 2003:19). God through the Holy Spirit inspires and sustains the ability of the PCG/counsellor to interpret and minister catharsis to the crisis-ridden person. To interpret is the art of assessing and understanding. It "implies seeking clarification,

gaining insight and obtaining a systemic understanding of a person's unique identity. It is an attempt to understand parishioners' [care receiver's] reactions within the network of existing relationships, social context and cultural influences" (Louw, 2004: 281). Interpretation plays a crucial role in the ability of the PCG to administer relief to crisis-ridden persons by utilising the spiritual and religious resources, especially within the hospital context. Spiritual sensitivity implies a personal maturity and growth on the part of the PCG.

4.3.2.7 Personal maturity

Personal maturity is one of the important virtues that a PCG should embody especially in the Nigerian hospital context. Ministering to persons with diverse backgrounds with sensitivity demands maturity and understanding. Maturity enables the PCG to exhibit diverse virtues and qualities such as those mentioned above. In addition, maturity enables an atmosphere of rapport to be established between the PCG and patients, where the patients can comfortably share their concerns with the PCG without fear of being misunderstood and judged. Maturity is what enables the PCG to attempt to understand the patient's worldview, beliefs and values, and try to help them from that perspective. This quality looms large especially in the Nigerian context, which values maturity which is often linked to the age and experience of the counsellor. As such, counselling was mainly carried out by elders, while children were not considered qualified to be counsellors (Kiriswa, 2002:30). Given this background, the PCG may not necessarily be an elder, but should be able to exhibit maturity in his or her conduct that speaks of experience and expertise that could engender trust from the patient. Personal maturity can also strengthen the PCG's ability to appreciate the value of the Nigerian patient's community consciousness and resources, which are indispensable to hospital care and the patient's existence in the society.

4.3.2.8 Community consciousness

Agbiji (2012: 80) has articulated "value for community" as one of the goals of Nigerian development. The reason is that persons in Nigerian society are basically viewed within community. The PCG as a facilitator of people's potential towards their full development, transformation and growth must have this communal quality. Nwaura (2000:88) has stated that the PCG should be a connecting link between the patient, family, hospital staff, the world and God. The idea of PCGs as intermediaries has been echoed by several scholars. Given the community consciousness and the communitarian way of life of many Nigerians in particular and Africans in general, the PCG must have the ability to work with groups in the hospital

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and to connect to community groups, which may include religious organisations, civil societies and NGOs. This is necessary, as has been discussed in Chapter Two, because for many Nigerians life revolves around the community, where interpersonal relationships are of high value. As such the community is an avenue where moral and spiritual values and behaviours are constructed, moulded and checked. A PCG with a community consciousness can help create a caring community by encouraging the various expressions of community such as the family, compound, village and other groups to be their brothers' keepers in sickness and in health. Therefore the PCG who could be of assistance in building more of such connecting links between the patient and community must have value for community and a consciousness to tap the resources of the community for the wellbeing of the patient in the helping relationship, despite the type of PCG he or she may be. The discussed qualities of the PCG remain essential irrespective of the category of the PCG.

4.3.3 Types of PCGs in the hospital context

The types of PCGs in the hospital seem to be taken for granted by Pastoral Care theologians. This seems to be the reason why not many of them are addressing the issue. However, Kirkwood (1995:xi-xiv) has categorised four types of PCGs: the hospital visitor, the lay pastoral worker, the visiting member of the clergy, and finally the chaplain. Kirkwood's classification provides a framework for the discussion on types of PCGs in this section. Nigerian society has a strong tradition of family ties and a sense of responsibility to look after the sick, even the hospitalised. It is common practice that family members would take turns or designate someone to stay with their sick in the hospital to provide spiritual, emotional, psychological and physical care in the form of food, hygiene, prayer etc. However, the ability of Nigerian family to be physically present to assist their hospitalised member is waning as the society is becoming more fragmented, as there is upward and downward mobility in search for better life. In extreme cases, some sick family members are left with no form of family support. This care is complemented by the patients' other relationships, such as friends, neighbours, religious members and professional PCGs etc. Thus spiritual and religious care providers could be classified into three different groups: the pastoral visitors, lay PCGs/volunteers ,and professional PCGs or chaplains. We will discuss each of these groups, beginning with the pastoral visitor.

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4.3.3.1 Hospital visitor

Persons who are termed hospital visitors come purposely to the hospital to offer spiritual and emotional support to their family members, friends, relations, church members or neighbours. They have no special skills except that they are moved by a sense of solidarity and personal conviction to identify with their loved ones and others in suffering. Such persons are allowed access to their care receivers' only at stipulated visiting hours, unless such persons also function as the primary caregivers of the patients in the hospital, in which case they are allowed unrestrained access to the patient. Such pastoral visitors are usually limited to their care receivers in their provision of spiritual care. However, in Nigeria such visitors who feel obliged to visit other patients are sometimes at liberty to do so in some hospitals. This study recognises the special role this group of PCGs plays in hospital care to the sick and their families. As Bickle (2003:4) argues, although they may not be professionally trained, they are all to some extent caregivers (spiritual and otherwise) for one another.

4.3.3.2 Lay PCGs/ volunteers

Lay PCGs/volunteers are pastoral visitors who represent a particular denominational faith and who undertake such role on behalf of their religious faith group as part of their religious expression, motivation and commitment to the suffering patients in the hospital. While some are ordained pastors or other religious leaders who volunteer their services on a part-time basis, the majority are lay persons. In some cases they maybe part-time pastors who also double as non-medical staff co-opted by the hospital to offer spiritual care. From the American background Kirkwood (1995: xiii) posits that, although this category of caregivers is normally given basic skills in hospital visitation, they do not have any orientation or special skill in hospital-based Pastoral Care apart from their religious experience and resources. These PCGs are, however, more skilled (especially the ordained volunteers) than the hospital visitors in offering religious and spiritual care to patients as a result of their exposure to some form of religious and/or theological education and training. They are also more recognised by the hospital staff as specific people who offer spiritual care to members of their faith group and are regular in their visits. Such caregivers may enjoy more privileges in carrying out their ministry outside of visiting hours. The hospital staff may sometimes call on them to offer prayers or sacraments to a patient at the patient's request (Kirkwood, 1995: xiii). This type of pastoral caregiving is also known as the "parochial model" (Orton, 2008:3) (cf. 6.3.1). Although relevant, these types of PCGs have limitations. According to Orton (2008:3-4), they may limit their care only to members of their religious denominations. People without a faith

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group or who cannot reach their pastor or religious support group may be ignored. Orton also mentions a major disadvantage such as their non-inclusion in the clinical team, because their roles are not clearly defined and understood; as such, the potential for collaboration and referrals is eliminated because they are not professionally trained. Carey and Cohen's (2009:364) research revealed that chaplains who had no tertiary education and who had not undergone CPE had restricted access to patients and medical staff, and were thus at a disadvantage in providing holistic care support. Orton (2008:3-4) also shares Carey and Cohen's view on the disadvantage of lay PCGs and volunteers.

4.3.3.3 The professional PCG (chaplain)

Piderman et al. (2010:1002) have argued that professional PCGs in the hospital are certified chaplains who are "theologically and clinically trained healthcare professionals whose work involves understanding the spirituality of patients and providing spiritual care appropriate to patients' expectations and needs. Their ministry complements the work of other health care professionals and is valued by patients". These professionals "benefit from a basic understanding of relevant aspects of the clinical sciences including an understanding of common medical terminology, major disease processes, diagnostic investigations, and common types of therapy and patient management" (Cobb, 2005:26). These professional PCGs are conceptualised in various ways as directed by the cultural, religious and social context as well as government policies, the healthcare institutions and chaplaincy associations that shape healthcare in such contexts (Kofinas, 2006:671; Standard for Healthcare Chaplaincy in Europe, 2008:682). For instance, Standard for Healthcare Chaplaincy in Europe (2006:682)[64] states that spiritual care is delivered by PCGs "who have been professionally trained in the area of pastoral care". As such, their services are delivered "as part of a multidisciplinary team". Cobb (2005:13-16) explains that their role places them as part of allied health professionals, and although they are not under the supervision of the Health Professional Council[65], they maintain some level of professional accountability through authorisation by their faith groups. They also coordinate all activities related to the patient's spiritual care, and are more often in full-time service employment with the

[64] The Standard for Healthcare Chaplaincy in Europe is a result of the 7th consultation of the European network of healthcare chaplaincy meeting in 2002 in Finland representing 21European countries and 40 representatives of churches and other organisations. The Standard for Healthcare Chaplaincy in Europe is a collective statement and a reference document describing pastoral care of faith groups in the area of healthcare through out Europe. This document "is meant to be a point of reference and guide for all faiths and denominations in shaping spiritual care offered in the area of healthcare" (Standard for Healthcare Chaplaincy in Europe, 2006:682).
[65] The Health Profession Council is a regulatory body in United Kingdom that is responsible for the state registration, standard of education and training, conduct and performance of allied health professionals.

healthcare institution (Cobb, 2005; Orton, 2008). In some contexts such as the US and England some of the professional PCGs (chaplains) are licensed by the state and professional organisation or authorised by their faith community (Cobb, 2005:3-4, 16; Orton, 2008). These PCGs are accountable to their religious body and/or the professional body where such professional bodies exist and/or to the institutional bodies that employs them. The word "professional" raises two concerns that demands clarification. Does it mean professionalism or professionalisation? Accordingly, professional connotes either professionalism or professionalisation.

According to the *Dictionary of Pastoral Care and Counselling*,

> professionalism means that clergy develop a specialised knowledge of the Scriptures, theology, history of religion, worship and liturgy, preaching, and pastoral care and counselling, establish and maintain standards of professional competence, ethics and morality; promotes the advancement of religious belief, express loving concern for those who receive their ministries and function consistently with the mission and purpose of the church
>
> (Murphy, 2005:959).

This means that professionalism strives for competent, efficient and credible practice. Swinton (2003:2-6), drawing on Alison Elliot, describes five components in professionalism: integrity, autonomy, back-up, support and respect.

Professionalisation means developing a professional status (by virtue of their training and passion of the necessary competencies for a particular job) so that Pastoral Care as a profession can be recognised by other healthcare professionals (Smeets et al., 2011:89). In this case, such a move would include four components of a body of knowledge that supports and underpins their practice: a code of professional ethics, occupational organisation controlling the profession, substantial intellectual and practical training, and provision of specialised skill or service. Ellis and Hartley (2008:152), writing from the perspective of the nursing profession, agree with Swinton and Smeet. In their assessment of the nursing profession (i.e. professionalisation of nursing), Ellis and Hartley (2008:152) state that traditionally seven standardised criteria have been put forward as a guide for a profession, which includes certain areas enumerated by Swinton (2003) and Smeet (2011). They include:

- possession of specialised knowledge;
- use of scientific method to enlarge the body of knowledge;
- education within institution of higher education;

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- control of professional policy, professional activity and autonomy;
- a code of ethics;
- life time commitment;
- service to the public.

This research is conducted in the spirit of these two aspects (professionalism and professionalisation) of understanding professional chaplains (PCGs), in the Nigerian context, which leans more to professionalism, than professionalisation. This is because a professional PCG in the strict sense is not presently attainable in the Nigerian context because PCGs are lacking in terms of most criteria that may qualify them as professionals in this specific sense. However the focus of this study is directed towards developing Pastoral Care that is competent, accountable and credible through developing a framework for education, training, conduct and performance and regulation of practice that is at the core of all professional disciplines.

Each of these types of pastoral caregiving has its unique place or role in the hospital space and none can replace the other, but they complement each other as discussed in Chapter Three (3.5). The first two types of PCGs (hospital visitors and lay PCGs/volunteers) are operational in most Nigerian hospitals, but the professional PCGs are just emerging. Therefore, the major focus of this study is on the professional PCG. The contention of this study is that PCGs who can fit appropriately into the hospital context are the third category (the professional PCGs – chaplains). This is because "the clinical environment is both a technical and a social one and chaplains need to understand how to work in this environment effectively and safely" (Cobb, 2005: xiv). To be efficient in the hospital space PCGs must know the hospital context well and understand the process occurring within that context (Swift, 2009:152). Such efficiency cannot be acquired by chance but by intentional study, self-reflection, purposeful and rigorous training, education and supervision.

Besides, the traditional role fulfilled by the medicine men, mediums and religious specialists as we discussed in Chapter Two (2.6.1.4) gives impetus to meeting the need for a professional PCG, as such a person needs to receive training in this area in order to earn the respect and trust of the community which he/she is to serve. This training, as we observed from the Ibibio traditional background, sheds light on the importance of training, skill and the calling of a PCG (2.4.5). Given this background, it is obvious that the PCG needs to earn the respect of the public in the health sphere, which is highly professionalised, by being professionally trained. Professionalism, as stated earlier, does not abrogate the obligation of

the laypersons and even unskilled persons within faith communities to offer care as their Christian/religious vocation and personal engagement as part of the holistic framework for pastoral caregiving in the hospital. Rather it seeks to improve and/or provide the necessary basic skills for other types of PCGs for appropriate care giving. The different types of PCGs could therefore be grouped under two major models of Pastoral Care in the hospital context. In view of one of the goals of this study, which is an appropriate model of pastoral caregiving to patients in the Nigerian hospital, it is necessary to discuss types of Pastoral Care models in hospital care so as to understand their strengths and weaknesses for the purpose finding an appropriate model (approach) that will assist the PCG to function in the Nigerian hospital context alongside other healthcare professionals.

4.4 Types of PCGs caregiving models in hospital care

In this section the different types of PCG models of caregiving in the hospital context will be discussed. The task of exploring the models is in line with this studies' search for an appropriate approach to pastoral caregiving in the Nigerian hospital context. In Chapter Three this study identified three paradigms in pastoral caregiving. In the same vein, three types of PCGs in the hospital context were identified. The broad categories of hospital care can be grouped into two broad models (cf. Engelhardt, 2003: 145) – the parochial and the professional model.

4.4.1 Parochial role model

According to Orton, the parochial model refers to the traditional delivery of Pastoral Care (Orton, 2008). By definition, this refers to the providers of hospital care who have not had professional training in hospital-based Pastoral Care, but who volunteer their services within the context of the hospital on a part-time basis. The parochial model locates its hospital ministry with the sick within the confines of their particular denomination. This means that the PCG, be it a pastoral visitor, a volunteer pastor or lay PCG, represents his or her particular religious group (Orton, 2008). Within this model the PCG need not have any knowledge of conversational techniques or methods (Schmidt & Egler, 1998:241). This is because the parochial model often takes the classical form – i.e. proclamation of the Gospel, prayer and use of Christian symbols and rituals (Schmidt & Egler, 1998:239) (3.3.1). This model maintains the exclusive stance of a particular faith (e.g. Christianity, Islam or Judaism) as the only authentic religious form of expression. With reference to the Christian faith, this model of care "assumes that the ultimate meaning and aim of all human history lies in Christ

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alone" (Schmidt & Egler, 1998:247). Thus, as Schmidt and Egler (1998) further explain, the exclusivity purports that "[o]nly Christianity has been granted a revelation function"; all other religions must consequently be "false" for only Christianity is the true and correct religion. For PCGs implementing this model in practice means turning away from patients of other faiths, rejecting genuine communication, or attempting to convert them. Engelhardt (2003:148) agrees with Schmidt that the model "possesses a harshly exclusivist character unaccepting of the religious and moral claims of others". To endorse this claim Engelhardt (2003:148) makes references to biblical passages such as John 14:6, John 3:5, Matthew 28:19-20 and Mark 16:16.

Engelhardt (2003:145) characterises the parochial model or what he calls" the traditional Christian hospital chaplaincy" and its goal as a desire and urgency for repentance, conversion and salvation before death, and obligation to convert patients to right worship and right belief. Such goal, according to Engelhardt (2003:146), functions through 1) aiding hospital patients to recapture right belief in their spiritual struggles by encouraging patients from their denomination to live an authentic Christian life through helping patient to denounce immoral relationship through conversion; 2) helping patients in rightly worshiping God through the truth claim of Christ as the only messiah, encouraging repentance and participation in fellowship; 3) aiding hospital physicians in properly using medicine and biomedical sciences; 4) aiding physicians, nurses, and hospital administrators to act in accord with norms of right worship, right belief and right conduct by encouraging health professionals and institutions not to participate in interventions forbidden by traditional Christian norms, critisising a healthcare ethos incompatible with traditional Christian norms. It also encourages them to recognise that standards of good religious worship and belief are more important than standards of good health care. The main focus of this model is the sustenance of the member of a Christian denomination or faith community during a crisis period of his or her life. The parochial model is therefore based on the classical paradigm's (cf. 3.3.1) main proposition, which is proclamation and deliverance from sin as the motivation for involvement in pastoral caregiving.

4.4.2 Professional role model

The professional model refers to pastoral caregiving that focuses on formal training (often in CPE training) of PCGs to function professionally within the hospital space. According to Orton (2008), this model considers meeting the holistic needs of the patients in the hospital irrespective of their religious affiliation. Van Buuren, Kaya and Ten Broek (2009:282) argue

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that the professionalisation of Pastoral Care in the hospital context implies a move from denominational caregiving of patients by their own caregivers, but a provision of spiritual care to the public at large, including non-believers. Many practising PCGs in the hospital therefore express a strong view that pastoral caregiving in the hospital should have an inter-faith[66] character. Hence, professional pastoral caregiving mostly takes an inter-faith perspective.

More than twenty PCGs in their collaborative work *Interfaith Spiritual Care: Understandings and Practices* published in 2009 by the Society for Intercultural Pastoral Care and Counselling and edited by Schipani and Buekert, subscribe to the professional model. These pastoral caregivers are drawn from different contexts around the globe. The conviction of these PCGs and theologians stems from the clinical pastoral and intercultural paradigms of pastoral caregiving as discussed in Chapter Three of this study (3.3.2 and 3.3.3). Their main thesis is that the hospital is a pluralistic context that requires the sensitivity of the care givers to cultural, religious and spiritual differences among the care receivers. From an ecclesiological and missional perspective, Ndhlovu (2008: 225) has argued that pastoral caregiving of the sick in Africa (in the midst of the HIV and AIDS pandemic) should have an interfaith perspective where the resources and strategies can be combined for a more positive outcome. "It is moving away from the institutional church to the missional [vision of the church] where the focus is not the church but the world". The reason, as Carey, Davoren and Cohen (2009:203) have argued, is that "[w]hile PCGs do not have an automatic right to minister to people of other faiths, they do have an obligation to respond equally to the needs of people of any faith and to ensure that people of all religious/spiritual beliefs have the right of access to religious/spiritual care". Carey, Davoren and Cohen (2009: 203) further reason that the inter-spirituality model is driven by the discovery that the majority of medical, nursing and allied health clinicians did not consider as a relevant issue whether the PCG's religious faith or denomination was the same as the patient's as long as the PCG was available to provide pastoral support to the patient. From the perspective of intercultural theory, as Schipani and Buekett (2009) state, intercultural research on Pastoral Care and counselling offers an analogous link with interfaith care in the sense that issues and principles in intercultural care giving also apply to interfaith spiritual care giving.

[66] Although slight variations must occur between spirituality and faith yet this study does not differentiate between the two. Thus, faith, spirituality and religion are not distinguished and are used interchangeably.

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PCGs and scholars who support the professional and interfaith model also ground their work on common ground theory. According to Shmidt's (1998:243) explanation, the advocates of common ground theory argue that "patients in the hospital are in similar situations, that they have certain things in common, and that this may permit their being accompanied whilst adopting the spiritual dimension". This implies that all patients are equal in their state of sickness. In that sense, all patients desire a certain closeness and help from God, such that there is a heightened sensitivity to the spiritual dimension as they tend to question the meaning of life as never before in a way that transcends religious and denominational barriers. This justifies the PCG's involvement with all patients irrespective of their faith.

Topper (2003: 122) argues that spirituality is the world's first religion; therefore all people have a shared spiritual quest for transcendence, hence are spiritually interdependent and make spirituality the common ground. Such common grounds are the need for meaning, love, forgiveness, hope and creativity, and addressing these needs constitutes some of the roles of the PCG (cf. 4.4). Therefore through the identification of such shared needs Pastoral Care can be carried out with patients in all religious traditions. Furthermore, although patients are in the same place and experiencing the same challenge (illness), the paradox and reality is that they are lonely (Shmidt, 1998:244). Therefore for most patients the hospital is a strange world in which the experience of sickness has uprooted them from their familiar community to a strange one, and so one of the tasks of the PCG is to represent *heimat* ("home') in the unfamiliar community. Therefore, common grounds can be explored through words, i.e. exploring the basis stories,[67] (which are common to all patients irrespective of religious background) and gestures,[68] i.e. ritual practices (e.g. prayer) that the patient and the PCG may have in common. As Viti (2009: 16) argues, the ministry of PCGs with people of other faiths is not about who believes what; rather it is to establish a rapport of trust by relating to their spiritual needs in a way that did not necessarily involve doctrinal beliefs. Based on the practical experiences of many chaplains in hospital Pastoral Care, Schneider-Harprecht (2003:96) argues that "patients and their families only rarely express the desire for, let alone demand, Pastoral Care by chaplains exclusively from their own denomination". He further

[67] By basis stories Schmidt means stories linked to elementary things experienced by all people irrespective of religious or cultural background.

[68] Gestures, as Schmidt (1998:245), explains have a special significance within the field of Pastoral Care because they represent "symbolic movements" which embody a specific cultural code, yet conveying something common to all human beings that go beyond that specific cultural code. Schmidt's explanation tallies with Uzukwu's (1999:40-50) theory of gestures as a body and symbolic African language, which expresses worship, that will be discussed in chapter 6 and which this study argues could be good resource for pastoral caregiving in the Nigerian hospital environment.

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argues that for many patients and family, what matters most to them is a personal positive relationship of trust with the PCG or counsellor, as in some cases patients' relationship with their home church or religious group is not very close (Schneider-Harprecht, 2003:97).

Consequently, the advocates of the professional model derive their framework from different theories such as the intercultural theory of pastoral caregiving (Schipani & Buekett, 2009:2; Jorgensen, 2009:219-258); common grounds theory (Schmidt, 1998:243-246; Viti, 2009:13) and Biblical foundations (Schipani, 2009:51-67).

However, Schmidt observes that the interfaith approach raises the question: What are the possibilities and limitations of the interfaith approach? Underneath this question lies an insistence that one's own religion is the only absolute truth. Schmidt formulates three models of relating with others of different faith: the exclusive, the inclusive and the pluralistic. He rejects outright the exclusive model as inappropriate because it attributes revelation "as a mark of quality only to Christianity" (1998:247). He privileges the inclusive and pluralistic models. Engelhardt (2003:149) argues that the primary goal of the chaplain in the professional model "ceases to be that of guiding patients toward repentance, conversion and salvation and instead becomes that of bringing patients to spiritual and psychological peace toward the goal of successful health".

Being critical of the professional model Engelhardt (2003:147-148) lists the underlying guiding principle and goals of the professional model in the hospital as: first encouraging patients to live their lives in their own terms in so far as it does not interfere with the rights of others. This is carried out by protecting patients against exploitation and proselytising in the face of illness and suffering. Second, it entails the chaplain respecting the other's religion by aiding patients to develop and appreciate religious rituals within as well as outside of their own religious tradition for spiritual and psychological wellbeing. Thirdly, the professional model supports patients to use medicine appropriately for their goal of self-fulfilment through collaborating with physicians and other health professionals in diagnosing and treating patients. Fourthly, it aids physicians, nurses and hospital administrators in providing health care that respects all persons, life-styles and faith. Fifthly, the professional model discourages health professionals and institutions from imposing their views on others by refusing to participate in or referring for interventions acts forbidden by their religious norms. Lastly, this model also aids the health care professionals to recognise that good standards of religious worship and belief should be nested within good standards of health care. Therefore the professional model as Engelhardt (2003:50) perceives it locates the PCG within the

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therapeutic horizon of effective secular health care and the social context of a strongly ecumenical profession. Accordingly, he argues that the result has been that the chaplain's identity is dissociated from his denominational affiliation and identity. In this way, the PCG offers ecumenical care to the patient and unites him/her to various denominations and religious groups.

An appraisal of the parochial and professional models of Pastoral Care will be necessary at this point of the study so as to locate their strengths and weaknesses for the purpose of initiating an approach to Pastoral Care that will be relevant to the Nigerian hospital environment.

4.5 Critique of the parochial and professional Pastoral Care models

In every model there are strengths as well as limitations. This section offers a critique of the models discussed above.

4.5.1 The parochial model

The parochial model opens the space for mutual care of one another. The non-emphasis on skills tends to draw as many people as possible as people take on the task of pastoral caregiving, where non-professionals are not discriminated against in terms of skills or training. Marshall (1995: 178) comments that lay persons are essential participants in Pastoral Care since the local community of faith is the primary context that PCGs construct and reflect about particular issues. As Marshall (1995:179) further emphasises; "Parishioners need not be taught how to do care as much as be offered an opportunity to engage in critical reflection about the nature of their care". The strength of the parochial model (in the case of Christianity) lies in the fact that it attempts to place the person and ministry of Christ at the centre of care as the foundation for the PCG's work with suffering people. It upholds the basic Christian tenets of Christ as the only way to salvation. It places the gospel and the Scripture, the sharing of God's message at the centre of its care. In this way the parochial model takes seriously Pastoral Care's function of healing, reconciliation and forgiveness and incorporates them as part of rituals and practices of the faith group. This model of care affirms the view of some pastoral care scholars who have argued that the church has always responded to illness with rituals and care (Dunlop, 2012:32). The sacrament of communion with its appeal to the sense of smell, taste and sight as well as the repetition of the old familiar words is often the only recognisable event in the life of patients with dementia and other related forms of cerebral deterioration (Dunlop, 2012:32; Louw, 2008:525; Ryan et al.,

2005:44-55; Shamy, 2003). As already discussed in 3.7 and 4.5, this study takes seriously this dimension of the parochial model as Nigerian patients need a saviour who can heal them and restore their relationship with themselves and their fellow humans. This gives PCGs an identity they can be sure of, because they can be sure of their own religious identity.

From a functional level the PCG can easily find common grounds and basic stories to meet the spiritual needs of the patient, because they share the same beliefs and values. The experience of difference can be minimised, because the patient would have been familiar with the PCG who can facilitate the building of trust in the helping relationship. The parochial model reduces the uncertainty that PCGs might face regarding the approach to adopt with patients of other faiths, because the need does not arise as they offer Pastoral Care only to patients of their denomination, thereby reducing the fear of misunderstanding.

However, although the parochial model might be the ideal model in a homogenous religious context, it poses a challenge in the public domain such as the hospital, which is pluralistic in nature. The major flaw is that the parochial model tends to provide care only to those who already belong to a faith group, especially one which is the same as that of the care giver and receiver, thereby neglecting those who have no faith group (Orton, 2008) and even at times patients who may belong to the same faith as the care giver but have different doctrinal persuasion. On the other hand, the demand for absolutism and a strong sense of having the truth and Jesus being the only way to salvation (in the case of Christianity) might drive the care giver to put evangelism at the forefront as his or her goal in providing Pastoral Care to the sick in the Nigerian hospital, giving rise to aggressive proselytisation. Farris (2009: 181) comments on this model of care being prevalent in Brazilian society. This could also be said to be true within the Nigerian society. It is in this sense that he states that “the need is to evangelise, not only in the sense of spreading the seeds of the gospel, but of gaining souls for Christ” (Farris, 2009: 181). This attitude to care often reflects marks of subtle fundamentalism and a certain intolerance of other religious experiences. Farris explains that “the need to defend their identity, beliefs and numerical growth of religious communities” breeds intolerance and makes ministering to patients of other faith impossible (Farris, 2009:181). Such strong motives might also reveal intolerance and exclusion of patients of other religious communities. This raises the concern as to whether such an approach to care displays enough sensitivity to the vulnerability and powerlessness of the sick? Can it be said that the decision of the patient to accept such an approach in such a situation is made freely and willingly without pressure? Putting evangelism as the primary motive of Pastoral Care to

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the sick in the Nigerian hospital is discouraged by this study in the face of the spate of religious violence in Nigerian society because of such an exclusive position and ideology. The first thing is not for the care receiver to repent or convert to a particular faith or religion, but for him or her to first of all experience God's presence, love and acceptance in their predicament through the non-judgmental and compassionate presence of the PCG. Love cannot be forced, but only given or received. Love built on trust is based on a willingness to be there for another person (Shmidt & Egler, 2009:249) despite his or her difference.

4.5.2 The professional model

The strengths of this model include the fact that the PCG is available to provide Pastoral Care to all patients needing spiritual and religious support irrespective of the PCG's religious faith or denomination. Such competence arises as a result of the intensive training (through CPE) to offer spiritual care to patients over a wide spectrum of religions. As (Glaz, 1995:192) puts it: "In the midst of the hospital, a well-trained PCG thinks in many directions at the same time: intuitively, interpersonally, ethically, systematically, historically, empathetically, and in the light of the faith tradition (the patient's as well as our own)". The professional model provides skills, and professional competence to the PCG. Susanto (1999:113) cites Heintink as arguing that specialisation, individuation and professionalisation of the ministry of Pastoral Care are required in terms of special knowledge, skills and dedication. He argues that Pastoral Care ministry is a calling and a profession in the sense that professionalism contributes to the greater service of God and the people whom PCGs serve. "Through the specialisation in ministry the faith community can provide Pastoral Care to persons with special needs and in crisis including those beyond the local congregation". Another strength of the professional model because of specialisation and professionalisation is the PCG's ability to collaborate with physicians and other health care professionals in patient care; hence they are most often considered as valued members of the health care team (Orton, 2008).

A further strength is the concern of the professional model of pastoral caregiving with developing a high sensitivity to the patient's needs, and discouraging health professionals and institutions from medical paternalism and imposition of their views on patients, as well as with protecting patients from aggressive proselytising in the face of sickness, suffering and vulnerability of the patients. In this way the professional model unlike the parochial model goes beyond mere therapy and takes up issues of advocacy, liberation, development and empowerment.

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Furthermore, professionalisation of hospital pastoral caregiving seeks to transcend the fragmentation threatened by denominational commitments (Engelhard, 2003:153) by embodying an inclusive care which reflects the kingdom of God as the context and foundation of Pastoral Care to the sick in the hospital. The professional model promises to be useful most especially in contemporary Nigerian society, where different religions struggle for supremacy over others, giving rise to religious tension and violence.

Despite the strengths of the professional model, it still has limitations. The first limitation of professionalism is the narrowing of Pastoral Care to the sick to specialised individuals. Thus, Susato (1999:113) echoing Heintink observes that "professionalism also decreases the participation of lay people taking part in Pastoral Care to the sick in the hospital". In order to avoid the side effects of professionalism Susanto has emphasised the development and training of lay people, including a CPE programme for lay people. The major criticism of the professional model is its tendency to move away from the other functions of the faith community such as teaching, preaching and worship (Susanto, 1999:144). In the light of these weaknesses Sustanto (1999:150), drawing on Heitink, stresses the importance of training for lay people; he advises that within the local churches the professional training through CPE will have to direct itself mainly towards the training of volunteers in Pastoral Care, liturgy and diaconal service. He emphasises that "CPE should be close to the church; the aim of CPE means that it should always be closely linked to the work of the pastor, the institution and the local church". Thirdly, it is observed that, professional chaplains who operate from the inter-faith perspective were somewhat ambiguous in their religious identity because of the tendency among most of them to be detached from their denominational affiliation. The detachment of some chaplains from their religious institution has raised the question of the identity of the chaplains as their basic theological and theoretical orientation. This has led to the downplaying of the scriptural resource and less use of it. Operating from an inter-faith perspective requires the PCGs to recognise the limit of inter-faith cooperation. The PCG does not need to give up or hide his/her own identity (e.g. belief in Jesus Christ as the saviour) in order to be respectful to the patient's religious path when ministering to patients of other faiths. Buecket (2009:148) warns that "engaging in the interfaith spiritual care caregiving therefore does not require that we give up our convictions, though they may be challenged". Respect means recognising and acknowledging the other's differences. "Identification with the belief of one's own congregation is an essential element of Christian identity. To abandon it and, for example, to argue and act with a Jew like a Jew, with Roman Catholic like Roman

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Catholic, with a Christian Orthodox like a Christian Orthodox seems to destroy one's personal religious identification. It would amount to self-exclusion from one's own congregation and would even contribute to that congregation's destruction" (Schneider-Harpprecht, 2003:98). Schmidt (1998:252) insists that "respecting other religion whilst maintaining one's own religious identity entails the acceptance of certain limitations for inter-religious pastoral care".

4.5.3 A model or an approach?

In view of the limitations of the above models, the questions that may arise are: Is a model necessary? Does a model meet the demands of holism that this study advocates? Can a model create space for appropriate and flexible utilisation of available resources? The question of a model becomes important for this study, because of one of its objectives (1.5) is to find an appropriate approach by which the PCG can be utilised to function adequately within the Nigerian space. According to Osmer (2008:115), a model is a sustained and systematic metaphor. Models are theories in which a familiar area of life is used to understand a less familiar area (Osmer, 2008:115). Therefore a model is a well-established method in which the rules must be kept. In this sense a model is a method and a method is procedural (Richards & Stephen, 2001:19) and exclusive. A single model like the medical model, as this study has argued all along, cannot address the complexities of human condition appropriately. Likewise a single Pastoral Care model could hardly satisfy the complex challenges of providing adequate spiritual/religious care in a pluralistic setting such as the Nigerian hospital and Nigerian society. Pastoral Care covers more than a single model of care can provide: "it implies a comprehensive and holistic approach which deals with humans within the systemic dynamics of human encounter" (Louw, 2004:348). In view of this study's advocacy for a space to be created for PCGs in Nigerian hospital care, it hopes to adopt a flexible, comprehensive and progressive stance. Louw has argued that this space should be where people can experience *heimat* (at-homeness), and an opportunity to develop their hidden inner resources (Louw, 2008b:105; 2005:341).

Accordingly, this study prefers a hermeneutical approach to modelling. An approach is a set of correlative assumptions (Richards & Stephen, 2001: 19) dealing with the nature of Pastoral Care. "It describes the nature of the subject matter [to be understood or explored]". Richards and Stephen (2001:19) state that within an approach there can be many methods or models. An approach therefore provides many options for Pastoral Care, as it is impossible to reduce pastoral models to a single model. Pastoral Care could also become inadequate when a single

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model is adopted, especially within a pluralistic context such as the Nigerian hospital context. An approach takes on principles rather than specific formula. It is explorative not definitive, inclusive rather than exclusive. It is in this sense hermeneutical. Hermeneutical thinking is holistic, which is less abstract and more concrete as it focuses an experience, perception and emotion (Louw, 2012:41-43). The patient's distinctive situation, circumstances and needs will determine what approach PCG can adopt. In this sense it will be safe to adopt an approach rather than a model as this could make room for the complexities of human and contextual conditions.

So far, it has been argued that the PCG embodies different identities according to training, and theoretical and theological orientation within a particular context. Hence PCGs subscribe to certain qualities which enables them carry out their responsibility or role according to expectation. Therefore the PCGs' identity is also linked to his or her role. As such, understanding the identity of the PCG is an attempt to understand the role of the PCG in the hospital context. The question then is what is the role of the PCG in the hospital context? However, to fully understand what role set a PCG could adequately exercise in the hospital, it is best to explore the contexts in which such practice has already been established. We will now turn to the specific role of the PCG (chaplain) within the Western hospital context to be able to draw from that context for the benefit of the Nigerian hospital environment, which is the main concern of this study.

4.6 The professional PCG (chaplain) in the context of Western hospital care

This section deals with the specific role of the PCG in the hospital environment. The need for the PCG in hospital care is hypothesised as a relevant and potential patient care team member. Nevertheless, there is need for clarification and articulation of what role the PCG assumes in this space. This necessitates the exploration of some of the contexts where professional pastoral care is operational or pastoral caregiving is substantially evident. This is geared towards investigating the various roles of the PCG in these contexts in order to draw insights from them for understanding the possible role of the PCG in the Nigerian hospital context. This exercise will explore the North American and European contexts under four themes: background, professionalism, role and remuneration. Exploring best practice through these four themes is intended to clarify the dynamics of PCGs role identity development in these contexts and to examine role theory claims about the processes of identity formation. The choice of these contexts is guided by the fact of the professional, sustained and enduring practice of Pastoral Care in healthcare settings.

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Exploration of the North American and European contexts is based on the framework of good practice. According to Osmer (2008:152), utilising good practice for normative reflection is beneficial in two ways. First, it holds out a model of good practice from the past or present with which to reorganise the present actions of pastoral care. Secondly, it can engender new insights into the good spiritual life and social values beyond those provided by the received tradition. As it relates to the notion of good practice, this study is based on the model of good practice from the past or present with which to reorganise pastoral care's present actions especially within the Nigerian hospital context. In other words, good practice helps pastoral care to generate new ways of doing things better by learning from the gains or mistake of other traditions as well as providing resources and guidelines (Osmer, 2008:153). Insights gathered from this exercise will underpin this study's articulation of the role of the PCG in the Nigerian healthcare system and hospital context. In line with the goal of this chapter and the overall goal of the study which aims at advocating the role of the professional PCG in the medical team, the study will limit the exploration of the North American and European hospital contexts where pastoral care is being practised to the background, professionalism, payment and role of the PCG (chaplain) in such contexts in this section.

4.6.1 PCGs in North American hospital context

4.6.1.1 Background

According to Ford and Tartaglia (2006: 675) "[c]haplains [PCGs] have existed in the United States since the first expeditions from England had their clergy accompany explorations of the New World". This history shows a relationship between religion and medicine that existed as early as the founding of America by the British settlers. Some American writers such as Tovino (2011:66) have observed that the said relationship has not been static but a dynamic mode of interaction which could be interpreted as friendly or antagonistic, incompatible or complementary, depending on the period in question. Therefore, Tovino (2011:66) argues that "[i]n the United States religion and medicine shared a constantly evolving and interwoven relationship seemingly characterised by action and reaction, participation and withdrawal, competition and cooperation". This also implies the changing roles of chaplains in the changing context of healthcare.

In narrating the history of chaplaincy in America Tovino (2011:59-60), a professor of Health Law and Policy at Houston University, explains that during the ancient and the medieval period, hospitals were built and managed by religious institutions, because there was no

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separation between the medical and spiritual needs of patients; these needs were addressed by the same person. Tovino (2011:59-60) points out:

> In the middle ages, the church was the official body that issued medical licenses to physicians who typically were monks or priests, and the church primarily provided care for the poor and the sick. The hospital of the middle ages was a religious house in which the nursing personnel had united as vocational community under religious rule.
>
> (Tovino, 2011:5960)

Thus, the chaplain and the physician was one and the same person. But as Tovino (2011:60) notes, the period before the Reformation brought about a separation between preaching and healing which resulted in guilds of surgeons and physicians seeking primacy in curing and healing to the exclusion of the clergy in some instances.

In colonial America the rise of scientific and empirical medical practice caused the church to withdraw its involvement in healing practices. "The new science of geology, psychology and scientific historiography 'questioned' fundamental biblical assumptions regarding human origins and developments, the historical and scientific accuracy of the Bible and the traditional views regarding the nature of the human psyche" (Tovino, 2011:63). Consequently, chaplaincy and medicine were considered as operating according to separate principles and were fundamentally incompatible. The resulting effect was the intellectual and professional division between religion and medicine, leaving care of souls to the clergy (chaplain) and care of the physical body to the physicians. Tovino says that this situation continued well into the 20th century, where American patients continued to utilise hospital facilities and physicians according to physicians' religious affiliations, socio-economic and ethnic group. Tovino points out that Catholic hospitals once again started to address the human, spiritual as well as the medical needs of the patient, as nursing sisters cared for patients and constantly called on priests (chaplains) to give spiritual care to their patients. This became the practice of Protestant hospitals too, where chaplains served mostly as volunteers in hospitals. The volunteer chaplains were mostly retired ministers of the parish who had no special training on caring for the sick apart from that acquired during their ministerial training. Their role was limited to prayer support and offering of sacraments. This was the scenario until the development of Clinical Pastoral Education (CPE) in 1925, which some American pastoral researchers view as the beginning of modern chaplaincy (Ford & Tartaglia, 2006:675; Sakurai, 2003:26-28; Tovino, 2011).

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4.6.1.2 Professionalism and professionalisation

Professional chaplaincy in America traces its beginning to CPE in 1925 and marks this date as the emergence of modern chaplaincy. CPE provides the opportunity for chaplains to add clinical training to their theological knowledge in the hospital setting. The pioneers of this method of learning believed that this supervised method was what the chaplains needed to develop skills that will be of greater benefit to the patient and the medical care of the patient (Ford & Tartaglia, 2006:675). This CPE movement developed into several pastoral centres throughout the USA that later united to form the Association of Clinical Pastoral Education (ACPE) in 1967. ACPE forms one of the professional bodies in North America responsible for the certification of chaplains, chaplain supervisors and the creation of staff chaplaincy positions in both mental and general hospitals.

In North America five professional bodies are responsible for the certification of chaplains and other PCGs who work in several other settings. They are the National Association of Catholic Chaplains (NACC), the National Association of Jewish Chaplains (NAJC), the National Association of Professional Chaplains (APC), the Association of Clinical Pastoral Education (ACPE) and the Canadian Association of Pastoral Practice and Education (CAPPE) (Sakurai, 2003; VandeCreek, 2011:85). The purpose of these associations is to express their views with a unified voice as clinically trained and qualified pastoral professionals with the intention of providing standardised and accountable service as well as strengthening their professional image (Orton, 2008:13). Consequently, in 2004 the above organisations established the Spiritual Care Collaborative (SCC),[69] where they articulated common standards to guide their training and practice as well as for the purpose of accountability.

According to the White Paper on professional chaplaincy jointly produced in 2001 by these five bodies, the certification of a professional chaplain requires:

- graduate theological education or its equivalent;
- endorsement by a faith group or a demonstrated connection to a recognised religious community;

[69] Before 2004 SCC formerly existed as the council on collaboration, under which their first unified statement:" Professional Chaplaincy: Its role and importance in healthcare", commonly known as the "White Paper", appeared. It also produced other documents such as "Common Code of Ethics for Chaplains, Pastoral Counsellors, Pastoral Educators and Students", "Common Standards for Pastoral Educators/Supervisors", "Common Standards for Professional Chaplains", and "Principles for Processing Ethical Complaints" (Orton, 2008:15).

- CPE equivalent to one year of postgraduate training in an accredited programme recognised by the constituent organisations, or approximately 1,600 hours of supervised training in a healthcare setting;
- demonstration of clinical competency that includes adherence to a code of professional ethics that protects patients, clients, residents and their families from proselytisation and potential abuse (VandeCreek & Burton, 2001:85-86).

The professionalising of chaplains is significant for identity and role of the chaplain in the American health care setting as chaplains are required to demonstrate expertise in their own field. Sakurai (2003) believes that the professionalising of chaplaincy must have facilitated the inclusion of spiritual care assessment of patients by the Joint Commission on Accreditation of Health Organisations (JCAHO) in 1997. Although the chaplain's professional identity is still being contested by some healthcare professionals (cf. Loewy & Loewy, 2007:np; Raymond de Vries, Berlinger & Cadge, 2008:23-27; Swinton, 2003: 2-8), some chaplains, especially the Roman Catholic ones, do believe this has yielded good dividends for the identity of chaplains in many hospital medical teams as members of the healthcare team. "Chaplains have become more fully integrated into the interdisciplinary team. As members of the team, the chaplain is now responsible for providing spiritual assessments, interventions, and documentation in patient charts" (Sakurai, 2003:27). From the Islamic perspective, Syed (2003:45) has also observed that health professionals recognise the importance of Islamic spiritual healing. Although being included as part of the multidisciplinary team may be the ideal for PCG, whether they are made part of the team or not is not the question at hand. The position of this study is that there should be an integration of spiritual care in Nigerian hospital care as part of holistic care through collaboration with the PCG. More recently, the Association of Professional Chaplains launched new standards of professional practice (Chaplains Launch New Standards of Practice, 2010:22).

A number of factors contributed to the employment and integration of chaplains in the North American context. The nature of the healthcare system[70] and its reforms warrant the inclusion of PCGs in their hospital structure. The need to meet the criteria for accreditation informs

[70] The health care system in US is not centralised but decentralised, therefore "there is no single central body responsible for regulating, or funding health services or facilities, or workforce planning". There are mainly two types of hospitals: for profit and not-for-profit. The majority of funding comes from profits from healthcare user (39%), private health insurance (24%) and government contributions (35%). Although the regulation of health care quality is done by several accreditation agencies, the largest and most recognised throughout USA being the JCAHO. To operate as a hospital, the hospital must meet the JCAHO standard for accreditation. In 1997 the JCAHO reviewed their standard to include provision for spiritual assessment for patients (Orton, 2008:12).

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their decision. Secondly, the size, finance, nature (religious affiliation) and the context[71] of the hospital are also decisive factors. According to Flanelly, Handzo and Weaver's (2004:np) research findings, the not-for profit hospitals employ more chaplains than the for-profit hospitals. They speculate that funding, higher volunteerism and a sense of community obligation might be the motivating factors. This means that the chaplains will experience their role in varying degrees as influenced by the payment status. All the same, the various roles indicate that the chaplains are significantly valued within the hospital.

4.6.1.3 Role

Whereas there are ongoing arguments of the role of the chaplain in the Northern American context, the contribution they can make is not in doubt. Tovino's review of current hospital policies and procedures demonstrates that many hospitals in USA perceive the chaplains as members of the healthcare team. Consequently, the hospital chaplain is sometimes regarded as a member of the healthcare team at best and at worst not as a member of the healthcare team but instead as walking between the world of religion and health (Tovino, 2011:71). Based on her research on the functions of hospital chaplains in many American hospitals, Tovino (2011:69) describes the role of hospital chaplains thus: "As part of their job hospital chaplains interact with patients and families, medical and nursing staff members, ethics committees and institutional review board members, hospital administrators, volunteers, and community members". Hospital chaplains perform many functions and services that are partly or mostly religious or spiritual in nature as well as several other functions and services that cannot be characterised solely by their religious or spiritual characteristics. He further asserts:

> The functions and services of today's hospital chaplain that are partly or mostly religious or spiritual in nature include but not limited to: providing spiritual care, including grief and loss care; performing spiritual assessment of patients; performing patient's risk screening, which includes identifying those patients whose religious or spiritual conflicts may compromise recovery or satisfactory adjustment; charting spiritual care interventions in medical records; protecting patients from unwelcome forms of spiritual care intrusion; reminding hospital workforce members and patients of the healing power of religious faith; facilitating spiritual issues relating to organ and tissue donation; designing and leading religious ceremonies of worship and ritual including prayer, meditation; reading holy text, worship and observance of holy days, blessings and sacrament; memorial services and funerals; rituals at the time of birth or

[71] Major hospitals have PC departments (PCD) staffed by salaried professional chaplains. Religiously affiliated hospitals and rural hospitals have more chaplains in their PCD, the majority of whom are volunteers and are less likely to have had specialised training. Professional chaplains are paid directly by the hospitals that employ them.

> other significant times of life-cycle transition, and theological observances' making presentations concerning spiritual and health issues; training and supervising volunteers, from religious communities who can provide spiritual care to the sick, conducting professional clinical education programs for seminaries, clergypersons and religious leaders; developing congregational health ministries; educating students in the health care professions regarding the interface of religion and spirituality with medical care; offering patients, family members and staff an emotionally and spiritually "safe" professional care from whom they can seek counsel or guidance; engaging in research activities relating to the development of spiritual assessment and spiritual risk screening tools, and promoting research relating to spiritual care at national conventions
>
> (Tovino, 2011:69-70).

Tovino adds that besides the performing functions that are purely religious or spiritual, they also carry out a number of services that cannot be said to be religious or spiritual in nature. Such services include communicating with caregivers, facilitating staff communications, resolving conflicts among staff members, patients and family members, referring patients to internal and external resources including other healthcare providers, patients' advocates, and community and social resources; providing "decent care" providing institutional support during organisational change or crisis (2011:69-70). Furthermore, they also participate in medical rounds and patient care conferences, interdisciplinary education; ethics committee and institutional board review, assisting patients and families in executing or completing advance directives; clarifying the application of institutional policies and behaviours to patients, community clergy and religious organisations. In addition they, organise in-service education; interpret and analyse cultural traditions that may impact clinical services; represent community issues and concerns to the organisation, as well as act as "cultural brokers" between institutions, patients, family members and staff (Tovino, 2011:69-71).

The White Paper summarises the above roles into ten generic functions of hospital chaplains. It also acknowledges that no one chaplain can or needs to perform every function.

1. Chaplains constitute powerful reminders of the healing, sustaining, guiding and reconciling power of religious faith.
2. Professional chaplains reach across faith group boundaries and do not proselytize.
3. They provide supportive spiritual care through empathetic listening, demonstrating an understanding of persons in distress. This includes spiritual assessment, grief and loss

care, referrals and linkage to internal and external resources, staff support relative to personal crises or work stress etc.

4. Professional chaplains serve as members of patients care teams by participating in medical rounds, charting spiritual care interventions; patients care conferences and interdisciplinary education.
5. Professional chaplains design and lead religious ceremonies of worship and rituals.
6. Professional chaplains lead or participate in healthcare ethics programmes.
7. Professional chaplains educate the healthcare team and community regarding the relationship of religious and spiritual issues to institutional services.
8. Professional chaplains act as mediators and reconcilers.
9. Professional chaplains may serve as contact persons to arrange assessment for appropriateness and coordination of complementary therapies such as healing touch, relaxation training/ Guided imagery, music therapy and meditation.
10. Professional chaplains and their certifying organisations encourage and support research activities to assess the effectiveness of providing spiritual care.

4.6.1.4 The question of payment in the USA context

Remuneration is an issue in this study in view of the scarce financial resources for healthcare in Nigeria, which this study suspects might be a factor to consider in providing religious and spiritual care through the PCG. Remuneration is often a subject of debate when it comes to the question of reward for services or payment in exchange for services rendered by caregivers. It even forms part of the code of Nigerian Medical Ethics Part D, No. 47 (2004:56). Within the medical profession the issue of what should be the wages of the medical doctors or if they should be paid at all is an age-old argument dating back to Hippocratic times (Kunhiyop, 2008: 354). In a market-driven economy where exchange of goods and services is categorised based on perceived needs and performance, the question of payment becomes an inevitable matter of debate. For the medical professionals who in the time of Hippocrates belonged in a subjective market where goods and services were traded without direct economic exchange, the question was more prominent. However, the progress in medical technology and expertise has shifted the question from whether they should be paid to how much is ethically right for physicians to charge patients (cf. Code in Nigerian Medical Ethics, 2004:56). Pastoral Care is currently in the same spotlight as the medical

profession was many years ago. According to de Vries, Berlinger and Cadge (2010:24-25), chaplaincy (Pastoral Care) is currently viewed by health care stakeholders as belonging to the subjective market. They are therefore asked to justify their pay in terms of quality improvement (QI). VandeCreek in Engeldhardt (2003:156) expresses the same sentiment when he suggests that

> [t]hese are changing times for hospital chaplains as well as for all healthcare. The focus is shifting from business as usual to constant examination of service delivery. This is demonstrated by relentless productivity reviews and by the need to produce more for less. Most hospital chaplains are concerned about these changes because they increase the need to demonstrate the benefit of pastoral care.
>
> (Engeldhardt, 2003:156)

In other words, hospital chaplains or pastoral caregivers are asked to "specify how their profession in the day to day work in the hospital contributes to the ongoing task of quality improvement in the healthcare". Such demand becomes difficult as chaplaincy or Pastoral Care work cannot be measured using conventional quality improvement instruments. David Kirkwood (2004:12) confirms Engeldhardt's claims that there is a limit to evidence-based approach. According to Kirkwood, evidence-based research can easily be exaggerated so that it obscures the reality of patient care. "[T]he endless variations among patents and constant evolution of technology and … procedures available will always make it impossible for research to provide answers to all the questions that practitioners have". Certain aspect of the practitioner's success in providing benefits and satisfaction will always depend on skills and attributes not acquired through research findings. The question of payment as it relates to this study is not so much of how much the PCG should be paid than who should be responsible for the payment for his/her services.

The provision of spiritual care in the USA is a response from the major credentialing body JCAHO as well as Medicare, and many states demand that spiritual care be provided to patients as part of healthcare which also forms part of their accreditation criteria. This was premised on the fact that spirituality is essential to the provision of pastoral care and payment for its services was justified, both legally and morally (Pulchalski, Lunsford, Harris and Miller 2006:398-416; Warnock 2009:468). Therefore, the provision of pastoral care services in USA healthcare settings as part of the holistic healthcare is paid for from funds generated from patients' fees, and private and public sources. As a decentralised system of healthcare, the provision of pastoral care varies. As independent institutions, each hospital determines the nature and number of PCGs it provides. Orton (2008:12) notes that generally, there are no

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clear role expectations, practice standards or employment criteria. As a result employment decisions are made independently at the local level of individual hospitals. Therefore, major hospitals have pastoral care department with full time paid Chaplains. The services provided by these PCGs necessarily conform to the institutional policies and day-to-day operations of the hospital (Orton 2008:12). In the rural areas or smaller hospitals, while they may have salaried chaplains, they are most likely to rely on pastors to support individuals with a connection with local congregations or particular faith traditions. Furthermore, religiously affiliated hospitals have more PCGs in their services but as Flannelly, Handzo and Weaver (2004:np) observe, they are less likely have special training for pastoral caregiving in the hospital and rely instead on their general training for ministry.

Therefore whoever pays for PCG's services has implications for the nature, model and utilisation of pastoral caregiving in each context. The issue for the Nigerian healthcare system and the inclusion of professional Pastoral Care is not so much a question of how much the PCG should be paid as who should be responsible for their payment. Whatever is the source of payment, it should be noted that the source of payment could in the long run have implications for pastoral care and its providers.

4.6.2 PCGs in the European hospital context

4.6.2.1 Background

The history of health care and religion in Europe indicates that chaplains have always been part of hospital care. The role of chaplains was never in doubt, although roles had to be defined and redefined according to the changing contexts and needs of European society. Consequently the organisation of chaplaincy differs significantly from country to country in Europe and is shaped by religious faith groups, health care institutions, state healthcare regulations, policies and chaplaincy associations (Kofinas, 2006:671; O'Driscoll, 2007:12; Standard for Healthcare Chaplaincy in Europe, 2006:682).

Swift (2009:9-27), in narrating the history of chaplaincy in England, asserts that "the practice of assigning clergy to work in hospitals has been a part of life in England for a thousand years". Gilliat-Ray 2010: also states that from 1970 there was the emergence of Islamic chaplaincy. According to Gilliat-Ray (2010:146), the Muslims involved in hospital care were often referred to as 'visiting ministers'. Their work was often voluntary and usually confined to several hours per week. This presence became more institutionalised in 2007 (Gilliat-Ray

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2010:146). Therefore, chaplains were part of the hospital setting from their inception. He explains that during the period before the Reformation chantry chapels existed within hospitals where prayers were offered. The coexistence of chapels and hospitals implied that the main purpose of hospital care was not only to save lives, but also to allow the pious to exercise Christian charity through healing. Therefore the role of the doctor was to advise the patients to see the pastor for confession and reconciliation and spiritual healing before the commencement of medical treatment. This practice indicated an underlying assumption that the soul was more import than the body. In this sense the operation of the hospital places the chaplain (PCG) at the centre of care. Swift argues that during the 13th century, when hospitals started to function as separate foundations apart from the church, the role of chaplains, although revised, did not change significantly; chaplains were still key figures within the hospital context. The hospitals still maintained the spiritual content of their treatment procedures. Every one living in the hospital was required to make confessions three times a year to receive sacraments three times a year. The chaplain was a central figure in the organisation of the hospital life of care in terms of charity, worship and administration for the sick-poor (Swift, 2009:12).

The Reformation and later periods brought radical changes to the operation of hospitals.[72] The hospital confessor (the chaplain) was re-named the hospitaller and his duties expanded. In line with his expanded duties, he was to have a Bachelor of Divinity (BD) or Master of Arts (MA) degree to qualify for the position (Swift, 2009:17-21). His role or duties included having oversight of the administering of the hospital, comforting the sick by his[73] exemplary life, visiting the sick, being present when they go to bed, and ensuring there is no drunkenness, disorder or blasphemy. He also kept records of those who enter and leave the hospital, and consulted with the surgeon for changes in schedule in addition to praying for the sick, hearing confession and conducting sacraments. The reviewed duties of the hospitaller and the government interest in hospitals meant that "the chaplain's obligation were no longer unified but separated, described in terms of duty to God through the king and governors as representatives of the city" (Swift, 2009:17-21). In addition, his remuneration was taken up

[72]The hospitals were nationalised and became more "royal hospitals" than ecclesiastical, which meant the government provided care, and internally hospital care became geared towards modern medical practice. The shift to medical science would also have implications for the role of chaplains; although chaplains still played key roles, the doctors would now take the centre stage. "The physician is directed to annex these responsibilities uniting the task of moral and physical inscription" (Swift, 2009:23). Five new hospitals were established to cater for the growing population of the sick-poor.
[73] Chaplains in this period were essentially males.

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by the governor. The hospitaller was to understand the importance of carrying out these responsibilities and the consequences of neglect. As Swift (2009:21) writes:

> As part of the motivation for his work, the hospitaller is reminded that if any in the house 'perish for lack of counsel and help and die in their sin, their blood shall be required at your hand'. In other words come day of judgment, for anyone who had failed to gain salvation because of their neglect, the hospitallar will have to make an answer".

The said period also witnessed neglect in the care of the sick-poor, which led to the disbanding of hospitals and the paying off of chaplains. The growing number of the poor led to the re-founding of voluntary hospitals, where the role of the chaplain was re-defined once again to provide moral instruction to the poor to be obedient, submissive and thankful to the authority that provided for their needs. "Holy communion or mass is not the focal point of the hospital or chaplain's activity. Now prayer and instruction are central, but only in a corporate sense twice a week" (Swift, 2009:33). O'Driscoll (2007:12) reports that by the 19th century these voluntary hospitals had increased in number around Britain. "The role of the chaplain or clergy person in such hospitals was to comfort the sick, teach religion, read the Holy Scriptures and lead ward prayers. Often, they were also the lead fundraisers for these hospitals and sat on their governors' committees" (O'Driscoll, 2007:12). The introduction of National Health Service (NHS)[74] in Europe in 1948, witnessed the beginning of the modernisation of healthcare service (a structured and specialised form of service) in which chaplains as part of this scheme must comply with the laid down standards.

4.6.2.2 Professionalism and professionalisation of chaplains (hospital PCGs)

The modernisation of healthcare in Europe invariably meant the beginning of modern Pastoral Care in hospitals, a movement away from the traditional parochial model. Unlike the USA, which has a decentralised healthcare system, healthcare in most of Europe and especially in the United Kingdom (UK) is publicly funded and dispensed by a centralised government directed by the NHS Trust. Unlike the USA, whose Pastoral Care services were not officially recognised by the major accreditation agencies until 1997 (Galek, Flannelly, Koenig, & Fogg, 2007:364), chaplaincy in Europe was part of the NHS initiative from its inception. This means that professional chaplains are listed as part of the health care team

[74] The NHS in the UK was launched as a government initiative in 1948 to attack the disease epidemic that threatened UK. This was to be a comprehensive service, free and available to all people with its major funding from taxation (Cobb, 2005:3-4). In the UK today the NHS is separately handled by the individual regions of Scotland, Wales, England and North Ireland, which are responsible for drawing up their own health policy, funding and provision of healthcare.

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under the NHS (Cobb, 2005: 13). What this means is that the government along with other health care professionals pays the chaplains or PCGs. The inclusion of chaplains in the NHS has implications for the role of chaplains in the healthcare team. On one hand, this appears to give chaplains a more confident identity in the public sphere of the healthcare system. On the other hand, it means that chaplains will share the pressure exerted by the changing nature of the constant NHS healthcare reforms, for instance, the NHS Reform and Health Care Profession Act 2004. This policy document made a change in the provision of healthcare, delegated some of the NHS duties to 100 regional health services called NHS Foundational Trust for the provision of health services according to the peculiar need of the community. Such health services were also expected to conform to the national service standards of healthcare. This means that the Trust will have to decide the type of Pastoral Care needed by the community in line with the healthcare privacy act contained in the standards for healthcare. Consequently, full-time professional chaplains have to offer professional multi-faith spiritual care rather than the religiously affiliated faith-based spiritual care. While majority of the chaplains were paid by the government, there are volunteer and part-time chaplains who are paid by their church affiliations. Therefore in the UK, for instance, a chaplain could be employed by the hospital (government) and/or religious authority to which the chaplain belongs. Each of these structures responsible for the payment of the chaplain also determines the role of chaplains and the services they are expected to offer.

As in the USA, the professionalisation process for all hospital chaplains includes 1,600 hours of CPE training and supervision or one year full-time training in addition to basic seminary or college graduate studies in theology. Furthermore, most chaplains are expected to have their church affiliation endorsement. For chaplains who desire to specialise, there is a further training in their area of interest, e.g. palliative care, cancer or paediatrics.

Many chaplaincies in Europe have a professional body that sees to the certification of chaplains. They include but are not limited to the Association of Hospice and Palliative Care Chaplains (AHPCC), the Multi-faith Group of Healthcare Chaplains (MGHC), the College of Health Care Chaplains (CHCC), Chaplaincy Academic and Accreditation Board (CAAB), Northern Ireland Healthcare Chaplains Association (NIHCA), the Scottish Association of Chaplains in Healthcare (SACHS), etc. These bodies have unique roles and functions separate from the NHS (Orton, 2008:8) and the Association of Muslim Chaplains (Gilliat Ray 2007:149). Many chaplains work as part of a multidisciplinary team. Nevertheless, current reforms in the healthcare setting in Europe puts the professional identity of Chaplains in

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doubt and, as in the USA, demand an articulation of the role of healthcare chaplains from these bodies. As Orton has rightly remarked, "wherever major organisational change occurs and traditional patterns of practice are revised, there will be debate, discussion and disagreement. The process of reform of healthcare chaplaincy is no exception" (Orton, 2008:7). This scenario led to research and publications on the role of hospital chaplains by chaplains and some health care professionals and collaborative work among healthcare chaplains in Europe. The collaboration led to the formation of the United Kingdom Board of Healthcare Chaplains (UKBC) in 2008. In addition, it led to the establishment of the European Network of Health Care Chaplaincy (ENHCC). ENHCC in 2002 drafted a statement which guides their professional practice (Standard for Health Care Chaplaincy in Europe, 2006:682). Among other matters, these bodies address issues such as the organisation and development of chaplaincy service; theological, pastoral and ethical matters; education; formation; and supervision. They present chaplains with a professional outlook, while enabling them to be more integrated into the healthcare system as part of the holistic vision of health care service. The resultant effect is the development of an integrated service standard, education and training that is patient-centred. This Standard, according to Kofinas (2006:673), secures the professional and scientific quality of the PCG as well as the protection of patients from unwholesome pastoral caregiving. According to Orton (2008), the NHS Education for Scotland (NES) has established a Spiritual Care Development Committee (SCDC) for the development of understanding and practices of spiritual care in Scotland.

4.6.2.3 Role

The Standard for Healthcare Chaplaincy in Europe (2006:682) stipulates that chaplains are authorised by their faith community and recognised by the healthcare system. In addition, the chaplaincy service works as part of the multidisciplinary team. However, Kofinas (2006:673) states that although "most hospitals in Europe have chaplains, in general there is reluctance in viewing them as healthcare service providers particularly from the medical staff". Additionally, the attempt to reduce the cost of healthcare prevents them from being included as members of the health care team in many European countries. However, in UK the NHS considers chaplains as a part of the healthcare team who are listed among the allied healthcare professionals (Cobb, 2005:13-16). The existence of a state church and a unified healthcare system and the continuous participation of the Church of England in matters of health care in the state create fertile ground for the development and professionalisation

process, which give a clearer identity to chaplains in Europe as members of the healthcare system.

The Standard for Healthcare Chaplaincy in Europe articulates the activity of chaplains as being available to patients, relatives, and other persons close to them including visitors and staff. The roles of the chaplain are outlined below.

1. To proclaim and defend the infinite value and dignity of every person.
2. To be a reminder of the existential and spiritual dimension of suffering, illness and death.
3. To provide a reminder of the healing, sustaining, guiding and reconciling power of religious faith.
4. To endeavour to see that the spiritual needs of people from different religious and cultural backgrounds are met, respecting every belief.
5. To try to protect patients from unwelcome spiritual intrusion or proselytising
6. To provide supportive spiritual care through empathetic listening, demonstrating an understanding of those in distress.
7. To provide religious worship, ritual and sacrament according to one's religious tradition.
8. To serve as members of the multidisciplinary healthcare team.
9. To provide and participate in teaching programmes for healthcare professionals.
10. To act as mediator and reconciler and provide advocacy for those who need a voice in the healthcare system.
11. To support and participate in research programmes about spiritual care.
12. To assess and evaluate the effectiveness of providing spiritual care.
13. To facilitate community awareness of the needs and demands of the people they serve, the carers and healthcare system.

As Cobb (2005:25) explains, each of these tasks demonstrates the multidimensional role of the chaplain. Thus, depending on the model of chaplaincy employed, some tasks may be emphasised over others.

4.6.2.4 The question of payment of PCG in Europe

The source of funding for pastoral care departments in Europe varies from country to country. While there are similarities between Europe and the US both in the source of funding and how pastoral caregivers are employed, there are also differences. For instance,

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both contexts are similar in the sense that pastoral care services are provided by a number of players. Funding for chaplaincy services could be derived from donations from churches and some churches offer to pay the salaries of their religious representatives, while some, especially the certified professional PCGs or chaplains, are paid from government funding, for example, the NHS in the UK (Orton 2008:5). The difference is that, unlike in the USA (4.6.1.3), in some countries in Europe including the UK funding for Pastoral Care departments is more directly part of NHS policy (2008:5). This is because the NHS considers meeting the Pastoral Care needs of patients and staff and visitors as fundamental to the care it delivers. The NHS therefore provides national standards for meeting the religious and spiritual needs of patients. Therefore, following the NHS Reform and Health Care Profession Act 2004 for an integrated model, Pastoral Care departments in the UK are publicly funded by the NHS Foundation Trust, with chaplains employed directly by the hospitals. What this means is that each NHS foundation Trust will have to decide on the amount and type of Pastoral Care services provided within the area with regard to the minimum requirement established by the standard. For example the NHS Trust may require that the Pastoral Care needed should be interfaith spiritual care depending on the demography of the area, to which the PCG must adhere.

Whoever pays the piper calls the tune, goes the popular adage. The issue of who should pay for the pastoral services to patients in the hospital carries some implications in terms of the PCG's obligation to the payer, as was evident in the US context, where the services of the PCG are determined by the means by which the PCG is given remuneration. In other words, the PCG is accountable to the source of his or her funding (Mohrmann, 2008:18-223). The source of PCGs' remuneration therefore calls for reflection on the impact, benefits and stresses that could be exerted on the healthcare institutions, the patients and the PCGs. However, James Johnson (2011:29) advises that regardless of who is responsible for chaplaincy services they should also be accountable to someone in the hospital, because the chaplain is a member of the hospital team, like the nurse, doctor, etc. From the perspective of this study, whoever pays for the pastoral services to a great extent determines the nature and content of the pastoral services. For instance, government-funded services would generally require, a form of pastoral service that does not lean towards any particular religious or denominational tradition as evident in the US and UK contexts. The services of the caregiver would take an interfaith approach, where the caregiver is expected to minister to people of all religions: Muslims, Christians and African Religious Traditionalists alike. In that sense, the

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caregiver's code of professional ethics would require that there be no proselytising or witnessing to one's faith to the patient. Stricter adherence to professional codes as well as institutional codes is demanded. Therefore in a situation where there is a conflict between obligation to the affiliated religion and the government, chances are that the PCG may be compelled to favour the decisions of his/her source of financial sustenance. On the other hand, a church or religious sponsored PCG would be obligated to provide a type of spiritual service in line with his/her tradition's religious beliefs and accepted rituals. In such case the caregiver may be inclined to provide services to patients of his/her religion as his primary duty.

In summary, the beginnings of hospital Pastoral Care in the North American and European contexts reveal a similarity to the Nigerian context in terms of the background history of medical and Pastoral Care practice. Pastoral Care in these contexts began with the parochial model of hospital faith-based ministry without specialised skills except for such skills as were acquired for congregation-based ministry. In the course of time efforts were geared towards gradual professionalisation and professionalism as revealed in the articles, reviews, White Paper, and debates in these contexts. Such process was catalysed by the changing context of health care and reforms in which hospital pastoral caregiving is located. The healthcare system is an evidence-based health service that sets basic standards for the members of the healthcare team to fulfil their roles if such roles are to be considered valuable to the team and even to the patient. This means that Pastoral Care in the hospital context must fulfil these standards as well. This informs the drive towards professional pastoral caregiving, geared towards efficiency, proficiency and competency to enable hospital PCGs an opportunity to be entrenched in the hospital context and to articulate their role in clear and meaningful language for the understanding of other members of the healthcare team.

4.7 The role of a professional PCG in hospital care

The exploration of the role of the hospital PCG in some developed contexts has revealed the changing identity of PCGs within the changing social structures, beliefs and values associated with the healthcare institutions. While the functions and activities of the hospital PCG are the same across the contexts we have so far considered, their roles differ according to the perceived identity of the chaplain or PCG in these contexts. The progression of traditional or parochial practice to embrace a modern and specialised or professional pastoral care giving in these contexts is a response to the changing and dynamic process of holistic healthcare and healing. Such identity could be said to be influenced by factors such as the nature of the

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healthcare service system, culture, religious affiliation and the ability of PCGs to articulate their unique contributions in such systems. Thus, in Europe, especially the UK, the NHS structure explicitly lists chaplains as allied healthcare team members and assists them towards professionalisation as healthcare team members. In US, although PCGs are well utilised by individual hospitals, their role in the health care team and structure is ambiguous because of a decentralised healthcare system consisting of numerous players. Thus, the promotion of spirituality and the professionalisation process of chaplains are driven by the chaplaincy's organisations. In all, the role of chaplains in these contexts is significant and their relevance undeniable, thereby holding great promise of holistic healthcare and vision of wholeness generally of Pastoral Care giving.

This has an implication for PCGs in the Nigerian hospital context that this study can draw from. The PCGs in the Nigerian context must therefore embody a practice that is credible and yet distinctively unique to their religious and spiritual direction of patients in their search for meaning, purpose and growth. It is expected that the PCG should be credible and competent to handle such issues that relate to his/her profession as he/she works in tandem with other professionals. Hospital pastoral caregiving through the PCG holds promise as an intuitive, imaginative practice embedded in the stories of the patient. PCGs are experts in spiritual/religious care (Williams, 2008: 9; VandeCreek & Burton, 2001:84-86).

The position of this study is that professional Pastoral Care has relevance in the contemporary Nigerian hospital and healthcare system in general. Koopsen and Young (2009:50) categorically state that chaplains are "a valuable spiritual resource in healthcare organisations". Studies across countries and cultures indicate that many people rely on spiritual and religious resources during hospitalisation to cope with their predicament (Flannelly, Weaver & Handzo, 2003:760-768). Similarly, a number of empirical studies carried out to determine patients' reliance on hospital pastoral/spiritual caregivers and evaluation of hospital pastoral/spiritual caregivers have also established the high value that patients place on hospital PCGs (Piderman et al., 2010:1002-1010; Chattopadhyay, 2007:262-267; Kernohann, Waldron, McAfee & Cochrane, 2007:519-525). Koopsen and Young (2009:53) argue that "Chaplains [PCGs] are also a tremendous staff resource since they can assist staff members in coping with their own grief and provide education in the areas of ethics, spirituality, and coping strategies". Empirical research also confirms the value of PCGs to the medical staff (Flannelly, Weaver & Handzo, 2003:760-768; Flannelly, Galek, Bucchino, Handzo & Tannenbaum, 2005:19-27). The above examples confirm that patients

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as well as hospital staff place a high premium on the role of hospital PCGs. Although these studies were carried out within the Western context, it is this study's assumption that this will also be the case with the Nigerian hospital patient and staff since they share the same high premium on spiritual and religious direction during illness. It has been shown in Chapter Two that Nigerians combine spiritual and medical approaches in dealing with illness. In addition, Nigerians as typical Africans are very religious and some of the hospital-based research in Nigeria identified spiritual causes to be responsible for some of the sickness. As such, this study insists that the role of the professional hospital PCG in Nigerian hospital care is vital.

4.8 Conclusion

Role theory and best practices provided the framework for the discussion of the role of PCGs in the Nigerian hospital context in this chapter. Role had been defined by this study as the behavioural repertoire characteristic of a person or group, which includes norms and values and which constitute their identity. Therefore, this chapter argued that the identity of the PCG is also connected to his/her role as such an attempt at understanding the identity of the PCG is also an attempt to understand the role of the PCG in the hospital context.

This chapter ascertained that, essentially, PCGs in the hospital context are spiritual and religious experts who are professionally trained to deliver spiritual and religious care services in medical contexts. It also emphasised that the PCGs embody different identities according to training and theoretical orientation within particular context. Hence PCGs subscribe to certain qualities which allow them to perform their role according to expectation (4.3.2). Three types of PCGs were identified as Hospital Visitors, Lay PCGs or Volunteers and Professional PCGs. On the basis of the types of PCGs, two models of PCGs caregiving in the hospitals were identified, namely the parochial role model and the professional role models (4.4). The strengths and weaknesses of these models were highlighted. This raised the question of whether a single model would be adequate to uphold a holistic perspective of caregiving. It concluded that a single model of pastoral caregiving is not adequate. This is because models tend to be rigid, losing sight of the flipsides of its method. An approach was preferred which allows the utilisation of many models. It highlighted that an approach takes on principles rather than a specific formula. It is also explorative not definitive, inclusive rather than exclusive and therefore hermeneutical. Hermeneutical thinking was established as holistic, which is less abstract and more concrete as it focuses on experience, perception and emotion (Louw, 2012:41-43).

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In accordance with the hypothesis that there is a need for PCGs in the hospital as a relevant and potential patient care team member, this chapter explored the role of the professional PCGs in the North American and European contexts, based on the normative framework of good practice. According to Osmer (2008:152), utilising good practice for normative reflection benefits from the past or present practice with which to reorganise Pastoral Care. It also engenders new insights into good spiritual life and social values beyond those provided by the received tradition (the Nigerian context). As Osmer (2008:153) suggests, good practice helps Pastoral Care to generate new ways of doing things better by learning from the gains or mistake of other traditions as well as providing resource and guidelines (Osmer, 2008:153).

The exploration of the history of pastoral and the role of the PCG within the healthcare system in the North American and European Context revealed a common history of similar patterns of relationship between the PCG and physician in terms of their background, professionalism, role and payment, but also differences. The context, which involves the institutional structure and the interactional influences, was seen as the driving force in role definition, construction and reconstruction of PCGs. The chapter also highlighted the fact that Pastoral Care is important in many healthcare organisations as well as for the medical professionals, and considers meeting the Pastoral Care needs of patients and staff and visitors as fundamental to the care delivered in these contexts. Generally, evidence from the context showed varying degrees of professional development, validation, roles in the hospital context, and how not to be considered as marginal. Therefore, the PCGs to a greater extent embody the major principles, theories and theologies of Pastoral Care as discussed in Chapter Three. From the role theory perspective it was evident that PCGs assume roles that define their identity, validates and legalises their presence in the hospital context.

Therefore, it has been established in this chapter that PCGs are not merely alternative but complementary healthcare providers whose practices are of recognisable value, as drawn from evidence of best practices from North America and Europe. In otherwords they are invaluable complements to all healthcare systems. Therefore they could be encouraged and supported as the frontline of healthcare provision for patients, family and staff in the Nigerian hospital context. However, the question arises as to how the PCGs can collaborate with the medical professionals in the Nigerian hospital context, for the purpose of enhancing the modern healthcare delivery system in Nigeria. This shall be the focus of this study in the next chapter.

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CHAPTER FIVE
THE PCG AND MEDICAL PROFESSIONALS: TOWARDS COLLABORATION IN HOSPITAL CARE

5.1 Introduction

In Chapter Four we discussed the identity, role and resources of the professional PCG in hospital care. Utilising role theory and drawing on best practices in Europe and North America, where Pastoral Care services are well established, the over-arching role of PCGs as it relates to Pastoral Care in the hospital context was articulated as meeting the spiritual and religious needs of the patients. Using research evidence, religio-cultural assumptions, individual and personal experiences, it was concluded that religious and spiritual care are significant and could contribute towards wholeness and healing, shorter hospital stays, less nursing time, less painful medication, better mental health and a better coping process.

As has been noted in 1.3 and 3.3, medical professionals are increasingly becoming aware that the medical model (including the biopsychosocial model) is not sufficient for holistic hospital care, and it therefore needs to accommodate complementary and alternative approaches (Doran, 2005:39; Ellis & Hartley, 2008:119-121). As such, this study argues that the inclusion of PCGs in Nigerian hospital care could improve quality care and patient satisfaction.

Yet the challenge is how such inclusion could be achieved without resulting in fragmented hospital care (Kreindler, Dowd, Star & Gottschalk, 2012:347-374). Similarly, NSHDP 2010-2015 (2010:40) observes that Nigerian healthcare is highly fragmented and linkages across different levels are weak. Earlier on the National Policy on Public Private Partnership for Health in Nigeria NPPPHN (2005) had raised similar concerns that "one of the key challenges to policy makers is how to form effective partnerships among different players in such a way that healthcare can be served sufficiently, effectively and equitably". However they also observed that "it is vital to understand the operations of different players … establish new relationships that will entail the act of learning, compromise, understanding and shared responsibility" in collaborative practices for the good of the care seekers. As such, the study raises the obvious question of how the role of PCGs in the hospital context could be aligned with the roles of other healthcare professionals for efficient, effective and holistic hospital care? This chapter therefore seeks to answer the underlying questions: Can the notion of collaboration assist both the PCGs and the medical professionals to address the

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Pastoral Care needs of patients for holistic and quality caregiving in the Nigerian hospital context? Would such collaboration be possible? Would it not involve ethical issues? Where it does, what are the possible ethical issues and how can they be resolved?

This chapter, which adopts a postfoundationalist paradigm, will employ Osmer's (2008:147-152) normative task of ethical reflection (1.6). Collaboration raises some theological, moral and ethical issues which must be reflected upon as a necessary process of authentic theological praxis. With regards to the theological question, the postfoundationalist framework goes beyond Pastoral Care. This postfoundationalist paradigm allows this study to have a cross-disciplinary conversation with the medical and social sciences without compromising the identity of Pastoral Care. It allows the PCG and the medical professionals shared resources of cognitive, pragmatic and evaluative dimensions through transversal reasoning. Although theology and medical science have different points of reference, epistemological foci and experiential resources, the transversal reasoning employed in this chapter provides common grounds for a collaborative vision. Thus the interdisciplinary task involved in the postfoundationalist paradigm is in a sense a hermeneutical and holistic approach. This holistic approach calls for strong and positive relations between PCGs and medical professionals. The holistic vision which serves as a common ground for the PCG and the medical professional is based on the theological understanding of personhood and the African understanding of personhood as discussed in Chapter Two. The postfoundationalist holistic approach makes it impossible to address the human predicament of sickness purely from the perspective of the Western biomedical model. It acknowledges the reality of the biomedical model and exposes its weaknesses.

The praxis of Pastoral Care views a person as a unit and ensures that all dimensions of that entity are taken into consideration in caring interventions. Therefore, the holistic approach of Pastoral Care regards individuals as relational and social beings living within a cultural system, which exerts influences on them (see Chapters Two and Three). A holistic framework takes into consideration the physical as well as the non-physical and spiritual components. The complex reality of illness therefore necessitates a collaboration of medical care professionals with Pastoral Care professionals within a team approach. Therefore it could be argued that the PCG and the medical personnel need to collaborate for holistic healing. The ethical issues involved in collaborative work that necessitates a team approach and arise from collaboration in hospital care will also be discussed below.

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5.2 Collaboration in hospital care

Kreinder et al. (2012:347-374), utilising social identity theory, have argued for understanding and overcoming divisions in healthcare through integration and collaboration among groups providing care in the healthcare context. They argue that collaboration can be fostered at the interpersonal level, operational level, systemic level and group level (Kreindler et al., 2012:348). They also state that the success of healthcare reforms, policies and practices is dependent on the ability of healthcare delivery systems to replace fragmentation and waste with coordination and cost effectiveness through collaboration across disciplines. Similarly, Doran (2005:39) argues that achieving quality healthcare depends on the communication, coordination and negotiation of healthcare professionals for a cohesive treatment plan for patients which overcomes fragmentation. The position of these scholars is affirmed by the Nigerian Policy document (NPPPHN 2005) that collaboration can contribute to creating a positive and enabling space for synergy of partners for improved services that would have otherwise not be possible individually. Thus in the National Health Sector Reforms (HSR) programme of the federal ministry of health collaboration is one of the seven strategic objectives (NPPPHN 2005).

Theologically, there is also increasing evidence that supports the biblical statement that five will chase a hundred and a hundred will chase ten thousand (Leviticus 26:8). The Bible clearly states that "a cord of three strands cannot be easily broken" (Ecclesiastes 4:12). This wisdom is gaining ever more recognition and acceptance in our world today. Howard Clinebell's(in Balch 1991:53) words of wisdom many years ago are ever more relevant to the contemporary Nigerian hospital care when he argues that

> the need, opportunity, and resources for clergy-doctor collaboration are greater today than at an previous period of history. In a society that fragments persons and relationships, it is imperative that healers get together. Otherwise, they will continue to contribute to the splintering of contemporary man. It is particularly important that healers of the body and clergymen, the healers of relationships (with self, other, and God), learn to work together more effectively as they deal with the same individuals and the same families.
>
> (Bach, 1991:53)

Given the fact that illness is a complex reality that defies a simple approach and unilateral position, it becomes necessary that the phenomenon of illness, pain and suffering requires a combined effort, skills and expertise including those of the PCG within the Nigerian hospital environment. This idea is supported by a growing literature and research stating the desire of

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patients to have their spiritual/religious and medical needs met while in hospital. As a result, this study advocates for Pastoral Care that embodies a holistic vision of care which is also spiritual and religious, and believed to be beneficial to patients' coping as well as for family and others in the hospital environment. Nonetheless, care for the sick and suffering involves relationships of trust, which holds both possibilities and limitations. Sometimes such a caring relationship involves the co-opting of others into the relationship. In this regard, De Lange (2011:2) has rightly remarked that a "care relationship is a complex interplay of different relationships, both formal and informal, and symmetric and asymmetric". But how is the trusting relationship affected and what are the ethical issues that may be involved in such actions? How would such ethical issues be handled or resolved? Is it necessary to embark on such actions? The standpoint of this study is that liaising with colleagues and other professionals to provide care is necessary and ideal, as illustrated by the above National Policy documents (5.1). In discussing collaboration, this study will look at the nature and basis of collaborations and the ethical issues that arise from this collaborative initiative of the PCG and the medical personnel in the Nigerian hospital context. What then is collaboration?

5.3 Definition of collaborative concepts

Brontein (2003:299) conceptualises collaboration broadly as an interpersonal process through which members of different disciplines contribute to a common goal that cannot be reached when individual professionals act on their own. But Doran (2005:40) notes that collaboration is a composite concept comprising of several sub-concepts. These include terms such as communication, coordination and shared decision making and teamwork. Doran (2005:40) argues that teamwork and collaboration are essentially synonymous. As such the essence of collaboration is to achieve teamwork. She defines collaboration as two or more persons working together. She explains that collaboration involves a relationship of trust, respect and joint contribution of knowledge, skills, and values to accomplish the goal of quality patient care. Thus she argues that within the hospital setting collaboration has often been understood as sharing of information, coordination of work and joint decision making on aspects of patient care (Doran, 2005:41). She further identifies three key features of collaboration as

- the active and assertive contribution of each party;
- the receptivity and respect of the other parties, contribution; and
- a negotiating process that builds upon the contribution of both parties to form new ways of conceptualising problems.

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This means that collaboration is dependent on effective communication. This *communication* involves a process where information is exchanged among the patient care providers and contributes to the continuity of care. Dougherty (2009:13) adds that the communication should be bidirectional to achieve joint problem solving. Communication also involves coordination that enhances collaboration. *Coordination* is therefore understood as the management of interdependencies among tasks by synchronising differentiated activities so that they function effectively in the attainment of the goals (Doran, 2005:42). Doran further argues that collaboration is carried out through the relationship of shared goals, shared knowledge and mutual respect.

Another term related to collaboration besides team work is what Dougherty (2009: 10) describes as consultation. He defines consultation as a "process in which a human service professional assists a consultee with work-related (caretaking-related) problem with a client system with the goal of helping both consultee and client system in some specific way" (Dougherty, 2009:11). The primary reason for consultation, according to Dougherty (2009:11), is that the expertise of the consultant is considered valuable for solving the problem. Although consultation is similar to collaboration, the difference between them is that consultation "is a stand-alone service" between the consultant and the consultee, while collaboration involves combined efforts of two or more experts for a particular issue. It is also temporal in that the relationship lasts only as long as the problem exists. Therefore collaboration in terms of consultation could be a one-on-one experience or in terms of teamwork could be a group process. Consequently, consultation, teamwork and collaboration are useful means of providing quality healthcare to patients. Having clarified the concept of collaboration, there is a need to examine the basis for collaboration between the PCG and the medical professional.

5.4 Basis for collaboration

It could be noted that discussions on collaboration with physicians and PCGs had already begun as early as 1929. Interestingly, this concern did not begin with the clergy but with a lay person. Ethel Hoyst, a Presbyterian lay person, had raised the concern: "will not those churches which are interested in Spiritual Healing help the cause more at present by emphasising the power of the spirit in maintaining Health and Abundance of Life, rather than by putting the emphasis on 'Curing disease'?" (Powell, 2001:99). She earnestly hoped that her proposal for there to be collaboration between church and medicine might help pastors to learn a more careful, rigorous and clinical approach to care while the physicians in turn learn

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how to “rekindle latent faith in patients” (Powell, 2001:99). In a nutshell, the discussion on collaboration could be said to be like a “chronic toothache” that must be given proper attention and treatment (as is ongoing in many contexts) rather than ignoring it as unimportant as such an approach has not cured the toothache in the past. Therefore, this chapter’s discussion on collaboration is an awakening of an age-old concern in a new way.

From the theoretical exploration of Pastoral Care and the PCG in the hospital context so far in Chapters One to Four, the role of religion (1.3) and the increasing recognition of this by the medical professionals has become evident (2.6.3.1) (Etteh, 2007:9-11; NPPPHN 2005) as has the mind-body-spirit interconnectedness (2.5). It has also revealed the limitations of medicine (2.6.3.5). It also provided increasing empirical evidence that patients turn to pastors during illness and want their spiritual needs addressed (2.2.4). It has also been substantiated that there has been a collaborative history between the religious community and hospitals (2.6.3.1). From this background the following themes will constitute the basis of collaboration between medical practice and Pastoral Care: research evidence from other contexts; increasing recognition of the religious and spiritual dimensions of care among medical professionals; patients’ turn to pastors during illness; some patients want their spiritual needs addressed; some patients choose their care providers based on spiritual interests; the limitations of medical practice; and the mind-body-spirit connection and the collaborative history of dealing with it (Young, 1954; Chappelle, 2006).

5.4.1 Research evidence from other contexts

The Handbook on Spirituality and Health first published in 2001 and republished in 2012 by *The Center for Spirituality, Theology and Health* documents more than 3,000 research projects on the relationship between religion and health. The relationship between religion and physical health addresses heart disease, hypertension, Alzheimer’s disease and dementia, immune functions, cancer and mortality (Koenig, King & Carson, 2012). In effect, many studies conducted on patients reveal that patients judge the spiritual and physical realms to be of equal importance (Erde, Pomerantz, Saccocci, Kramer-Feeley & Cavalieri, 2006:np). But the medical model neglects the spirit of the suffering person as a contributory, or even the primary, factor in determining the health or sickness state of persons (Terrell, 1993:6).

Understanding the patient is not only an art but a vocation that is embedded in spirituality, which many physicians lack the necessary training. According to Muller (2011), “there is a growing awareness of the link between spirituality and health, but most doctors are

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completely untrained in taking a spiritual history and many are unaware of the substantial evidence demonstrating that faith has a positive impact on illness prevention, coping with illness, recovering from surgery and treatment outcomes". Muller's observations confirm Louw's (2008:41) assertion that a holistic approach to care recognises that "in order for the person to be healed, the structures in society as well as the dynamics within relationships should be healed as well".

5.4.2 Increasing recognition of religious and spiritual dimensions of care by medical professionals and organisations

The World Health Organisation report published in 1998 recognised that:

> Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith-in healing, in the physician and in the doctor patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension
>
> (WHO, 1998:7).

Furthermore, some medical professionals recognise the legitimacy of patients' spiritual needs and consult with trained PCGs when it becomes necessary to address spiritual needs outside of the competence of the medical professional as part of holistic care. Young (1954:6) and Read (2006:4)[75] agree that many patients who consult with medical doctors today have symptoms of sickness but have no biological (or organic) disease to account for their symptoms. Such sicknesses are medically classified as functional sicknesses. Hence there is an increasing recognition and sensitivity to religious and spiritual caregivers to minister to the needs of these patients. Admittedly, some research shows that some medical professionals by their attitude towards religious faith believe that religious faith is not essential for the medical professional, the patient and the hospital setting (Powell, 2001:104, Weaver, Flannelly and

[75] According to Read (2006:4), "surveys from different countries throughout the … world have shown that on average between 30 and 40 per cent of people who seek health care have illnesses that have no clear cause and no obvious basis in pathology". This condition, according to Read, constitutes an enormous cause of stress and crisis for the patient. The crisis of not knowing what is wrong impacts on their comfort and quality of life. Many of their symptoms seemed to represent the changes that had taken place in their lives. They all had a story to tell and when they had told it, their illness became so much easier to understand and often seemed to improve (Read, 2006: xi). Read (2006: xii, 11) regrets that the focus on the scientific evidence and physical cure has caused doctors to lose sight of the 'narrative' and meaning of illness, because doctors are trained to diagnose and treat organic disease, not to understand the 'meaning' of illness and therefore not trained to understand the patient (Read, 2006: 11).

Stone, 2002:216-219). Sloan, a staunch critics of the inclusion of religion in modern medical care (quoted in Weaver, Flannelly & Stone, 2002:216), argues that "[r]egardless of what the empirical evidence is, bringing religion into medicine not only makes no sense, it's simply wrong to do so, even if there were solid evidence – which, of course, there isn't". However Weaver, Flannelly and Stone (2002:216-219) dismiss Sloan's criticism of religion and spirituality in modern healthcare as ignoring the facts, not being objective but making a subjective selection of materials and picking on sweeping statements which are capable of distracting the readers.[76] Research carried out by Adewuya and Oguntade (2007: 931-936) on doctors' attitudes towards mental sickness in Nigeria revealed that more than 50% of the participating doctors (312) believed that evil spirits, witches and sorcery were responsible for mental illnesses. According to Adewuya and Oguntade's (2007:934) interpretation, "[a] supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and spiritualist and traditional healers preferred". Adewuya and Oguntade's suspicion is confirmed by Ibrahim and Odusanya's (2009) research finding that half of the female doctors believe that cancer can be healed through prayers. These research projects indicate the importance of the PCG to the healing process among Nigerian patients and suggest the need for medical personnel to collaborate with PCGs in hospital care within the Nigerian environment.

5.4.3 Patients turn to religious leaders during illness

Larson, Milano, Weaver and McCullough (2001:129) report that a great deal of research indicates that PCGs are frontline mental health providers and are constantly called on to take up this role in many settings. Similarly, some Nigerian physicians have reported that many patients visit pastors or other religious leaders once they suspect a dysfunction in their system, be it physiological or mental (Unuhu, Ebiti, Oju & Aremu, 2009:24). Oluwabamide and Umoh (2011:47-52) also report that patients in AKS hospitals demanded the services of pastors. The findings and reports of such practices imply that clergy and PCGs act as frontline health individuals who provide the needed support to patients and may be considered by them as their primary health and physiological health providers. This is because for many patients, illness and eventual hospitalisation raises spiritual concerns which

[76] For further reading on the argument cf. Koenig, Larson, Collins, and Benson (1999) "Religion and Medicine: A Rebuttal to Skeptics" *International Journal of Psychiatry and Medicine*, 29(2):123-131; Sloan, Bagiella and Powell (1999) "Religion Spirituality and Medicine" *The Lancet*, 353: 664-667; Sloan (2000) "Religion, Spirituality and Medicine", *Freethought Today;* Levin (1994) "Religion and health: Is there an association, Is it vital, and Is it causal? *Social Science and Medicine,* 38(11):1475-1482; Levin and Vanderpool (1989) "Is Religion Therapeutically Significant for Hypertension?" *Social Science and Medicine*, 43(5):849-864.

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they struggle with. Therefore the patient places hopes on the pastors to assist them to understand what is happening. Hence, they are the first contact for the patient before he or she considers consulting the physician. At some time it might be that the pastor encourages them to go to hospital before he/she summons up courage to visit the hospital. Consequently, the PCG is placed at a unique role of providing assistance to Nigerians who sense the onset of a sickness.

5.4.4 Some patients want their pastoral needs to be addressed

Some patients want their pastoral needs to be addressed when they are sick. This underscores the fact that addressing pastoral needs is equally important in the healing or recovery agenda of patients. For instance, VandeCreek clearly observes that "patients turn to what they hold sacred because they want help with their spiritual struggles during illness. These struggles, however, can contribute to spiritual deterioration or become chronic if they are not resolved" (VandeCreek, 2010:5). While they seek the best medical experts and hospitals for their illness, they do not just submit their physical bodies for treatment; patients go with their spiritual convictions, beliefs and values as well. However, the issue arises as to how well prepared Nigerian medical professionals are in assuming this role of addressing all the dimensions of the patient's being by way of recognising the importance of including pastoral care in hospital care and seeking collaboration with the experts of spiritual care such as the PCG? Understandably, the medical practitioner cannot handle all of the patient's needs; not only does he lack the competence to do so, but it is not feasible for an individual or a single profession to take on such a vast amount of responsibility (Hill & Smith, 2010:175). This is where it becomes very pertinent for the medical professional to consult with the trained PCG, who has the competence to provide timely and appropriate spiritual intervention.

5.4.5 Some patients choose their care providers based on spiritual interests

Msomi (1991: 68) reports that some African patients are dissatisfied with a "technologically oriented" hospital treatment and desire that a healing which comes from a religiously oriented source should be integrated into their treatment. Larson et al. (2001:130) report that patients are likely to choose physicians of the same faith because they believe that such physicians will better understand their spiritual concerns and probably address them. Similarly, exploring the history of Pastoral Care in the USA in our previous chapter, Tovino (2011: 65) and Oates (1978:68) also thought that patients choose their physicians based on religious similarity in the hope that their total needs, including their spiritual and religious needs, will

be addressed. The researcher's personal experience as a pastor confirms that when asked why they chose a particular hospital over the other, patients respond that they do so because such hospital is a Christian hospital or not. However, many physicians are not trained to address deep spiritual issues beyond taking a spiritual inventory. Besides, the fact that they are constrained by time to do so is another challenge. Furthermore, although some physicians might have basic knowledge of providing spiritual care, for some hospitals it might become a breach of their ethical code as it might be considered inappropriate for physicians and nurses to provide spiritual support, as this could lead to a confusion of roles (Williams, 2008:12). It therefore becomes clear that there are limits to the provision of holistic care by medical professionals and PCGs, based on the expertise of each professional. Given such a situation, it is in the best interest of patients and overall integrity of the Nigerian healthcare system to ensure that collaboration between the PCG and the medical personnel is initiated and sustained.

5.4.6 Limitations of medical practice

According to Young (1954:2), Plato had already recognised the limitation of medicines, especially in their inability to mediate spiritual healing and wholeness. For Plato (quoted in Young, 1954:2):

> As you ought not to attempt to cure the eyes without the head or the head without the body, so neither ought you attempt to cure body without the soul, and this … is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also, for the part can never be well unless the whole is well … And therefore, if the head and the body are to be well, you must begin by curing the soul.
>
> (Young, 1954:2)

In recognition of this weakness of medicine, Hill and Smith (2010:175) concur with Plato that any culture [practice] founded chiefly on science and rational explanation will be impoverished because of its inadequate competence to meet the human quest for meaning.

Nigerian medical practice and indeed all medical practices have limits and weaknesses, as discussed in 2.6.3.5. Limitations need to be acknowledged and addressed rather than ignored. The fact is that medical professionals, no matter their best possible efforts, cannot in themselves remedy medical and spiritual problems. While they can work to address some of the weaknesses, some solutions to other weaknesses lie beyond their reach. The Nigerian Code of Medical Ethics recognises the fact that medical professionals have limits in the provision of care and it calls the medical professionals to the admission of this fact.

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> Practitioners may associate professionally with non-medically qualified people where this is relevant to the proper care of patients, but they must ensure that in any collaboration with any of the allied professions or para-professions, the persons involved are recognised by members of their discipline and are competent to perform the task to be required of them
>
> (Code of Medical Ethics, 2004:17).

Dealing with such problems requires collaboration within the medical professional with an interdisciplinary disposition which includes other professions with the requisite expertise that can contribute to holistic healing, such as Pastoral Care. Parboteeah and Cullen (2010:99) have established a link between workplace performance and spirituality. Parboteeah and Cullen, after reviewing several research projects on spirituality, discovered that spirituality is increasingly being associated with "increased commitment to organisational goals…, increased profits and morale … and higher levels of productivity … among other positive outcomes" (Parboteeah & Cullen, 2010:99). Such spirituality fosters a sense of community in which the staff can offer their whole self to work by contributing to the caring of others. To ensure continuity of care, medical professionals should collaborate with PCGs who provide spiritual care not as part of their job but as the job they are trained for and competent to carry out.

5.4.7 Mind-body-spirit connection and collaborative history

The history of modern medical practice in Nigeria reveals that there was collaboration between medical care and religion at the early stage. Responsibilities for pastoral care rested on the same individual who was a priest-cum-physician. For instance, Rev. Dr David Roberson and Rev. Zerub Baille doubled as physicians and PCGs in the hospital at Duke Town and Mary Slessor hospital respectively (Ecoma, 1996:177-178). The majority of the hospitals and clinics in Nigeria owe their existence to the mission churches and have served a significant number of patients in Nigeria. Therefore, the basis of collaboration could also be said to be rebuilding a fallen foundation with an even stronger and more enduring structure of care. Furthermore, the growing amount of research carried out in many parts of the world establishes the fact of the mind-body-spirit relationship in healthcare (VandeCreek, 2001; McClung, Grossoehme & Jacobson, 2006; Wittenberg-Lyles, Oliver, Demiris Baldwin & Regehr, 2008; Meyerstein & Ruskin, 2007; Dukor, 2010). Since there is a positive connection between religion and health care for patients, hospital care demands a holistic approach that

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addresses all dimensions. It is important that medical professionals assess the religious and spiritual concerns of patients so as to be able to develop appropriate interventions rather than ignore them. In considering the basis of collaboration, it is also important to consider the nature of the collaboration.

5.5 The nature of collaboration

Here, this study appeals to the work of De Lange (2011:2), who has identified two types of caring relationships which are relevant for this study; the neighbourly caring relationship and the *socious* caring relationship. He defines the neighbourly relationship as an informal relationship and personal encounter between the caregiver and the care receiver. Consequently, the relationship is devoid of a mediator or a third party as well as of a structure or history. Compassion for the needs of the other and friendship form the foundation and motivation for this relationship rather than skills or expertise. On the other hand, he conceptualises the *socious* care relationship as a mediated form of care which lacks the intimacy of a personal relationship and occurs within a structured societal framework. S*ocious* caring relationships are relationships between a doctor and patient, nurse and patient, pastor and client etc. This study leans more to a consideration of the *socious* caring relationship, a formal relationship between the patient, family and medical staff. The relationship is determined by the PCG's skills and expertise that obligates him/her to care for the other. However an authentic caring relationship should have both components. According to De Lange (2011:3):

> Characteristics for a modern professional [sic] of care is the conflict-ridden combination of the neighbour and the socious dimensions within the relationship of care. There is no good care without intimacy. At the same time institutional care is directed towards evidence based control and efficiency. Caring for neighbour is per definition without limits. The care for the socious is limited by the care for another neighbour.
>
> (De Lange, 2011:3)

Pastoral and medical care relationships are formal relationships. The main motivation for the patient's willingness to enter into such contractual relationship is the trust in the professional expertise of the PCG and the healthcare professional. Hence, the obligation and the responsibility of the professionals should be to ensure that such skills and knowledge are carried out for the greatest good of the patient in order to sustain his or her trust. This is necessary in the sense that no one individual or group is a compendium of knowledge as we are all finite beings limited in knowledge, understanding and skills. In order to satisfy the

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hopes of patients for good and appropriate hospital care, it becomes necessary that care professionals must collaborate with other colleagues within the same field and other related fields.

What should therefore be the nature of the collaboration? De Lange's (2011:2-5) concepts of symmetrical and asymmetrical care relationships could be useful. He defines a symmetrical relationship as one in which both partners in the relationship are equal in relation to the goal of their relationship and they function as colleagues. He also perceives such relationship to be equal in love as partners, in dignity as human beings and in rights and obligations as citizens, while in an asymmetrical care relationship there is no equality in the relationship between the caregiver and the patient in which the care receiver depends on the skill of the caregiver. The expertise of the caregiver puts him/her in a position of power in the caring relationship. However, the power of the caregiver increasingly diminishes as patients become increasingly less dependent on the decisions of the caregiver and are more autonomous, demonstrating their desire and capability by taking their fate into their own hands and participating in their process of achieving wellbeing. In the light of De Lange's insight, caring relationships should be symmetrical. However, this chapter's focus is on the relationship between the PCG and the medical personnel and other healthcare professionals.

Bruinstein (2003), in her article "A model for interdisciplinary collaboration", has attempted to develop a model of collaboration for social workers which is useful for this chapter's task of searching for an appropriate approach to collaboration between PCGs and medical professionals. She insists that the medical personnel (i.e. physicians and nurses) cannot sufficiently meet the demands of managed care without the assistance of other helping professionals (2003:297). She is guided by the notion that critical knowledge of what constitutes and influences collaboration is essential. In this sense, she mentions five components of an interdisciplinary collaboration: *interdependence, newly created professional activities, flexibility, collective ownership of goals and reflection on process.* These she says are the keys for successful collaboration. Likewise, Balch (1991:48-51) has mentioned issues of identity and authority which borders on personal relationship, pastoral identity and professional interaction. In the same vein Underwood and Mosley (1991:57) mention four essentials for a PCG: physician relationship as mutual understanding and appreciation of each other's unique role; good communication; openness to share and learn from one another; and frequent opportunity to work together. On the other hand, Doran 2005:41) simply characterises three components of collaboration as the active and assertive

contribution of each party; receptivity to and respect for the other parties' contribution; and a negotiating process. Dourherty (2009:13) mentions the development of shared goals, bidirectional communication and joint problem solving. As evident from these scholars, there are no common components of collaboration. However, this study can identify broad areas of common agreement. These include the notion that collaboration is a relationship built on mutual trust and respect that are meant to complement one another, which implies shared goals and mutual benefit, and that such benefits can only be optimised when there are clear roles and identities of each partner. Based on this background this study identifies four essential elements of collaboration that could determine the nature of PCG and medical/healthcare professionals' relationships: equality/complementarities, mutual respect, clarity of roles, and identity and collaboration with shared benefits.

5.5.1 Relationship of equality/complementarities

Care relationships between or among different caring professionals have a symmetrical dimension. The collaborative relationship between the PCG and other health care professionals can be perceived as symmetrical and should be a symmetrical relationship of equality in terms of the goals, functions, obligations and respect for the dignity of one another in the caring relationship. Health care is a growing body of expertise and shared respectful and collegial relations between health care workers (Campbell, Gillett & Jones, 2005:13). Although the medical doctor may be at the helm of affairs taking responsibility for the patient's treatment and follow-up, such responsibility does not mean a medical hierarchy in the sense that the physician is the king and therefore not subject to interference by colleagues. In addition, in discharging such functions as treatment and follow-up, the physician should not be seen as one who resists the participation of other disciplines in the provision of care within the hospital environment (Campbell, Gillett & Jones, 2005:31). In support of the collaboration of caring professionals, Campbell et al. argue that "clinical freedom is dead" in view of the fact that the complexity of sickness requires that care be implemented from different perspectives.

> Clinical freedom is dead, and no-one need regret its passing. Clinical freedom was the right – some seemed to believe the divine right – of doctors to do whatever in their opinion was best for the patient. In the days when investigation was non-existent and treatment as harmless as it was ineffective, the doctor's opinion was all that it was, but now that opinion is not good enough.
>
> (Campbell et al., 2005:32)

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Hence Campbell et al. (2005:32) suggest that the ideal relationship among caring professionals should be a mutual one for the purpose of support and honest criticism. Mutual respect between medical personnel and the PCG could enhance the functionality of their relationship within the medical team in the hospital context.

5.5.2 Relationship of mutual respect

Carey and Cohen (2009:353) argue that there seems to be a 'subtle antagonism' between chaplains and physicians as a result of the different values they have internalised over many years of attending seminary and medical school. However, they have identified five components of a successful relationship between the physician and hospital chaplain: mutual understanding and appreciation of each other's unique competences, views, insights and contributions to the helping-healing enterprise; willingness and opportunity to communicate; openness to learn from each other; a robust sense of professional self-esteem; and more frequent opportunities to work together in helping the same patient (Carey & Cohen 2009:354).

Mutual respect has been identified as necessary for successful collaboration (Chappelle, 2006:213; Balch, 1991:49; Eyer, 1991:19). Mutual respect refers to mutual understanding and appreciation of each other's unique competences, willingness and opportunity to communicate and more frequent opportunities to work together. PCG seeks to collaborate with the medical personnel not as a matter of competing for relevance or supremacy, but as partners towards achieving the common goal of alleviating suffering where possible and helping patients to generate meaning in their situation. PCGs as much as the physicians are motivated by love and concern for patients to meet their desired needs and to alleviate their suffering. VandeCreek and Lucas (2001:48) rightly observe that some of the problems facing care professionals include how to first become a team and function as a collaborative team. This is a significant challenge for the healthcare professionals in Nigeria, as observed by Augustus (2006:257-265). Mutual respect among the caring professionals could therefore contribute substantially to the functionality of the team for a more meaningful practice. According to Balch (1991:49), mutual respect can be fostered by personal and professional interaction[77] between PCG and the medical personnel. The clarity of identity and roles of

[77] According to Balch (1991:49-50), professional interaction can be fostered through 1) incorporating written goals, and objectives into resident care plan; 2) actively participating in case conferences, rounds and patient assessment conferences; 3)participating in the institutional ethics committee by chaplains; 4) willingly sharing knowledge at every level and opportunity; 5) mutually assisting and supporting one another in carrying out their respective roles.

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each collaborator could also contribute to mutual respect as each collaborator will appreciate the unique contribution of the other to the healing process, which could also lead to the building up of trust among collaborating members.

5.5.3 Clarity of roles and identity

Several scholars have identified the issue of identity as a necessary component. Topper (2003:105) argues that a good image or identity can increase the caregiver's energy, strengthen their inner vision, develop their spiritual consciousness and give meaning to their care. Eyer (1991:24) observes that when such identity is lost, PCGs may experience frustration in collaborating with physicians who may be confident of their identity. Such loss of a clear identity is not peculiar to PCGs, but in fact affects most helping professionals including those working in medicine, social work, psychiatry, psychology (Ashley and O'Rourke 1989:77). This might well be why De Vries, Berlinger and Cadge (2008: 23-27) refer to chaplains in the hospital context as lost in translation in their quest to find acceptance by other professionals in the hospital space. Whereas the view of De Vries, Berlinger and Cadge may be harsh, the point they seek to drive home is quite pertinent. PCGs or chaplains are unique in their roles and identity. As such, they can only maintain their relevance within the hospital space by maintaining that uniqueness of identity and role.

This study brings to the fore, among other concerns, the identity and role of the PCG within the hospital context for the purpose of educating other professionals within the Nigerian hospital context and the Nigerian public of the importance of the PCG in the provision of religious and spiritual care. In this regard Reese and Sontag (2001:2) note that ignorance on the part of the collaborative partner on the expertise, skills, training values and theory of the other partner strains the collaborative relationship. They view such ignorance as arising from the way in which healthcare professionals receive their training in isolation from others. Therefore, it is the duty of the PCG and the medical personnel to clarify their identity and role and not simply assume that the medical personnel and patient understand their task (Balch, 1991: 49). In the light of Balch's statement, Chappelle (2006:208) speaking from personal experience of collaborating with PCGs, argues for the need for specialised training and education in collaboration. For instance, medical personnel may understand the work of the pastor in the hospital in terms of the traditional role of preaching to save the lost soul, whereas the PCG's role in fact goes beyond such an account.

The researcher's personal experience of working with patients in the hospital substantiates this point in the sense that even though patients were introduced to the PCG and their role clearly explained (or so we assumed), patients still had the traditional view of the pastor as just a preacher. When the researcher carefully explained that she was there to listen to the stories of the patients and to join them where they were, there was a positive response as against the initial resistance and avoidance. Fitchett et al. (2011:704-707) have also reported similar experiences in their research. Yim (2001:46) may be right when he states that meeting people where they are without imposing one's own salvation or preaching agenda is the professional PCG's value, which many may not be aware of. In the context in which the researcher worked, the PCGs clearly articulated their role to the medical collaborative team and kept to the professional code of pastoral ethics. In that way the collaborative team understood that PCGs were not there for the illness but for the person of the patient, and that was helpful. Such misunderstanding of roles or non-intentional role blurring, if not clarified, might create tension and anxiety between the professionals in a multi-religious and pluralistic context such as the hospital.

In essence, the identity and role of the PCG and the medical personnel who should comprise the members of the hospital team should be clearly communicated and understood within the relationship. Yim (2001:46) acknowledges that such communication may not be an easy task; it demands competence from the PCG, failure of which may mean that he/she can be lost in the collaborative effort. When the medical personnel understand the PCG's role in clear and concrete terms, there can be greater collaboration with the PCG. Thus, the challenge for the PCG is to be conversant with the professional language of the health/hospital care profession to function effectively. The PCG needs to have a general knowledge of mental and physiological illness to be able to engage meaningfully within the hospital space. Such insights are usually given to the PCG in training.

The training, identity and role of PCGs underpin the fact that PCGs are not trained to cure disease, but to understand patients in relation to sickness. In other words, they are concerned with what meaning the patient is investing the sickness. The understanding of the PCG's role could help provide insight into the medical personnel on how best to relate with PCGs in their unique roles and vice versa. Understanding the rigor of training which professional PCGs go through and their competence could generate more interest on the part of medical personnel to collaborate with them. For instance, if the nurse understands appropriately the role of PCGs, he/she will not call on the doctor to sedate a patient who is experiencing fear but will

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rather will call on the PCG to bring his or her healing presence (McClung, Grossoehme & Jacobson, 2006:149).

Therefore, the need for PCGs to be clear on their professional identity and authority and the source of this identity is imperative and can reduce blurring of roles. There is no gainsaying that the pastor/caregiver should be comfortable with her identity and should understand herself and her spiritual role. Many trained PCGs have proven themselves in this regard (Palmer, 2001:95-102; Faulk, 1991:33-45). The work of PCGs and chaplains viewed in this way makes them valuable partners, who complement the medical personnel in very significant ways. Such understanding can reduce the challenge the medical personnel and PCGs may experience in the cause of collaboration. The goal of communication is therefore to convey to the health professional how the PCG-physician consultation can contribute to the overall wellbeing of the patient, family and staff.

5.5.4 Collaboration with shared goals and benefits

Collaboration with shared benefit does not allow for a contest of power and authority, where the medical professional may see the PCG as a threat or as not worthy to be in that space. Shared benefit is engendered by what Bronstein (2003:301) calls *collective ownership of goals*, which involves a shared responsibility in the entire process of defining, developing and attaining goals. The collected ownership of goals in turn leads to newly created professional activities which are collaborative acts that can achieve more than could be achieved by that same professional working independently (2003:300). Shared benefits also necessitate flexibility of roles which, involves a fruitful compromise, in which case there is intentional occurrence of role blurring. This can only occur when there is a strong professional identity. Balch (1991:48) argues that of central importance in regard to collaboration "is mutual understanding and appreciation of each other's unique competences, views, insight, and contributions to the helping-healing enterprise". This mutual understanding prevents collaboration from being uni-directional (i.e. seen as doing a favour to the PCG or chaplain, in which case the initiative comes only from the PCG) and encourages bi-directional collaboration – which both do value. For example, medical professionals should be able to acknowledge the vulnerability and frustration they sometimes experience in the midst of medical failure and death of patients despite their best effort and their need for pastoral support (Faulk, 1991: 41). The PCG should also be able to acknowledge his/her strength and limits. This forms the foundation for any collaborative venture, in which both can create shared goals and creatively work together. Such an approach could be fostered in a humble

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way, where the PCG and the medical personnel can request assistance in each other's area of expertise outside one's professional role training.

The clarification of the identity and role of each professional partner sharpens collaborative ministry of care giving within the hospital context which requires ethical imperatives.

5.6 Ethical issues bordering collaboration

In a healthcare setting care involves a process of moral reflection. This means that care is not given in a vacuum but is informed by a set of norms and values. The assumption is that care involves series of actions borne out of definite and conscious choices. Dealing with human beings raises moral questions about attitude or behaviour, and in what way the care should be provided and to what extent one should be responsible for one's behaviour and actions. These are ethical questions and relate to morality – how best to conduct one's life as one relates with others (Seedhouse, 2009:17-18). This is because any engagement affecting the quality, value and ending of human life and relationship raises concern for many people. Mooley (2011:3) remarks that "care is central to morality in the ethics of care". Ethics and morality are closely linked together. Morality comes from the Latin word *mos* meaning custom or usage, while ethics comes from the Greek word *ethos* which has almost the same meaning (Kunhiyop, 2008:2). While morality deals with actual human practices, ethics deals with the question of how things ought to be done.[78] Ethical reflection therefore serves to guide human conduct as well as assists persons or a group to conform to the norms of morality for better outcomes, since there are no automatic guidelines for humans (Uduigwomen, 2003:3). Ethics points to the dimension of human morality which emphasises the dignity of the human person. As Ashley and O'Rourke (1989:15) insist, the principle of human dignity is involved in all ethical decisions, which should satisfy both the innate and cultural needs of the person. The concern of this chapter is not to delve into the different theories of ethics or which theory should guide the ethical process, but rather to discuss the ethical principles involved in collaboration. It might be noted that this study holds to a holistic ethics which recognises all theories as valid depending on the situation and context. According to Augsburger (1986: 248), "any holistic ethic must contain all three [theories] but each ethic tends to choose one as the fundamental principle and others as corollary means of decisions making".

[78] Kunhiyop (2008:3) does not agree with the separation of ethics from morality, because of the tendency to separate theory from practice in the sense of compartmentalising ethics to the academic sphere and morality to what is useful and true to a real-life situation. Kunhiyop's observation is taken seriously in this study as the distinction is to provide clarity and does not mean that ethics and morality should be taken separately.

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The healthcare and Pastoral Care professionals are guided by *ethos* albeit from different perspectives and foundations, which guides their professional practice and relationships with others. For the medical professionals this ethos is known as codes of ethic, which is not merely ethical but may have legal implications as well. Such ethical endeavour may help to clarify professional identity and relationships. However, when it comes to the professional relationship with other professions or practitioners, collaborative relationship may present a moral dilemma and blur their understanding of what ought to be. Collaboration in the view of this study may sometimes accentuate the haziness and dilemmas faced by healthcare professionals. However, when there is a common goal, such dilemma might be easier to navigate and might even be surmounted. McCurdy and Fitchett (2011: 59) remark that professions share a common goal to improve professional practice including Pastoral Care. In healthcare such a goal is to do good and no harm to the patient, or to reduce suffering to use a pastoral term. The Geneva Convention Code of Medical Ethics (quoted in Campbell, Gillett & Jones, 2005:31) states: "The health of my patient will be my first consideration. Such health embodies a holistic vision of patient wellbeing, which drives all to seek the *summum bonum* highest good of patients through interdisciplinary collaboration". Campbell, Gillett and Jones (2005:31) remark that

> the most dangerous practitioner is the 'loner' who attempts to work in isolation from colleagues in the field, and without reference to those who have different expertise either within the medical disciplines or other professional field. In order to work in the best interest of patients every practitioner must learn to share the decision-making process with others, to consider alternative diagnoses and treatment, and to find correction or support when the decisions are specially difficult and uncertain.
>
> (Campbell, Gillett & Jones, 2005:31)

Collaboration is therefore a moral and ethical responsibility that all healthcare and Pastoral Care professionals have towards the sick and suffering in the hospital despite the seeming challenges. This implies that the medical professionals and PCGs should be guided by an ethic of altruism –serving the interests of others – rather than egoism – serving one's personal interest. Kiriswa (2003:47-56) notes that issues such as referral, confidentiality and respect for the counselee are ethical issues that cannot be overlooked in pastoral counselling. Lukens Jr (1997: 43-56) has also identified essential elements for ethical counsel which are relevant for this study: confidentiality, informed consent of patient, documentation, proper ending of treatment and dual relationships. Although Kiriswa's and Luken's categories are important within the context of counselling and should be given consideration by the PCG in his or her practice as a whole, in view of the focus of this section on collaboration with the medical

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professionals within the context of the Nigerian hospital space, this study considers confidentiality, referral, informed consent and documentation as of special significance to this study, in addition to maintaining professional boundaries and the bioethical implications of collaboration, as will be discussed below. These ethical issues, which also have moral and even legal implications, are often what make medical professionals hesitant to collaborate with other professionals as it tends to blur the ethical boundary for responsible ethical practice regarding patient care and adherence to a professional code (Code on Medical Ethics, 2004:1, 52). The following ethical issues will be discussed below: confidentiality, informed consent, referrals, maintaining professional boundaries, documentation, and the biomedical ethical implications of collaboration in healthcare and their implication in collaborative and holistic care with the PCG within the hospital environment.

5.6.1 Confidentiality

One of the ethical issues involved in collaboration is confidentiality. Confidentiality in the medical context arises from the principle of respect for patients' autonomy. Patients' autonomy is only one of the four main principles or rights of patients in healthcare. Other rights of the patient are beneficence (doing good), non-maleficence (doing no harm) and justice. According to Moodley (2011:42), autonomy literally means "self-rule". It refers to the right of every individual to make decisions for him/herself. Theologically, the self-determination of persons as expressed in autonomy recognises human freedom, which is expressed in the message of salvation of the Christian faith (Russell, 2011:124).

In healthcare this will entail "allowing the patient to make the final decision regarding his or her treatment after providing all the necessary and relevant information" (Moodley, 2011:42). Therefore, autonomy entails an obligation of telling the truth to the patient, respect for the privacy of others, protecting confidential information, obtaining consent for intervention with patients (Moodley, 2011:42). As it relates to the relationship of healthcare professionals with other helping professionals, the obligation to obtain consent from patients and protection of their confidential information appears paramount in the healthcare setting. This is because, as said in Chapter Four (4.3.2.4), confidentiality relates to the communicative relationship between the patient and his/her physician or other health care professionals in the hope of receiving appropriate care and the promise that their very personal and vulnerable information will not be divulged. Such practices engender respect for the patient, create trust and promote health and healing (McCurdy & Fitchett, 2011:59).

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The seriousness of confidentiality and informed consent is stipulated clearly by the Nigerian codes of Medical Practice and Pastoral Care and the literature on counselling. In the Nigerian medical and Dental Association confidentiality forms part of the code of conduct for professional practice and the maintenance of human dignity (Code on Medical Ethics in Nigeria, 2004:52). In part D of the Code entitled “improper relationship with colleague or patient”, Code No. 44 headed “Confidentiality” states:

> The profession takes very seriously the ethics of professional secrecy whereby any information about the patient that comes to the knowledge of practitioner in the course of the patient doctor relationship constitutes a secret and privilege information which must in no way be divulge by him to a third party. The medical records are strictly for the case and sequence of continuing care of the patient and are not for the consumption of any person who is not a member of the profession. Practitioners are advised to maintain adequate records on their patients so as to be able, if such a need should arise, to prove the adequacy and propriety of the methods, which they had adopted in the management of the cases
>
> (Code of Medical Ethics, 2004:52).

Unfortunately, many healthcare professionals in Nigeria decry the many breaches of confidentiality among nurses, physicians and other healthcare professionals. According to Anumonye (in Nnenyelike, (2010) such breaches raise concerns for the Nigerian healthcare system and are currently receiving attention in the media and among healthcare practitioners. For example, Katib (2011) writes:

> A patient is ethically and professionally protected on any medical information relating to them. Healthcare professionals especially doctors should protect their patients in this relationship because it is the right of the latter. Common observations have revealed that hospital practitioners like nurses and laboratory scientists in some instances are fond of discussing the confidential document or medical status of patients openly with colleagues to the hearing of other patients or even outsiders. Apart from the fact that this practice is unethical, it shows a betrayal of trust on the part of these supposed professional who are expected to be guardians of patients’ confidential information. Patients with some pain should not be further unleashed with psychological pain through the careless gist by health care staff during/after working hours.
>
> (Katib, 2011)

If Katib’s observation is true of such professionals, then there is a serious need for the re-orientation of Nigerian healthcare professionals on what professional practices entail.[79] Be

[79] C.f. The Code of Medical Ethics in Nigeria (2004:53-54), Part D.

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that as it may, confidentiality and informed consent is proving a tough challenge to healthcare systems generally. Siegler Mark terms it a “decrepit concept”. According to him,

> medical confidentiality, as it has traditionally been understood by patients and doctors, no longer exists, this ancient medical principle, which has been included in every physicians oath and code of ethics since Hippocratic times, has become old, worn out, and useless, it is a decrepit concept. Efforts to preserve it appear doomed to failure and often give rise to more problems than solutions
>
> (Mark ,2011)

Moodley explains that the principle of autonomy and confidentiality is not an absolute rule but a *prima facie* rule that must be fulfilled in the absence of another stronger rule (Moodley, 2011:42). In other words, there are instances where a breach of confidentiality could be justified. In many cases confidential information is shared all the time among healthcare team members and is recorded in the medical record[80] (McCurdy & Fittchet, 2011:61). Therefore Dhai and McQuoid-Mason (2011:87) state that when patients choose to share some information with their practitioner, they choose to relinquish their privacy. Hence, they advise that patients should be made aware of the limits of confidentiality and make an informed decision and give consent before information is shared, not after.

The relative and complex character of confidentiality creates a challenge for healthcare workers and sometimes may hamper collaboration with others outside the fold. Erde, Pomerantz, Saccoci, Kramer-feely and Cavalieri (2006:398) observe that confidentiality and privacy are key issues in hospital care and sometimes present a dilemma for the hospital delivery of healthcare. In some healthcare institutions the PCG is considered as an outsider and not a member of the team. This accounts for why they are not allowed access to medical records in such institutions.

The confidentiality and privacy rules differ from context to context and the nature of relationship and position of the PCG in the hospital space. For example, as was discussed in Chapter Four, in the United Kingdom the debate on whether the PCG is a member of the team does not arise as they are seen as members of the healthcare team. Thus, the question of whether sharing information with the PCG is a breach of confidentiality can be clearly

[80] Medical records pose a particular challenge to confidentiality as third parties can access such information. Although consent is supposed to be obtained from the patient by the third party before such information is accessed, in many instances this does not happen for many reasons. The advent of information technology also poses a particular challenge to confidentiality as many medical records and a good deal of health information is now stored on electronic databases. Persons outside of health practitioners can easily access information stored on databases. Consequently, these databases are vulnerable to hackers, viruses and spyware that might leak this information for selfish ends (Dhai & Etherege, 2011:29-30).

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answered. In the USA (in some healthcare institutions), however, the ambiguity of the PCG in the healthcare team raises some debate. This is exacerbated by the US Health Insurance Portability and Accountability Act (HIPAA). This privacy rule explains that healthcare "does not include methods of healing that are solely spiritual" (Tovino 2011: 59). It concludes that the clergy or other religious practitioners who provide exclusively religious healing services are not health care providers. As Tovino (2011:60) reports, this statement has led to several divergent interpretations from healthcare attorneys that hospitals and physicians are prohibited from sharing individually identifiable information with hospital chaplains/PCGs. Others argue that the privacy rule failed to distinguish between the hospital-employed chaplains who work within the healthcare team and the community clergy. There are several arguments that hospital PCGs who are staff of the hospital and who provide services should be distinguished from the parish clergy or pastoral visitor or volunteers who are not part of the hospital staff. This is because the hospital PCGs' duties extend beyond providing solely religious care. However, if the PCG's service is not considered as part of healthcare, this means that disclosure of patients' information to PCGs may be considered as a breach of the confidentiality contract of the patient. Not regarding him or her as a part of healthcare would imply that for the PCG to access patients' information beyond the directory information there must be a written authorisation by the patient to access that information (Tovino, 2011:60).

Tovino (2011:60) further argue that those who support chaplains' or PCGs' access to patients' protected health information (PHI) base their argument on the reason that the hospital chaplain's duties go beyond solely spiritual or religious services. Secondly, state laws and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards require hospitals to address the spiritual needs of patients. Thirdly, several Medicare programmes and research projects acknowledge that spiritual or religious care has a beneficial and therapeutic effect on patients' medical condition. Fourthly, there is the lack of any reported cases involving hospital chaplain's inappropriate use or disclosure of PHI (Tovino, 2011:60).

It is further argued that several conditions warrant the chaplain gaining access to or use of PHI. Such conditions apply when they 1) attend to a physician's or nurse's referral to provide religious or spiritual care to patients; 2) participate in ethics committee discussions about a particular patient; 3) access the list of newly admitted in-patients to locate the room number of a particular patient requiring religious or spiritual care; 4) prepare paper work relating to a

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dead patient; 5) coordinate funeral arrangements; 6) refer patients to social workers or another healthcare provider for additional social or health services; 7) discuss a patient's spiritual needs with another member of the clergy who may be familiar with the patient; and 8) chart the religious or spiritual care service provided to the patient. These duties make it impossible to deny the chaplains or PCGs access to PHI. Such access to a patient's information solely to respond to the patient's needs and not out of curiosity or for personal interest is within the terms of confidentiality or justifiable breach of confidentiality for the good of the patient. Provision of quality health care requires that information necessary for the patient's treatment be disclosed to the practitioners directly responsible for the care of the patient (Uduigwomen, 2003:195). However, if they access PHI for personal gratification, or access the record of a patient for whom they are not responsible for providing Pastoral Care, this is certainly a breach of confidentiality just as a physician or nurse who accesses such information of patients under their care will be in breach of confidentiality.

The argument so far reveals an ethical problem of collaboration between the PCG or chaplain and physician. This is an ethical problem in using PCGs within the hospital space. But these problems are reduced by clarifying what role the PCG would be playing and to what extent he or she is to be involved in hospital care. Understandably, the incidences of breaches of confidentiality and informed consent within the Nigerian healthcare system and the responsibility placed on the doctors by the Codes of Conduct when erroneously interpreted might might lead to the exclusion of many potential professionals who might be of great benefit to the patients. Nevertheless, the codes of medical ethics are formulated for the purpose of advancing co-operation among healthcare providers and with others to promote and protect the health of all people. This code is in line with the argument of this study that collaborating with trained PCGs in the hospital is not just ethical, but indicates sensitivity to the patients' needs for holistic care. Therefore, role clarification as discussed in 5.5.3 could help determine the extent and limit of confidences a medical professional could discuss with the PCG.

In this researcher's opinion, information shared by the physician or nurse or any other healthcare practitioner with the PCG which is relevant to the case of a patient and for the sole purpose of providing spiritual care should constitute appropriate confidentiality and not a breach of the code. It is hoped that such collaboration can be developed to the extent that patients will indicate interest in and a desire for Pastoral Care. Such interest can be identified at the admission of each new patient, in which case the function of PCGs and their services

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can be clearly explained to the patient. The patient is given the opportunity to consent to pastoral visits as part of the therapeutic intervention, in which case, a clear record is maintained of the pastoral intervention given. In other words, only information relevant to the care of patients should be charted in the medical record or verbally shared to the necessary third party.

5.6.2 Informed consent

The principle of informed consent is an offshoot of the autonomy principle of the human being capable of reason and making choices based on their values and beliefs towards satisfying their desire for self-realisation, self-transformation, self-development and search for meaning. Informed consent is an acknowledgement and show of respect for the privacy, rights, autonomy and dignity of the human person. Beauchamp and Childress (2009:105) define informed consent as "an individual's autonomous authorisation of a medical intervention or of participation in research". Such consent which intends to safeguard the privacy of persons and respect for individual autonomy might not only involve giving them the chance to make choices, but also giving them the choice not to make decisions when they don't want to do so. Beauchamp and Childress (2009:105) argue that patients should have a correlative right to choose as opposed to the mandatory duty to choose. From a Pastoral Care perspective, informed consent could be said to be rooted in the concept of the image of God, *Imago Dei*. God always gives man the freedom to choose after explaining the consequences of each action. Jesus could also be said to have practised informed consent before embarking on healing his patients. He often asked: What do you want me to do for you? Do you want to be healed? (Deuteronomy 28:1-68, John 5:6).

Informed consent as a core aspect of clinical ethics and bioethics devised in a legal situation to prevent harm to patients; however, the ground for informed consent has shifted from prevention of harm to the demonstration of respect for the autonomy of individuals (Anthony, 2009:38). Two issues are involved in the practice of informed consent. The first is that informed consent involves individual's autonomous consent which can be verbal, express, tacit or implicit. Secondly, informed consent should be understood as the institutional or legally valid authorisation from patient or family, often in a specified written format before treatment or research. Beauchamp and Childress (2009:120) classify the seven essential elements of informed consent into three categories.

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1.) Threshold elements or preconditions involve elements of competence and voluntariness. Competence involves the ability to make understand and decide, and is judged to the degree of understanding of the patient, while voluntariness constitutes the degree of freedom to make such decision without coercion or manipulation.

2.) Information elements involve elements of disclosure of the material information, recommendation of a plan and understanding of the information given as well as the plan recommended.

3.) Consent element, which involves decision in favour of the plan and authorisation of the chosen plan. Within the consent elements, various types of express consent, tacit consent implicit consent and presumed consent can be identified.

Informed consent is an attempt to provide more culturally appropriate care to patients as well as provide medical professionals with appropriate ways to manage patients' information. It is aimed at protecting patients from the paternalistic belief that the healthcare professional could do anything to the patient, even if contrary to the patient's desire so far as it serves the best interest of patients (McQuoid-Mason & Dhai, 2011:69). Beauchamp and Childress (2009:120) argue that although many physicians define informed consent in terms of one element of *disclosure* of information, many patients hold disclosure of information less pivotal in medical and clinical care than the recommendation of a particular plan like surgery and medication.

In the light of the above discussion on informed consent the physician-chaplain/PCG-patient relationship carries both the patient's autonomous consent and institutional or legal rules of informed consent. It is believed that in many Nigerian hospitals patients would be briefed by the hospital administration on the patterns of working with patients in the hospital on the first visit or admission to the hospital as part of good medical practice.[81] Such information is intended to allow patients the opportunity to understand how the different medical professionals operate to obtain the possible best practice and outcome in the patient care and to ensure continuity. As Beauchamp and Childress (2009:106-107) explain, the patient by that act delegates his or her right of autonomy to the medical staff to act on his/her behalf.

[81] Responsible hospital care requires that the patient take part in determining what should or should not be done to or for him (cf. WHO Key Components of a Well-functioning System May 2010). Underlying this argument is the researcher's assumption that no one understands the patient better than the patient himself does. They are the experts of their lives. This means that they "have many skills, competences, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems" (Alice Morgan, 2000: 2) if motivated appropriately. This enables the patient to exercise his/her autonomy in an informed and responsible way as a human being and not simply an object or a case study.

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They conclude that "health professionals should always inquire in general terms about their patient's wishes to receive information and make decisions, and they should never assume that because a patient belongs to a particular community or culture, she affirms that community's worldview and values". Such information allows them to grant informed consent or delegate such right to the hospital team or family or whoever else is worthy of their trust. Campbell and Gillett (2005:26) explain that the emphasis on informed consent does not invalidate the situation that the professional will sometime act in trust for the patient's good. It is the assumption of this research that many Nigerian patients do not object to such collaborative approaches to care, but in fact desire such care that involves the PCG and the medical personnel, and that such desire is often the overarching reason behind their choice of hospitals (2.6.3.2). It is common to hear Nigerians say that it is foolishness to surrender your fate into the hands of one man. For them, "the more hands, the better the care". Therefore the collaboration of the nurse or doctor with the PCG, to provide Pastoral Care to patient who has given general consent to the medical administrators to provide him/her with holistic medical care (which implies roles of other professional), will still act within the range of informed consent. However, where the physician or nurse faces a dilemma or is unsure as to the extent of the collaboration, informed consent can still be received from patients as it concerns specific procedures which may arise and which may not have been discussed with the patient. He or she could also discuss with peers and other colleagues to determine the best approach rather than simply ignore this vital issue out of fear or assumption of what should be. In essence, each case should be taken on its own merit. As a matter of fact, it is expected that consent be sought from the patient before the patient could be referred to a PCG for consultation.

5.6.3 Referrals

Oglesby (2005: 1048) has argued that the advancement and specialisation in meeting human needs by caregivers has both positive and negative impacts. While it has increased the quality of care, it has also threatened the holistic understanding of persons in that it has tended to concentrate on the parts rather than the whole. In order to reduce part of the losses the idea of collaboration and concept of the team emerged. The process of referrals was a means of bringing every resource available to a particular situation. In this regard, the Code of Medical Ethics in Nigeria 2004: 53 section 41a states:

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> It is desirable and indeed a requirement of ethics that every practitioner in dealing with patients must recognise his own limitations in skills and facilities, and thus be able and willing at all times to refer such circumstances to better skilled or better equipped colleague or hospitals. It is professional misconduct for a practitioner to cause detriment to a patient by failing to refer to others a case he (sic) cannot handle effectively
>
> (Code of Medical Ethics, 2004:53).

Accordingly, Oglesby (2005:1049) mentions three essential procedures that should guide all referrals, namely the timing of referrals, the process of referrals and the resources for referrals.

a) Timing of referrals: This refers to the time when the caregiver recognises an inadequacy in any of the three essential areas. Timing requires that the caregiver first evaluate whether he has sufficient time to address the needs of the person satisfactorily; second, whether he possesses the skills to deal with the issue; and third, whether he can be emotionally present and supportive despite his own burdens and brokenness.

b) Process of referrals: This implies that care should be taken that the patient does not experience the process of referring as rejection, in which case the caregiver relinquishes responsibility for the patient, or the caregiver retains overall responsibility for the patient but calls on colleagues as needed to provide particular and specific services.

c) Resources for referrals: This raises the question of the resources available on the area. This implies that the caregiver should have prior knowledge of the competence and quality of care, which is given by various professionals and organisations. As Oglesby (2005:1049-50) states: "The basic principle in any and all referrals is the well-being of the careseeker. This principle offset any tendency toward a grandiose assumption that the caregiver is omnicompetent and needs no assistance, on the one hand, and the tendency to down play one's own resources and healing abilities, on the other".

There is a growing desire among patients for holistic care from medical professionals. Holistic care makes it impossible to care for patients efficiently without collaborating with other professionals. There is a growing awareness that many professionals are less able to meet the needs of patients on their own without collaboration (Bronstein, 2003:299). For instance, physicians and nurses are less able to meet the spiritual needs of patients. Such inadequacy is due to limitations of the medical discipline in terms of lack of training in spiritual care giving, limited time, organisational constraints (Williams, 2008:12) and limited understanding of roles and expertise of the PCG. As part of a collaborative approach, there is

the need to recognise one's competence and the boundary up to which one can competently offer significant help to patients. The NSHDP 2010-15 (2010:44) section 2.2.4 has highlighted as one of its goals the strengthening of the referral system and mapping network linkages for a two-way referral system. Bronstein (2003:300) relying on collaborative interdisciplinary theories notes that part of the advantage of collaboration is the merging of expertise and knowledge from different professionals to maximise outcomes with today's complex problems. Therefore, the reliance on others' skills and resources allows collaborators to use their time efficiently on what each knows and does best. Such efforts will be effective when the collaborators believe that they have more to gain than to lose and can foster the referrals process.

Collaborative practices in terms of referrals are necessary because of the increased requirement for accountability and documentation of complex diagnoses and treatment plans. Such demands often fall short of what individual training can provide. In this regard, referral forms part of the professional ethos and ethics of health care. The pattern of professionals clinging to a helping relationship because of a feeling of omnipotence or possessiveness, or out of fear that their inadequacy might be exposed, then goes against the ethical code of conduct to act for the benefit of the patient. There is a growing body of research on referrals between the hospital chaplain or PCG and the medical professionals on matters of pastoral needs (Fitchet et al., 2011:704-707; Galek, Flannelly, Koenig & Fogg, 2007:363-377; McClung, Grossoehme & Jacobson, 2006:147-155; Carey & Cohen, 2009:353-367; Wittenberg-Lyles, Oliver, Demiris, Baldwin & Regehr, 2008:1330-1335).

Studies conducted by Galek, Flannelly, Koenig, and Fogg, (2007:363) note that patients' pastoral needs often go unmet by the medical professionals in hospitals and other healthcare settings (Galek et al., 2007: 370). Given the centrality of religion and spirituality in patients' process of healing, healthcare reforms in many contexts mandate the provision of Pastoral Care as part of holistic care giving. Carey and Cohen (2009: 353) observe that there has been an increasing debate about physicians including Pastoral Care as part of their holistic care; however, instead of undertaking it themselves, they should collaborate with chaplains to realise this goal[82].

[82] However, as Galek et al. (2007:370) observe from their research, the medical professionals' relationship with the chaplain, the principal person designated to provide pastoral care, depended on the professional's perspective on religion and spirituality. As such, the physician's belief system and religious values influence the care that he or she gives to the patient. Many physicians they observed claimed to be non-religious, which creates a professional gap in patient care that leaves the patient without guidance and counsel regarding pastoral

Physicians must attend to the spiritual concerns of their patients because the physician is not value free and may affect the care he or she gives to patients. One need not be a person of faith to encourage the faith of the other. Such openness to the spiritual framework of the patient promotes trust in the physician. By using a simple spiritual inventory the medical professional can identify the needs of patients and refer them to PCGs for appropriate intervention instead of ignoring them or applying a medical solution of medication to a pastoral need.

Bronstein (2003:301) argued in her *Model of Interdisciplinary Collaboration* that one of the characteristics for successful interaction is *collective ownership of shared goals* (5.3, 5.5.4). Therefore, when physicians and PCGs are committed to shared goals of patient-care as their obligation, mission and strategy, the practice of referral of patients to chaplains will become more feasible. An ethic of accountability to holistic patient-centred care will make physician/PCG care possible despite seeming differences. Referring patients to another colleague does not mean that there must be a perfect consensus. The ethical issue that arises here is “to whose benefit is the referral”? The patients cannot be left in the cold because of personal beliefs. The central dynamic in referral is “a form of consensus among team members that reflects neither the extreme of perfect unison nor that of unbridled conflicts” (Bronstein, 2003:301). Accountability requires that the referrer be sensitive to the patient by extracting the patient’s consent to be seen by another professional, which means that care should also be taken to explain to the patient the reason for the referral as patients might interpret it as sign of rejection or as being a hopeless case.

The implication for the Nigerian hospital system which seeks to be committed to holistic health care is that the hospital system should regard Pastoral Care as an authentic component of the patient’s wellbeing and a necessary factor in the patient’s healing process. This is in line with the WHO’s Quality of Life WHOQOL index, which includes spiritual and religious beliefs as one of the domains of its assessment (WHO, 1998:5). The Nigerian hospital system should also realise that providing spiritual care belongs to the domain of PCGs as that is what they are trained to do. However, basic forms of spiritual care can be and should be provided by all professionals within the hospital context, for only then can the medical professionals assess and recognise a particular patient’s need for a more sensitive and competent pastoral

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care needs. On the other hand, they reported that nurses were more likely to attend to the pastoral care needs of patients and were more likely to refer patients to chaplains on deeper spiritual issues beyond their expertise.

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intervention. But collaboration also necessitates maintaining professional boundaries as an ethical norm.

5.6.4 Maintaining the ethical boundary

Implied in referral is also the ethical issue of recognising and maintaining boundaries. Ethical boundaries require that the professionals in the hospital context such as doctors, nurses and Pastoral Caregivers etc., should have a more profound understanding of what professionalism entails. Such understanding goes beyond technical expertise and remuneration, and involves clear and appropriate loci of responsibility (Hunter 1995:28). This also means that keeping boundaries should necessarily involve clarity of roles, skill and expertise as well as acknowledgement of competencies. Although as stated in 5.5.3, there is an element of role blurring which may be involved in boundary shifting, role blurring should not be taken as the norm. Therefore maintaining professional boundaries will enhance complementarity (5.5.1) and mutual respect (5.5.3) as an ethical responsibility. David Hunter adds that:

> Being able to care responsibly for others requires a willingness to be examined by one's peers and supervisors, to study… it also requires struggling with one's own hidden motivations, limits and blind spots, receiving care for ones own needs and deficiencies and being willing to participate in a community of mutual supervision and consultation.
>
> Hunter (1995:28)

Therefore, collaboration emphasises the importance of professional accountability in caregiving. An ethics of responsibility and accountability will receive more attention in 6.10.1 under pastoral ethics, professional standards and code of conduct. It is worth noting that being accountable also entails documenting the caregiving process.

5.6.5 Documentation of patient information

The importance of documentation in healthcare is emphasised in the Code of Medical Ethics in Nigeria (2004:50), part D, 42D: "A member of the medical profession who hands over [or refers] his patients to another must take every endeavour to ensure that the case is handed over with appropriate details of the case history in reasonable time for his colleague to acquire a grasp of the case". Cobb (2005:113) rightly remarks that documentation of patient care is established good practice for health care professionals with its ethical and legal obligations as informed by the Data Protection Act. In this sense, documentation serves a risk-management function and brings to the fore an important ethical issue in healthcare which may also have legal implications when linked with the issue of confidentiality, informed consent and referrals.

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It follows therefore that documentation may take different forms and is written for different purposes. Therapeutic documents may record the history of all steps that have led up to a significant outcome. Morgan (2000:96) argues that therapeutic documents that have the patient in focus can be empowering as they may record the commitments and steps that patients have taken to assist them to reclaim their lives. Lukens (1997:51) is of the opinion that for the sake of legal implications negative feelings should also be recorded as having been evaluated. Morgan (2000:96) states that issues of confidentiality should be considered regarding what information should be recorded. Cobb (2005:115) suggests that patients should be told at the start of the consultation that a confidential record of their contacts will be kept as a matter of routine and the patient's consent should be documented in the medical record. Lukens (1997:51) states that an accurate record and information helps the caregivers in the assessment process as well as in planning and continuing the course of treatment.

Cobb (2005:113) argues that "[w]hen a patient is referred to a chaplain, either as a referral by a health professional or as a self-referral by the patient, a minimum set of information is required by the chaplain that needs recording". Cobb explains that when a patient indicates that the information may not be disclosed to anyone else, the patient's wishes should be respected unless there are clear grounds for disclosure in the public interest. This also implies that such information may not be documented. Also, it is best practice for chaplains to record their patients' contact details as part of a multidisciplinary care records. Pastoral Care records are best made on printed forms that have the approval of the Medical Record Committee (Cobb 2005:116).

According to Cobb (2005: 116), the content of the chaplaincy record may typically consist of three categories:

- The information necessary to identify the patient and any established or pre-existing needs (e.g. name, religious observance, etc.);
- Information associated with the current episode of care (e.g. ward, reasons for admission);
- Information specific to the current referral to the chaplain (assessment of need and planed care).

Cobb further explains that the record should summarise the contact with the PCG in such a way that it can withstand two tests. First, any other PCG should be able to read the summary, understand the nature of the referral, the care the PCG offered and any action that needs to be

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taken. Second, the patient should be able to read the record, without being offended or in disagreement with what has been written, and deems it a reasonable summary of the pastoral encounter with the PCG. Cobb warns that record should not contain the PCG's personal opinions about the patient, the patient carers or visitors. Documentation of the medical record of patients may also reveal some biomedical ethical decisions that the healthcare professionals are confronted with.

5.6.6 Biomedical ethical implication of collaboration in health care

Ethics presupposes freedom and responsibility. In other words it is concerned with motivation for conduct (Uduigwomen 2003:17). Uduigwomen (2003:14) remarks that there are two views on the relationship between ethics and religion. One view states that religion and ethics are separate. In other words an individual's practice of medicine stems from certain moral principles which in turn are influenced by ones' religious background. Morality is the direct object of ethics, while in religion it is God, prayer and worship. The other view states that both religion and ethics are concerned with the moral conduct of humans, and as such presupposes freedom and responsibility. Religion, therefore, becomes a way of viewing morality and becomes a medium by which human norms, values and conducts are judged. "By norms is meant the basic criteria that help one to understand the truth (essence) of being qualities, the meaning of life, driving forces (motives) and the destiny or *telos* of things"(Louw 2008:269). On the other hand, values are internalised norms. The focus on the biomedical issues in this study is based on the inseparability of religion and ethics. Biomedical ethics is connected with the principle that guides medical practices in healthcare in order to ensure consistency and conformity in the moral and ethical beliefs norms and values in the conduct of the professional.

Uduigwomen (2003:22) states that the core of biomedical ethics concerns the question of the nature and meaning of life. New methods of research in biochemical, pharmaceutical and medical care have resulted in dramatic developments in healthcare that have complicated *life* and *death* – the two basic elements of our being human (Louw 2008:285). At stake are basic questions such as when does life begin? What is death and at what point is a person considered dead? Is it right to prolong life or terminate it for whatever reason? Is a medical technology like organ transplant, in vitro fertilisation, cloning etc. "playing God"? In consequence, "clusters of theological and ethical issues arise, relating to God's sovereignty, man's value and stewardship of creation's resources" (Louw 2008:285) etc. The above

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ethical dilemma involved in caring procedures must necessarily involve a theological perspective in attempting to address such questions.

The very complexities of this biomedical issue suggest that a sure answer from a singular perspective is impossible. Therefore Louw (2008:292) may be right when he claims that ethical decision making is not about the final decision itself, but about the quality of the process. The quality of the process may also imply the “who”, “what”, “why”, “where” of the process. Better still, when the issue of meaning is introduced it takes the discussion beyond mere medical ethics and invites other perspectives such as pastoral ethics into the discussion (6.10). Therefore Uduigwomen (2003:22) views biomedical ethics as having a connection with ethics and modern medical technology as it affects the control of human life. In this regard, the Draft Health Promotion policy (DHPP) (2005:12) of Nigeria, NSHDP 2010-2015 and NPPPHN (2005) policies represent visions in the right direction. Specifically, DHPP (2005:12) states as one of its underlying principles and values the importance of partnership and collaboration of professional groups. Collaboration of health professionals with PCGs points towards an ethical responsibility that could “empower individuals and communities to make informed decision about their health” (DHPP 2005:12), which NSHDP 2010-2015 (2010:45) believes will contribute to the quality of health facilities and an increase in their use by Nigerian citizens.

5.7 Conclusion

Having been established that spiritual care is important in health care organisations including hospitals, this chapter posed the question: Can the notion of collaboration assist both the PCGs and the medical professional to address the Pastoral Care needs of patients? The purpose of this chapter was to establish the importance of collaboration in healthcare with PCGs for quality patient care. In this regard, collaboration has been defined in this study as an interpersonal and professional process that enables healthcare professionals and PCGs to contribute to a common goal of promoting the health of patients through consultation and team work. Consequently this chapter reveals that understanding and overcoming divisions in healthcare could be achieved by collaboration in healthcare among professionals, which should also include the PCG. The National Policy on Public Private Partnership for Health in Nigeria (NPPPHN 2005) admits that collaboration can contribute to creating space (c.f. 1.8.6) for quality care of patients. Therefore, historical antecedents, limitations of medicine, mind-body connections as well as the patients’ desire for Pastoral Care all need to be addressed to provide the basis for collaboration (5.4).

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Essential to the basis for collaboration is also the nature of collaborative relationships which have been identified as complementarities, mutual respect, clarity of roles and identity, as well as shared goals and benefits (5.5). Furthermore, this chapter showed that collaboration involves ethical, moral and spiritual concerns in healthcare. It highlights the fact that to provide high-quality care collaboratively, healthcare professionals and PCGs must understand and respect their client's needs, attitudes and concerns. This in turn leads to improved client satisfaction, dignity and worth. Thus healthcare involves a process of moral reflection as it affects the quality, value and dignity of human life and relationship.

Therefore some ethical issues such as confidentiality, informed consent, referrals, maintaining professional boundaries, documentation and biomedical ethical issues (5.6) were explored. Confidentiality forms the core of medical practice because it is connected to the patient's right of autonomy. Respecting the patient's autonomy is demonstrated in respecting the patient's privacy, protecting confidential information and obtaining informed consent. Such ethical conduct in healthcare necessarily requires documentation. Ethical practice also entails maintaining professional boundaries as well as adopting appropriate ethical discernment in the biomedical process of caregiving. A collaborative approach through team work is a moral and ethical responsibility that healthcare and Pastoral Care professionals owe the suffering patients, which could lead to the harmonisation of inputs into hospital care and higher ethical standards.

This chapter has highlighted the idea that in order to achieve success in collaboration through consultation and a team approach to hospital care in Nigeria, the PCG and healthcare professionals must be aware of the influences on the processes of collaboration, which can facilitate or impede their success. Collaboration is only possible through hard work, commitment and careful utilisation of an appropriate Pastoral Care approach. An appropriate Pastoral Care approach through which the PCG can mediate Pastoral Care within the Nigerian hospital context will be the focus of Chapter Six.

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CHAPTER SIX

THE HOLISTIC PASTORAL THEOLOGICAL APPROACH TO PASTORAL CAREGIVING IN THE NIGERIAN HOSPITAL CONTEXT

6.1 Introduction

This chapter's focus is on proposing an approach to Pastoral Care giving in the Nigerian hospital context. This falls in line with the main objective of this study, which is to ascertain whether the inclusion of the PCG in the Nigerian hospital space with an appropriate Pastoral Care approach can improve the quality of hospital care and increase patient satisfaction. It was confirmed in Chapter Three that Pastoral Care is relevant and could contribute to holistic caregiving, thereby improving the quality of hospital care in Nigeria. In adopting Osmer's research design within a post-foundationalist methodology of practical theology, Chapter Two dealt with the background of health and healthcare within AKS culture and worldview. It addressed the issue by asking: What is going on? In this regard it reflected on the traditional, Christian/religious and medical approach to health and healthcare among the Ibibio of Nigeria. In Chapter Two the study revealed that the cultural values and religious beliefs of a Nigerian patient determine his/her perception of illness and influence their illness behaviour, healing practices and the meaning they derive from such practices. Therefore, medical care requires a holistic approach that takes into account the intricacies of illness, which involve the spiritual and religious dimensions. By exploring the meaning and nature of Pastoral Care through theological theories, Chapter Three focused on the interpretive task by asking: Why is this going on? The exploration of the meanings and nature of Pastoral Care revealed that it is a viable vehicle through which spiritual and religious care can be appropriately mediated in the hospital. Chapter Four dealt with the normative task of good practice in exploring the question: What ought to be going on? In this regard the roles and identities of the professional PCG were explored utilising role theory and best practices from the USA and Europe. In Chapter Five the normative task of ethical interpretation was used to explore the possibilities of collaborative practices between the PCG and the medical professionals in view of the moral, ethical and even legal implications of the PCG's involvement in hospital care. It raised the question of the appropriate framework for the engagement of Pastoral Care in its task in the hospital context in AKS.

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This chapter is designed with reference to Osmer's fourth task of practical theology – the pragmatic task (1.6.3). As Osmer (2008:176) points out, the pragmatic task often "provides help by offering models of practice and rules of art. Models of practice offer leaders a general picture of the field in which they are acting and ways they might shape the field toward desired goals. Rules of art are specific guidelines about how to carry out particular actions or practices". In the light of the above, this chapter is concerned with an appropriate approach for PCGs to carry out their tasks and roles of care giving with competence within the Nigerian hospital space. Accordingly the pragmatic task of practical theological interpretation has to do with formulating approaches that can change situations in ways that are appropriate and desirable. Hence it is the task of leading change (Osmer, 2008:175). Change implies the need for sound leadership qualities and competence. Osmer (2008:176-178) identifies three forms of leadership:

Task Competence: This is the ability to excel in performing the tasks of a leadership role in an organisation. Osmer 2008:176) emphasises that this task is a crucial part of leadership.

Transactional Leadership: Transactional leadership, according to Osmer (2008:176), is the ability to influence others through the process of trade-offs, in which case there is reciprocal and mutual exchange between the interested parties. In this regard, it may involve meeting the needs of the organisation in return for the organisation meeting the needs of those involved in the organisation.

Transformational Leadership: Transformational leadership is an ability to enact deep change through a process that fundamentally alters the identity, mission, culture and operating procedures of an organisation. This chapter is more concerned with task competence and transformational leadership with the goal of enhancing the quality of the healthcare system through the transforming practice of Pastoral Care.

Aligning with these pragmatic and functional perspectives of practical theology as discussed above, this study is also aware of Purve's (2004: xxviii) concern that Pastoral Care should not be defined in a functional mode. However, because this study argues for Pastoral Care given in a hospital context which operates within a highly functional category, Pastoral Care needs to articulate its unique contribution in clear functional and pragmatic terms.

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The chapter will begin by reiterating the key issues which have been discussed in Chapters Two to Five. This will be followed by the rationale for development of the holistic pastoral theological approach. The approach will be further explained by defining the goals and objectives, defining the space for the approach its operations, its relationship with disciplines of healthcare as well as its distinctiveness. The key components will then be considered. This will be followed by the role and responsibility of the PCG, tools for rituals and practices that will form part of the resources for a pastoral assessment tool. The chapter will in addition consider training and the curriculum, professional standards and codes of ethics as important areas in the holistic pastoral theological approach.

6.2 Revisiting the key issues in Chapters Two to Five

Chapters Two to Five of this study have argued the following points:

- Wholeness and health are among of the most important concerns of many Ibibio/Nigerians;
- Ibibios understand illness and health in holistic terms. Sickness is perceived in terms of naturalistic, personalistic and supernatural perspectives;
- Religion plays a vital role in maintaining health or negotiating for health when illness looms in the individual and communal life of Ibibios/Nigerians daily and thus reveals the influence of religion and spirituality on them both at the individual and corporate levels;
- The interrelated nature of sickness, poverty and hunger illustrates the complex nature of illness, which defies a purely scientific approach. It reveals a demand for a holistic approach to healthcare to achieve quality care and enhancement of the human dignity towards quality of life;
- WHO WHOQOL 1998 has identified personal, religious and personal beliefs as one of the domains of quality of life assessment that affects quality of care and suggests that the spiritual and religious dimension should be part of healthcare;
- The healing practices and intervention of the medical model of medicine as adopted in AKS hospital care in particular, and hospital care in Nigeria in general, have hardly undergone any significant structural and policy change since colonial times. This undermines the cultural aspects of sickness and leaves little room for the spiritual/religious dimension;

- Medical science, although beneficial, cannot singularly meet the health needs of the sick because of its limitations in meeting the spiritual and religious needs of patients for meaning and purpose. Consequently, published studies of perception of selected illnesses in Nigeria reveal that modern hospitals have not been able to adequately meet the health needs of Nigerians generally and Ibibios in particular;
- Spiritual quest is not only the concern of the patient, but hospital staff and organisations who are also hungry souls at heart desiring spiritual/religious interventions;
- Though the physician's agenda may involve spiritual assessment, all the same, physicians do not have the training, expertise or time to provide total spiritual care as such provision is the unique contribution of PCGs. There is therefore a spiritual gap that needs to be filled in the Nigerian hospital care;
- The NPPPHN (2005) has stated that alternative healthcare providers, whose practices are of proven value, shall be encouraged and supported as frontline of health care provision for many people. Such providers will be brought under regulations to ensure adherence to rules and healthcare guidelines.
- Pastoral Care as a unique discipline with its distinctiveness as embodied in its foundation, goal and context takes the complexity of illness seriously in its holistic perspective, therefore are valued by many healthcare systems.
- Meeting the spiritual needs of patients is the unique contribution of Pastoral Care which is best carried out by professional PCGs;
- PCGs and professionals must necessarily collaborate. Collaboration is a moral and ethical responsibility that healthcare and Pastoral Care professionals have towards the sick.

These key points give rise to the rationale for a holistic pastoral theological approach for Pastoral Care practice in the Nigerian hospital environment.

6. 3 Rationale for the development of an approach for PC in the hospital

The rational for the development of a framework for Pastoral Care in hospital care is based on the WHO (1998:7) report, which states that "the medical model which seeks to treat patients by focusing on medicine and surgery and gives less importance to belief and to faith in healing … is no longer satisfactory". Medical practice must "realise the value elements

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such as faith, hope and compassion in the healing process. The value of such spiritual elements in health and quality of life" demands a move "towards a more holistic view of health that includes the non-material dimension". However, the National Health Policy on Public Private Partnership for Health in Nigeria (NHPPPHN) (2005) states that one of its key challenges is how to form effective collaboration among the different institutions in such a way that health care can be served efficiently, effectively and equitably. Nevertheless, the NHPPPHN (2005) also stated that alternative health practitioners whose services are of proven value shall be shall be encouraged and supported as the frontline of healthcare provision for many people. However, it warned that such providers shall be subjected to regulations to guarantee observance of rules and healthcare guidelines.

Therefore, the development of a holistic pastoral theological approach is based on the above healthcare report and policy respectively. It is also based on the notion that the current models of care are not fulfilling the holistic needs of the Ibibio religious patient (as evident in Chapter Two). The increasingly mechanistic model of medicine, concerned only with the eradication of diseases and symptoms, highlights the need to introduce the pastoral elements to healthcare. Hence, a new approach synthesising the concept of Pastoral Care, a Pastoral Care code of ethics, health behaviour and practices from the interreligious perspective as well as incorporating the principles and practices of Pastoral Care as embedded in the foundation, goals, function and context is needed. Fostering effective collaboration and partnership among all health players is articulated as one of the seven strategic objectives of the national health reforms (National Policy on Private Public Partnership for Health in Nigeria, 2005). According to the WHO (2010), "a well-functioning health system responds in a balanced way to a population's needs and expectations by improving the health status of individuals, families and communities defending the population against what threatens its health, protecting people against the financial consequences of ill health, providing equitable access to people-centred care and making it possible for people to participate in decisions affecting their health and health system".

6.4 A holistic pastoral theological approach to Pastoral Care in the Nigerian hospital context

In the light of the issues raised in the previous chapters and revisited in 6.2, the holistic pastoral theological approach embodies an intercultural perspective of Pastoral Care practice for the effective implementation of Pastoral Care in the hospital context. An intercultural

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perspective on Pastoral Care practice takes seriously the message of Scripture, the person of the patient and the context in which the patient is embedded. It further makes room for useful components of care that could arise based on the needs that emerge in the process of caregiving and the context of care as a result of a human and contextual response to change. Human beings are dynamic, just as human society and institutions are dynamic and responsive to change that is inevitable as time progresses. Therefore, caregiving in the Nigerian hospitals has to be proactive for the purpose of maintaining openness to change to remain relevant to the care seekers. Over and above the human, institutional and contextual changes, God's revelation in its varied ramifications is dynamic and speaks anew to humankind, institutions and contexts as time progresses. Such a stance on care giving could also enhance the human dignity of successive human generations as they grapple with issues of wholeness. It is for these and other reasons such as were advanced in 4.5.3 that this study prefers an approach of Pastoral Care instead of a Pastoral Care model. This approach to Pastoral Care in the hospital goes beyond mere care or cure, preaching or prayer, presence or counselling and takes on issues of advocacy, justice, development and empowerment as well as moral and bioethical issues. It is in this sense holistic. This study calls this approach a holistic pastoral theological approach. This holistic theological approach offers an alternative between the two models (the parochial and professional models). There is no need to choose one model over another, but rather new understandings should be generated that could open up new possibilities for authentic Pastoral Care practice in the Nigerian hospital context as envision by the post-foundationalist paradigm of practical theology. So in a sense it is not really necessary to argue which model is authentic, but rather to add to the pastoral resources for practice.

A holistic pastoral theological approach as a proposed paradigm for the PCG's engagement in the hospital care draws its inspiration from the parochial (volunteers, pastoral visitors) and professional (full-time or part-time professionally trained chaplains) models of Pastoral Care in the hospital and values specialisation. The sources that inform this approach derive from best practices from the traditional African and Christian religious world views of Nigerians and the US and European contexts as gleaned from literature reviews of Pastoral Care theories as well as empirical and evidence-based research as discussed in the previous chapters.

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As stated in 6.3 above, it is an integrated approach. It draws from various strands of Pastoral Care models. The parochial and professional components have been so chosen because they correlate with the Ibibio/Nigerian worldview and approach to healing which is holistic (Chapter Two). Thus, the integration of healing approaches and the collaboration of healing practitioners is the ideal form of care for the Ibibio/Nigerian patient. A holistic theological pastoral approach is also appropriate because the existing models of Pastoral Caregiving in Nigeria include a broad spectrum of ministry (as this study established in 3.7). These models of Pastoral Caregiving in AKS corresponded with the goal and functions (3.8) of Pastoral Care which embodied holistic perspectives that touch on all the dimensions of Ibibio life. Consequently, the manner in which troubled Ibibios seek solutions to their problems in an eclectic manner (utilising all methods available to them) is a pointer to the fact that the inter-denominational, inter-religious and socio-cultural stance of many hospitalised patients will welcome both the parochial and professional Pastoral Caregiving approaches with some adjustments of the approaches as provided for in the proposed holistic theological pastoral approach. Also, Ibibios need the verbal communicational skills of counselling to be combined with the loving acts (*diakonia*) (even though Pastoral Care in Nigeria has a broad scope and various forms); specialised or professional ministry is also needed (Chapter Three). The holistic pastoral theological approach therefore relies on the parochial model and professional model that incorporates interfaith perspectives of caregiving that are evident in many professional Pastoral Care models of hospital care.

Parochial model: A holistic pastoral theological approach also draws on the parochial model that holds to the core message of each religious tradition. For example, the centrality of the gospel message of Jesus Christ is the way the truth and life of our salvation and wholeness in the case of Christianity. Nevertheless, this approach rejects the aggressive proselytising of the patients that may characterise the motive, intention and goal of Pastoral Care under the parochial model propelled by the classical paradigms of pastoral theology. Although professionalism is advocated, this study also advocates that Pastoral Caregiving must not only be done by professionals but by all members of the faith community. The role of lay people in doing ministry as volunteers is necessary, because of scarce resources – professionals are normally fewer in number than the needs to be met. Furthermore, there is always an opportunity for growth from the volunteers; they can be given basic training to engage in ministry. The holistic pastoral theological approach allows room for the parochial model in the sense of utilising lay PCGs who have a heart, passion, motivation and

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commitment to visiting the sick. Though skill is not stressed for this group, basic skills are advocated and could be provided for them to enhance their "being presence". The parochial model provides a broad level and participation of church members to provide Pastoral Care to their friends, neighbours, family and church members. The study will now turn to the significance of the professional model for a holistic pastoral theological approach of care.

Professional model: The holistic pastoral theological approach utilises the inter-faith perspective of Pastoral Caregiving that is evident in many professional Pastoral Care models of hospital care. Although the PCG does not need to compromise or hide his or her particular religious identity, the PCG should be able to reflect an ecumenical perspective in carrying out the pastoral function in the hospital with patients of other faiths as the kingdom perspective requires. Buecket (2009:30) remarks that "engaging with persons of other faiths hospitably is an imperative for [religious caregivers]". It demands that the PCG moves deliberately from the comfort zones to welcome the stranger or the alien or the different other who longs for healing and hope (Schipani, 2009:62). As Brad Mellon (2003:60) advises, "it is not only important that the chaplain who serves patients of different faiths possesses a theological foundation, but he or she must also be able to balance personal convictions with the orientation and faith of those receiving care". In that sense, the PCG in the hospital should endeavour to have some understanding of the patient's faith. It could be noted that the best approach to inter-faith Pastoral Care could be for all Christian denominations to cooperate as a single group that provides care for all Christians and Muslim PCGs to offer care to all Muslims irrespective of sect. Both Christian and Muslim PCGs may form chaplaincy teams, meet together to share perspectives of their faith that can reduce misunderstanding, form common goals and enhance greater cooperation for the spiritual wellbeing of the patient. The hospital reality in AKS which is multi-religious, multi-denominational and multicultural demands both meeting with people of the same faith and people of other faiths.

The holistic pastoral theological approach favours professionalisation in the sense of improving the quality of Pastoral Care ministry that already exists, noting the strengths of the traditional parochial form of Pastoral Care and improving on them while eschewing the not-so-helpful aspects of the model such as its exclusiveness and conversionist focus. To do Pastoral Care in a sophisticated and highly technical context such as the hospital, one must be equipped with knowledge and skills and display personal growth. Knowledge provides the theoretical framework for Pastoral Caregiving, skill enhances the PCG's competence and personal growth authenticates the PCG to engage spiritually and emotionally in care giving

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appropriately (Susanto, 1999:204). This is in view of the reality that the medical code of ethics does not permit non-professionals to be part of the medical team for patients' treatment, because the team must maintain a high level of competency and expertise (Chapter Five). The hospital is an evidence-based environment dominated by cost-containment efforts, management by objective and outcomes of standardised research studies that require professional competence and accountability. PCGs, with the aid of the holistic pastoral theological approach, are required to carry out Pastoral Care meaningfully and more intentionally by being able to assess the spiritual and pastoral needs of the patients.

The benefits of specialisation and expertise as embedded in the professional model of Pastoral Care could enhance the functionality of the holistic pastoral theological approach to Pastoral Care in the Nigerian hospital context in the sense of maintaining high ethical conduct and patient satisfaction in the services of the PCG. Chaplains whose training and experience uniquely qualify them to provide spiritual care during times of suffering and questioning are an invaluable resource who could collaborate with medical staff in providing Pastoral Care to the patients and staff (McClung, Grossoehme & Jacobson, and 2006:151). This implies that professional PCGs "are more than 'hand holders' or last-minute performers of religious rites. While they may conduct formal religious services their larger role surpasses solely religious concerns and address all aspects of spirituality in the health care system at the patient, staff and system level" (McClung, Grossoehme & Jacobson, 2006:149). The holistic pastoral theological approach incorporates goals and objective, defining the space, its relationship with other disciplines, its distinctive character, key components, the role and responsibilities of PCGs, tools for ritual and practices, tools for pastoral assessment, training and curriculum, professional standard and codes of ethics. The goal and objectives of a holistic pastoral theological approach will now be discussed.

6.4.1 The goal and objectives of the holistic pastoral theological approach

Pursuant of the National Health Policy of Nigeria's goal to provide effective, efficient, quality, accessible and affordable health services, the goal of the holistic pastoral theological approach to providing Pastoral Care in Nigerian hospitals is to enhance the contribution of Pastoral Care to the holistic care in the hospital, which aims at improving the quality of care and life of the patient through facilitating growth in the individual, family and community towards wholeness and spiritual wellbeing. In line with this goal, its objectives are:

- To articulate the role of the professional PCGs within the hospital context;

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- To build confidence and trust in the PCG's provision of spiritual and religious caregiving in Nigerian hospitals;
- To promote and sustain equitable, efficient, accessible, quality health care and patient satisfaction in the hospital (1.4) through provision of pastoral resources for healthcare policy making on Pastoral Care in the hospital;
- To develop a framework for Pastoral Care in the hospital that can serve as guide to assist the PCGs for appropriate and meaningful mediation of patients, family and all who desire such, as well as medical and allied healthcare professionals interested in helping clients to address their spiritual and religious needs;
- To develop a framework for pastoral assessment of patients in the hospital in line with WHO's quality of life proposal on spirituality, religion and personal belief of patients as quality of life measures;
- To improve the skills and resources of the PCG in the Nigerian hospital context;
- To add to the pastoral resources for hospital Pastoral Care practice.

The goal and objectives of the holistic pastoral theological approach mentioned above requires defining the space in which the approach can be engaged.

6.4.2 Defining the space for the holistic pastoral theological approach

The holistic pastoral theological approach, although a framework designed for pastoral and spiritual caregiving in the hospital, could also be used in faith communities and other institutions that desire Pastoral Caregiving. With the holistic pastoral theological approach, the concept of healthcare is regarded as inclusive of the Pastoral Care needs of patients guided by their authoritative scriptures, writings and traditions of the respective religions of the patients. The location of this study within the hospital context gives the added impetus for a holistic stance. It agrees with Giacalone and Jurkiewicz's (2010:13) argument that "workplace spirituality is more easily understood within a holistic context". This is because Pastoral Care extends beyond the patients and relations to the hospital staff, which could rightly be termed workplace spirituality. The holistic pastoral theological approach is an approach that is open to religious and non-religious patients, family and staff alike. It has the capacity to meet the needs of patients irrespective of the patient's religious affiliation, belief and practices while maintaining the unique identity of the PCG's religious affiliation. The location of this approach in the context of the hospital also raises the question of the relationship of Pastoral Care with other disciplines within the hospital.

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6.4.3 The relationship of the holistic pastoral theological approach to Pastoral Care with disciplines in healthcare

The goal of the holistic pastoral theological approach implies that there is a relationship between Pastoral Care and other disciplines such as the medical and social sciences. The similarity in goals to improve the quality of life of the individual, group and community has also been informed by the fact that the field of caring is claimed by many professions but not exclusively owned by any (Pretorius-Heuchert & Ahmed, 2007: 17). Theologians have therefore articulated the ways theology is related to other disciplines in the field of caring. These relationships suggest an interdisciplinary relationship and foundation for PCG engagement in hospital caregiving.

It is arguable that medical and social sciences (e.g. psychology, psychiatry and social work) have their roots in religion. Much of what is being done by these fields was originally under the jurisdiction of the religious community through the diaconate ministry which carried out works of charity, welfare, education, medical work, counselling and prayer (2.6.3, 3.3, 4.3; see also Crisp, 2011:667). As noted by Beth Crisp (2011:667), social work (welfare service) was provided by religious organisations. Thus the impact of secularisation may well have impacted on the thinking and views of other helping professions in Nigeria as in other parts of the world as it relates to their relationship with Pastoral Care. In addition, the taking over of these domains (hospitals and medical centres which were initially under the control of the church in some countries and in Nigeria) by the government and placing them with the professionalised experts (psychologists, social workers, and educationists) displaced the church from the public arena and created a gap between care and faith (Briunsma, 2006:168). With the secularisation of society, and the taking up of tasks by other organisations that were previously performed by religious bodies such as the church, the church's role narrowed in focus and was redefined in private terms of spiritual guidance and support of members within the confines of the church (Bruinsma de-Beer, 2006:168). However, Pastoral Care in places such as the United States of America and Europe is a developed profession within the hospital context and its distinctive role and significance has benefited such contexts over the years (4.6). Interestingly, in Nigeria, despite the challenges of secularisation and the underdevelopment of the professionalised Pastoral Care ministry and the disconnect between spiritual and medical care in the hospital context, there is still a yearning for Pastoral Care within the Nigerian hospital environment, as this study has shown in Chapter Two.

Thus as observed elsewhere (3.3 and 4.3), if there is a connection between Pastoral Care and the medical and social sciences, what sort of relationship is it? Is Pastoral Care the same as social work? Is pastoral counselling psychotherapy? What gains/losses can psychological insights bring to Pastoral Care? What is the role of psychology and psychotherapy in Pastoral Care and counselling? What does Pastoral Care do that other professional disciplines such as psychology, psychiatry and social work do not? There are obviously similarities and differences between PCGs and counselling by psycho-social experts. The similarities are that these disciplines all claim to help human beings with problems and they use a similar method – counselling. However, Bruinsma-de Beer (2006: 168) has argued that a method or field cannot be a good starting point, but rather the differences found in the disciplines' presuppositions or foundations. Bruinsma-de Beer's argument implies the acceptance in the medical sciences that interdisciplinary engagement is necessary and essential.

Although Pastoral Care makes use of psychological, anthropological and sociological materials and resources in the engagement of care receivers, and such resources have the potential to enrich the work of Pastoral Care (Watts, Nye & Savage, 2002, Marshall, 2004:140); such care is at the same time unique. While Pastoral Care is distinct from psychology, psychiatry and other health care approaches in its perspective, motives and assumptions, they are related. Pastoral theologians have attempted to explicate this relationship in different ways. Pastoral theologians are divided about the relationship of Pastoral Care, particularly of pastoral counselling, with psychology and psychotherapy. On one side are scholars such as Delkeskamp-Hayes (2010a:1-8), who holds the view that psychology and psychotherapy are incompatible with Pastoral Care and pastoral counselling. On the other side are scholars such as Gartner (2010:48-60) and Dober (2010:61-78), who maintain a positive orientation towards psychotherapeutic practices. Others prefer to take the middle ground. Louw (2004: 100), like Bruinsma, suggests that the relationship between Pastoral Care (theology) and other caring professions as enumerated should be understood in terms of *perspectivism*. Although they all assist the totality of human beings to live more meaningfully, they operate within different paradigms. According to Benner (2000:13), the meeting point of psychology and Pastoral Care is their focus on the "soul" as the subject of care. Psychology, as Benner explains, means "science of the soul" (Benner, 2000:13).

Louw makes a valid point for this study, which argues for holistic and team collaboration among helping professionals in Pastoral Care. According to Louw (1998:32), "human beings cannot be neatly divided into segments in such a way that spiritual functions are delegated to

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Pastoral Care, psychic functions reserved for psychology and the social dimension is split between sociology and social work". What is important, however, is that each discipline understands its unique contribution when working with the whole person towards such a goal. Perspectivism suggests the notion of bipolarity and uncovers the tension that exists between the disciplines – revelation and experience, life issues and faith issues, soul care and psychotherapy. He argues that tension is unavoidable as it describes the difference between two disciplines that have possible links (Louw, 1998:32). Therefore such tension is healthy, because it reveals the difference between the nature of the revelation and the nature of our human existence in the world. As such it could be argued that "bipolarity creates a constructive tension of dynamic mutuality between God and human beings" (Louw, 1998: 34-35). However, Louw notes that bipolarity has limitations, which include the fact that it can reduce the unique character of Pastoral Care to a psychological category. For example, the theology of the development of faith becomes reduced to the psychology of self-development (Louw, 1998:32). Louw therefore suggests that bipolarity be supplemented with a convergence model which incorporates the eschatological perspective of the human relation between God and humans.

Gartner (2010:48-60) notes the tension that exists between Pastoral Care and other helping professions. However, in his integrative model of psychological and theological language, he proposes that the relationship between Pastoral Care and psychology should be understood as complementary. Thus, Pastoral Care should be open to any perspective. Such understanding demands the proficiency of the Pastoral Caregiver in both theological and psychological language. According to Gartner, integration becomes necessary, because Pastoral Care places as central the concerns of the care receiver, which means that the Pastoral Caregiver's use of any category depends on the language of the care receiver in a given situation. In other words, the care receiver determines the themes for the pastoral conversation (Briunsma de-Beer, 2006: 172). Similarly, Dober (2010:63) suggests that "an integration of psychological (and in particular psychoanalytical) knowledge into the theory and practice of Pastoral Care is imperative in order to promote the goals proper for that care". Gartner, Louw and Dober's articulation of Pastoral Care's relationship with other professions places Pastoral Care as a complementary model of health care or medicine, not merely alternative model, according to Ellis and Hartley's (2008:110-121) articulation. Borrowing the definition of the National Centre for Complementary and Alternative Medicine (NCCAM), they define complementary

medicine as "a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine [i.e. biomedicine]".

However, Delkeskamp-Hayes (2010:4a) argues that the tension that exists between Pastoral Care and others is not only methodological, but also the result of incompatible anthropologies as well as foundations.[83] In analysing the positions of Dober (2010:63) and Gartner (2010:48-60), Delkeskamp-Hayes (2010:84b) expresses doubt whether their approach will not interfere with the character of Pastoral Care and counselling and the goals they seek to pursue. According to Delkeskamp-Hayes (2010:84b), "it will become clear [that] such approaches to pastoral counselling, in implicitly adopting secular theoretical assumptions and value commitments, affect not only the method of pastoral counselling but also its theological goals". For instance, classical or traditional Pastoral Care has sin and confession at the heart of counselling, while the psychotherapeutic practice of Pastoral Care deemphasises confession and emphasises counselling to promote human potential. The displeasure of the psychotherapeutic practice of Pastoral Care at the traditional practice lies in the understanding that confession focuses on a care receiver's sin and gives the caregiver authority over the care receiver. It is the assumption of some scholars that the uncritical integration of models that are more psychological than pastoral (theological) has made Pastoral Care Pastoral Care givers to function as poorly trained generic psychotherapists and preachers of self-actualisation rather than proclaimers of the gospel (Berinyuu, 1988:90; Benner, 2000:38-39).

Hunsinger (1995) agrees with Gartner (2010:48-60), Bruinsma de-Beer (2006: 172) and Dober (2010:63) to the point that Pastoral Care and the Pastoral Care giver should be proficient in both theological and psychological language. However, Hunsinger (1995) strongly opposes the view that these languages should be and can be integrated. She emphasised that the languages (theological and psychological) must be kept distinct by learning the grammatical rules of each in order to maintain its integrity. Arguing from a Barthian theological stance, she advocates that to maintain uniqueness without being lost in the interdisciplinary project, the Pastoral Caregiver must learn to be skilled at the language of

[83] Sigmund Freud, recognised as the father of psychotherapy, is viewed by many scholars as a person who was intensely averse to religion in general and Christianity in particular. Jacob Needleman (in Benner, 2000:38) remarks: "modern psychiatry arose out of vision that man must change himself and not depend on an imaginary God for help. Over half a century ago, mainly through the insight of Freud and through the energies of those he influenced, the human psyche was wrestled from the faltering hands of organised religion and was situated in the world of nature as a subject for scientific study". As a result, the care of sinful souls was reframed to the cure of sick minds (Benner, 2000:38-39).

theology as well as psychology (Hunsinger, 1995:5). Furthermore, she describes the interdisciplinary relationship by making use of the "Chalcedonian" concept. Hunsinger (1995:7) advocates that the connection should be viewed in three perspectives as follows:

- "Indissoluble differentiation" – psychology and Pastoral Care should not be mixed up as though they were the same thing;
- "Inseparable unity" – Pastoral Care and psychology should not be totally separated from one another as if they are in separate compartments;
- "Indestructible order" – there should be a strong theory about the nature of the relationship and a clear sense of which takes precedence.

Hunsinger (1995:7) argues that Pastoral Care can work simultaneously with two different goals – for example, trusting in one's resources and trusting in God's providential care and goodness (Hunsinger, 1995:7). Hunsinger's view could be considered valid in the sense that for as much as Pastoral Care relies on God's grace and goodness by faith, theories and skills are also very important as skills also sharpen the quality of faith and trust in God. Hunsinger's model, which stresses the need for Pastoral Care to maintain its distinct language embedded in its goal, content and foundation, is also enlightening. However, her two language fluency which requires extensive training (maybe two degrees) in theology and psychology or any other field, although tenable in the American context, might not be very plausible in a developing country such as Nigeria, where poverty is rife and most people struggle to get basic education and specialise in a particular field. Understandably, Hunsinger, speaking as both a psychologist and theologian, outlines the benefits of such double training as indispensable. Although such qualifications will be an added advantage, a basic knowledge in psychology and other related fields, and a professional qualification in pastoral theology, care and counselling which can allow Pastoral Care to collaborate with other fields is what this study subscribes to as expedient and tenable within the Nigerian environment. For this reason this study utilises Osmer's interdisciplinary methodology as a reference point through which Pastoral Care within the Nigerian hospital context can engage in a dialogue with other professions towards the alleviation of human suffering.

Osmer's interdisciplinary methodology (2008:167) implies that the goal of Pastoral Care's dialogue with other fields is to contribute to social transformation that alleviates suffering. By this statement he explains that the real crisis confronting theology is not meaning *per se* but

human suffering. Osmer's approach applies to a wide range of disciplines; that is why he actually calls it cross-disciplinary because it is not restricted to the field of theology and psychology. He argues that the relationship should be that of mutual influence and critique, not a "one-way traffic" (Osmer, 2008:166). More than mutual influence, theology must also listen to and transform insights from other fields which imply a different language from other disciplines. The knowledge from other fields is meant to help theology carry out its distinctive task in a transformational approach. Furthermore, this interdisciplinary approach is not about language games or dialogue within the academic community but about concrete issues of human struggles (Osmer, 2008:170). In other words, the interdisciplinary approach involves creating networks that transverse one another and share common resources. Transversality means that disciplines or networks) intersect, meet and converge without achieving coincidence. For instance, the hospital treatment team, patient's family and patients in the ward interact within the hospital environment, and decision making and communication are situated in this group. The degree of their contribution to the healing process depends on the degree of their transversality in the communication, which means that communication can flow downward, upward and across. Therefore, the interacting network can explore the levels of interaction with other fields for maximum results through effective communication (Osmer, 2008:171). In the view of the research, this approach could be valuable for the discussion in the following sections on Pastoral Care collaboration with health care professionals in the Nigerian context. Furthermore, Mpolo (1991:27) has argued "that Pastoral Care and pastoral and practical theology in Africa, while rooted in [religious] faith should be enriched and supported by psychology, psychiatry and social sciences ... as well as African psychology, world view and religious thought". Hence, it should be dialogical to the extent that it sustains a consistent relationship with these fields. Whereas collaboration between Pastoral Care and other disciplines such as psychology, psychiatry, social work etc. may be deemed indispensable within the Nigerian hospital context, the question as to what the unique character of Pastoral Care is when compared with other disciplines, especially within the Nigerian hospital environment, still needs to be clarified.

6.4.4 The distinctive character of the holistic pastoral theological approach of Pastoral Care

Speaking on the notion of identity, which it could be argued relates to character, Ashby (2003:71) postulates that "the integrity of a vision for the future depends on the trajectory established by identity formation and consistency of commitment over time". Ashby's

statement illuminates for Pastoral Care the need to maintain an identity if its vision and goals are to be realised and maintained. The distinctive identity of Pastoral Care becomes important pre-eminently because its sense of identity is tied to its perception of God as well as its understanding and valuing of humans in the caring relationship (Tisdale, Doehring & Lorrraune- Poirier, 2005:53).

Stone (1996:16) seems to assert these components of God, understanding and valuing of humans, when he argues that the uniqueness of Pastoral Care is that it approaches care from a theological framework based on Christian theology. Stone elaborates that "Christian theology is distinctive in its perspective on what it means to be human, its concept of health, and its understanding of human plight and rescue. It often perceives in the suffering person's words a different struggle and end point" (Stone, 1996:16). The implication of Stone's argument is that Pastoral Care approaches the suffering of persons with warmth, openness and acceptance with a view to finding a transcendent meaning (Stone, 1996:16). Thus Pastoral Care in this sense could be said to depend in its engagements on a sound theological perspective of the place of God in suffering and the value God places on those in suffering. The mediation of the transcendent in a situation of suffering where many questions are often asked that are beyond the human ability to provide adequate answers and where the search for meaning is often heightened coupled with fear, could be relieving and stabilising for the patient and the caregiver.

Stone's view of the uniqueness of Pastoral Care also includes it as ministry that occurs within the context of the religious community (the community of saints) (1996:17). In this sense Pastoral Care in whichever context it is offered connects such context with a long tradition of Pastoral Care that embraces the faith community and bridges many generations. In this light Pastoral Care is guarded against the "privatism or pietism that has often affected secular psychotherapy" (Stone, 1996:17). It could be deduced from this view that the uniqueness of Pastoral Care lies in its frame of reference (theology) and the context in which care occurs. This uniqueness of Pastoral Care reflects the degree of care through which Pastoral Care mediates its ministry to the afflicted and the resources that are available to such care whenever it is offered. Such uniqueness could be helpful to the Nigerian patient in the hospital environment. Nigerians as typical Africans place a high premium on the transcendent (God) and the community, especially in moments of affliction because of the resources that could benefit them from these constructs. This could well be why Jean Masamba ma Mpolo (1994:18) posits that "to live in an African traditional context is to participate in the

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protection of life, the survival of the family and the continuity of the community. One is called to share in the life-giving processes through ways of living in the community and ones' capacity to transmit life to the next generation". The assurance of still belonging to the community in the "strange" hospital environment and the unbroken fellowship with the patient's ageold traditions as they relate to transcendence and community could be additional benefits that could enhance healing. These components are in line with this study's discovery of the African/Nigerian understanding of community and healing (Msomi, 2008:26, 27) as discussed in Chapter Two. Furthermore, by its emphasis on community, this study attempts to shift the approach of care within the Nigerian hospital environment from a medical model which sees illness as based solely in the individual with very little understanding of the complex environmental forces contributing to the patient's sickness.

Louw (1998; 98-100) has further pointed out that "[p]astoral care understands the encounter between God and humans from the perspectives of the comforting effect of grace, presence and identification with human need and suffering. It interprets this comfort in such a way that God's care reveals a horizon of meaning, which in turn gives hope and generates faith". The concepts of grace, presence and identification located within the ambit of God's encounter with humans in need and suffering in Pastoral Care, especially for the Nigerian religious patient within the hospital environment, places Pastoral Care on such a pedestal to mediates meaning, hope and faith. John Patton (2005:850) has also located the uniqueness of Pastoral Care in the role and accountability of the PCG. He views the PCG as a "representative of the central image of life and its meaning affirmed by their religious communities". It is in this light that Patton views the Pastoral Caregiver as a representative of the faith community to which he/she is accountable.

Whereas Louw and Stone share in this view of community and its connection to care, Purves (2004: xviii) insists that the uniqueness of Pastoral Care should be located on "the care of God for us in, through, and as Jesus Christ; as such it is an expression of the gospel of revelation and reconciliation". Purves here suggests that the faith community is engaged in Pastoral Care "only secondarily, derivatively, and above all, participatively" (2004: xviii). Purves's statement is crucial for Pastoral Care and Pastoral Caregivers in the hospital context who could be tempted to over-rely on their professional skills. While skill is highly needed and also what this study recommends, a holistic pastoral theological approach of Pastoral Care also relies on the Holy Spirit to engage in care without which such engagement faces the danger of being reduced to psychological counselling, which has the potential of eroding the

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uniqueness of Pastoral Care. The Holy Spirit also underpins the foundation of Pastoral Care which is founded on God's shepherding and suffering presence through Jesus Christ and the empowering of the Holy Spirit.

Megazi (2005:160) points out that the uniqueness of Pastoral Care in the centrality of grace encourages acceptance as it emphasises the longing of every Christian to be accepted unconditionally. Although all other professions claim to provide spiritual care, they engage in it not as their primary responsibility; however, Pastoral Care approaches care from the perspective of experts in attending to spiritual needs (McClung, Grossoehme & Jacobson, and 2006:147). It therefore follows that in a situation where the value of a person is diminished in the sense of brokenness, confusion, loss and alienation, the holistic pastoral theological approach of Pastoral Care can contribute by its uniqueness towards redeeming and restoring those vital aspects of personhood.

Furthermore, in terms of the anticipated outcomes, conversations, relationships, resources of care and securing the Pastoral Care ministry, Pastoral Care maintains a uniqueness that is different from all other helping professions, as will be argued below. While Pastoral Care may be similar to other care-giving professions in some ways, the anticipated outcome in its engagement is not simply change as envisioned by others, but healing and transformation (Tisdale, Doehring & Lorrraune-Poirier, 2005:53). Therefore, the distinctive character of the holistic pastoral theological approach of Pastoral Care is its major concern of dealing with questions of ultimate meaning and concern. At the heart of this concern is the concern about the care receivers' relationship with self, others and God. The central theme of the holistic pastoral theological approach of Pastoral Care is restoration to wholeness. The uniqueness of Pastoral Care lies in its ability to deal with the issues of forgiveness, fear of death and offering of hope, which transcend the present situation. In terms of the pastoral conversation, according to Louw, the uniqueness of Pastoral Care is the fact that pastoral conversation is a trialogue in the sense that God is the third partner in the encounter, operating through creation, and Scripture interpretation as enabled by the indwelling Spirit (Louw, 1998:247-248). The anthropological presupposition is that humans are relational beings dependent on God for spiritual nurturing and development as opposed to the psychological presupposition that humans are autonomous beings with the potential for self-actualisation. A disturbance of this relationship as enunciated by Pastoral Care results in guilt, despair, anxiety and complete meaninglessness, while in psychology a disturbance between the self and ego leads to dysfunctional behaviour. The emphasis on Scripture as a crucial basic source of knowledge,

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according to Louw, is a distinctive characteristic of Pastoral Care. In Pastoral Care people often have informal contact with the Pastoral Caregiver apart from any special Pastoral Care and counselling that may take place. In Pastoral Care the Pastoral Caregiver often takes the initiative to seek out the care receiver, whereas the psychologist has hardly any informal contact. Often the care receiver seeks out the psychologist and makes an appointment. Beyond the mentioned distinctiveness of Pastoral Care from other similar professions, Pastoral Care embodies an approach in which human problems are neither reduced to psychological perspectives that mainly focus on human potential, nor to theological reduction whose focus is preaching. To summarise, the uniqueness of the holistic theological pastoral approach of Pastoral Care lies in a specific discipline of Christian theology within the context of community which addresses the transcendent dimension in suffering. Such dimension includes the participation of God in Jesus Christ through the Holy Spirit to impart the comforting effect of grace, compassion and presence in human suffering. The grace of God as revealed in the unique resource of Scripture is to enable the patient to deal with the issues of forgiveness, reconciliation, restoration and hope. Therefore Pastoral Care deals with the question of ultimate meaning and concern with the purpose of healing and transformation as experts in dealing with the spiritual needs of patients as opposed to other disciplines whose primary role is not geared towards spiritual matters.

The discussion so far shows that the holistic pastoral theological approach in Pastoral Care is dependent, independent and interdependent. Pastoral Care and indeed the holistic pastoral theological approach of Pastoral Care is dependent on God (in Jesus Christ) and the Holy Spirit (the *paracletos*) in His mission to the world. It is independent (from other disciplines) with its unique resources of the Bible, prayer and religious rituals; and interdependent with other fields of human helpings to engage in caring by way of participating in God's mission to the world. The holistic pastoral theological approach in Pastoral Care and counselling is therefore unique in the sense that it imparts spiritual healing to the patient. From this theological stance, the distinctive contribution of the holistic pastoral theological approach is articulated below.

6.4.5 The distinctive contribution of the holistic pastoral theological approach in the medical team

A collaborative and team approach to hospital care demands highly trained Pastoral Care professionals with a robust sense of personal and professional identity (Carey & Cohen,

2009:354) for their unique competences to be appreciated; this engenders mutual respect with shared goals and responsibility for good ethical and medical practice in inter-professional relationship (cf. Chapter 5.3.2). This study argued in Chapter Five for a need for more dialogue and collaboration between doctors and chaplains or PCGs. The holistic pastoral theological approach is also a team approach. The term "team" is commonly used to refer to two or more persons or a group that comes together for a common task or service. All members of the team have the common goal of seeing to the wellbeing of patients in their care. They harmonise their input to hospital care, give information and acknowledgment one another, and exchange knowledge where necessary. The coordination of different professionals from the diverse fields of healthcare is what most literature refers to as the multidisciplinary or interdisciplinary team. Each has an ethical responsibility towards the other to protect their professional reputation.

The medical team should be an interdisciplinary project. It involves the skills of a variety of persons, especially professionals of health care, to bring about quality health. Akunyilli (2004:23) bemoaned unethical practices within the health care system because of lack of collaboration of medical doctors with pharmacists and other health professionals. A team ministry approach to care giving has two dimensions. The first is collaborative team ministry. This implies a continuous interaction in which everybody participates in common problem solving. The second form is collegial, in which the team shares responsibilities for the patients. In most cases the professionals are the ones whom patients deal with very directly. Medical practitioners make use of modern medicine for the treatment of sickness and diseases. Modern medicine contributes a lot towards a significantly higher quality of human life. It can alleviate the suffering of persons to the barest minimum. These feats are attributable to increasing developments in medical science and technology. Thus, the practice of medicine in these respects is good. The understanding that modern medicine is good could be supported by Jesus' practice of healing the man born blind in John 9:1-7. His mixing human saliva and earth to administer as medicine on the blind man's eye (Gutherie, 1994:1045; O'Day, 1995:653)[84] could be argued to be a form of medical practice. However, medical care practitioners need to team up with other helping professionals for holistic care. Jesus' ethics of healing also shows different forms of healing practices (cf. Mathew 8:3, 8:13, Mark 5:21-43 etc.).

[84] Both Gutherie and O'Day in the *New Bible Commentary* and the *New Interpreter's Bible* respectively point out that it was a popular belief in the Greco-Roman world that to mix clay with spittle would have a healing effect on eye problems.

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The complexity of health problems often requires a professional skill for harnessing of all available resources to address them. Hence, this study suggests a review of the Nigerian medical team which in practice could collaborate with all other supporting medical fields, including the PCG and the patient in a collaborative and collegial team approach which could have many advantages.

Advantages of team approach: A team approach will be of benefit to healthcare in that there is the harmonisation of inputs to hospital care, information sharing among the caring professions, and an exchange of knowledge where necessary for quality and coherence of care, all of which enhances patients' satisfaction. Including Pastoral Care and PCGs within an integrated healthcare team allows the patient and the care providers to work more coherently. It could improve access to care for emotional and spiritual support without the medical personnel having to seek out a pastor at a church office, who might not be available when needed. Furthermore, it reduces the risk and stress of patients not having any pastoral support due to some circumstances which may not allow them access to their pastor. The competent team "sees the patient as a subject to relate to rather than an object to be changed" (Topper, 2003: 92). Therefore, within the team approach great care should be taken by the team to separate problems/disease from the patient.

A team approach will minimise some of the limitations in the Nigerian health care system, increase the confidence of Nigerians in the health care system, and bridge the gap between medical care and Pastoral Care as life care. It offers the opportunity of merging the skills, knowledge and expertise from different disciplines, thereby maximising resourcefulness towards effective handling of today's complex problems. Working as a team holds the promise of reasonably spreading the heavy work load among other professionals and thereby reducing the level of burn-out in some medical personnel and the consequent impact of this on the patient and the quality of care offered. It ensures coordinated and integrated continuity of care to ensure quality care. It guarantees that a patient is assessed across all dimensions of functioning using competent professionals to address the specific problem. This means that an assessment of the patient should be based on inputs drawn from all dimensions of the patient's functioning. It follows that members of the team should sit together, discuss their findings, feelings and hunches together with the professionals' observations and, with the patient's consent, agree on the action plan.

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Working as a team ensures that all members of the team act professionally according to the codes of ethics of their field. Competent medical practice requires that each member be passionate and committed to his or her job. They need to listen to one another and respect each other's opinions and area of jurisdiction. Each team member therefore should remain within their domain of competence and should not make unjustifiable jumps to opinions on something about which they have no particular expertise (Benner, 1998: 68-69). However, as a component of collaborative ministry, a reasonable amount of *interdependence, flexibility* and deliberate *role blurring* could be expected such as, for instance, a nurse or doctor praying for the patient and the PCG explaining the risk of uncompleted doses to the patient. Such team advantage requires *collective ownership of goals* and continual *reflection on the process* through team and peer reviews. A superior opinion should take precedence, while team members should respect one another's differences. It is important that the team members seek knowledge of one another's resources so that they can better understand the dynamics involved with respect to each patient and the eventual resolution. A team approach therefore allows for interpersonal and inter-professional interactions.

Collaborative and collegial team ministry has the potential of creating new structures, reviewing policies and improved service delivery. For instance, the creation of a pastoral department where pastoral and spiritual issues are adequately handled and where the medical and pastoral intern work with patient and family could enhance collaboration within the Nigerian hospital environment (Bronstein, 2003:300).

However, in order to achieve success in an interdisciplinary team approach to hospital care in Nigeria, the PCG and the healthcare professionals must be aware of the influences on the process which can facilitate or impede its success. These influences should not just be acknowledged, but they must be understood and worked through. In other words, successful team ministry does not just happen; it is the result of hard work. These influences, as Bronstein (2003:302-304) categorises them, are: professional role, structural characteristics, personal characteristics and history of collaboration.

a) *Professional role:* According to Bronstein, a strong sense of one's professional role includes adhering to the value and ethics of one's profession, respect for professional colleagues, and a holistic view of practice consistent with one's profession. However, team spirit can be hampered by difficult attitudes of team members. Human beings can easily misunderstand other members' roles. This usually results from long years of prevailing

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stereotypes. It frequently leads to hurtful feelings and alienation. Better communication and the ability to handle conflicts more effectively will result in better cooperation among team members (Pera & van Tonder, 2005: 76-79).

b) *Structural characteristics:* Structural characteristics relevant to team ministry include "manageable case load, an agency culture that supports interdisciplinary collaboration, administrative support, financial commitment necessary to sustain collaboration, ways that administration allocate resources and assign work, professional autonomy and the time and space for the collaboration to occur" (Bronstein, 2003: 303. 304).

c) *Personal characteristics:* Bronstein (2003:303) conceptualises personal characteristics as the way professionals accept and value one another as persons outside of professional roles. Acceptance of individuals is influenced by the respect and trust they have for one another, which creates a positive quality of communication that in turn creates a space conducive to working together.

d) *History of collaboration:* Bronstein (2003: 304) refers to the experiences of the professionals in interdisciplinary collaboration with other colleagues. Positive experiences improve the willingness of the disciplines to collaborate, which means those with negative experiences will need greater motivations to see the need for such collaboration. The long-standing uneasy relationship between religion and psychology is a typical example in this regard. For the purpose of optimising care for the benefit of the patient, this challenge should be patiently worked through.

On the basis of the above goals, relationships, distinctiveness and the particular contribution of the holistic theological pastoral approach to the healthcare team, the next section will discuss the contribution of the PCG in the Nigerian hospital context through a discussion of the role of the PCG in the holistic pastoral theological approach. This will be followed by discussions on the resources of the PCG, pastoral assessment, training, and pastoral ethics in hospital caregiving that takes into account professional standards and codes of conduct.

6.5 The role of the PCG in the holistic pastoral theological approach to hospital care

6.5.1 Assessing Pastoral Care needs and creating meaning in suffering (the theodicy question)

Bickle (2003:3) asserts that healthcare providers have identified pain as the fifth vital sign, which they are required to address in order to alleviate the four vital signs of temperature,

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blood pressure, heart rate and respiration. Pain as he perceives it "is not only physical but involves the whole person – body, mind and spirit". However, "he notes that few resources have been allocated to address the spiritual pain of patients. Chaplains (trained professional Pastoral Caregivers) are often absent or in short supply at many health care institutions". Spiritual pain implies a deep spiritual need for meaning and purpose. Therefore, it is widely accepted among pastoral theologians and pastoral health care practitioners that the overarching role of the PCG in the hospital is meeting the Pastoral Care need[85] of the patient, family and hospital staff (Swinton, 2008; Williams, 2008; Nauta, 2008; Fitchet, Lyndes, Cadge, Berlinger, Flangan & Misasi, 2011; Louw, 2000, 2008:223-226). Being present to the pastoral needs of patients, family and staff is envisioned to be their unique and overarching role in the patient care team in the hospital (Swinton, 2008:) as well as being specialists in spiritual care (Fitchet et al., 2011:706). Most health professionals are usually occupied with the disease, diagnosis and prognosis and the best medical procedure to employ in order to cure the disease. The role of the PCG, as Lorna Rattray posits, is to address the spiritual needs, as the PCG is concerned with the whole person and not with the disease (Rattray, 2002: np). Patients and staff sometimes consider the PCG as a legitimate person with whom spiritual concerns can be discussed. According to Williams (2008:10), attending to spiritual needs of patients and family can create meaning in suffering. Although people search for meaning in all they do and in what happens to them (Nauta, 2008:586), this search becomes more pronounced during sickness. The pastoral needs of patients are varied, depending on the coping resources available to the patient, which require pastoral assessment.[86] Kernohan et al. (2007:519) report from their research findings that most patients identify as their top pastoral

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[85]Louw (2008:63-64) mentions five existential life issues which Pastoral Care deals with in its quest to facilitate healing and wholeness of the human person: **Anxiety**: the fear of being rejected and isolated within the dynamics of human existence. Man's basic need is intimacy; **Guilt**: Everybody experiences guilt and guilt feeling in some way or the other. Our feelings of shame, disappointment and failure are part of our being human. Guilt is related to our sense of responsibility and influenced by religion and culture. Therefore our basic need is freedom and deliverance; **Despair**: to be exposed to meaninglessness and void. Man's basic existential need is anticipation in hope; **Helplessness and vulnerability**: people often become incapacitated when their coping skills become inadequate in handling some of their daily life problems. They often become emotionally sick because they remain victims within the different network of life. Their basic need is support and spiritual need is *koinonia* (fellowship); **Disillusionment, frustration, anger and unfulfilled needs**: Anger is an expression of frustration due to unfulfilled needs. Unfulfilled needs cause deep-seated disappointment concerning life expectation. Disappointment exposes one's feeling of powerlessness. Their basic need is life fulfilment, direction and transformation. Spiritual need is gratitude, joy, promissiotherapy and ethics.

[86] Driscoll-Lamberg (2001:129), drawing from Bergin and Richard's (1997) work, mentions five reasons for a pastoral assessment: 1) helps PCG to better understands the patient's world view; 2) ascertain what impact a patient's religious/spiritual orientation may have on him/her; 3) determine if patient's religious-spiritual belief and community could be used as a resource to help them cope, heal and grow; 4) decide which spiritual interventions could be used to help the patient; 5) determine if the patient has unresolved doubts, concerns, or needs that should be addressed.

needs: to express true feelings without being judged; to have time to think; to have hope; to deal with unresolved issues; to prepare for death; and to speak about their important relationships. The importance of a skilled PCG in handling these issues in the Nigerian context cannot be over-emphasised. The PCG trained in handling issues of meaning in suffering can be of great benefit to the patient who is given space to express his/her self without being judged.

Generally, illness presents challenges to patients and deconstructs their beliefs about God and life. This might lead to questions about identity (who am I?), purpose (why is this happening to my daughter?) and meaning (where is God in all this? Does God care about me? Why is God allowing my enemies to torment me?)

Undergirding these questions are emotions of anger, frustration, loneliness and anxiety. These are meaning questions that have no easy answers. They are "unique to each individual, and can lead to a greater depth of spirituality or faith or to a loss of whatever belief sustained it" (Williams, 2008:10). Understanding the dynamics involved in the ill and hospitalised patient reveal clearly the role of the hospital PCG. This is a spiritual dimension, which the health professional will hardly address. Although, psychologists are well trained to handle emotional matters, these are not merely emotional issues but spiritual matters. Besides, many Nigerians are not disposed to handle their problems with psychologists. Psychological explanations may not make much sense to them as would the religious approach (Ghunney, 1993:101). In addition, Hill and Smith (2010:175) have argued that "[p]sychologists are just beginning to study the centrality and importance of meaning to human experience". Again, "despite their benefits, science and rational analysis frequently fail to fulfil people's need for meaning". Those who turn away from religion may not experience through any other means the powerful consolations, ecstasies, and moral certainties that religion can offer" (Hill & Smith, 2010:175-176). On the other hand, some religious denominations may rebuff their members questioning God and getting angry with Him when facing a crisis. To question or get angry with God is considered blasphemous (Lester, 2003:2-3). Silencing the patient's anger might in this sense cause emotional withdrawal. But as Lester argues, anger as emotion is part of human nature, and expressing emotions, even anger, creatively can be a strong ally for growth in self-recovery, self-understanding, courage, hope and intimacy with God and others (Lester, 2003:189-202). Facilitating this process is clearly the work of PCGs.

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Attempting to address meaning questions is what the Christian tradition has traditionally and theologically termed theodicy. Theodicy simply means attempting to justify God in the midst of evil and suffering. Halle (2010:139) simply interprets the theodicy question as "the cry of man before God and against God … a cry which rings throughout world history". In the same vein Williams (2008:11) writes: "Suffering is one narrative theme that permeates the entire healthcare system and, as such, spares few patients and professionals. Trauma (and illness is a trauma) results in suffering and people who suffer, cry, mourn, wail, complain, moan, i.e., they lament". The "questioning cry", which sounds simple, conceals a complex reality. Theologians over the centuries have attempted to address these questions, albeit on the basis of a philosophical and theological/biblical abstraction often far removed from the actual experience of the sufferer.[87] This sentiment is well captured by Halle (2010:142) who asserts: "The existential cry of the sufferer has developed into the logical problem of the philosophy of religion". However, the skilled PCG wrestles with this question in the lived experience and stories of the patient until he discovers meaning for himself. The skilled PCG takes a journey with a person's pains and suffering.

Theodicy questions well-handled and facilitated have great benefits for the patient. First the patient's emotions are comforted and the emotional burden which comes as a result of the patient's illness is eased. Secondly, theodicy strengthens and empowers the patients as they experience a sense of support and belonging. Thirdly, it facilitates the acceptance of the illness and reduces self-blame. Fourthly, their personal relationship with God develops into a mature faith and growth. It also reduces fear and uncertainty of death. Facilitating the creation of meaning requires a great deal of pastoral competence and sensitivity. The PCG can assure the patients of God's presence, care and love through his/her presence.

[87] Systematic theologians have attempted to answer the question of evil and suffering purely from rational and philosophical perspectives, with the result being even more problematic than solution [not clear what this means] (Dau, 2010:107; Halle, 2010:137157). From pastoral theology, three models have traditionally been formulated in Christian history: *the retaliation model*, which explains that suffering is a divine punishment from God resulting from man's disobedience, willful intentional acts of evil and neglect of responsibility; *the plan model*, which explains that suffering, is part of God's plan for man in order to elicit faith, hope and trust in God; *the compassion model*, which explains that God loves humanity, identifies and suffers with those who suffer. It appears that most pastoral theologians are in support of the compassion model. "Here the question of Christian theodicy is identified, and it is assumed by passibilists, that only a suffering God can be justified in the face of so much human suffering" (Heaney, 2007:172-173). Taking the theological position is not as important as listening to and understanding the patient's experience and making sense to them in line with their needs and role expectation of God. Therefore, it is not necessarily the question of why patients suffer, but how they can respond appropriately to suffering in relation to their faith.

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6.5.2 Presence

Scholars mostly describe Pastoral Caregiving as basically a ministry by presence (Purves, 2004:193-194). Presence suggests being with the patient that also implies sustaining as a prerequisite to other roles of the PCG. Sustaining relates to comfort – the courage to be. Humans are known to have great resilience and inner strength in the face of calamity. This strength is fostered by the will to live and make meaning out of the debilitating situation. However, these survivors need a support system – a sustaining presence, comfort and courage to persevere and find new ways of living creatively in the long term of life's journey. The pastoral role of sustaining implies the acknowledgement that not all problems will be solved; the sick might not be physically or completely cured, but they might experience love, support and affirmation from the religious resources as a dimension of healing. The communal emphasis of the traditional African religions and theologians implies the solidarity of the caregiver with the sick and suffering, which bespeaks presence (Berinyuu 1988: 88). From a Christian perspective, according to Purves (2004:199), caregiving is not about the PCG but about God's care for people through Jesus Christ. Going by Purves's statement, it could be said that the caregiver's sustaining presence is a sacrament. His/her presence mediates or incarnates Christ's presence with the suffering person in concrete human terms. Communication of God's love in verbal and non-verbal terms is often made possible by mere presence. PCGs bring a dimension of compassion to medicine. Most patients feel lonely and isolated from their loved ones. For example, patients in the intensive care units (ICU) of hospitals or clinics are hardly allowed visitors, especially children for fear of destabilising them. Nevertheless, such patients need people who can identify with them. It is true that such vulnerable patients should be shielded from unnecessary intrusion and stress from visitors. However, such patients even those in coma, though they may not speak, can hear and feel a loving and caring presence. However, family members may not always be physically present because of the demands of their jobs. The patient might sometimes interpret this absence as neglect and abandonment. Hence, they might feel depressed that no one cares for them. Although the PCG's presence might not substitute the role and expectation of the patient's family members, the PCG's visit to such patients might largely alleviate such feelings. The caregiver's compassionate presence and prayer can thus assist such patients to cope with such feelings of disappointment and self-pity. People who are suffering have heightened sensitivity to our human responses in either actions or words. In addition, the PCG's availability may speak better than words.

The PCG's presence may speak volumes of God's unceasing love and presence to the patient. The research by Piderman et al. (2010:1009) on hospital patients reports that most patients connect the PCG's visit metaphorically as "reminders of God's caring presence who prays or reads scripture with them". Hospitalisation threatens a patient's sense of security. The presence of the PCG in this sense can help the patient and can be cathartic from a spiritual dimension; they feel better and get better faster. The patient can also experience the liberational and salvific grace of God through the reading of the gospel story.

6.5.3 Mediating salvation and liberation

Mediating salvation, liberation and empowerment must necessarily be one of the roles of the Nigerian PCG in the Nigerian hospital in the light of 3.5, 3.6, 3.7, 3.8 and 3.9. Lekwata (2003:88) argues that the function of Pastoral Care in Africa must necessarily involve liberation.[88] This stems from the reality of evil – witchcraft, sorcery and possession by an evil spirit. There are different types of exorcism and the potential of their being misused is great. Lekwata (2003:91) recommends a ministry of exorcism, which involves the invocation of the Holy Spirit to possess the person anew or reawaken in the person the power to overcome evil by emphasising the lordship of Jesus over the powers of evil. The structural dimension of oppression means that the PCG's liberating role should go beyond exorcism and should also involve conscientisation. The process of conscientisation involves creating awareness or consciousness in the oppressed that they can transform the situation of oppression in which they find themselves. Thus, conscientisation begins from becoming aware of the self towards achieving societal transformation (Miller 2009:101; Magaziner, 2010:129).

Therefore, the distinctiveness of the PCG lies in his or her witness to God's love (Purves, 2004: 199). Such a person adopts the biblical tool for achieving healing. Likewise, in the hospital context the primary aim of the PCG is to be present to the patient and address his spiritual needs. However, the PCG's presence is not to seek to proselytise the patient at all cost. In fact, the PCG's role is not to evangelise, but to share the gospel with patients of the

[88] Liberation implies one's ability to act freely without unnecessary restraint. Liberation relates to freedom, which commonly means to be in command of one's possessions and fortune. To be fully human means that one is liberated to exercise this freedom. In this sense, freedom is related to human rights and dignity. There are different types of human rights, which includes freedom of religion, freedom of expression, freedom of association etc. The inability to act freely means that one is in bondage. Theologically, PC embodies a massage of liberation and liberating acts. According to Nathamburi (1999:137-138), at the heart of the Old Testament is the exodus story and in the New Testament the resurrection for our liberation. "God takes the burden of sacrifice, for our liberation. God liberates us by taking our suffering upon the divine self. Our freedom is guaranteed because it is Christ himself who paid the price for it. God became human so that we human beings can gain freedom. Personal faith is believing that Christ has set us free and we can no longer summit to the yoke of slavery (Gal. 5:1)".

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same religious faith in an appropriate way. Sometimes patients of other faiths might inquire about the PCG and may indicate interest in his or her faith, but the PCG must be aware of the ethical code of conduct in handling this situation (Fitchett et al., 2011:706). This makes the task of the PCG as a witness to the gospel a sensitive and difficult one.[89] However, the PCG's conduct, ideologies and beliefs, language about God the creator who breathes His life into us should not be quaint and strange. It should embody the testimonies of the Gospel as an experienced reality of the faithfulness of God who saves.

Salvation, as Louw describes it, is a term which implies the uniqueness of God's works of redemption, indicated by God's gracious dealings with sin, illness and death, which enables people to live anew. Salvation is an all-embracing concept, which is indicative of what we already are in Christ and includes the dimension of recovery and healing. Salvation, however, is more comprehensive than healing (Louw, 1998: 54, 2000: 64). The environment also enjoys the full benefit of the redemptive work of Christ. However, human beings are the key benefactors of salvation, not only in the sense of a shared benefit but in the sense of their daily living. Salvation has both an individual and a corporate dimension. This is apparent in the individual's daily experiences, when he or she indulges in sin that may or may not have a direct consequence as an affliction. Therefore, the PCG both recognises and engages the ambiguity which abounds between sickness and sin, mental illness and demonic powers, etc. (Anderson, 2001: 229). The PCG can mediate salvation to patients to experience this transformative and new state of being which transcends all ambiguities of sin or sickness (both physical and psychological).

As already hinted above, physical and emotional liberation is a vital issue in the calling, identity and response of the PCG. Human beings need liberation from circumstances, structures and events, which restrain them from flourishing as God wants. Total healing is most feasible when care giving offers significant assistance towards relieving the social and environmental conditions which militate against the patient's life and existence. In such a situation the PCG can, in the absence of the social worker within the hospital, take up such advocacy roles to create change in their social and physical environment. Fundamentally, the calling, identity and ministry of PCGs are liberational.

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[89] Fitchett et al. (2011:704-707) noted that when patients sense a chaplain's attitude is judgmental or that they wish to convert them, they are reluctant to seek the service of such a chaplain. Understanding chaplains in these roles as judge and evangelist are common beliefs among many patients; therefore the patients need to be educated about the proper roles of chaplains.

The PCG's role in this way can concretise Jesus' message and ministry of salvation in the Bible. Jesus' message and ministry of salvation could be said to be well captured in Luke 4:18-19: "[T]he spirit of the Lord is on me, because he has anointed me to preach good news to the poor. He has sent me to proclaim freedom for the prisoners …. To release the oppressed, to proclaim the year of the Lord's favour". According to Anderson (2001: 228), the ministry of Jesus depicts evil as demonic and satanic oppression, which dominate a person's life and manifests itself in sickness. In this case, a more substantive healing is achievable through exorcism. The caregiver seeks to mediate salvation and liberate the body, soul and spirit through the therapeutic process involved in forgiveness and redemption.

6.5.4 Forgiveness, confession and reconciliation

Forgiveness, confession and reconciliation are central to the religious traditions in general and Pastoral Caregiving in particular as well as the African traditional healing practices as evident in Chapter Two (2.4.3.2) and Chapter Three (3.7) of this study. It also receives attention in the Islamic faith in Nigeria. According to Yahya (1995:1), "[t]he Quran enjoins the believer to always seek forgiveness of Allah". This is because relationships are vital to traditional as well as contemporary religious Nigerians. A broken relationship with others and God poses a great threat to the wellbeing of the individual self and community (Augsburger, 1986:82). As such, the role of the PCG in responding to the spiritual needs of the patient is mediating forgiveness and/or confession, which is aimed at reconciliation and restoration to wholeness. Forgiveness is an act of showing mercy to one who is guilty of an offence. It leads to a personal transformation. It is an act through which salvation is made possible. According to Leith (1993: 156), the New Testament depicts Christ as the victim who takes our sins upon himself and forgives us. Hebrews 10:10 compares Christ to the faultless victim who, through his vicarious death on the cross, assures forgiveness and communion with God. "Forgiveness declares that the guilt has been borne and the possibilities of life are now altered" (Leith, 1993: 156). This implies the extension of the divine grace of God to persons who are guilty of sin; it mediates forgiveness through the Holy Spirit to the patient who may feel that his sickness is as a result of God's judgment on his sins. The individual's daily experiences in sin may or may not have a direct consequence as an affliction. This may be coupled with guilt and doubt about the forgiveness and abiding presence of God.

It is common for patients to feel guilt about their condition. When confronted with their own guilt, people feel a basic need to confess their guilt to a trusted person. Kettunen (2002:19), in

his study of *The Function of Confession: A Study based on Experience*, reports that confessants seek relief from their burden through confession. In so doing they hope that they will get rid of the guilt feeling of condemnation so that their lives can become more bearable. The role of the caregiver is to reassure the patient of God's forgiveness and presence, which can bring healing to the patient. To be successful, Kettunen advises that the PCG (the confessor) should diagnose the root of the confessant's distress. He notes that it is of great importance to the confessants that the sin they have confessed have a name. However, the relief comes not in naming the sin, but from God's promises in the Gospel (Kettunen, 2002:18). Given Kettunen's findings, it is important not to make light of the patient's feelings and to avoid hasty absolutions. Care should be taken through the listening process to identify the problem, i.e. to distinguish between guilt and guilt feelings.

Consequently, some Christian scholars like Anderson (2001:218) believe that confession and repentance are preconditions for forgiveness. This resonates with the Islamic position as expressed by Yahya (1995:2) that forgiveness will only be granted to those who, after confessing, seeking forgiveness and repenting of their sin, do not go back to the same sin they had repented of (confessed). The reason why God will forgive them is because he is merciful (Yahya, 1995:2) and omnipotent (Schirrmacher, 2008:50); therefore his mercy stems from the fact that he is great and powerful and does what he will to whoever, not because he loves them as the Christian Scripture stipulates (Schirrmacher, 2008:50). The theology of confession and repentance and reconciliation with God and others differs among scholars of different religions or even the same faith group. Scholars are not unanimous in thinking that confession and repentance necessarily precede forgiveness. However, there is the recognition across religious groups that confession, repentance and forgiveness (Watts, 2006:163) are vital components towards relief of the patient's guilt. Hence, Louw (1998: 410) argues that confession, repentance and restitution should be regarded as a consequence of forgiveness and not preconditions for earning forgiveness. The PCG may not insist on confession, repentance and restitution as a condition for forgiveness. Forgiveness is a work of grace, which liberates and instils peace to the soul of the patient and enhances reconciliation. Therefore the element of love should receive more attention in mediating forgiveness.

Reconciliation operates through forgiveness, which restores broken relationships. The beginning process of reconciliation is grounded in forgiveness and unconditional love. Christ demonstrates this unconditional love in that, while we were yet sinners, he died for us (Romans 5:8). The resultant effect is peace *shalom* (Romans 5:1) (Louw, 2008: 76).

However, there cannot be peaceful relationships within the community without justice. Thesnaar (2010:94) argues that there cannot be peace, wholeness and healing when justice is absent. Seeking peace and reconciliation is more than mere agreement to co-exist; it involves a building of bridges and the respectful interaction of conflicting stories. Speaking from a Christian perspective, the God we meet in Jesus Christ is also a healing, restoring and right-setting God. Thus, the PCG is an ambassador of a healing, restoring and reconciling God in Jesus Christ. Such a person is called to break down the walls of hostility and re-establish the broken relationship of the patient with others and God. The PCG is also called to participate in the sharing and alleviating of the agony, frustration and hopelessness of the sick and troubled person.

Healing is more substantive when *shalom* is restored in the relationship of the victim and the community to which he or she belongs. Physical and emotional liberation are also central to the calling, identity and response of the PCG to meaningful transformation of the conditions that rob people of their human dignity and freedom (Louw, 2008: 76). In addition, reconciliation is crucial in a situation where a patient's illness results from a curse from a family member or abuse. Such a patient may suffer emotional trauma, which often results in more complications. In such a crisis-ridden context, a key to the recovery of the patient lies in the forgiveness and restoration of the broken relationship with the estranged family member.

There is pain involved in forgiveness, confession and reconciliation, therefore the PCG should not rush the process but make allowance for people's natural resistance. Forcing a patient into a situation in which confession, repentance or forgiveness is demanded from them might be ineffective and could damage the therapeutic process. The dynamics of addressing these issues with the hospitalised patient is quite different from the dynamics involved in addressing it with a healthy person. Consequently, these delicate issues should be addressed at the invitation and initiation of the patient as his spiritual concern which the PCG can facilitate. Therefore, "the PCG's role as confessor and reconciler, skilfully and competently handled can restore hope to the hopeless circumstances of the sick" (Louw, 2008: 76).

6.5.5 Hope

Hope is essential to the human condition (Bickle, 2003:16) and central to Pastoral Care to the sick. Kasonga (1994:58) asserts that hope must be the main thread orienting the process of Pastoral Caregiving, because it provides a theological foundation for healing from enslaving

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conditions. According to Bickle (2003:15), patients in hospital sometimes experience a sense of helplessness and hopelessness when they are stuck in a situation from which they do not seem to see a way out. Anxious feelings, frustration, fear and despair also characterise such patients. “Hope happens when one comes to accept his or her illness and to feel peace with their acceptance” (Bickle, 2003:15). Pastoral Care as spiritual/faith care proclaims hope. P.W. Pruyser in the *Dictionary of Pastoral Care and Counseling* defines hope as “a realistic and adaptive response to extreme stress or crisis in which the person acquires a patient and confident surrender to the uncontrollable transcendent forces” (Pruyser, 2005: 532). The Christian lives in the tension of the already and not yet. Hope imparts comfort to patients. Comforting a patient implies a dimension of hope which is both existential and eschatological. However, Bickle (2002:20) posits that hope can be engendered through receiving adequate information. Accordingly, a situation that offers no options, no medical opportunities and no voice in deciding how to deal with the illness inhibits a feeling of hope and faith development.

There is a close connection between hope and faith in a Bible-based Christian life and practice. The Epistle to the Hebrews 11:1, for instance, describes faith as the substance of things hoped for and the evidence of things not seen. Christ brings redemption to creation through His sacrificial life of service, death, resurrection and ascension. God’s purpose is life, not death; God’s purpose is human flourishing, including health, not sickness (Verhey, 2002: 101). God’s future power stands opposed to the domain of death and fights against what militates against human flourishing. Yet, in our reality of everyday life, we are still experiencing these existential issues. Consequently, PCGs can deal with anxiety, guilt and fear of death. PCGs therefore may not allow the existential hope to be the only form of hope, as this suppresses the reality of true life and death, hence communicating false hope (Louw, 2008: 545-546). As such both eschatological and existential hope must be held in creative tension. This expresses the faithfulness of God as it is demonstrated by His identification with our suffering.

Thus, the PCG’s role includes a readiness and availability to stand with those whose lives have been threatened. The PCG also helps them to withstand the disorders that threaten their lives and existence. He/she assists them to remember Jesus and appropriate hope in him in order to celebrate His life, death and resurrection. With such a Christ-centred hope, the suffering can also endure dying with more confidence in God.

6.5.6 End of life care to terminally ill patients

According to Fitchett, Lyndes, Cadge, Berlinger, Flanagen, and Misasi (2011:704), it is generally established that spiritual and religious care are an essential aspect of palliative care. The rise of modern medicine and its successes in handling several diseases and illnesses fosters the illusion that all human diseases will be overcome. However, modern medicine is limited in its pursuit of a cure for certain sicknesses and diseases. The realisation that there are many diseases that defy the doctor's knife and skill makes all illusions about cure dissipate in the face of the stark reality of terminal diseases such as cancer. Flannelly et al. (2003:760) report that most patients may turn to search for other means for sustained meaning. Many patients find such meaning in spirituality and religion.

Studies by Kernohan et al. (2007:519-525) indicate that spiritual support is one of the most urgent needs of patients at the end of life. Patients have often been found to cling more to spiritual resources for their coping at such times. Most terminally ill patients have concerns about their process of dying. Hence, they constantly ask questions related to issues of death, such as what is heaven like? Will I be alone at the time of my death? These questions are a way of coming to terms with their illness and preparing for death. Turning to spiritual resources enables them to cope and adjust, seeing life as a challenge to be lived. Such findings have given increase attention to end-of-life issues in health and palliative care (Flanelly et al., 2007:212-225) and have developed effective standards to address patients' pastoral needs (Kernohan et al., 2007:519). However, studies also indicate that less than 10% of physicians address the pastoral needs of patients (Koenig, 2004:1194-1200; Chattopashyay, 2007:264). Some physicians and nurses may be reluctant to address the patient's pastoral need for reasons ranging from lack of time, lack of expertise, fear of taking over the role of priests, to underestimation of spiritual influence on the patient.[90] Overlooking the pastoral needs of such patients might make them more disillusioned in the face of failed medical treatment and impending death. Understandably, these excuses are real in the face of the limited work force in Nigerian hospitals and the absence of the PCG. If adequate provision can be made by health institutions for the spiritual needs of patients to be met, through the presence of the PCG, such challenges can be ameliorated within Nigerian health

[90] Koenig (2004:1194-1200) also reports that many physicians feel uncomfortable to address the spiritual inclination of patients. He further states that it has been observed that less than 10% of physicians address the spiritual needs of patients.

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institutions. The physician cannot be what he is not. Here the presence of the PCG for the patient can bring relief and a dimension of hope to him or her.

In the case of death and bereavement, the PCG can be of immense support to the grieving family members. Sometimes the death occurs in the hospital with family members around. Although they do realise that their loved ones would die one day, it often comes as a shock to them when it eventually happens. They often need to be calm and their minds prepared for the news to be broken to them. Sometimes the nurse and the doctors may be overwhelmed with other responsibilities to other patients, and may not have the time to prepare family members and friends of the deceased before the news and to offer them the much-needed emotional support. The PCG can perform this role function to be with the family and offer them much-needed comfort and encouragement. Many PCGs and other healthcare professionals perceive this ministry to the dying, bereavement and grief of patients and their family as one of the most significant contributions of PCGs in the hospital (Cobb, 2005:65-78; O'Driscoll, 2007:14). PCGs have been known and acknowledged as being of great help in assisting the patient's family as well as hospital staff to deal with their loss and to facilitate the grieving process. Ford and Tartaglia (2006:677-678) acknowledge this role of PCGs in the hospital:

> One area where chaplains [PCGs] are growing more specialised is in end-of-life care. With the rise of hospice and subsequently of palliative care, chaplaincy has become an integral component to medical approach to death. Chaplains support patients as they wrestle with often the largest spiritual issues of courage, meaning, personal worth, and connection in their lives. They facilitate open and honest communication about death within families and among staff who are often afraid to even say a word. They support the dedicated staff as they perform spiritually athletic feats of care day after day. They provide bereavement counselling to those who have lost spouses, jobs, roles, parents, meaning and love.
>
> (Ford and Tartaglia, 2006:667-678)

A trained PCG adopts the necessary flexibility in order to minister to the patient and family. His/her embodied presence of the Gospel exists as a bridge and platform for listening, comforting, and praying for persons who are willing and available to receive the ministry of Pastoral Caregiving. Besides the patient in the Nigerian hospital context, the PCG's role extends to the hospital staff.

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6.5.7 Healing the healer – pastoral support for hospital staff

Dehler and Welsh (2010:65) have argued that how “people experience their work becomes increasingly central to their lives because it serves as a source of spiritual growth. They bring their whole selves to the workplace and seek to integrate work into their lives”. In addition, “they bring the desire to engage their acquired skills more fully and to attain a sense of fulfilment from being challenged by their work” (Dehler & Welsh, 2010:65). Such desires Parboteeah and Cullen (2010:99) suggest are met by spirituality. Spirituality at the workplace, according to Parboteeah and Cullen (2010:99), “suggests going beyond accomplishing organizational tasks, which may have meaningless intrinsic value to the worker’s work. Rather spirituality views work as necessary nourishment for workers’ souls”. Therefore, they strongly believe that “spirituality can benefit employees by helping them deal with the realities of today’s workplace, finding more meaning in their work and lives and connecting with other people”. Spirituality also can benefit employees in the sense of helping them “deploy more of their full creativities, emotions and intelligence” (Parboteeah & Cullen, 2010:100). Based on Dehler and Welsh (2010) and Parboteeah and Cullen’s (2010) assertions, this study contends that the absence of meaningful pastoral care could lead to the phenomenon of burnout.

In contemporary Nigeria burnout is becoming a common phenomenon in a country that is fast becoming production oriented. Most of her citizenry define their essence by what they do. Often roles and functions become determinative of relationships. Consequently, the staff experiences pressure which usually results in burnout when a visible sense of dissatisfaction sets into relationships.[91] Burnout is related to compassion fatigue. Compassion fatigue can be defined as “stress from helping or wanting to help a traumatised person. It results from overexposure to trauma. While burnout refers more to exhaustion in terms of professional identity and feeling of overwhelmed incompetence, compassion fatigue refers to exhaustion in terms of activity and input” (Louw, 2008: 135). Burnout and compassion fatigue are very common among the medical staff who meet with a wide variety of people in crisis. Such patients can cause serious stress for the staff. According to Benner, “dealing with souls is

[91] Burnout does not have a clear-cut definition. It is used in a variety of ways in conversation. It is very difficult to differentiate between burnout and compassion fatigue. Robert Wicks, borrowing from Edelwich and Brodsky, defines burnout as a condition whereby a person experiences a “progressive loss of idealism, energy and purpose experienced by people in the helping professions” (Wicks, 1985:91). Lynne Baab simply defines it as “the body doing the work but the spirit is not present” (Baab, 2003:33). It is a state of emotional exhaustion caused by the stress of one’s work or responsibilities. Burnout is an old phenomenon. Biblically, the story of Elijah (1Kings17-19) is normally used as a typical example of burnout in the Bible.

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more demanding than dealing with things. Things don't resist our helping interventions in the way in which people so often do" (Benner, 1998: 206).

Most Nigerian hospitals (especially the government-owned hospitals) as discussed in 2.6.3 are underfunded, understaffed and ill-equipped (Adebayo & Oladeji, 2006; Pearce, 2000; Uduigwomen, 2003). As a result of these challenges physicians and other medical staff in Nigeria are constantly faced with debilitating situations within the care environment. Often the bulk of medical staff approach health care delivery with an enthusiastic spirit to serve. As they engage with a myriad forms of human suffering and pain, such medical personnel become vulnerable to various challenges associated with their work (Uzochukwu, & Onwujekwe, 2005:4). According to Bowen, Ferris and Kolodinsky (2010: 129), "organisational volatility and constant change have resulted in increased uncertainty, ambiguity and insecurity in workplace". These conditions can arguably result in burnout. Adebayo and Ezeanya (2011:7-13) have identified burnout among nurses in Nigeria. The effect of burnout on physicians and nurses who attend to isolated self-alienated patients can be devastating. This can also result in loss of enthusiasm, irritability, apathy, cynicism, powerlessness, fatigue, frustration and lack of selfless service in the staff.

Koenig (2004:1199) has rightly observed that healthcare professionals who deal with death and life issues need a spiritual reserve and support to stand up to these challenges, which potentially diminish joy and fulfilment. A closer look at the AKS/Nigerian medical system will reveal that most of the medical staff experience burnout. Such burnout indicators include the display of apathy, impatience and hostility to patients by some hospital staff of many Nigerian public hospitals. Given such a scenario, it becomes more evident that the role of the PCG will have immense benefit for the hospital staff. A professionally trained PCG stands to offer therapy to all and sundry. Wittenberg-Lyles, Oliver, Demiris, Baldwin, and Regehr (2008:1334) report in their research findings that "chaplaincy appears to be the choice of comfort and aid among team members who experience work-related stress".

A PCG supports and shares responsibilities with other health care professionals. Such pastoral identity can be of immense benefit to the doctor and other health professionals in the team. The responsibility of PCGs suggests more than fulfilling counselling needs. Thus, the PCG's presence in the hospital space provides a significant platform for approaching the spiritual dimension of care in a more informed way. The PCG can be of immense support to such staff in offering a space for the medical staff to debrief, thereby enhancing their

emotional and spiritual wellbeing. VandeCreek and Burton (2001:91), report that some physicians and nurses believe that professional PCGs can play an important role in helping staff to cope with their problems and should help staff to do so. This is part of the pastoral identity and spirituality of a professionally trained PCG, which can also assist the medical team in moral and ethical issues.

6.5.8 Partner in the process of moral discernment on ethical issues

Ghunney (1993:104 has suggested that Pastoral Care in Africa should include moral and ethical dimensions and in fact asserts that Pastoral Care in Africa is incomplete without these dimensions. This is because the African reality is full of dos and don'ts which might bring some pathological distress to the patient. In this sense, a trained PCG may be a partner-in-progress in cases of the moral discernment required in some pathological cases. Hesch (1987: 41) claims that "chaplains are often looked to by patients or families who are presented with a moral dilemma in the hospital. At other times, families regard chaplains not as interpreters of divine will, but simply as trained moralists who are able to give wise counsel about the appropriate ways of handing medical problems, especially at a time when their emotions prevent their objective assessment of the situation". Some decisions that confront the patients, family and doctors involve moral dilemmas. Such states of affairs often necessitate questions, for example: Should a pregnancy that threatens the mother's life be aborted? Or should pregnancy resulting from rape be kept? Or should treatment be withheld from a patient who has been in a coma for a year? These ethical or moral questions, among others, constitute dilemmas faced by healthcare professionals. "Difficult ethical dilemmas regularly arise in today's highly technological healthcare systems, i.e. decisions to withdraw aggressive treatment. Unavoidably, such decisions interact with personal values and beliefs of all involved". It is further argued that "[p]rofessional chaplains, who are frequently members of ethics committee, provide spiritual care of staff members as well as patients and families affected by these complex issues" (VandeCreek & Burton, 2001:84).

Ethics relates to the dimension of decision making and of responsibility which has become a crucial issue in health care, because it relates to the notion of human dignity, norms and values. This removes the responsibility for making decisions on behalf of the patient from the medical staff to the patient and family. The medical team often plays an advisory role. A relationship of trust and confidentiality between the patient and the medical team is required

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to facilitate this process successfully. This becomes essentially an ethical issue (Louw, 2008: 267-285).

Religious faith does not provide straightforward answers to these life issues. According to Anderson, "the crises we face are borderline situations where the command of God is ambiguous. This ambiguity arises because the command and the moral will of God are rooted in the freedom of God and consequently demand that there be freedom for the human being to discern and to do the will of God" (2001: 219). Thus, the PCG's presence in the hospital context (as one trained and experienced) can illuminate faith that is substantiated by theological insight to the patient, family and doctor. This can assist them to make substantive decisions that might free their conscience (Wheeler, 1996: 101-108; Louw, 2008: 242). In essence, the ministry of Pastoral Caregiving is a witness to the Gospel.

The PCG has great potential in the formation and practices of ethics/ethical committees within a hospital context. It can be concluded that the PCG can play a significant role in the formation and sustenance of ethics/ethical committees within a hospital context. As the official document on Pastoral Care in hospitals states, "chaplains [professionally trained PCGs] play an important role in mitigating situations of patient/family dissatisfaction involving risk management and potential litigation" (VandeCreek & Burton, 2001:91). This implies that a professional PCG can also serve as intermediary between the patients and their families and the medical staff, as they are trained to explain ethical issues that have a spiritual dimension in ways that the patient, family and healthcare professionals involved can understand.

6.5.9 Intermediaries and networkers

PCGs can act as intermediaries between the patient, the medical staff and the family. They can mediate between the difficult patients and medical staff, or vice versa. Pera and van Tonder (2005) characterise difficult patients as those who make the medical staff feel uncomfortable, frustrated and ineffective. Usually difficult patients are less likeable than others. Again, issues such as race, tribe, religion and economic status can influence the care of the patient, rendering the patient's conduct unacceptable to the medical staff. Furthermore, patients who may be guilty or responsible for their condition are also classified under difficult

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patients. This latter group includes attempted suicide patients, drug addicts and AIDS patients who engage in high-risk behaviours (Pera & van Tonder, 2005: 74)[92].

While the PCG may not diagnose or disclose a medical condition to the patient, as it is the prerogative of the physician to do so, they can liaise with them to get the relevant information and explanation that can put the patient's mind at rest. The PCG can function as an intermediary to explain or re-explain the meaning and implication of such information. In this way, the PCG can be helpful to the patient and family in making their experience of hospitalisation less difficult. His/her identity and calling as an advocate for the patient's interests can bridge the gap between the patient and the medical staff.

The PCG can also serve to network and to sensitise religious faith practitioners on medical and mental health concerns in contemporary Nigeria. He/she belongs to a community of faith in a religio-centric environment. For example, fake and counterfeit drugs are a great menace to Nigerian society. Their effect, as Akunyili states, "is the greatest evil of our time and the highest weapon of terrorism against public health … it is an ill wind that does nobody good. The evil of fake drugs is worse than the combined scourge of malaria, HIV/AIDS and armed robbery put together" (Akunyili, 2004: 20). A number of producers of fake drugs are members or adherents of faith communities. Thus, the PCG and the religious communities can cooperate with the government to curb the menace of this health risk. The faith community can transform into a ready platform for addressing the members of the community about the health risk involved in such practices. As Akunyili further argues, "we can only combat the menace of fake drugs and other substandard regulated products through team work … one way to solve this problem and for health practitioners to effectively contribute in eliminating the problem, is by fostering interprofessional relationships thereby tapping from one another's core competence. This will help frustrate the drug counterfeiters" (Akunyili, 2004: 22-23).

Furthermore, research by Akinyemi et al. (2009:998), and Omo-Aghoja and Okonofua (2007:47) on perceptions and attitudes of hospital staff and patients on certain medical conditions indicates that there was need for medical education and counselling for the

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[92] In addition, some patients may be non-cooperating because of pain or they struggle to adjust to the strange world of the hospital environment. Experience of hospitalisation make patients feel vulnerable and overwhelmed. In such a situation patients and family members may be confused and overwhelmed by the medical information given to them. Such medical information is sometimes coded in medical jargon incomprehensible to the patient. Consequently, some family members may need more explanation, which the medical staff is sometimes not available or disposed to give. At other times, the patient might have a selective memory about the information released to them. Some medical staff may have little patience with such patients.

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community using faith-based organisations, among others. Thus, a professionally trained PCG can play a significant role in curbing the menace of counterfeit drugs in contemporary Nigeria. He/she can adopt a constructive approach in order to discuss medical /mental health issues with religious faith practitioners in the community.

The PCG can be an important bridge between the community, religious leaders and the hospital and healthcare system in Nigeria. In situations where religious faith seems to conflict with medical procedures, the PCG can dialogue with religious leaders and members by providing information and implications on the basis of which they can make informed decisions. Some churches in Nigeria have a health week, when the PCG can function as a liaison figure from health institutions to train and educate such religious leaders on current health challenges.

6.5.10 Research development and training on religion and spirituality

Dehler and Welsh (2010: 65), drawing on Handy (1998) posits that "like people, organizations are also hungry spirits at heart". They further argue that the way people experience their work becomes increasingly central to their lives, because it serves as a source of spiritual growth as such organisations are required to meet the meaning needs of their members. "Work places that allow people to remain true to their deepest belief in their daily work … provide not only an outlet for personal expression[but will] become the only way for companies to make profit", because they create the context for creativity (Dehler & Welsh, 2010:66). This indicates that religion and spirituality are not only important and beneficial to patient and family (Fitchett, Lyndes, Cadge, Berlinger, Flanagen, & Misasi, 2011:704), but also important and beneficial to staff and organisations. The implication of the above findings for this study is that healthcare organisations in AKS cannot afford to ignore the phenomenon of religion and spirituality, but must conduct research on how they can incorporate religion and spirituality in their context. This is because, as Parboteeah and Cullen (2010:99) argue, "people are seeing the workplace as a primary source of connection with other people". Therefore, besides the benefit of spirituality to patient and staff, it also benefits the organisation "because their employees are more satisfied and happy with their work, potentially enhancing organizational performance" (Parboteeah & Cullen, 2010:66). Given the overall benefit of spirituality to all involved, healthcare systems in some contexts in the world are developing and researching the interaction between medicine and religion/spirituality to enhance integrated and holistic services to their users. It is believed

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that all humans are inherently religious and resort to forms of religious practices for coping during illness and other stressful situations, finding them beneficial. Such findings have helped the healthcare system in many contexts to reform or evolve health policies that do not undermine the spiritual dimension of patients. While extensive research has been carried out on the interaction of religion and African medicine in Nigeria, little or no evidence-based research has been done to establish the importance of spiritual beliefs on coping and their influence on the recovery or non-recovery of hospitalised patients beyond general assumptions (Antai, 2009:57). Furthermore, no research has been done to determine the benefit of religious beliefs and practices to the hospitalised Nigerian patient. Other issues such as how spiritual care should be carried out in the hospital also need attention. The professional PCG in the hospital can undertake research on religious and spiritual care in Nigerian hospitals, the development or adoption of appropriate spiritual care assessment tools to assist in spiritual care inventory, as well as assessing the effectiveness of delivering spiritual care in Nigerian hospitals.

Besides research, the PCG can help facilitate the development of clinical pastoral education (CPE) (the basic training requirement for spiritual care in hospitals worldwide that have a Padtoral Care department) which is appropriate to the Nigerian context. He/she can also educate healthcare professionals, medical students regarding the interface between religion, spirituality and medical care by participating in multidisciplinary seminars and conferences. In this sense, the professional PCG can function as a spiritual consultant in educating the care system on spiritual matters. Such available information can assist the patient, family, staff and government in making informed decisions and policies concerning patients' spiritual care (VandeCreek & Burton, 2001:88).

The chaplains can also train the lay PCGs, pastoral visitors and volunteers on the basic skills of spiritual caregiving and hospital codes of conduct and etiquette. There is often friction between the hospital staff and visitors arising from ignorance of role expectations. Such friction can be minimised by offering basic training on institutional procedures for effective ministry. He/she can increase the PCG's workforce by training congregational clergy who are interested in hospital ministry.

In summary, the role and benefit of the PCG in hospital care to the sick is to provide spiritual and emotional support to the patient, patient's family and staff as they journey between the worlds of illness and health in search of meaning and purpose. They function to guide,

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change, liberate, transform, comfort, reconcile and convey hope as well as promoting networking between patients, family, medical staff, religious bodies and the larger community. This is undertaken to generate and sustain trust in God and his promises so that they can gladly say in the mist of sufferings and pains “in all things God works for the good of those who love Him who have been called according to his purpose” (Romans 8:28-39). There are vital resources that are relevant to the PCG in his or her ministry to the sick in the hospital context.

6.6 Resources for ritual and practices of PCG in the holistic pastoral theological approach

Rituals and practices are intrinsic in essentially every religious tradition, but especially in the African traditional religions and African Christian practices (McClure, 2012:274; Foley, 2012:143-152). Berinyuu (1988:98) has advised that Pastoral Care must be provided in dialogue with the culture in which it locates itself for practice. In like manner, many African and pastoral scholars have recommended the use of religious symbols, rituals and practices as tools for providing comfort and healing to the sick. In the light of Berinyuu’s suggestion, this study draws its tools based on insights of good practice gained from the North American and European practice of Pastoral Care and from the African religious faith practices to propose tools for Pastoral Care in the Nigerian hospital context. From the traditional African setting analysed in Chapter Two and Pastoral Care discussed in Chapter Three, there are correlations, similarities and differences of resources used by Pastoral Care and the traditional African to foster spiritual healing. Such resources include prayer, scripture, music and dance, and the use of oil for healing. Fellowship meals and sacrifices also correspond to the Christian symbols of the Sacraments. This section discusses prayer, Scripture, fellowship, sacrament, religious literature, anointing oil and music as the PCGs’ resources. These religious resources are needed by the patients daily or weekly for their coping and healing process in the hospital. They have been widely associated with positive outcome such as alleviating anxiety and guilt, and increase a sense of security (Hodge 2001:209). Although these resources are not exhaustive,[93] this study limits the tools to seven as enumerated above, because they are very commonly demanded resources by patients and staff for their religious rituals and practices. By tools we mean the religious and spiritual resources and practices available to the professional PCG in the hospital context that can assist him/her in carrying

[93] There are other religious rituals such as baptism and naming ceremonies, and funeral rites which are practised by many faith communities that the PCG can explore depending on the situation and demand.

out his or her spiritual and religious functions and responsibilities. These tools can complement medical care practices for the benefit of hospitalised patients. When these resources are appropriated in an ethically responsible way, they can assist patients to experience healing through the abiding presence of God. Prayer will be the first religious/spiritual tool or resource to be considered.

6.6.1 Prayer in a hospital context

Prayer is regarded as a core ritual practice of healing in many religions including African Traditional Religion (Mbiti, 1975:1-2), Islam (Syed, 2003:45-49) and Christianity. Although the mode, style and content may differ among these religions, there is a general consensus that prayer is directed to higher power or Supreme Being known as God, *Allah*, *Abasi* etc. (Mbiti, 1975: 36). Mbiti argues that the majority of prayers offered have to do with life, health and healing. Thus for African Traditional Religion prayers are directed to God, divinities, spirits, the living dead and personification of nature (Mbiti, 1975:3). For the Muslims, prayer (*salaat*) forms one of the five pillars of Islam (Syed, 2003:45; Pulchalski et al., 2004:689; Wehbe-Alamah, 2008:83).

Prayer is commonly defined as communication with God. However, this communication, as Louw explains, is distinct from ordinary communication as in the formulation between sender (prayer) and receiver (God). It exists as a faith-based reaction within the context of communion *(communio)* with God (Louw, 1998: 429). This uniqueness transforms prayer into a fellowship and a God-man relationship. In a more simplified fashion Mbiti (1975: 128) states that prayer carries the idea that God listens to people and they should continue to call upon him. Syed (2003:45) asserts that studies have proved the benefits of fasting during the month of Ramadan. Many Muslims believe that prayer has a beneficial effect on sickness such as recovery from pain of the heart, stomach and intestine, produces happiness and contentment in the mind, suppresses anxiety and extinguishes the fire of anger. In addition prayer increases love of truth and humility before people; it softens the heart and creates love and forgiveness, and abhors revenge (Syed, 2003:48). Therefore as a ritual which shares common ground with nearly all religions, prayer is a vital tool for the Pastoral Caregiver in the hospital context for intercultural Pastoral Caregiving. However Kirkwood (1995:100-106) warns that prayer should be undertaken with great sensitivity as it can become a weapon instead of a tool in the hands of the PCG, in which sense it might not benefit the patient. According to him, there are two traditional concepts of prayer: praying at every visit to the

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patient or only when asked to pray. Space does not permit this study to delve into this argument, but suffice it to say that each of these positions has its strengths and weaknesses. The issue then is for the PCG to know when he/she should pray with the patient. A sensitive PCG, according to Kirkwood (1995:106-109), would know when patients desire prayers. That many patients believe strongly in prayer is never in doubt.

The belief in the efficacy of prayer has significance for the patients in Ibibio/Nigerian hospitals as evidenced in Chapter Two. It is an important form of ritual which connects the physical, social, psychological mystical and spiritual level whereby the people draw strength from God to transform their lives.

The benefits and importance of prayer cannot be overemphasised. From a religious perspective, Syed (2003:48) points out that prayer is viewed by many Muslims as beneficial to them. This is also the view of other religious traditions such as Christianity and African Traditional Religion. From a clinical (empirical) perspective, some scholars have sought to prove that prayer is important for mind and body healing. The mind is believed to be responsible for what one thinks or believes, which can have either positive or negative effects on health (Maier-Lorentz, 2004:24). The mind and body continually send messages to one another; these messages produce biological and physiological changes that help determine the health status of an individual. Responses made to these messages may result in either illness or wellness (Maier-Lorentz, 2004:25). Therefore, prayer as a mental or psychological activity (besides its communion character) elicits a positive response from the mind and has beneficial effects on the patient. According to Maier-Lorentz (2004), as early as 1951 scholars sought to establish empirically the importance of prayer and its benefit as an intervention model to patient's healing.[94]

[94] Similarly, according to Maier-Lorentz (2004:26), in 1988 Byrd also conducted research on the benefit of intercessory prayers on 393 cardiovascular patients in a coronary care unit. Results on the cardiovascular patients revealed less cognitive heart failure, fewer use of diuretics, fewer had cardiopulmonary arrest and less pneumonia. However, critics doubted if those assigned to pray actually prayed, and if they did, why it had to be only born-again Christians, or could the results have been the effect of the patient's personal petition to God (Maier-Lorentz, 2004:26). Whatever the critics' misgivings, the effect of prayers was not in doubt. Likewise Maier-Lorentz (2004:26) reports that in 1998 Sicher, Targ, More and Smith carried out a research study on the effect of prayer on 40 people living with HIV and AIDS. Here people of all faith where selected to pray for the patients for six months, ranging from Christians, Hindus, Muslims, Buddhist to Jewish. Results indicated that prayer has a positive effect on patients. People prayed for had significantly fewer new AIDs-related illnesses, lower illness severity rating, fewer doctor's visits and hospitalization, and fewer days in the hospital (Maier-Lorentz, 2004:26). Despite the criticisms, the findings in these researches underscore the point that prayer should be used as an important means of intervention for healing before and during hospitalization for coping. Prayer is an important tool through which the Pastoral Care giver performs his or her roles.

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Prayer is authoritative when it is rooted in God's word (Scriptures). Some patients derive comfort and consolation when prayers are offered for them. PCGs can make use of prayer in an organic way to mediate God's presence to the patients who may require it. Therefore, it is advisable that PCGs seek the consent of the patients before they pray. They should also ask the patient what they would like to pray about (Louw, 2008: 256-7). It is also advisable that prayer at the bedside should not be long and loud.

6.6.2 The use of the Scriptures within a hospital environment

Of the three dominant religions in AKS, only Christianity and Islam are religions of the book. In other words both Christianity and Islam are guided by the written authoritative sources of the Bible and Qur'an respectively as authoritative and divinely inspired word of God for guidance in matters of faith and life. From the Muslim point of view, the Qur'an is the inspired and verbally passed down word of God binding on all Muslims everywhere (Schirrmacher, 2008:13; Wehbe-Alamah, 2008:39). Besides the Qur'an there are also the Islamic traditions (*hadith*), which are the recorded sayings of the prophet Mohammed, and the early Islamic followers and scholars which contains instructions about the religious obligations of Muslims (2008:14).

On the other hand, the Bible is the church's memory reduced to writing by the prophets and the apostles who were the original witnesses of and believers in God's revelation and work that constituted His people (Leith, 1993: 270). It is a theological and spiritual witness rather than an historical source book (Ballard, 2007:36). The Scripture also exists as an indispensable tool for Pastoral Care: it helps us to understand God's self-revelation and God's will for creation. The scriptures (such as Bible in the case of Christianity and Qur'an in the case of Muslims) are perceived by the believers of these faiths to elicit faith, hope and love for them[95]

[95] In recent decades the Bible has undergone much criticism from different quarters, notably from feminist and womanist activists, although some groups regard the Bible in a more positive light than others (Wacker, 2006:634). The seeming condemnation of the Bible has made many PCGs in the Western world more wary of using the Bible as an intervention tool in the secular and pluralistic sphere. For the Christian PCG, the Bible is his/her distinctive, authoritative and major resource for his or her pastoral engagement, in the same way that DSM IV is the authoritative material for the clinical psychologist or psychiatrist, which contains guidelines for their engagement. The Bible as a universal resource, which is accessible to all, frequently appealed to, and subject to individual interpretation is also open to abuse (Tidball, 2008:201). Such abuse does not invalidate the use of the Bible by PCGs as Western PCGs are inclined to doing, but calls for a careful and meaningful engagement, which has the potential to empower and transform. The biblical tradition forms the primary body of knowledge which underpins the practice of Pastoral Care in the hospital context (Swinton, 2003:4). For the Nigerian Christian and PCG, the Bible is central in shaping their views about God, his revelation to man and interpreting the Christian faith. For Nigerian Christians the Bible is a book for the people, not a book only for

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Scripture functions as an indispensable aspect of the pastoral strategy. Therefore, Pastoral Caregiving as a faith-based health care delivery service must not neglect the use of Scripture. Louw (2008: 254) also advises that the scriptural text should be used in an organic way as part of the therapeutic process. The PCG should not use it as a mini-sermon devoid of awareness of how patients will respond to it in a particular situation. The PCG's failure to use the Bible in a responsible way can demonstrate insensitivity in the sense of saying the right thing at the wrong moment, or saying the right thing in the wrong way. He can easily become legalistic in his use of the Bible as a result of a lack of awareness of how patients could respond to the Bible. The Scripture is an infallible resource for the PCG's life and praxis of ministry. The PCG must regard scripture as central to his hospital pastoral functions as inspired by God useful for teaching, rebuking, correcting, and training in righteousness, so that he may be thoroughly equipped for every good work (2 Timothy 3:16-17). "But that does not mean every question will receive a direct and immediate answer or that it is some form of supreme reference book where we can find obvious solutions to all the problems we face in life" (Tidball, 2008:198).

The PCG's conscience, actions and intentions are judged by the standard of God's word. The PCG is motivated by the Scripture, founded on the Scripture, structured by the goals and objectives of the Scripture, developed systematically in terms of the practices and principles modelled and enjoined in the Scripture. A Scripture-rooted practice of Pastoral Caregiving could also enrich fellowship.

6.6.3 Fellowship in hospital care

Fellowship – *koinonia* – constitutes one of the powerful resources for Pastoral Care. It is suggestive of a gathering of the people of God in worship. Fellowship provides an opportunity for mutual sharing, support, prayer and scripture study for patients and staff. Fellowship might take various forms such as Bible study, or traditional liturgical worship service. Fellowship as *koinonia* in community provides a space for the medical team which needs support to function well (Louw, 2008: 254). Based on research conducted among patients, it seems that participating in a faith-based community such as a church and mosque, scripture study group or prayer meeting has significant benefits. It has been associated with increased empowerment (Hodge, 2001:209). As evident in Chapters Two and Three the centrality of community to Africans and Nigerians has been described by various African

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the pastors or scholars; it is a book for all, not just for the intelligentsia. Many are familiar with the stories and contents of the Bible. Many read it almost every day and derive pleasure in doing so (Kalu, 2010d: 217-221).

scholars (Mpolo, 1994; Udo, 1994). Uzukwu (1999:40-50) points out that the community provides the context for rituals and religious rituals which are means by which the people participate and discover, renew and experience the foundation of life. The life and worship of the community "provide the occasion for the development of faith, formation and decision" (Childs, 1992: 6). It provides the context for a more successful realisation of the healing process. Therefore fellowship is a necessary resource for effective Pastoral Care in the Nigerian hospital setting. It provides an opportunity for the patient and staff to share their fears and faith together to strengthen each other. Fellowship could be said to affirm the biblical text "as iron sharpens iron so a man or woman sharpens the countenance of his friend". A patient who lacks family, friends and significant others can draw immense encouragement and support from fellowship, either in the form of support groups or as a worship service. Healing is not complete until the patient is restored to the community. The role of the PCG, then, is to facilitate the involvement of patients in appropriate and significant ways possible in the community. Hence, it is necessary that the PCG belong to a faith community (Benner, 1998: 218). Community forms and informs the context where a PCG's being and functions are cultivated. The community of faith as a healing community exists as a sacrament where healing can be experienced by all.

6.6.4 Sacrament (celebration of Holy Communion in the hospital space)

The sacraments are the churches' practices and symbols as they are carried out in anticipation of God's coming reign in fullness. They mediate the presence of God to His people (Bosch, 1991: 11). The importance of sacraments to Nigerian patients can be appreciated from Uzukwu's (1999:50) statement that there is no aspect of everyday life that does not come under the influence of religious ritual. The reason, according to Uzukwu (1999:43), is that "rituals provide active liberative expression for the oppressed". Kiriswa (2002:29) shares in Uzukwu's view on the importance of religious ritual in healing and explains that ritual instils support, concern and love, as well as helping the person to experience forgiveness, acceptance, reconciliation and a sense of belonging, i.e. that he/she is not alone in facing faces life's challenges. In this sense, the Holy Communion for the Christian is a fundamental rite of the Christian community because of its meaning derived from recalling the self-gift of Jesus the life giver (Uzukwu, 1999:188). The Holy Communion often ushers in a real time of celebration of the steadfast love of Christ. Hence, it constitutes a significant aspect of the healing process. Thus the Holy Communion is the most powerful ritual for the sick and suffering, because it comforts and empowers them to bear witness and be steadfast in Christ

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and refreshes them in their pains and suffering: "we do not lose heart. Though outwardly we are wasting away, yet inwardly we are being renewed day-by-day….our light and momentary troubles are achieving for us eternal glory that far outweighs them all. So, we fix our eyes not on what is seen but what is unseen. For what is seen is temporal, but what is unseen is eternal" (2 Corinthians 4:16-18). It can also inspire them to reflect deeply on the meaning of their suffering and the purpose of life. This can also result in a deepening of their faith as well as renewal of discipleship. Confession, forgiveness and reconciliation of sins precede the Holy Communion as a symbol of God's presence and restoration. Hence, Holy Communion can heal "through strengthening and nourishing the wounded soul of the repentant" (Mwaura, 2000: 90). The Holy Communion as a sacrament can have a therapeutic impact on patients. In hospital care the PCG can introduce it to the willing patients during worship in chapel with in-patients and staff. He can also introduce it to bedridden patients in the ward who may desire to partake of it.

6.6.5 Religious literature

The use of religious literature by the caregiver can be considered an important component of pastoral therapy. It exists as a necessary aid in the healing process. Religious literature can serve devotional purposes. Therefore, patients can read some religious literature that they may find helpful and that can enrich their personal meditation. A devotional guide specially designed for the suffering could be of help in building, stabilising and sustaining the patient's spiritual life. Such literature can help boost the faith of the suffering and break the boredom of the hospital environment. However, the PCG should exercise wisdom in the use of these materials as some of them might not be adequate or suitable. The PCG can read Christian literature with a view to understanding and explaining such a Christian healing approach to the patient in addition to the use of anointing oil, among other things.

6.6.6 Anointing oil

The use of oil as faith support in the healing process is gaining widespread acceptance in contemporary African/Nigerian societies (Mpolo, 1994:28). From the traditional concept of healing within the Ibibio traditional society in particular, oil derived from palm kernel *(manyangha*) is believed to possess the power to neutralise the potency of poison and diabolical powers. In the New Testament oil is used as a symbol of healing. This practice of anointing the sick has continued through the Christian era in caring for the sick (cf. 3.5.1). For example, the parable of the Good Samaritan (Luke10:25-37) alludes to the use of oil for

the healing of the afflicted. The Epistle of James also instructs the church to pray and anoint the sick with oil (James 5:14). This suggests a helpful connection with the African belief in the potency of some oils. Berinyuu (1988:104) therefore suggests that anointing the sick should be incorporated to Pastoral Care to the sick in Africa as a component of holistic healing. The PCG in the hospital setting can therefore tap into this developed concept of the use of oil to boost the faith of the sick in the hospital. The use of oil can mediate the presence of "the sovereign God of surprises" in the life of a patient. Hence anointing oil can be a sacrament of anticipated healing.[96] The PCG can introduce this practice within the hospital context to patients who may desire it. Music, like anointing oil, has a therapeutic dimension that can minister healing to the sick.

6.6.7 Music and dances

Music is one of the resources of healing both in the African traditional and religious context (Ghunney, 1993:103; Berinyuu, 1989:123-126) as has also been observed in Chapter Two. Music in Africa is often produced from singing, clapping, stamping feet and bodily movement in addition to drums, horns and whistles, and more recently keyboards, guitars and trumpets. As Maboea (2002: 80) observes, dancing often accompanies music and is done as a form of obtaining power and expressing gratitude to God or spirits. Thus Kalu (2010h: 86) concurs with Maboea that "[m]usic has always been central in human expressions of heartfelt responses to the divine". In this sense they relay their feelings, mode and desires through songs. Music may have a recreational, relaxing and calming effect on some patients. Given this background, music is also recommended for use by the caregiver. This depends on the state and the preference of the patient. Soft and meaningful music can convey relief and solace to the sick. In my group work with sick patients in the hospital setting, patients enjoyed a great deal of the music we played. They confessed to the peace, calmness and relaxation in the therapeutic space of music. Such music can be drawn from hymns, the classics, contemporary and traditional tunes.

[96] Many Pentecostal churches in Nigeria have monthly anointing services and tarry nights. The focus of these services is on ministering healing and dealing with other problems ranging from economic to spiritual. There is also an extensive use of anointing oils. Usually this is olive oil that has been consecrated in prayer by the pastors. This service attracts people from different religious backgrounds and denominations. Some members from the missionary churches believe strongly in its use. I have personally had some members bring these oils for consecration for their private use.

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Pastoral tools can also provide resources for the PCG in the holistic pastoral theological approach to develop a framework for pastoral and spiritual assessment of patients as one of his or her roles (6.5.1).

6.7 Processes of pastoral assessment of patients

Quality care of patients demands a planned and intentional intervention which demands appropriate assessment of patients' pastoral needs. As a component of the holistic pastoral theological approach, Pastoral Care attends to pastoral assessment of patients. In 3.4.1 the prominent element of Pastoral Care was articulated as being able to attend to the question of meaning which arises from suffering. Therefore in 6.4.5.9 and 6.6.1 of this study, one of the functions of the holistic pastoral theological approach of Pastoral Care and the role of the PCG based on the same approach of Pastoral Care were articulated as interpreting and assessing pastoral needs. Pastoral assessment of patients is a necessary component for Pastoral Care engagement in the hospital, as it could guide the success of the engagement of Pastoral Care in hospital care. Therefore, it was argued that interpretation is the bedrock of good Pastoral Care as its other function. It helps in giving structure and planning of the pastoral encounter. Accordingly, it was argued in 6.6.1 that the overarching role of the PCG in the hospital is providing pastoral care to the patient. Without assessment, the PCG cannot provide Pastoral Care to patients in a way that can address their specific spiritual needs.

Given the above background it becomes necessary for this study to explore a Pastoral Care assessment framework or approach that the PCG can utilise in the Nigerian hospital context in his or her care giving to the sick. Given the background of Nigerian people and the context of care which is mainly a hospital setting, this assessment framework must take a holistic perspective.

6.7.1 Types of pastoral assessment approaches within the holistic pastoral theological framework

Pastoral assessment is both a state of perception and a process of information gathering and interpretation of care seekers' Pastoral Care needs (Fitchett, 1993:17). It can be done implicitly or explicitly (Topper, 2003:29-30).

Implicit/intuitive approach: Topper (2003:31) has argued that most caregivers do not immediately think of their care actions in terms of intentionally assessing the care-receiver's needs. They have used a more intangible and intuitive approach such as hunches, dreams,

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premonitions, spiritual insight etc. However, this position is changing as much literature in the past decade has been giving more attention to explicit pastoral/spiritual assessment of patients (Monod, Rochat, Bula, Jobin, Martin & Spencer, 2010; Hodge, 2001).

Explicit approach: The explicit assessment can be carried out in three major forms: the pastoral conversation, the semi-structured interview and the questionnaires.

Topper (2003:32) considers *pastoral conversation* as a means of making an initial pastoral assessment. Such pastoral conversation makes use of some open-ended questions. The second form is the use of a *questionnaire*, also known as quantitative method, which involves using a set of pre-formulated questions (Louw, 1998:478). The value of questionnaires may lie in the short time required for the assessment compared to the qualitative approach. Written questionnaires are best used with educated patients and patients who are not in a good condition to write unless there is someone to assist them. The third approach is the semi-structured interview with open-ended questions, also known as the qualitative method, which involves a formal dialogue with the patient guided by structured open-ended questions that can be modified to the patient's level of understanding. In the holistic pastoral theological approach the PCG could make use of any of the approaches that best suits the situation and the goal of the assessment. However, the question is why is pastoral assessment necessary?

6.7.2 The significance of pastoral assessment in a holistic pastoral theological approach

The importance and central role that assessment plays in the holistic pastoral theological approach to Pastoral Care (6.4) and other helping relations cannot be overemphasised (Hodge, 2001:211; Sherwood, 1998: 80-100; Fitchett, 1993:20). The importance of pastoral assessment of patients pastoral needs in the hospital could be summed up with Fitchett's (1993:20- 21) eight reasons for spiritual assessment. First, it provides the foundation for action through the careful and intentional facilitating of the caring process, which provides the basis for goal setting and eventual outcome. Second, it provides the foundation for communication with patients through which data and information can be gathered that can form the basis for action. Third, assessment provides the foundation for contracting. The contract or agreement enables the patient and caregiver to have a common goal and to work more purposely on the problem. It provides the basis whereby necessary supports can be enlisted for the patient's needs (Fitchett, 1993:20). Fourth, it provides the foundation for evaluation of the care process through feedback from both parties for continued action or revision of the goal or termination, as the case may be. Fifth, it provides the foundation for

personal accountability. By goal setting and enlisting the necessary resources available and evaluation of the process, assessment keeps both the caregiver and the patient accountable for the resulting outcome. Sixth, accountability leads to quality assurance of caregiving in the sense that feasible and realisable goals are set and a means whereby they can be evaluated. Seventh, pastoral assessment could establish a foundation for research and development of programmes that could improve the quality of care. Finally, pastoral assessment is the touchstone of professional identity; it defines and shapes what Pastoral Care does and does not do. This study agrees with Fitchet (193:23) that as stewards of life, PCGs must be careful to handle the task with which they have entrusted with great accountability for the lives that are placed in their care and the consequences of their intervention by ensuring that it is just and true. Because contexts and situations differ, there is no universal pastoral and spiritual assessment model. This reality has given rise to different assessment models according to the context and goal of the assessment. The table below shows some example of pastoral assessment models.

Table 4 : Pastoral assessment models

Inventor(s)	Assessment models	Assessment area
Monod et al.	SDAT	Meaning Transcendence Values Psychosocial identity
Topper	Four Spiritual Needs Model	Meaning Needs to give love Needs to receive love Needs for hope, forgiveness and creativity
Hodge	Interpretive Anthropological Framework	Affect, Behaviour Cognition Communion Conscience Intuition
Louw	Pastoral Diagnostic Chart	Faith analysis Religious analysis Theological analysis

Fowler	Developmental Stage Model	Trust Symbolizing/Fantasizing Moral development synthesising Individuation Reintegration Universalising
Capps	Thematic Model	Providence Grace/gratitude Repentance Vocation Vs. Inferiority Faith Communion Vocation, generativity Vs. stagnation Awareness of the Holy

Source: Compiled by the researcher

Most of the pastoral assessment models above are built on previous models. It could also be observed that each of the models is an attempt to improve on a previously existing model. In other cases they reframe the existing model. For instance, Topper's (2003:39-41) model of *four spiritual needs* is a revision of the American Nursing Association's *spiritual needs assessment model*, while SDAT is an adaptation of Topper's four spiritual needs assessment with modification. Hodge's model involves a renaming of Fitchet's spiritual dimension of his model. In the opinion of the researcher, each of the models covers a particular area of interest and method of assessment. For example Capps's *thematic model* aims to assess the patient using some biblical themes, Clinbell's *holistic model* looks at the dimensions of the individual, the story model assesses the needs of patients through stories, the rational-analytical model focuses on the problem area, and the *developmental model* assesses the needs of the patient through the identified stages of human development. Implicit in these models are assumptions of what Pastoral Care needs entail for the patients. This explains the rigidity of the models. For instance, the stage model has been criticised as imposing predetermined levels and structures on the patient's spiritual experiences rather than accepting the client's stories on their terms (Hodge, 2001:206). Furthermore, Monad et al. (2010:6) argue that structure assumes the idea that patients' spiritual needs can be put in a box.

However, as noted by some scholars, spirituality is dynamic and cannot be so quantified (Franklin & Jordan, 1995:281; Hodge, 2001:204) and therefore calls for flexibility. Undoubtedly, the models so far discussed provide rich assessment tools and perspectives through which the PCG can engage in the pastoral assessment of the patient, but on closer investigation they seem to be fragmentary. What, then, is needed as an approach for pastoral assessment that allows for flexibility and creativity for these models to be used in the assessment of patients in such a way that useful elements of different models can be used for the benefit of the patient? This also enables the utilising of a variety of resources to get the job done without being limited to the limited space and resources of a particular method or model.

6.7.3 Holistic pastoral theological approach for pastoral assessment

Scholars such as Topper (2003:46) and Fitchett (1993:90) have suggested that a caregiver can adopt any model for spiritual assessment or create his or her own model. PCG can choose from, modify or create his/her own model based on their specific goals, context and process (Fitchett, 1993:90-100). Topper (2003:46) has also argued that a good approach to pastoral assessment must be both functional and substantive.[97]

According to Fitchett (1993:90), selecting an approach to use for pastoral assessment or developing a new one can be based on three major guidelines: (1) the PCG's concept about the spiritual aspect of life, which he argues could be explicit or implicit, functional or substantive, have one or more dimensions, be static or developmental, with a dynamic perspective and be holistic; (2) the PCG's concepts of norms and authority in the assessment process. This, according to him, should address questions of power. Does the patient have an active or passive role to play in the process and in defining the result? Does the approach assume a context of growth or dysfunction? (3) The third guideline addresses the context and process. The process here refers to the form in which the assessment should be carried out. The process is in part influenced by the context in which the assessment is carried out. The process also determines the form of assessment. In terms of the process, this study proposes that the caregiver adopts the most appropriate framework depending on the goal and the skill of the PCG. Therefore the assessment process can be facilitated through informal conversation and the use of semi-structured questions and questionnaires where appropriate.

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[97] A substantive model of pastoral assessment refers to what the person believes or the substance of meaning. Functional model implies how a patient lives his or her meaning or belief.

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The context and process should take into account the setting in which the approach can be used, the form of the framework, the relationship of the framework to the clinical ministry process, how much training is required to understand the framework, and how much time it takes to use the framework. Also, Topper (2003:87-88, 145) suggests that such approach should be guided by the end goal of the Pastoral Care intended. Furthermore, the language used should be understandable by the patient, especially where it involves questionnaires. In addition, Topper (2003:87-88, 145) counsels that such approach should be guided by the end goal of the Pastoral Care intended. Furthermore, the language used should be understandable by the patient, especially where it involves questionnaires.

Consequently, the holistic pastoral theological approach as a hermeneutical approach adopts a multidimensional approach and hermeneutical stance to the pastoral assessment of patients. It allows for the utilisation of different frameworks. It also recognises that there are times that the single framework could be used to make a simple assessment. For instance, the complex framework is not needed to assess the religious background of the patient. In other instances a comprehensive framework might be necessary in order to make a comprehensive assessment of the care seeker's pastoral needs. This suggests that the PCG in the Nigerian hospital context can adopt from the various assessment frameworks the tools and approaches that may suit his/her Pastoral Care goals for an encounter.[98] However, it is important that PCG generally holds to a holistic perspective when undertaking a pastoral assessment of patients' needs. In this sense it requires a holistic framework. Such holistic framework should consider the holistic dimension as well as the spiritual dimension such as the 7x7 holistic framework designed by Fitchet (1993:42). Table 5 below illustrates an example of the content of holistic approach to pastoral assessment using the 7x7 model.

Table 5: the 7x7 framework for pastoral assessment

Holistic dimension
Medical component
Psychological component
Psychosocial component
Family systems component
Cultural component

[98] In the view of this study, the Interpretive Anthropological Framework (IAF) is a reframing (renaming) of the spiritual dimension of the 7x7 model in anthropological language. The value of the IAF is providing open-ended questions that can become readily available for the PCG to analyse the spiritual components.

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Community issues component **The spiritual component** Belief and meaning Vocation and consequences Experience and Emotion Courage and Growth Ritual and Practice, Community Authority and Guidance

Source: Adapted from Fitchett 1993:42

The holistic pastoral theological framework embodies holistic and spiritual components. The 7x7 model is illustrated in Table 5 above.

The holistic component: The holistic dimension is guided by the fact that the human person is a connected whole. What affects one aspect of a person's life directly or indirectly affects other dimensions of that person. The PCG, who assesses the spiritual dimension of the patient without understanding the holistic components of **medical**, **psychological**, **psychosocial**, **family systems**, **ethnic and cultura**l as well as **societal components**, is potentially at risk of making an inappropriate assessment. For instance, some drugs can affect the mood, behaviour and the psyche of the patient, in such a way that the patient might experience disturbances in his or her dreams as a spiritual attack. A PCG who has no idea of such reaction could be tempted to evaluate it as a spiritual attack. Evaluating the patient in the holistic dimension can afford the PCG an opportunity to discover a problem and refer appropriately. Furthermore, a person is a product of the society whose ethnic and cultural heritage influences the way in which he or she experiences care or lack of care, his or her illness behaviour and coping skills (Chapter Two). In Fitchett's (1993:44) view, "The assessment process needs to include these perspectives in order to avoid inappropriately imposing values from one's own culture".

The spiritual component: Fitchett is convinced that the spiritual dimension should include **beliefs and meaning, vocation and consequence, experience and emotion, courage and growth, ritual and practice community as well as authority and guidance**. These spiritual categories resonate totally with the Nigerian spiritual perspective. The spiritual dimension

explores the *beliefs and meaning* of the patient, according to Fitchett (1993:47). However, people derive meaning and purposefulness in life through participation in a community that is shaped by their beliefs and values, which are often influenced by religion. Also their belief about what they are called to do influence their vocation and their sense of fulfilment.

Other equally important components of the spiritual dimension are *experiences and emotions*. Fitchett (1993:47) argues that many people undergo a core spiritual experience, which indicates either an encounter with God or the devil, or other events which may have lasting effects on them. An example of such experiences in Nigerian parlance is a demonic encounter with witches and sorcerers, and having vision or spiritual foresight.

Fitchett's consideration of *courage and growth* is another important and relevant component. The patient's experience in life may have an influence on his or her ability to change and make adjustments. Therefore courage in the patient is viewed in terms of the patients' ability to "enter into a spiritual doubt, to tolerate times when we reject as false or inadequate some or all of what we have previously believed … it is also the courage to experience a conversion, turnaround, and breakthrough" (1993:47), rather than being brave or tough. The question regarding courage and growth is how people are able to adjust their attitude, aptitude, beliefs and norms in the face of challenging situations.

Rituals and practices are means through which people derive purpose and identity, therefore a necessary avenue to assess. Assessment could involve questions of how a person's participation in worship affects his or her life. Or what does partaking of Holy Communion mean to him or her?

The participation in ritual and practices may also reveal the patient's value for the community. Community provides the context for rituals for Nigerians. They are also avenues of discovering meaning and fostering their human dignity (cf. 4.5.3). As evident in 3.7.2 of this study, rituals and practices are part of the identity of Nigerians and as such should not be omitted from the assessment approach.

The last aspect in the holistic pastoral assessment framework is *authority and guidance*. Authority and guidance focus on where people find the authority for their beliefs, meaning, sense of vocation and duties and for their ritual and practices (Fitchett, 1993:50).

This study assumes the 7x7 framework upholds a holistic perspective. It provides a general framework for organising the data for a more detailed spiritual assessment and subsequent

plans for intervention. For each of the items in the framework, different approaches could be used. In the view of this study this framework builds on other models and creates room for the use of other frameworks. Holistically, the content of 7x7 could be expanded with other frameworks of the substantive category, e.g. using Louw's diagnostic chart for assessment of faith, religion and God images of patient of the same faith as the PCG. Louw (1998:320) argues that his pastoral diagnostic chart for assessment of faith is a substantive approach to 7x7 frameworks. Therefore the holistic pastoral theological assessment approach is flexible in the sense that it allows room for the caregiver's creativity, imagination and spontaneity. This framework also fits into the interfaith and multidisciplinary perspective of Pastoral Care in the hospital for professional PCGs, while not ignoring the parochial perspective of pastoral visitors and the volunteers.

In terms of the method of assessment, this approach utilises or favours the conversational approach, which allows the patient to tell his/her stories and share his/her concerns in his/her own terms. This allows for a trusting relationship (1993:41) and reduces the risk of a breach of confidentiality. Some scholars have suggested that pastoral conversation which is less intrusive should be used by pastoral visitors and volunteers who have less training on the quantitative and qualitative instruments of pastoral assessment (Topper, 2003:69). Yet 7x7 could also be adopted into semi-structured interviews for the initial assessment of patients in the hospital for intervention (e.g. McSherry's in Topper (2003:85) or Hodge's Interpretive Anthropological Assessment; cf. Table 5 below).

The 7x7 frameworks and sample of IAF open-ended questions are tabulated below in Table 6 to show how one framework could be used to augment another in the holistic pastoral theological framework. In Table 7 below the 7x7 framework is also presented alongside other spiritual tools that can be used for assessment.

Table 6: 7x7 framework and sample open-ended questions

7x7 Holistic framework (spiritual Dimension)	Interpretive Anthropological Framework	Open ended questions (IAF)
Belief and meaning	Affect and cognition	**Affect**: How does your spirituality give you hope for the future? What aspect of your spiritual life give you pleasure? What do you wish to

		accomplish in the future? What role does your spirituality play in handling lives sorrow? Enhancing joy? Coping with life's pain? **Cognition**: What are your current religious/ spiritual beliefs? What are they based on? What belief do you find particularly meaningful? What does your faith say about personal trials? How does this belief help you overcome obstacle. How does your belief affect your health practices?
Vocation and consequence	Implied in affect	
Experience and Emotion	Intuition	To what extent do you experience intuitive hunches (flashes of reactive insight, premonitions, spiritual insight)? Have these insights been strength in your life? If so, how?
Courage and growth		What sort of personal experiences stand out for you during your years at home? What made these experiences special? How have you changed or matured from these experiences?
Ritual and practices	Behaviour	Are there particular spiritual rituals or practices that help you deal with life's obstacle? What is your level of involvement in

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		faith-based communities? How are they supportive? Are there spiritually encouraging individuals that you maintain contact with?
Community	Communion	Describe your relationship to the ultimate [God]. What has been your experience of the ultimate? How does the ultimate communicate with you? How have these experiences encourage you? Have there been times of deep spiritual intimacy? How does your relationship help you face life challenges? How would the ultimate describe you?
Authority and Guidance	Conscience	How do you determine right and wrong? What are your key values? How does your spirituality help you deal with guilt (sin)? What role does forgiveness play in your life?

Source: Compiled by the researcher

Note: The questions are framed within an inter-disciplinary, interfaith context, allowing the framework and questions to be used with patients who may not share the same religious faith with the PCG. These questions are not rigid either in sequence or language; rather they are guides, hence could be reframed to suit the particular patient, context and the goal of the caregiving (Hodge, 2001:208).

Table 7: 7x7 framework and other spiritual tools that could be used

Spiritual Dimension	**Other spiritual tools**
Belief and meaning	Louw's pastoral diagnostic chart for assessment

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	of faith, religion and God images (Louw 1998)
Vocation and consequence	Louw's stage Model 1998
Experience and Emotion	Veach and Chappel Spiritual Health Inventory(SHI)Veach and Chappel (1992:142-143), Louw's Spiritual awareness exercise(Louw 2008a:228)
Courage and growth	Genia's Spiritual Experience Index (Topper, 2003:81, Genia 1997), Fowler's, Ivy"s and Capps Developmental Models.
Ritual and practices	Maloney's religious assessment tool, Sacramentally Focussed Religious Assessment (Topper 2003:64)
Community	McSherry's Religio/Spiritual Index (1978), Louw's pastoral diagnostic chart
Authority and Guidance	Ellison and Paloutzian's Spiritual Well-being Scale (Topper, 2003:71), Maloney's religious assessment tool (Topper, 2003:61-3)

Source: Compiled by the Researcher

The holistic pastoral theological framework for pastoral assessment such as it illustrated by the above examples has the advantage of presenting the PCG in the Nigerian hospital context with various resources to suite the PCG's skill, purpose of assessment and context. The holistic pastoral theological approach therefore emphasises flexibility and appropriate utilisation of models created or adopted.

Appropriate assessment of the Pastoral Care needs of patients and the utilisation of appropriate pastoral assessment resources requires education and continuous training of the PCG. The next section describes training for hospital PCGs and volunteer or hospital-at-home PCGs.

6.8 Training and curriculum for PCGs

Assessment skills require training in the relevant areas. The holistic pastoral theological approach takes into consideration the issue of training of PCGs for their specific context and the required curriculum that should dictate the content of such training. Based on the

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professional and specialised concerns of this study that could complement the parochial approach as it relates to engaging PCGs within the hospital context, the training and curriculum entails three levels: Level 1 professional PCG, Level 2 hospital-based volunteers and Level 3 hospital-at-home PCGs. It is also assumed that, although this form of training will primarily address specialised and professional care givers, it will also make provisions for volunteers and non-professional PCGs.

6.8.1 Level 1 Training: Professional PCG

Level I training is the professional-level training which has two options.

Level 1 Option 1 Training

This training is carried out in accredited centres (mostly located in the hospital) known as Clinical Pastoral Education (CPE) (cf.3.3.2),[99] of which there are none in Nigeria. According to Daniel Susanto (1999: 63) CPE is a model of pastoral education that has basic components of goals, method and programs.

Goal: According to Susanto (1999:63), the general goal of CPE is to enhance pastoral ministry, which could be described as helping the student to develop awareness of his pastoral identity, pastoral skills, and of himself or herself, thereby enhancing personal growth.

Method: The above goal is carried out through *reflection* of pastoral *action* under *supervised* conditions. Action is engendered through pastoral interaction and relationship with patients, peers, supervisors, medical professionals and institutional staff and in worship situations, although the patient remains his or her primary source of encounter. These encounters or helping relationships are evaluated through reflection on the written Verbatim [100](Miller-McLemore, 2008:8 & Susanto, 1999:70

The programme: According to Susanto (1999:75) and Miller-McLemore (2008:9), the programmes of CPE vary from centre to centre; however, there are basic elements of CPE that are common to all. These basic programmes are Pastoral Care to persons in the CPE institutions, reporting such Pastoral Care practice through verbatim reports, leading worship

[99] See CPE website, Gerkin (1996) and Jones (2006) on the development of this model of training.

[100] Verbatim report is a written version of the pastoral conversation from memory after the conclusion of the pastoral conversation. The intention is to reproduce as closely as possible the actual conversation between the PCG and the patient. This takes the format of a dialogue but also contains other components such case history, coded name, gender, occupation, marital status, age, religious affiliation and physical condition of the patient as well as an interpreted and analysed version of the conversation by the PCG (Jones, 2006:129).

and reporting this service for the group discussions, individual supervision with supervisors, and peer group activities. It also includes theory which consists of seminars and reading assignments on several themes. At the beginning of the programme the student is required to write a contract as well as a report at the end of the programme.

CPE is a form of education that is lacking in Nigerian theological colleges[101] and hospitals. Yet it is a form of education that is much needed in Nigeria (Nwachuku, 1994:83). CPE makes a contribution to pastoral education; theologically CPE gives the student the opportunity to make his/her theology actual and relevant to the concrete situation. It must be noted that the role of CPE is only a supplement to the theological education of pastors, which is usually acquired in a seminary or university (Susanto, 1999:168). Heitink (quoted in Susanto, 1999:168) argues that if Pastoral Care is to maintain its place in the market of mental and spiritual care, professionalisation is essential. “Pastors will have to show themselves to be professionals, capable of inter-disciplinary cooperation with representatives of other helping professions”. Although CPE makes a contribution to pastoral education, that does not mean that CPE is enough for educating someone to be a pastor or to do Pastoral Care. Nevertheless the value of CPE lies in the fact that it is flexible and could be adopted and adjusted into any context. Because CPE originated from the clinical/hospital setting, it is one of the best models for Pastoral Care to the sick in the hospital. Therefore this study proposes that training for PCGs for hospital caregiving should necessarily incorporate elements of CPE.

However, since CPE is not yet evident in Nigeria, those interested may therefore be required to train outside of the country. Such centres are available worldwide.[102] Some professionals are trained in the university, divinity schools or seminaries as part of their degree programme, while others take up a professional training in a CPE-accredited centre after their degree programme in theology, psychology or related field. Therefore, in the Nigerian context the PCG who desires CPE professional training may necessarily have to take up such training beyond of the shores of the country, until such time as centres are established in Nigeria. Although this study considers this training valuable, it is very expensive and may therefore cut down on the number of professionals trained. However as has been noted, CPE is not

[101] Uka (1994:151) came to this conclusion after surveying major theological seminaries. After many years the situation has not changed.

[102] Information for training may be found in such websites as www.healthcarechaplaincy.org , www.nhs-chaplaincy-spiritualcare.org.uk, www.uams.edu/cpe/training_programs, www.acpe.edu/studentsIntlStudents.html etc .

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generic and could be adapted to suit each context. For CPE to be appropriate and meaningful, it should be suitable to the context in terms of education, theological training and ministry practice. This is because CPE is a theological activity as well as a model of education (Susanto, 1999:191-192). In this light, an alternative option for training of professionals is presented below.

Level 1 Option 2 Professional Training

The option 2 training involves a process that could work in that such training centres could be started in Nigeria by inviting some professional caregivers working in the different disciplines of healthcare in collaboration with the pastoral facilitator. It would be advisable that such training take place in the hospital. This would allow the co-optation of medical professionals to give the clinical part of the training to the PCGs as well as bring the PCG closer to where the sick are. Organising training in the hospital setting could improve the nature of collaboration, as discussed in 5.4. In this regard this study finds Jim McManus's (2006: 668-669) model of training of professional PCGs valuable; he believes the model could be adapted to different contexts.

McManus's (2006:668-669) multidimensional approach identifies six domains that the PCG's training should focus on: theological, spiritual, ministerial, reflexive praxis and development, sectorial knowledge and skills, and health and social sciences applied to chaplaincy. According to him, "[a] domain-based approach provides both the flexibility for different faith groups to meet the part-faith and part-function education of chaplains" (McManus, 2006:669).

Theological: Theological training includes the requisite knowledge for faith communities which the ordained and non-ordained full-time PCG may have.

Spiritual: This includes include personal life and discipleship, prayer and worship life.

Ministerial: Ministerial skills include interpersonal skills including self-care and working with others, boundaries and effective interpersonal intervention.

Reflective praxis and development: Reflective praxis and development includes one's spiritual life and development. This involves recording and analysing of verbatim reports on psychological, sociological and theological issues emerging from the encounter with the patient.

Sectorial knowledge and skill: Sectorial knowledge and skills is focused on health issues, structural and cultural competence, e.g. healthcare policies and practice.

Health and social sciences applied to chaplaincy: This dimension of training may include the sociology of health and illness, psychological aspects of health and illness, psychological development across the lifespan, health behaviour, stress and anxiety, coping, grief and bereavement.

McManus's (2006:668-669) model is useful for this study because it provides ample opportunity for multidisciplinary training of PCGs, where the different disciplines collaborate to provide holistic training that takes into consideration the complex dimensions of illness. As is obvious from the above, the training of professional PCGs for the hospital context goes beyond faith traditions and practices to incorporate other related fields of healthcare. Such collaboration could help strengthen the team vision with shared benefits, mutual respect, complementarities and shared goals as envisaged in Chapter Five. However, this model may represent an ideal and could be adjusted to fit the Nigerian context. Such modification may involve adopting the level 2 volunteer and parochial model of Pastoral Care.

6.8.2 Level 2: Volunteers

Volunteer Pastoral Care service has numerous advantages. Cobb (2006:96) emphasises that firstly it presents unique opportunities for people to volunteer their services to caring for the sick. These services may include visiting patients in hospital wards, accompanying patients to chapel services, running errands for patients such as buying food, helping them in their personal hygiene, and giving them Holy Communion (for the ordained volunteers). Such volunteer PCG's services will be a great support to the patient, whose family may not be available because of circumstances beyond their control. Furthermore, they can serve as links between local faith communities, the professional chaplain and the hospital organisation in general. Thirdly, they make support more available to a wide range of patients. It reduces the hospital cost of recruitment and payment of the full-time professional chaplain. Fourthly, it increases the reach and profile of chaplaincy within the hospital (Cobb, 2006:96). Volunteerism becomes an important aspect of caregiving as part of the vision of holistic care. Joda-Mbewe's argument for the involvement of laity in missions within the Malawian context can also apply for Pastoral Care, which is also a mission in a sense. According to Joda-Mbewe, "involvement of laity in missions seeks to empower the laity for holistic ministry ….as all God's people have the right to be gospel bearers" (2002: 253-253). His

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argument is premised on the fact that professionals will always be few as resources are too scarce to train sufficient numbers.

Training of volunteers: According to Cobb (2006:96), recruiting and selecting suitable people for volunteer roles requires careful preparation and well thought-through processes. Similarly, Janet Brown (2004:203) an African has also lent her support for the training for volunteers. In this regard, Cusack (2003:142) has described the basic plan of action for volunteer recruitment and training as well as writing a volunteer job description, determining the method of recruitment, organising training, discussing the process of supervision and evaluation and sustaining volunteers. The above as outlined by Cusack means that volunteer's work does not mean doing whatever or however one likes, but must abide by certain standards such as being organised, supervised and evaluated. As a part of meeting the required standards of volunteer service, writing a job description is imperative.

Writing a job description: This, according to Cusack, describes the specific task to be done by the volunteers. In the case of the hospital volunteer the task involves visiting the sick in the hospital. Volunteers should be made to understand what is expected of them. For instance, they will be supervised and evaluated as well as given information about the needs for training and development and they will be supported.

Recruitment: Cobb (2006:97) and Cusack (2003:142) argue that recruiting volunteers requires well thought-through processes. Brown (2004:203) in her participatory action research (PAR) for her PhD in Africa suggests that the baseline criteria for selecting volunteers should be those who demonstrate a "heart" for the sick (i.e. compassion), and possess an ability to learn through training as volunteers. This includes availability when needed and patience (Cusack, 2003:143). Such people could be sorted into the faith groups (Brown, 2004:203) or by other means (Cusack, 2003:142).

Training: Training and orientation may incorporate other professionals within the field of healthcare to give an inter-disciplinary character to the training. Therefore, training could include social/interpersonal skills, listening skills, empathy and compassion, understanding boundaries, and the ethics of hospital care (Cusack, 2003:143). The duration of training is to be determined by the level of education and skills of the participant. Training coupled with their talents and strengths gained from life and work experiences can make them more competent to work more meaningfully with the sick. At the end of the training a graduation ceremony could be organised and certificates stating their areas of training could be awarded

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to the volunteers (Brown, 2004:12). The awarding of certificates could add to the authenticity and seriousness of the training. It could be a form of reward and incentive for their time and services, since they may not have monetary rewards. The training programme also gives the facilitators the opportunity to observe and work with candidates and to evaluate their suitability for the role.

Supervising and evaluating: "Supervision entails providing formal or informal opportunities to speak with volunteers about their experiences as they attempt to reach out to the [sick]". The purpose of supervision and evaluation is to give volunteers an arena in which to ask questions, share stories, express concerns, and, more important receive affirmation (Cusack, 2003:144). Brown (2004:212) strengthens the argument even further when she argues that "this is a significant consideration when one realises the emotionally draining tendency that comes from caring for the types of patients that will be cared for by the volunteers. Since the volunteers will be receiving no monetary reward, it is especially important they are given a strong sense of accomplishment and motivation from within their own rank every one or two weeks for emotionally sharing time". In the case of the volunteers a written evaluation may not be necessary unless so desired by the volunteers.

6.8.3 Level 3: Hospital-at-home PCGs

The Level 3 training is informed by the understanding that caring for the sick is a ministry of the whole community of faith. As was already stated in Chapter Four, all pastoral visitors are spiritual caregivers to their care receivers. This training is done to bridge the gap between the hospital and the home (Brown, 2004:212; Ndhlovo, 2008:78); in other words they serve as PCGs to hospital-at-home patients (1.8.3). Some patients who are discharged might need continued spiritual care, beyond the availability of the chaplains. From this understanding, the third level of training might take place in the church or mosque where the pastoral visitor is trained for the needs of the members in the faith community who are sick, hospitalised or who are homebound. This training is provided for pastoral visitors. It also provides an opportunity for the whole faith community to receive basic training for the caring of their sick and loved ones. The target groups are all members of the faith group and members of the family. Scholars such as Magezi (2005:220), Susanto (1999:210), and Reimer and Wagner (1984:42) have suggested that Pastoral Care training should not be far removed from the faith community, meaning there should be more training available for a greater number of people. This is because "when the patient faces discharge, hospital staff will frequently realise that a

referral service for follow-up is needed. At times, especially in rural communities, the pastor or Imam is the only available helping resource" (Reimer & Wagner, 1984:42). As was evident in Chapter Two (2.6.3, 2.6.3.2), most hospitals are situated in the urban areas, while in some rural areas there are neither hospitals nor clinics. Magezi (2005:220) has argued that churches (and in some instances mosques) are the only community institutions apart from schools in many African communities; hence they are used by many organisations as a point of distribution for medical relief. Magezi's observation also reflects the Nigerian scenario. Training within the church and other religious groups is inevitable in the light of 2.2.4 and 2.6.2, which discussed the role that religious organisations play in healthcare. Skill is not emphasised at this level, because most pastoral visitors are known by the care receivers, in which case trust has already been built. However, training could provide them with more resources to be more effective PCGs to their family, friends, neighbours and fellow religious group members. As Reimer and Wagner (1984:42) rightly argue, training becomes important as good intentions are never enough (Reimer & Wagner, 1984:42). Therefore, the hospital-at-home PCGs need some form of training and skills development to carry out certain tasks more effectively.

Reimer and Wagner (1984:93-101) have suggested three models of training lay PCGs which are well suited and can be adopted for this study's task. These models are: Model 1 – informal resourcing; Model 2 – recruitment and network-building; and Model 3 – training lay care-giving teams.

Model 1: As Reimer and Wagner 1984:94-95 explain, this model is suitable for a small church (or mosque) of less than 100 members. As such, the training can be done informally through sermons, reminding the members of their responsibilities to care for one another in joy or sorrow. Guidelines for good visitation to members in hospital or hospital-at- home can be offered to the members through this medium. Furthermore, the pastor or imam can identify members and engage them to visit the sick members. This is because the first model is what the Nigerian churches are involved in. Here the role of the pastoral visitor is more limited than the volunteers in the second level and the professionally trained PCGs in level 1.

Model 2: This model is for middle-sized churches (or mosques) of 100-250 members. According to Reimer and Wagner (1984:96-98), this model augments the first model by being more organised. This implies that the pastor or imam selects members who have an interest in caring for the sick and have skills in listening. Reimer and Wagner (1984:97)

observe that the existing groups in the church (boards, study groups, Sunday school groups and fellowship groups) can be ready platforms for training. Or they might "develop intentional networks of support for people in any time of crisis". These can be done geographically (many churches in Nigeria operate cell groups which can also serve this purpose), by interest, or by commitment. Within the Nigerian context, it is suitable to provide training for this group over one weekend every quarter. The group meeting times can provide an immediate opportunity for feedback and mutual support.

Model 3*:* Reimer and Wagner advise that for churches more than 250 and mega-churches or mosques, hospital visiting must be done systematically. In that regard, the training of pastoral visitors for service to its members may resemble Level 2 training above. The difference between Levels 2 and 3 is that while Level 2 training takes place in the hospital setting and the PCG visits members and others who might request a visit in the hospital as a supplement for the professional PCGs, the Level 3 services may be primarily to its members of the faith community and family and friends. Reimer and Wagner's church-based training programme is similar to Ndhlovu's (2008:79-79) church training programme for home-based (hospital-at-home) care. This model was utilised within the Zambian (African) Church context. As Ndhlovu reported in his doctoral dissertation, it proved to be successful in providing training for rendering care to people affected by and infected with HIV and AIDS in the comfort of their homes. According to him, the training and activities included training for family infection control, nutrition and basic nursing care, counselling clients and family members about disease, provision of pastoral support, prayer and Bible reading. It also included linking patients with health centres and hospitals for specialised care, provision of material services and nursing services as well as housekeeping (Ndhlovu, 2008:78-79). Professional or specialised Pastoral Care and volunteer or non-specialised Pastoral Care require attention to pastoral ethics, which may involve professional standards and an ethical code. Such an approach is also consistent with the holistic pastoral theological approach.

6.9 Pastoral ethics, professional standards and ethical codes for the PCG

Chapter Five of this study focused on the normative task and argued that collaboration between PCGs and medical professionals raises ethical issues that should be considered. That chapter provided an interpretive guide on what the professionals in collaboration ought to do. However, it did not provide strategies for such ethical action that can influence the praxis of Pastoral Care for the desired quality care. Therefore, this chapter, and more specifically this

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section, which deals with the pragmatic task, provides strategies for ethical action. The questions guiding this section are: How can PCGs provide more effective and relevant Pastoral Care to patients in the hospital? How do PCGs as individuals and as professional groups exercise responsibility in caregiving? These questions involve ethical decisions and conduct. Hence, this section is concerned with the professional ethics of the PCG in the healthcare context. The code of ethics entails discussions and cautious consideration in professional Pastoral Caregiving.

Don Browning has suggested that Pastoral Care should consider itself a dimension of theological or religious ethics. He implies that it is the primary task of Pastoral Care to bring theological ethics and other areas of professional ethics into the context where it is practised. Bush (2006:17) posits that pastoral ethics could be understood to share with other areas of applied professional ethics a common tradition of moral discourse. "We [PCGs] must draw on the best moral insights we hold in common with other professions, so others with whom we reside in society and with whom we share cultural patterns of meaning can appreciate or judge our own professional ethics" (Bush 2006:17).

Central to the ethics of responsibility theory is the "self" in understanding theological and healthcare ethics. This is because PCGs are involved in caring relationships which tend to be nurturing and healing, but also have the potential to be destructive (Cobb 2005:156). This is because of the power dynamics involved in the relationship. Therefore Cobb (2005: 156) advises that PCGs should exercise their power with sensitivity, discernment and with ethical boundaries. This then becomes a matter of personal character which Joseph Bush (2006:5) calls the "ethics of being". Character, as he defines it, is a personal capacity to will and do good (Bush 2006:6) Ethics of being attends less to the person as a moral agent and more to action itself and options for responding that may be present in a given situation. Booij and Leeuwen (2008: 180) caution that ethical behaviour requires more than an application of standards or rules and protocol. It also demands that professionals recognise their own moral views as well as those of the patient. As such, responsible behaviour entails commitment that surpasses technological thinking. Therefore an ethics of being is also an ethics of responsibility.

6.9.1 An ethics of responsibility

The ethics of responsibility has received attention in pastoral theology (Louw 2008:285; Eybers 1991:55-86), social and medical science (Oyetunde and Brown 2012). Eybers

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(1991:55-86), building on H. Richard Niebuhr's ethics of responsibility for his pastoral ethics, states that the self is central to the understanding of the responsibility theory. He argues that Niebuhr's ethics are so appropriate for his pastoral ethical task because Niebuhr is interested in the moral life and thus in a phenomenological analysis of human moral existence in the context of suffering (Eyber 1991:13). According to Eyber, people are agents, which implies that they are in charge of their conduct. As such, conduct is dependent on the person's interpretation of action within a community of shared meaning that is facilitated by "the responsible self" – a phrase coined by Niebhur (1991:13). Therefore an ethics of responsibility is related to values.

Eybers (1991:61) claims that there are four basic assumptions in the theory of responsibility: response, interpretation, accountability and social solidarity.

Response: Response is a moral action upon individuals guided by the person's [PCGs] interpretation of such action. As such there can be no response without interpretation.

Interpretation: Interpretation underlies a certain kind of response. Interpretation occurs when the person desires to know what is happening to him or her.

Accountability: Accountability has to do with the fact that in every response that a person makes, he or she takes into account that he or she can expect reactions to it. In line with this understanding, Eyber (1991:61) argues that accountability is another way of posing the question: To whom or what am I responding to and in what context? Hence accountability identifies the self-expectation of reactions to its own responses and the sense of judgment implied in that expectation. Therefore when a person responds to an issue, he or she expects others within the context to object, confirm or correct their responses in social solidarity.

Social solidarity: Social solidarity means that a person has a continuing and consistent relationship in a given community. This means that a responsible self-act is undertaken within a relationship, which in turn implies that the community is interdependent and self is part of the whole. All these elements of responsibility underline one fact – a degree of shared expectations is necessary for ethical responsibility to be mutually meaningful and acceptable. Therefore Cobb (2005: 93) advises that the Pastoral Care department "needs a clear and shared vision of its orientation, values and purpose that is understood and supported by all members".

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The above pastoral ethics of responsibility, in my opinion, also has some correlation with an ethics of responsibility from the social perspective of role theory. Although Eybers (1991:13, 55-86) made it explicitly clear that his foundation is theologically rooted in Niebuhr's theology, one could find other similarities with his conceptual elements of responsibility with role theory concept (c.f. 4.2). It is worth noting that Oyetunde and Brown (2012) have also found a correlation of the role theory concept with the nurse's professional ethics of responsibility and accountability. Responsibility from the role theory perspective strives to explain the behaviours of individuals in social institution through they roles the play. An ethics of responsibility from the perspective of role theory is based on four assumptions. Oyetunde and Brown (2012:109-110) summarise the four assumptions of the role theory of responsibility aptly:

- People define role for themselves and others based on social interaction, observation and learning;
- People form expectations about the roles that they and others play;
- People subtly encourage others to act within the role expectations they have for them;
- People will act within the roles they adopt.

PCGs' role behaviour is determined by role expectations of appropriate behaviour in that position (social solidarity) and changes in role behaviour occur through an interactive process of role sending and role receiving. Therefore the role expectations of professionals are of responsibility, accountability and conformity to ethical standards.

Consequently, Louw (2008:285-287) posits that an ethics of responsibility in health care addresses

- The quality of human decision making and the possible consequences for human behaviour, its impact on other human being beings, the quality of life as well as on the environment;
- The quality of motivation and intention
- The quality and character of human actions;
- The character of "respondability" and maturity;
- The quality of the hermeneutical process;
- The quality of human relationships and the interactions within the space of interconnectedness;
- The objective goals in life and the way they are connected to meaning and direction;

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- The appropriateness of information and knowledge as well as the interaction between science and human experience;
- The dynamics within the context.

Louw's ethics of responsibility implies that pastoral ethics in health care should be holistic in terms of ethical thinking, conduct and processes of decision making. In other words he advocates a holistic ethics of responsibility.

A holistic ethics is also propounded by Carla Mariano (2001) from the social spiritual perspective on health care. Carla Mariano (2001:np) explain that in the holistic ethics framework acts are not performed for the sake of law, precedence or social norm, but rather from the desire to do good freely for the sake of witness, identity and contribution to the unity of the whole. Therefore an ethics of responsibility emerges first and foremost from within one's own or the groups' character and perceived relationship with the event or environment. She points out that "[h]olistic ethics has it that no act, principle or person is independent, therefore an individual's actions have a ripple effect throughout humanity". Mariano is convinced that a holistic responsibility ethics encourages spiritual self-actualisation, with the belief that individuals who elevate their self-awareness in turn promote the whole community. Professional ethics in healthcare has often been approached from the perspective of responsibility and accountability, which entails maintaining professional standards.

Pastoral Care as a professionalised ministry in the hospital would be expect to maintain a professional standard and code of ethics to warrant collaboration with healthcare professionals and to ensure sound ethical practice and quality service. Rempel (2009:115) suspects that the absence of common standards of practice among the clergy may be the reason that health care institutions were reluctant for long to call on clergy, because they did not know what to expect from them. "Most pastors are accountable to their denominations. Some are accountable only to their congregations. Some ministers are self-appointed" (Rempel, 2009:115). However, as evident in Chapter Four (4.3.1 and 4.3.2), most contexts in North America and Europe have certain professional standards. In view of the above, PCGs in the Nigerian context should be able to articulate a standard for professional practice that is consistent and realistic in relation to the context.

6.9.2 Professional standards

Professional standards have to do with values and norms that guide the practice in setting the goals of the professional as well as upholding responsible behaviour and attitudes of

professionals. As a discipline Pastoral Care needs to be guided by certain principles and guidelines. Pastoral Care of people who come from a wide range of religious backgrounds, or with no religious background, at a vulnerable time in their lives requires specialised preparation, ongoing professional development and appropriate accountability in both public and faith-based institutions. This is necessitated by the fact that most healthcare professionals are certified by a professional body and, as such, they are accountable not only to their employer but also to their professional association (Rempel, 2009:115). Furthermore, a professional standard implies a response to the human dignity of the patient. It is our moral and ethical obligation to uphold the patient's dignity, honouring who they are. Cobb (2005: 107) puts it nicely: "it is because chaplains believe in the value, worth and possibilities of being human that they are morally committed to refrain from harming the people they care for and are obliged to ensure that their personal encounters must operate within the parameters of disciplined, competent and accountable practice". Thirdly, professional standards ensure proper accountability in personal, ecclesiastical, professional and administrative authority while avoiding compromise (Rempel, 2009:118).

The assumption is that PCGs can preserve the integrity of the faith of the patient without compromising the integrity of his or her own faith. In this regard, the Association of Professional Chaplains' code of professional standard states that professional standards and the code of ethics are "statement of hope and belief in the ability of professional chaplains to assume their rightful place among other helping professions who hold certified practitioners to specific standards of accountability for ethical behaviour". Thus Booij and Leeuwen (2008:180) argue that training, specialisation and experience are necessary to ensure consensus in decision making, although the way the standard should be applied needs reflection according to the peculiarity of the context and situation. To respond adequately to the situation the PCGs will have to be honest with themselves about the limits of their expertise and ability (Bush 2006:37). Bush's advice implies that PCGs set boundaries about their professional practice. Cobb (2005:108) observes that such standards should be hermeneutically discerned and should take into account predetermined factors such as the relationship to any relevant law, policy and guidelines, constraints of time and place, knowledge and understanding, skill and competency and professional code of conduct. Table 8 below illustrates some possible professional standards that may be considered.

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Table 8 Professional standards

1. Theological training. 2. May or may not be ordained, but must be endorsed by their faith community. 3. Adherence to a professional code of ethics and engage in ongoing professional development. 4. Work with patients of all faiths without attempting to proselytise them. However, if appropriate and requested to do so, they may share their own faith (Bueckert, 2009:48).

Professional standards help provide a reference for PCGs to recognise practices, actions and types of relationship that are opposed to ethical care and that may be or are actually harmful (Cobb 2005:109). For this reason professional standards always include an ethical code of conduct, which serves as a guide to PCGs' attitude and behaviour and actions with patients and family members and hospital staff.

6.9.3 Code of conduct

A code of conduct has been the authoritative ethical guide for addressing the moral and ethical dilemmas faced by professionals today (Code of Medical Ethics, 2010). The challenges the hospital PCGs may face include, among others, the fact that pastoral work is wide ranging and often relatively unstructured, informal and irregular (Cobb 2005:108), and as such may lead to role confusion and role blurring. However, hospital PCGs is responsible for their personal and professional conduct and must be able to justify their actions and practices to Pastoral Care seekers and institution and colleagues (Cobb 2005:155). Therefore, the Association of Professional Chaplains (APC) states its professional ethical code and its processes to support it are motivated by a concern for the safety and wellbeing of those whom they serve as well as of its members. "Ethical behaviour is a justice issue. Honesty about competency, clarity about professional roles and the ability to articulate and keep appropriate boundaries while still entering into empathetic pastoral relationship are critical to the public

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respect for trust in the work of professional PCG. However, the PCGs code of ethics should be seen in the light of restorative rather than retributive justice".

However, Booij and Leeuwen (2008:180) warn that professional ethical behaviour consists of more than a mechanistic application of rules and protocols and entails commitment that surpasses technical thinking. Professional behaviour, they say, should balance the personal aspect of commitment with the profession's code of conduct. Given the multiplicity of ethical views in contemporary society, any ethical code will require careful reflection and the best possible action. Such code of conduct incorporates the morals, socially acceptable principles and standards of right and wrong and values, philosophical , familial and cultural ideals that serve as a framework for an individual decision (Mariano 2001:np).

A code of conduct for professional PCGs is very important not only within the hospital environment, but also where such care is engaged. This is significant because healthcare organisations will expect PCGs in the hospital context to function effectively as a professional and organisational unit. The following may serve as guidelines for drawing up possible codes of conduct by the PCG in the Nigerian hospital context. This implies that these points should not be used in a fixed way, but should be adapted with sensitivity to the peculiarity of each hospital context.

1.) Act at all times in ways that promote trust and confidence in their profession.
2.) Act at all times to promote and safeguard the interests and well-being of those in their care.
3.) Affirm the equal dignity and worth of those in their care and respect their differences including, but not limited to, ethnicity, gender, age, disability, religion and spirituality.
4.) Respect the view that each faith group has a right to hold to its own values, traditions, beliefs and practices.
5.) Maintain good standing in their faith community.
6.) Ensure that their conduct, dress and personal appearance are consistent with their profession and appropriate to the setting in which they work
7.) Maintain clear boundaries in the areas of self-disclosure, intimacy and sexuality.
8.) Avoid areas of conflict but in the event that a chaplain has to withdraw on grounds of conscience, faith or ethical principles, endeavour to refer to another chaplain and facilitate the transfer and continuity of care.

9.) Respect confidentiality.

10.) Respect the autonomy of those in their care including the freedom to make decisions contrary to the beliefs, practices or opinions of the chaplain.

11.) Respect the skills, contributions and integrity of colleagues.

12.) Work in a collaborative and co-operative manner with colleagues and communicate effectively with them within limits of confidentiality (Cobb, 2006:155-161).

13.) Observe the hospital basic ethical code.

It is worth noting that maintaining good ethical conduct that is appreciated by all entails maintaining trust and respecting confidentiality.

6.10 Conclusion

This chapter has proposed an approach for Pastoral Care in the Nigerian hospital context that might be used by PCGs. The main hypothesis of this study was that the inclusion of the PCG in the Nigerian hospital space with an appropriate Pastoral Care approach can contribute to the quality of hospital care to improve patients' satisfaction. Within a post-foundationalist methodology of practical theology, it addressed the pragmatic task of theological interpretation. According to Osmer (2008:4), the task of theological interpretation deals with determining strategies for action that can lead to desirable change of the situation to what ought to be going on. In this regard, the holistic pastoral theological approach was proposed. It argued that Pastoral Caregiving within the Nigerian hospital context has to be approached from a holistic and intercultural perspective called the holistic pastoral theological approach.

The holistic pastoral theological approach incorporated the two main models of Pastoral Care giving in the hospital context, namely the parochial (volunteers and pastoral visitors) and professional models. Both models were found to have strengths that can be used to enhance care in the hospital and by extension the hospital-at-home. The parochial model is considered to give an opportunity to lay persons to engage in Pastoral Care to the sick as their religious responsibility to their fellow persons. Furthermore, it could alleviate the shortage of workers in professional caregiving, creating space for more hands to be involved. However, the nature of the hospital context favours a professional caregiving adopting the inter-faith perspective because of the pluralistic nature of the hospital. Professional Pastoral Care favours collaboration with other medical professionals, which promotes competence, skill and professionalism. From a professional perspective, it was argued that Pastoral Care should be offered to all patients who may require it and their needs for such so determined.

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The holistic pastoral theological approach is envisioned to assist the PCG in the Nigerian hospital context to attend to the Pastoral Care needs of patients appropriately. The holistic pastoral theological approach has been so proposed bearing in mind the cultural and religious background of Nigerians regarding issues of sickness and health discussed in chapter 2-5. The rationale for the development of this approach was based on the WHO (1998) report that elements of the faith, religious and personal beliefs of patient should be integrated into healthcare for more holistic care of patients. It is also based on the NHPPPHN (2005) health policy as well as the desire of many Nigerians for a more inclusive approach beyond the medical model.

Therefore in line with the above-mentioned rationale and the National Health Policy of Nigeria (2005), the goal is to provide effective, efficient, quality, accessible and affordable health service; the goal of this approach is to enhance the contribution of Pastoral Care to holistic healthcare within the space of the hospital. This goal implies that there is a relationship between Pastoral Care and the medical sciences in healthcare. This study established that such a relationship suggests an interdisciplinary collaboration and foundation for PCG engagement in the hospital. However, this study also highlighted that the holistic pastoral theological approach is distinguished from other healthcare approaches in its role and accountability as embodied in the PCG as representative of God and faith community, who also embody the central theme of restoration to wholeness. The holistic pastoral theological approach is able to deal with issues of forgiveness, fear of death, and hope which transcends the human situation.

From these distinctive qualities of the holistic theological pastoral approach, this chapter also established that it could make a distinctive contribution to holistic hospital care through a collaborative and team approach that has many advantages. This distinctive contribution also highlights the role of the PCG as assessing Pastoral Care needs of patients, presence, mediating salvation, forgiveness, confession, reconciliation and hope. In addition, it also attends to bereavement process, and provides pastoral support on moral and ethical issues as well as in networking, research and development. It further argued that such Pastoral Care roles are enabled by pastoral resources and practices such as prayer, Scripture, fellowship, sacrament, religious literature, anointing oil, music and dances.

The Pastoral Care resources further assist the PCG to carry out pastoral assessment of patients. The chapter attended to the processes of pastoral assessment. Therefore an

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assessment framework – the holistic pastoral theological framework – was proposed that could enable the PCG to make use of the existing tools or create his/her own assessment tool. This approach is an adaptation of Fitchett's 7x7 spiritual assessment frameworks. Fitchett's framework was found to be relevant to the study based on its embodiment of holistic and spiritual components. However, the chapter advised that such assessment should be done in such a way that the warmth and spontaneity of the helping relationship is not jeopardised.

Assessing Pastoral Care needs of patient appropriately, the chapter argued, requires training of the PCG in the relevant area. Consequently the study discussed three levels of training: the professional PCG, the volunteer PCG and the hospital-at-home PCG; such training could prepare those (PCGs) to carry out their services. Finally the chapter attended to professional standards and codes of ethics. It argued that the care of patients involves a moral and ethical obligation that requires a pastoral ethics of responsibility. It also drew on the NHPPPHN (2005) in terms of which caregivers should be brought in line with regulations that ensure adherence to rules and healthcare guidelines.

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CHAPTER 7

PCGS IN THE NIGERIAN HOSPITAL CONTEXT: EVALUATIONS, RECOMMENDATIONS, RESEARCH CONTRIBUTION AND CONCLUSION

7.1 Introduction

This chapter concludes this study on PCGs in the Nigerian hospital context from a pastoral theological perspective. The research hypothesised that the inclusion of the PCG with an appropriate holistic approach to the care of hospitalised patients could contribute towards quality care and greater satisfaction of patients in the Nigerian hospital context (1.4). Using a post-foundationalist paradigm and structured on the basis of Osmer's practical theological research design, this study discovered that PCGs' Pastoral Care resources and practices are of proven value. Following on this discovery, this chapter offers a synopsis of this study's findings. It also makes recommendations based on the study of the Nigerian cultural, political and religious and hospital situation as well as on best practices from the Western contexts where specialised and professional Pastoral Caregiving is practised. This will be followed by an outline of the possible areas for future research as well as the conclusion of the study.

7.2 Evaluation of the study's hypothesis and objectives

This section presents an evaluation of the hypothesis and objectives of the study, beginning with the hypothesis.

7.2.1 Evaluation of the hypothesis

This study posited that the inclusion of Pastoral Care and professional PCGs in Nigerian hospital care could contribute to more holistic hospital care and healing which will take into account the Pastoral Care needs of the sick, thereby enhancing the quality of care and satisfaction of patients in hospitals. This hypothesis is based on the assumption that the current biomedical approach to healthcare and indeed hospital care in Nigeria does not address the Pastoral Care needs of patients significantly. Spirituality and religion play a role in the coping, recovery and/or possible healing of patients in the hospital. Pastoral Care, whose unique resources and practices are of proven value, can contribute towards the realisation of a more holistic care and healing, especially through PCGs in the Nigerian hospital context.

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This study utilised the post-foundationalist research paradigm of practical theological methodology (1.6.2) in the investigation of this hypothesis. Accordingly, Osmer's (2008:4-12) four tasks of practical theology (1.6.3) were used to structure and organise information towards achieving the objectives of the study. The research used data gleaned from available and relevant literature, documented evidence-based and empirical findings from pastoral and practical theology and other related fields. Consequently this study confirms the hypothesis that professional PCG with a holistic pastoral theological approach to Pastoral Care is of proven worth and can contribute to more holistic care of the hospitalised patient in Nigeria, thereby improving the quality of care, patient satisfaction and eventual improvement of the quality of life. This hypothesis was confirmed through the following objectives that were outlined in 1.5 of this dissertation.

7.2.2 Evaluation of the research objectives

The objectives of this study in line with the hypothesis were:

- To explore health and healthcare in the Nigerian historical, socio-political, religious and hospital contexts with particular reference to Akwa Ibom State of Nigeria, so as to understand the factors that inform the context in which Pastoral Care may be required;
- To explore the theories of Pastoral Care with regard to health care in the hospital in order to understand the meaning and nature of Pastoral Care;
- To present the theological resources that the Pastoral Caregiver can bring to the Nigerian hospital context for a more holistic health and hospital care delivery system in Nigeria in the sense of bringing such resources to bear in the mediation of religious and spiritual care;
- To discuss how the PCG can collaborate with the health care professionals within the hospital context using an appropriate Pastoral Care approach;
- To explore an appropriate approach through which the PCG could function in the hospital context.

7.2.2.1 Health and healthcare in the Nigerian historical, socio-political, religious and hospital context

This objective was addressed in Chapter Two. In this regard it reflected on the traditional, Christian/religious and medical approach to health, sickness and healing in the Nigerian

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context. By employing Osmer's (2008:4-12) descriptive empirical and interpretive tasks to answer the question, What is going on? (1.6.3), its findings revealed that religious and cultural values are the means through which people conceptualise the meaning of sickness, healing and wholeness. These values also influence patients' sickness behaviour and healing practices and the meaning they derive from such practices. In this regard this study ascertained that religion permeates the fabric of Nigerian society. It plays very significant roles in the coping skills of many troubled Nigerians.

Furthermore, wholeness and health are among of the most important concerns of Nigerians and the global community as demonstrated by the millennium development goals (MDGs). The study has shown that Nigerians in pre-colonial Nigeria had defined ideas about sickness and healing that were enshrined in their cultural understanding of the body and body function. Thus, before the advent of medical science and Christianity, there was ATR and traditional healers who utilised religious and spiritual resources as well as herbs in their healing practices. For such Nigerians, and indeed Nigerians of succeeding generations, religion and medicine stem from one source and were – and are still – seen as complementary. In addition, the interrelated nature of sickness, poverty and hunger illustrates the complex nature of illness, which defies a purely scientific approach. Consequently, the study found out that three healing traditions exist in Nigeria – the traditional, the spiritual and modern Western medicine – and sick Nigerians may choose between and sometimes may combine all forms of healing practices.

However, although the contemporary Nigerian hospital has its foundation in the Christian and religious community, it currently significantly lacks the spiritual and religious component in its healing practices and intervention. It is modelled after the Western pattern of hospital caregiving which was brought to Nigeria by the colonial rulers and the missionaries. The practice of medicine in Nigeria has hardly undergone any significant structural and policy change, especially as related to Pastoral Care, since colonial times. This pattern undermines the cultural aspects of sickness and leaves little room for the spiritual and religious dimension. This means that what has been affected is the human dignity and identity of Nigerians. The study found that medical science, although beneficial, could not on its own meet the health needs of the sick, because of its limitations in addressing the spiritual needs of patients for meaning and purpose. Published studies of the perception of selected illnesses in Nigeria confirmed that modern hospitals have not been able to meet the health needs of Nigerians adequately. This limitation is notable because a spiritual quest is not only the

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concern of the patient, but also of hospital staff and organisations, who are also hungry souls at heart desiring spiritual and religious interventions. This limitation of modern medical practice drew attention to the boundaries of competence and created a space for collaborative practices. Inevitably, there is a spiritual gap that needs to be filled in Nigerian hospital care. Bridging such a spiritual and religious gap is seen to be the responsibility of Pastoral Care.

7.2.2.2 The meaning and nature of Pastoral Care

Chapter Three therefore investigated the meaning and nature of Pastoral Care. The chapter fitted into Osmer's (2008) interpretive task of practical theology. The engagement of this task was intended to ascertain whether Pastoral Care could be relevant to the spiritual and religious needs of patients in the Nigerian hospital context and therefore considered to be of proven value according to the NHPPPHN (2005) policy stipulation. The investigation of the theories and practices of Pastoral Care and the understanding of the resources of Pastoral Care confirmed the hypothesis that it is a relevant and most appropriate discipline of proven value for the mediation of religious and spiritual care in the Nigerian hospital.

As such, findings in the chapter revealed, in line with its objective, that Pastoral Care although extensively used to refer to the work of pastors is a concept used comprehensively to include the religious engagement of people both ordained and non-ordained within and outside their faith community. Therefore, Pastoral Care in general is concerned with human souls and their experiences within the physical, social and spiritual environment. Pastoral Care, as this study found, is not a monolithic concept but is expressed variously according to traditions, context and dispensational changes in the practice of care. However, the Christian tradition has always understood Pastoral Care as care of souls. Central to this tradition is the notion that Pastoral Care involves a response to the human experience. Hence, it is motivated by God's love for humanity exercised by faith communities for the benefit of all people. Therefore, the shepherding metaphor has maintained dominance among other metaphors in its use to express the nature of Pastoral Care. The different understandings, practices, methods and resource authority are in concert with the economic and global changes.

Consequently, through the investigation of the paradigms of Pastoral Care the study confirmed that Pastoral Care is a dynamic practice that responds to shifts in the contexts in which it is practised. The findings indicate that Pastoral Care in Africa, while rooted in biblical faith, should be enriched and supported by the clinical and social sciences and other fields relevant to the understanding of the person in a care relationship (3.10). The findings

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also showed that these models of Pastoral Care (as reflected in the shifts) were important expressions that can lead to the transformation of Nigerian society in general and specifically to the hospitalised patients in distinctive ways. The distinctive identity of Pastoral Care is founded on the theological standpoint of care. It was identified in the care of God in Jesus Christ, through the Holy Spirit as revealed in the Holy Scripture, carried out by the *laos* of God within the *communion sanctorum* of God's Kingdom. This uniqueness of Pastoral Care was further expressed in the goal, foundation and context of Pastoral Care. It has a connection with the social, physical, spiritual and ecological dimensions. The purpose is to cultivate spiritual growth and wholeness. As a result, the uniqueness of Pastoral Care shifts the approach of care from the medical model, which focuses on the disease, to the whole person within a complex of environmental influences and a network of relationships. As such it takes a holistic approach which does not ignore the interrelatedness of other dimensions in dealing with issues of ultimate concern and meaning. It concluded that Pastoral Care embodies a vision of wholeness which resonates with the Nigerian holistic view of life and as such could be relevant to mediate religious/spiritual care to Nigerian patients in the hospital. In the final analysis it also revealed that the different perspectives and practices of Pastoral Care enrich the diversity of care to patients in the hospital that could benefit hospital care as a whole. Thus the objective of the chapter as also related to one of the objectives of the study in the consideration of the meaning and nature of Pastoral Care was achieved.

7.2.2.3 The theological resources and role of the professional PCG in the hospital

The objective of the enquiry on the theological resources and role of the professional PCG in the hospital was aimed at establishing the relevance of the professional PCG in the Nigerian hospital as well as the resources that the PCG can bring to the Nigerian hospital space. This objective was addressed in Chapter Four. Osmer's (2006:6-15) normative task of good practice (1.6.3) was employed in this regard. Good practice and role theory (4.2) were used to investigate these roles. It presumed that good practice from different developed contexts as well as the traditional and Nigerian Christian practices of caregiving could assist in the articulation of the role of the PCG in the hospital space.

Findings indicated that the PCG could be defined as a person from the faith community who may or may not be ordained, but supports people in their life's journey in dealing with illness, surgery, incapacitation, bereavement and death as well as birth and celebrations. In this regard three types of PCGs were identified: the hospital visitor, the lay PCG/volunteers and

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the professional PCG. The professional PCG was the main focus of this study, although hospital visitors and volunteers are equally relevant.

Consequently it was established that good Pastoral Caregiving lies in the PCG's virtues and attributes, which implied that PCGs were more competent to offer spiritual and religious care in the hospital than other health professionals. This means that the qualities of good PCGs are dependent on their being, knowing and doing functions as defined by their goal and context. Thereupon the role of the PCG was articulated drawing from the insights of the Western context of North America and Europe. The study established that good practice helps PCGs to generate new ways of doing things better by learning from the gains or mistakes of other traditions, which could also provide resources and guidelines. The contexts were examined in terms of their history, professionals and role. It was discovered that there were similarities with the Nigerian context in terms of the history, and of medical and Pastoral Care practice. Pastoral Caregiving in these contexts began with the parochial model of hospital faith-based ministry without specialised skills, except for such skills that were acquired for congregation-based ministry. It was in the course of time that efforts were increasingly geared towards gradual professionalisation and professionalism as revealed in the articles, reviews, White Paper, and debates in these contexts. It was against this background that the objective of the possibility of collaboration between the PCG and the medical professionals in the hospital context was pursued.

7.2.2.4 Collaboration of the PCG and the medical professional

This objective was explored in Chapter Five entitled "The PCG and the medical professionals: towards collaboration in hospital care". The foundation for the analysis of this chapter was that a single model such as the medical model cannot adequately address the whole person of the patient. The spiritual and religious needs of the patient, for example, are often overlooked, especially within the Nigerian context. The study discovered that the quality of the health care system is poor and underdeveloped, and as such calls for the medical professional and the PCG to collaborate in hospital care. It employed Osmer's methodological framework of the normative task of ethical reflection (2008:4-12) (1.6.3) within a holistic interdisciplinary framework (1.6.1, 1.6.2).

The study revealed that care requires the combined efforts, skills and expertise including those of the PCG within the Nigerian hospital context. Collaboration was defined as an interpersonal and interdisciplinary process through which members of different disciplines

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unite to achieve a common goal that would not be possible if individual professionals were to act alone. The basis of collaboration were found to be increasing recognition of the religious dimension by some medical professionals, patients seeking out pastors during illness, patients desiring their spiritual needs to be addressed as well as choosing their care providers based on their spiritual interests. Findings in the chapter also indicated that the nature of collaboration should be based on mutuality, equality and complementarity. As such, collaboration requires clarity of roles and identity in order to recognise shared benefits. This chapter confirmed that collaboration involves an ethical dimension, because care involves a process of moral and ethical reflection. Ethical reflection serves to guide the care practitioner's conduct. Therefore collaboration is in itself a moral and ethical responsibility that medical professionals and PCGs have towards the patients. The ethical considerations relevant to collaboration were confidentiality, informed consent, referrals and the ethics of remuneration. Findings in this chapter motivated the development of the holistic pastoral theological approach to Pastoral Care through which the PCG can foster care alongside other healthcare professionals in the hospital context.

7.2.2.5 The holistic theological pastoral approach

The objective of Chapter Six was tailored to address one of the objectives of the study, namely to propose an approach through which the PCG can function within the Nigerian hospital environment. To this end, the chapter aimed at developing a framework for the engagement of PCGs in the hospital context. Therefore a holistic pastoral theological approach for PCG in the Nigerian hospital context was proposed. It utilised the pragmatic task of Osmer's practical theological methodology. The holistic pastoral theological approach utilised both the parochial and professional approaches to caregiving. It was argued that the framework is organised around meeting the holistic needs of patients in the hospital irrespective of their religious or non-religious affiliation. Therefore, the holistic pastoral theological approach sought for an alternative to the two existing models of Pastoral Care: the parochial and professional models. The holistic theological pastoral approach sought to combine models hermeneutically and inter-culturally in view of the human and contextual response to change. It suggested that for effective Pastoral Caregiving in the hospital, the approach to care must be holistic. This requires the unique character of Pastoral Care rooted in God as personified in Christ as revealed in the Scripture and empowered by the Holy Spirit. It also rejects the aggressive proselytising of patients that may characterise the motive, intention and goal of Pastoral Care in the parochial model. The holistic pastoral theological

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framework also privileges an interfaith approach, and as such it demands specialisation and training. The professional model could assist the PCG to carry out his or her role appropriately in the hospital space.

The holistic pastoral theological approach requires that Pastoral Care should be carried out more meaningfully. It demands the pastoral assessment of patients' pastoral needs. Pastoral assessment, as the study argued, is a means of gaining perspective on the patients' condition and determining the needs of patients. However, this could not be done without training. Hence training and a curriculum were proposed for the various PCGs. It also proposed the professional standards and ethical codes for PCGs in the hospital context for quality assurance and patient satisfaction.

7.3 Recommendations

The recommendations presented below are based on the findings of the literature study and empirical research materials from the field of Pastoral Care, theology and healthcare.

1. *Policy making that gives dignity to the patient*: This study recommends that the policy makers of the Nigerian healthcare system should consider the unique identities of Nigerian patients, their sickness behaviour and the meanings of illness and health in formulating healthcare policies. This will ensure a patient-centred and patient-friendly policy that could enhance the dignity of the Nigerian patient. Given the abovementioned issues, this study urges the government to make justice and mercy more realisable for the weak and vulnerable in contemporary Nigeria. This will mean that both the government and theological faith practitioners are summoned to rediscover, strengthen and sustain the necessary cooperation with each other. It also means that the government should create, as a matter of urgency, a more enabling environment for theological voices to play substantive roles in the practices of medical and Pastoral Care in the country. Such theological voices can challenge the government to give more serious attention to the issues that frequently lead to burnout within the Nigerian medical profession. It will, inter alia, include the challenge to equip the hospitals adequately and encourage the necessary legislation which can ensure and substantiate the inclusion of skilled PCGs in every hospital in Nigeria.

2. *Interdisciplinary co-operation*: This study suggests a responsible collaboration between health care professionals and PCGs in Nigeria. In the traditional African society the approach of healers is holistic and never fragmented. This

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multidisciplinary cooperation could ensure coherence of care, which increases quality of care and enhances patient's satisfaction and staff support in difficult circumstances. It could also minimise some of the limitations of medical practice in Nigerian hospital care. The health care system in Nigeria stands to benefit from this type of integrated care. Ignoring the spiritual dimension of healing is denying the vital aspect that defines the Nigerian person. Achieving total health may remain elusive within the Nigerian medical system if it is pursued by medical professionals alone; there is a need for team work.

3. *Professional training for PCGs*: Theological colleges and health training institutions in Nigeria are challenged to introduce and incorporate the study of clinical pastoral education as a form of education and training for PCGs in particular and pastors generally. The introduction of this form of training into the theological and health institutions' curriculum will help to equip pastors to help people deal with meaning questions in the context of suffering. In other words, churches as part of the communities of faith are also summoned to greater competence in communicating compassion and love of God to the sick and the suffering. The churches' calling, life and ministry are in essence social; hence this challenge of competent knowledge of ethical principles and practices of care in the hospital context. The training of such prospective PCGs can produce well-equipped, competent and skilled PCGs to meet the challenges of the hospital ministry in contemporary Nigeria. Daisy Nwachukwu and Emele Uka, notable Nigerian pastoral scholars, also lend their voices to these recommendations. Nwachukwu (1994:82-83) puts it more clearly:

> The pastor needs formalise training in professional counselling techniques so as to be able to go beyond the mere "chitchat" and small talk used to calm down anxieties for temporary relief. There is need for highly professionalised pastoral counseling sessions to get down to the root of the emotional burdens and problems ….This are a process, which the traditional medicine man does not get involved with. Here, clinical pastoral education is highly recommended over and above giving few courses on Pastoral Care and counselling.
>
> (Nwachukwu 1994:82-83)

The training of PCGs for the Nigerian hospital context should take an interfaith perspective. This means that the task of the PCG should be to work within the patient's faith and belief system to assess the patient's own religious resources for healing. However, the denomination of the PCG may come into play when religious rituals of a particular faith are required.

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4. *Inclusion of Pastoral Care in the training of medical and nursing students:* Nigerian medical schools are also challenged to introduce and incorporate some Pastoral Care dimensions into their curricula for students in training. It might help create more value for ethical medical care. For decades medical practice within the hospital context has been reduced to (exclusively) the scientific and clinical to the neglect of the spiritual categories. Diseases are viewed only from the pathological perspective. This training will enable physicians to approach the patients as whole persons instead of parts or as objects. "There is no way medical care can be reduced to the body and be good medicine" (Hauerwas, 1998: 75). This suggestion can also inspire medical caregivers to appreciate the role of the PCGs in the hospital context.

5. *Establishment of protocols for referrals to PCGs and pastoral assessment process:* The Nigerian medical team should establish a protocol for referral of patients to the PCG for Pastoral Care to the patients. This also means that an appropriate system should be put in place for the pastoral assessment of patients. The basic assessment process should evaluate the importance of religion for the patient's coping, the helpfulness of religious symbols and rituals for the patient, and religious support network of the patient. The success of this process depends on the medical staff recognising the Pastoral Care needs of the patients, and to refer the patient accordingly to PCGs. In that sense the medical staff needs basic training on pastoral assessment. It could also be of great benefit both to patient and staff that PCGs be included in the medical rounds of doctors both in the general hospitals and the psychiatry units.

6. *Inclusion in the Medical Ethics Committee*: It is recommended that an experienced PCG should be included into the medical ethics committee. As is evident in the previous point, his or her inclusion is a necessity given the role that religion plays in the moral and ethical perceptions of Nigerians. Such inclusion can represent both the faith communities and the patients' voices in the ethics committees of hospitals and clinics, and can assist in the resolution of bioethical and moral dilemmas. Including a professional Pastoral Caregiver into the committee holds great promise for restoring and substantiating the necessary contribution of theology in checkmating some unethical practices and procedures within the Nigerian medical practice. Above all, there is a crucial need for theologically formed and informed communities to

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cooperate with the government in reconstituting, restoring and celebrating the human dignity of persons, especially the sick in Nigeria.

7.4 The holistic pastoral theological approach contribution to research

Research on the effect of religion and spirituality on the sick in Nigeria has generally been conducted from the historical, sociological and anthropological perspectives. The issue of religion and spirituality has been a subject of scholarly attention for the past ten years in the global scene. Little has been done from the theological perspective and no scholarly work presents insight on how religious and spiritual component as Pastoral Care might be appropriately incorporated into the intervention plan of patients in Nigerian hospital care. This study presents a contribution towards an understanding of the role of PCGs in hospital care from a pastoral theological perspective. This study has contributed valuable insights to practical theological research towards addressing the place of religion and spirituality in the mode of Pastoral Care in hospital care in the following ways.

Interdisciplinary research (Chapter Five): This study's focus on spiritual, religious and Pastoral Care in the healthcare setting in Nigeria is directly underpinned by the interdisciplinary and cross-disciplinary research focus that invites dialogue between the fields of practical and pastoral theology and medical and social sciences. It therefore provides a wealth of insights into the existing body of knowledge on the growing discussions of forming effective collaboration with different healthcare players for efficient, effective and equitable healthcare.

The role of the professional Pastoral Caregiver in the Nigerian hospital context (Chapter Four): This study has documented the importance of including Pastoral Care as an essential component of hospital care beyond the *ad hoc* services rendered by faith representatives at the periphery. It therefore emphasised the need for Pastoral Care to move beyond the parochial and intuitive care caregiving to a more intentional, effective, skilful and professional practice that ensures efficient and quality caregiving.

Interfaith Pastoral Caregiving and collaboration (Chapters Four and Five): This study has argued that religious communities must necessarily move beyond denominational and religious boundaries in organising and implementing programmes for the welfare of the people. Pastoral Care is intercultural and interfaith in perspective. Caregiving should necessarily embody the positive African religious values, whose worship transcends time and place and structure, and whose main objective is the glorification of God. As has been argued

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in this study, the Nigerian context is increasingly pluralistic and complex, and so a single perspective or answer can no longer suffice. It has noted the evils of sectionalism, denominationalism and fundamentalism in the frequent religious violence that undermines the dignity of human life and which makes constructive dialogue difficult and even impossible. It therefore stresses collaboration at all levels – micro, meso and macro. Collaboration, this study argues, will make room for tolerance and the creation of space to enable understanding, tolerance, compromise and shared responsibility that allows professionals to contribute to the general good of the people

The development of an approach for the engagement of PCGs in the hospital (Chapter Six): This study most crucially has contributed to the development of a framework for the inclusion and operation of Pastoral Caregiving in Nigerian hospitals. This approach is also intended to serve as a basis for policy making in the area of providing Pastoral Caregiving in the Nigerian hospital. It is therefore a response to the holistic understanding of Africans, which also corresponds to WHO's call for a holistic approach to healthcare that considers the spiritual, religious and personal belief elements of the patient.

7.5 Emerging areas for further research

The findings of this research open up collaborative opportunities for professionals in the helping professions.

- First and foremost, since this research was mainly library based, more research opportunities should be provided for an empirically based investigation to test the theories and acceptability of the theoretical claims and recommendations among Nigerian patients, health service providers and the medical professionals that this research has presented.
- Secondly, although this research is focused on the Nigerian hospital context, it could also be relevant to other corporate institutions in Nigeria. Therefore this research opens opportunities for research in the field of workplace spirituality and Pastoral Caregiving (such as banks, industries and other corporate institutions) as an emerging field of interest globally and most importantly in the Nigerian context.
- Thirdly, research to determine the influence of religion on the choice of hospital by patients in Nigeria may also be helpful. In this light research into the interface of medicine, spirituality and religion in Nigeria could assist policy makers to be better informed about the role of religion and spirituality in the Nigerian healthcare system

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so as to guide the policy makers on ways to incorporate religion and spirituality into hospital care meaningfully and appropriately.

- Fourthly, since collaboration is an emergent practice in Nigeria, more research on collaboration is therefore required. This could open up an understanding and enabling environment that allows the harnessing of valuable and scarce resources for quality healthcare delivery from all perspectives.
- Fifthly, research into further reflection on the Clinical Pastoral Education (CPE) as a form of education for faith-based communities (FBCs), FBOs and religious leaders in Nigeria and the process of its adaptation to the Nigerian context is necessary. This study merely introduced the issue by means of raising awareness of its existence and it therefore needs further discussion.

7.6 Conclusion

This study presents a contribution towards an understanding of the role of PCGs in hospital care from a pastoral theological perspective. Sickness, as this study has established, is a physical, social, political as well as a spiritual challenge; hence its prominence as an issue in both the Nigerian and global scene as is represented in the millennium development goal of the United Nations and WHO WHOQOL indices. This raises questions of meaning, relationships and wholeness. The Nigerian quest for wholeness is a search for meaning, significance and purpose in life, especially in illness and suffering.

Consequently, hospitals constitute a healing environment where Nigerians seek healing and wholeness. But the poor healthcare system is unable to sustain this hope of the Nigerian people adequately. However, the NSHDP 2010-2015 (2010) set in motion reforms to address the poor healthcare system. Earlier, the National Health Policy on Private Partnership on Health in Nigeria (NHPPPHN 2005) had stated that alternative healthcare providers whose practices are of proven quality will be supported and encouraged as frontline healthcare providers for many people and such providers will be brought under healthcare regulations. But what is important in providing healthcare that meets the Nigerian people's hopes and ensures their satisfaction is an understanding that their search for wholeness is also a search for ultimate meaning – a search for God who is trustworthy to be practically involved in their wellbeing. This search for ultimate meaning in God is adequately addressed by Pastoral Care, whose main goal is assisting the care seekers in their search for meaning and wholeness towards transformation and growth. Its goal then resonates with the Nigerian view of life. Nigerians, as this study has shown, believe in holistic care. They do not separate medicine

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from religion and by extension spirituality, as both come from the same source (God). Pastoral Care has been established by this study to be of recognisable and proven value in its resources and practices of soul care through the ages in the way that it nurtures and sustains wholesome personality. Therefore PCGs are found to be important to healthcare institutions including hospitals. Furthermore, the WHO WHQOL has confirmed that health care and hospital care will do better in their caring ministry if they integrate the religious dimension into their intervention procedures and processes. This presupposes that, despite the numerous benefits of the medical model in treating and curing the physical dimension of certain diseases, it is inadequate. Its inadequacy can be seen especially in its inability to address the Pastoral Care needs of patients. Hence collaborating with PCGs from a holistic pastoral theological approach can contribute to holistic and quality hospital care for greater patient satisfaction. Such collaboration, this study contends, is moral, ethical and could enhance the holistic care and dignity of patients. The holistic pastoral theological approach therefore, privileges an interfaith approach, specialisation and training of PCGs that ensures professional ethical standards that assure quality care and patient satisfaction.

The medical professionals and healthcare policy makers are urged to integrate the Pastoral Care dimension into their treatment plans in line with the WHO WHOQOL (1998) recommendation and in line with the NHPPPHN 2005 policy to support trustworthy alternative healthcare providers. The assumption of this study is that where there is a need for the inclusion of Pastoral Care into the Nigerian hospital context (and the need has been established) and if there is a will on the part of the Nigerian medical system and the government to reform the medical system to make provision for such inclusion, there will be a way. The beginning point may be to initiate dialogue on the possible way of realising such goals, which this study is actually doing. The policy makers of Nigerian healthcare should take into consideration the unique identities of Nigerian patients, their sickness behaviours and their understanding of illness and health. The policy makers can no longer overlook the religious and spiritual and ethical dimensions of care embodied in Pastoral Caregiving. Such an endeavour could have a positive impact on patient care in Nigerian hospitals in restoring and maintaining the human dignity of their patients, as has been established. Thus the study confirms the research hypothesis that the inclusion of the PCGs into the Nigerian hospital context to mediate spiritual and religious care could enhance quality hospital care and increased satisfaction of patients in such care.

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