PROJECT ABSTRACT

Master of Chaplaincy

Adventist University of Africa

Theological Seminary

Title: AN ASSESSMENT OF FACTORS MITIGATING AGAINST CHAPLAINCY SERVICES IN ADVENTIST HOSPITAL ILE-IFE OF OSUN STATE, NIGERIA

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Date Completed: February 2025

In achieving the mission of Seventh-day Adventist (SDA) Church, the church adopts healthcare and spiritual care for patient, patient relatives and clinical staff. The SDA Hospital, Ile-Ife is widely known as a result of the work of Dr. Madgwick who was the health secretary of the general conference at the time, who came to Nigeria in 1939 to conduct a feasibility study to determine an appropriate location for the anticipated medical institution. The SDA hospital at Ile-Ife was foremost healthcare facility established by the church for members of community at large. It at a time cover the space of whole Nigeria as patient comes from all over the regions of Nigeria to access medical care, especially members of the church. In order to achieve its goal, Spiritual work and healthcare have been adopted side by side. With the improvement of healthcare, there is a necessity for professional pastoral caregiving in the hospital.

The case in the SDA Hospital at Ile-Ife is unique. The church and hospital management sees the vacuum of needing pastoral caregiver identified as a chaplain which steps were taken to address the need. But it’s not been optimally used because it's sometimes limited to conventional ways of ministry, prayer and devotion, hereby, making it just a "fill in the gap" ministry. Pastors without chaplaincy experience or having undergone clinical pastoral education were posted by the conference to serve as chaplains without formal training. Other aspects of care have been left to the expertise of the medical workers. This call for assessment of healthcare chaplain to identify factors that could be mitigating against chaplaincy services in providing whole person care in the recovery of patients in the hospital.

To attain the findings of the research, literature was widely consulted on professional healthcare chaplaincy which presented rise to the qualitative approach in the research. Research questions were intended to determine the factors mitigating against chaplaincy services in SDA Ile Ife.

Participant feedback identifies factors limiting chaplaincy services in SDA Hospital Ile Ife, and the need to provide holistic healing for the patient, patient relations and, hospital staff through spiritual and emotional care. This necessitates quick action in the employment of a trained chaplain or training the current chaplain of the hospital who has the calling and qualities of a chaplain to provide adequate spiritual and emotional services beyond prayer which he is known for.

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A project

presented in partial fulfillment

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This project is dedicated to the glory of

God Almighty, the God of possibilities.

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CHAPTER 1

INTRODUCTION

Background

Chaplaincy services in hospitals are essential for providing holistic care that complements medical treatment by addressing the psychological and spiritual needs of patients, families, and healthcare staff.[1] These services offer critical support during illness, loss, and existential crises, helping patients find peace, families cope with stress, and healthcare workers avoid burnout. Despite their importance, many hospitals lack adequate chaplaincy services due to limited resources, undervaluation of pastoral care, and a shortage of trained chaplains.[2] This gap in care leaves patients without the comprehensive support necessary for true healing and well-being.[3]

One primary difficulty rests in the diversity of religious beliefs and practices among individuals seeking chaplaincy support.[4] Negotiating this diversity while maintaining a sensitive and inclusive approach presents a significant challenge for

[1] George Fitchett et al., "Evidence-based Chaplaincy Care: Attitudes and Practices in Diverse Healthcare Chaplain Samples," *Journal of Health Care Chaplaincy* 4, no. 20 (2014): 144–60, https://pubmed.ncbi.nlm.nih.gov/25255147/.

[2] Harold Ray Griffin, Alla Adams, and Dana Foster, "Demands on Hospital-based Chaplains: An Observational Study," *The International Journal of Religion and Spirituality in Society* 9, no. 3 (2019): 63-74.

[3] Brad B. Brown, "A Training Program for Non-Chaplain and Volunteer Chaplains Conducting Spiritual Care at Feather River Hospital in Paradise, California" (DMin diss., Andrews University, Berrien Springs, MI, 2016), https://doi.org/10.32597/dmin/425.

[4] Kathleen J. Greider, "Religious Location and Counseling: Engaging Diversity and Difference in Views of Religion," in *Understanding Pastoral Counseling*, ed. Elizabeth A. Maynard and Jill L. Snodgrass (New York: Springer Publishing, 2015), 235–56.

chaplains, as they must navigate the complexities of providing pastoral care that resonates with a broad spectrum of faith traditions.[5] This lack of recognition may result in inadequate resources, training, and support for chaplains, exacerbating their challenges in delivering effective pastoral care. Additionally, the secular nature of some institutions and the growing trend of religious diversity within communities can pose hurdles to the integration of chaplaincy services, leading to a potential mismatch between the spiritual needs of individuals and the available support.[6]

In assessing the barriers to chaplaincy services globally, researchers and practitioners have undertaken comprehensive studies to identify and understand the challenges that impede the effective delivery of pastoral care in various cultural and healthcare contexts.[7]

The pandemic has had enormous global control generating extensive concern and distress for many people. Chaplains are therefore expected to be comfortable and equipped with the necessary abilities to offer consolation at periods of intense pastoral and emotional need. This phenomenon instantly points to a variety of perspectives regarding the function of chaplaincy. It is concerning that the majority of chaplain respondents struggled to comprehend their job prior to the initial pandemic wave. It is

[5] Christina M. Puchalski et al., "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (2014): 642–56, https://preciousheart.net/Seminary/Prison-Bibliography.pdf.

[6] Sofia Gomez et al., "Chaplain-physician Interactions from the Chaplain's Perspective: A Mixed Method Analysis," *American Journal of Hospice and Palliative Medicine* 38, no. 11 (2021): 1308–1313, https://journals.sagepub.com/doi/10.1177/1049909120984390?icid=int.sj-full-text.similar-articles.

[7] Suzan Willemse et al., "Spiritual Care in the Intensive Care Unit: An Integrative Literature Research," *Journal of Critical Care* 57, no. 2 (2020): 55–78, https://pubmed.ncbi.nlm.nih.gov/32062288/.

not unexpected that others surrounding chaplains are also unsure of their position if they are unable to explain it.[8]

In the 1970s, the World Health Organisation acknowledged the importance of the spiritual dimension in healthcare.[9] One of the causes of this is that, in the West, public interaction with religion has deteriorated as interest in secular and alternative viewpoints has increased.[10] Nevertheless, the preponderance of NHS staff & patients still associate chaplaincy with religion.[11]

Previous investigations have highlighted obstacles such as limited recognition of the importance of pastoral care in healthcare settings, insufficient training and education for chaplains, cultural and religious diversity posing communication challenges, and varying institutional support for chaplaincy services. These barriers have been acknowledged as significant impediments to the universal implementation and accessibility of chaplaincy services,[12] prompting the need for targeted interventions and policy changes to address these concerns on a global scale.

Seventh-day Adventist Hospital Ile Ife is not been left out in experiencing several barriers that limit the effectiveness of the chaplain. In evaluating barriers to

[8] M. Best et al., "'This Ward Has No Ears': Role of the Pastoral Care Practitioner in the Hospital Ward," *Journal of Health Care Chaplaincy* (2020): 1–15, https://pmc.ncbi.nlm.nih.gov/articles/PMC7975854/.

[9] F. Winiger, "More Than an Intensive Care Phenomenon": Religious Communities and the WHO Guidelines for Ebola and Covid-19," *Spiritual Care* 9, no. 3 (2020): 245–255. https://jliflc.com/wp-content/uploads/2020/07/23658185-Spiritual-Care-%E2%80%9CMore-than-an-intensive-care-phenomenon%E2%80%9D_-Religious-communities-and-the-WHO-Guidelines-for-Ebola-and-Covid-19.pdf.

[10] NHS Education for Scotland, "Spiritual Care Matters: An Introductory Resource for All NHS Scotland Staff," accessed 21 June 2023, http://www.nes.scot.nhs.uk/media/3723/spiritualcaremattersfinal.pdf.

[11] B. Ryan. "A Very Modern Ministry: Chaplaincy in the UK," accessed 21 June 2023, file:///C:/Users/COMPAQ/Downloads/13-19-PB%20 (1).pdf.

[12] Emily R. Haines et al., "Barriers to Accessing Palliative Care for Pediatric Patients with Cancer: A Review of the Literature," *America Cancer Society* 124, no. 11 (2018): 2278–2288, https://acsjournals.onlinelibrary.wiley.com/doi/10.1002/cncr.31265.

chaplaincy services in Africa, existing research has shed light on a range of challenges specific to the continent. Studies have emphasized the diverse religious and cultural landscapes across African countries, underscoring the need for culturally tailored approaches to pastoral care.[13]

In assessing the barriers to chaplaincy services in Nigeria, previous discussions have highlighted several challenges, including inadequate funding, limited awareness and understanding of the role of chaplains, and a shortage of trained personnel.[14] Additionally, issues related to religious diversity and the need for cultural sensitivity have been identified as potential obstacles to chaplaincy services in Nigeria.[15] Efforts have been made to address these challenges through advocacy for increased funding, educational programs to enhance awareness, and initiatives to train more chaplains in Nigeria.[16] However, practical case studies provide further insights into the complexities faced on the ground. For instance, in a healthcare setting, a lack of collaboration between chaplains and medical staff may hinder the integration of pastoral care.[17] In educational institutions, a case study reveals that inadequate

[13] Jacob K. Olupona, *African Religions: A Very Short Introduction* (New York: Oxford University Press, 2014), 47.

[14] Benjamin Yemson Nuhu, "The Impact of Professional Healthcare Chaplains on Patients' Recovery Nature in Jengre Seventh-day Adventist Hospital, Nigeria" (MA thesis, Adventist University of Africa, Nairobi, Kenya, 2020), https://irepository.aua.ac.ke/items/81964366-6632-4f82-85c9-21a6ee428734.

[15] Cletus Kpobar Aakol, "Professional Chaplaincy as Bridge between Spirituality and Holistic Healthcare in Nigeria" (MA thesis, Regent University, Virginia Beach, Virginia, 2020), 28314284, ProQuest Dissertations.

[16] Hilary C. Ike, "Organizational Improvement of Nigerian Catholic Chaplaincy in Central Ohio: Towards Effective Collaboration for Rural and Community Development in Nigeria" (DEd. diss., Ashland University, Ashland, Ohio, 2019), https://etd.ohiolink.edu/acprod/odb_etd/etd/r/1501/10?clear=10&p10_accession_num=ashland1574697 3577402.

[17] Emem Agbiji and Obaji Mbeh Agbiji, "Pastoral Care as a Resource for Development in the Global Healthcare Context: Implications for Africa's Healthcare Delivery System," *HTS Theological Studies* 72, no. 4 (2016): a3507, https://hts.org.za/index.php/hts/article/view/4525/1002.

training programs for chaplains can result in ineffective support for students navigating spiritual concerns.[18] Furthermore, in prisons, issues of religious discrimination and insufficient resources may impede chaplains from providing comprehensive services to inmates.[19]

When barriers exist, patients and their families may feel that their emotional and spiritual needs are not adequately addressed, leading to dissatisfaction with the healthcare services.[20] Barriers to chaplaincy services may reflect broader issues in the organizational culture of a health facility. This can affect the overall climate for pastoral care and may require addressing systemic challenges to ensure the integration of chaplaincy services into the healthcare team.

There is a growing body of literature exploring the role of chaplaincy services in healthcare settings, but there is a need for research that delves into context-specific challenges to effective chaplaincy services in context-specific settings.[21]

Established in 1940, SDA Hospital Ile-Ife contains 128 patient beds and is governed by the Western Nigeria Union Conference. More generally, the hospital developed the SDA School of Nursing in 1948, the SDA Midwifery School in 1950, and the SDA College of Health Technology in 2020. Community Health, Pharmacy Technicians, Health Information Management, and Medical Laboratory Science

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[18] Sammy Orwenyo, “The Role of Theological Training in Pastoral Ministry within the Seventh-day Adventist Church: A Case Study of the Theological Seminary at the Adventist University of Africa (AUA), Rongai - Kenya” (MA thesis, University of Nairobi, Nairobi, Kenya, 2014).

[19] Katie Hunt, "Non-religious Prisoners’ Unequal Access to Pastoral Care," *International Journal of Law in Context* 18, no. 1 (2022): 116-131, https://doi.org/10.1017/S1744552322000039.

[20] Elisabeth Assing Hvidt et al., “'We Are the Barriers': Danish General Practitioners' Interpretations of Why the Existential and Spiritual Dimensions Are Neglected in Patient Care,” *Communication and Medicine* 14, no. 2 (2017): 108-120, https://journal.equinoxpub.com/CAM/article/view/10389.

[21] Yakubu Ishmael Hakim, "Development of a Chaplaincy Ministry That Impacts Wholistic Healthcare in Tamale Adventist Hospital, Ghana" (MA thesis, Adventist University of Africa, Nairobi, Kenya, 2021), https://irepository.aua.ac.ke/items/aed81e4f-924b-4730-802a-9e574c94f46f.

Technicians were the first four departments of the latter, which was founded and put into service on January 1, 2020. The new facility is situated in Ile-Ife, Osun State, Nigeria, on the grounds of the SDA Hospital.[22]

At least two clinics opened in other places thanks to the initiative of Ile-Ife Hospital. They are the now-closed Igbobini Clinic, Adventist Medical Centre, and Inisa. The hospital has decreased infant mortality in Ile-Ife and the surrounding areas and employs a great amount of persons in the zone. The hospital also runs a postgraduate residency program in Family Medicine and a horsemanship program for doctors. There are six wards at SDA hospital, namely: general outpatient, pediatric, emergency, male medical and surgical, female medical and surgical, private, obstetrics and gynecology, and specialty clinic. A total of 28 nurses, more than 20 doctors (consultant physicians, resident doctors, and medical officers), and 30 ward maids who are currently working at SDA Hospital, Ile-Ife includes technicians and other cadre of staff support to ensure the delivery of good-quality health services for patients.

Investigating the barriers and challenges unique to Adventist healthcare facilities is crucial for enhancing pastoral care and ensuring holistic well-being for patients, their families, and healthcare staff.[23] Adventist Hospitals serve diverse populations, and understanding the cultural nuances and religious diversity within

[22] Michael A. T. Senne-Aya, "Seventh-day Adventist Hospital Ile-Ife," Encyclopedia of Seventh-day Adventists, published December 7, 2020, accessed 14 January 2021, https://encyclopedia.adventist.org/article?id=EC2N&highlight=y.

[23] Mpho Makgopa, "The Spiritual Factors Influencing Health-seeking Behaviour among the Seventh-day Adventist Group Members in Tshwane Gauteng Province" (MA thesis, University of Pretoria, South Africa, 2021), 6.

these healthcare settings is vital.[24] Investigating how chaplaincy services address or struggle with cultural sensitivity and diversity issues can provide insights into tailoring pastoral care to meet the needs of a varied patient demographic.[25] Understanding how well chaplains integrate into the healthcare team and contribute to the overall patient care experience is essential for promoting holistic care.[26] This research work help close the gap by contributing to the development of targeted interventions and strategies to enhance chaplaincy services at the SDA Hospital, Ile-Ife to ensure that that pastoral care aligns with the unique context and values of these healthcare settings.

Barriers identified include limited resources and infrastructure, which hinder the establishment and sustainability of chaplaincy programs in many African healthcare settings.[27] Additionally, the impact of historical and political factors on the recognition and integration of chaplaincy services has been explored, revealing how varying degrees of institutional support influence the accessibility of pastoral care.[28] Despite these challenges, some noteworthy initiatives have been undertaken to address these barriers. For instance, a case study in South Africa has highlighted the

[24] Elisa J. Blethen "Cross-Cultural Management in Healthcare: A Case Study of Malamulo Hospital, a Seventh-day Adventist Mission Hospital in Malawi, Africa" (PhD diss., Fuller Theological Seminary, School of Intercultural Studies, 2018), 1, https://digitalcommons.andrews.edu/hrsa/199/.

[25]David Glenister and Martin Prewer, "Capturing Religious Identity during Hospital Admission: A Valid Practice in Our Increasingly Secular Society?" *Australian Health Review* 42, no. 6 (2017): 626-631,https://pubmed.ncbi.nlm.nih.gov/27764647/.

[26] Lisa A. Ruth-Sahd, Hauck B. Carolanne, and Kaitlyn E. Sahd-Brown, "Collaborating with Hospital Chaplains to Meet the Spiritual Needs of Critical Care Patients," *Dimensions of Critical Care Nursing* 37, no. 1 (2018): 18-25, https://pubmed.ncbi.nlm.nih.gov/29194170/.

[27] Michael Matthew, "Faith Borders, Healing Territories & Interconnective Frontier? Wellness & Its Ecumenical Construct in African Shrines, Christian Prayer Houses & Hospitals," *Numen* 22, no 1, (2019): 240-260, https://periodicos.ufjf.br/index.php/numen/article/view/29619.

[28] Ronita Mahilall, "Spiritual Care in Hospice Palliative Care Settings in South Africa: National Curriculum Needs, Description of Provincial Services, and a Local Case Study" (PhD diss., Stellenbosch University, Stellenbosch, South Africa, 2021), 11.

success of collaborative efforts between healthcare institutions and religious organizations in developing culturally sensitive chaplaincy programs.[29] This case study emphasizes the importance of community engagement and partnership in overcoming barriers to pastoral care in the African context.

This research investigates the possible factors mitigating against chaplaincy services in Seventh-day Adventist Hospital, Ile-Ife, Osun state.

The researcher investigates how well do staff and patients of the SDA hospital, Ile-Ife, Osun State, Nigeria understand the role and functions of a chaplain in a hospital setting? And how well is whole patient care integrated into the training of medical personnel working in the SDA hospital, Ile-Ife, Osun State, Nigeria?

Statement of the Problem

The integration of effective chaplaincy services within the broader healthcare system is essential for effective collaboration and the provision of holistic care. However, the lack of proper integration and consultation between the chaplaincy department and other healthcare professionals may hinder the seamless delivery of services.

Ultimately, addressing these factors can lead to improved patient outcomes, increased satisfaction, and a more holistic approach to healthcare within the Adventist tradition.

Justification

Investigating the barriers to chaplaincy services at the SDA Hospital in Ile-Ife, Nigeria is crucial for several reasons. First of all, chaplaincy services are absolutely

[29] Andre de la Porte, "Spirituality and Healthcare: Towards Holistic People-centered Healthcare in South Africa," *HTS Theologies Studies/Theological Studies*, 72, no 4 (July 2016): 1-9.

important in giving patients, their families, and medical staff spiritual and emotional support[30] By identifying and understanding the barriers that hinders the effective delivery of these services, hospital administrators can work towards enhancing the overall quality of patient care. Secondly, Nigeria is a multicultural country with various religious beliefs and practices.[31] Investigating the barriers to chaplaincy services can help ensure that the hospital caters to the religious and spiritual needs of all patients, irrespective of their faith or denomination.[32]

This inclusivity promotes a sense of respect, understanding, and well-being, ultimately contributing to the holistic healing process. Furthermore, exploring these barriers can shed light on any institutional or organizational factors that may impede the provision of chaplaincy services. By addressing these obstacles, the hospital can enhance its capacity to provide comprehensive care to individuals in need.

Delimitation

The survey focused on healthcare staff, inpatients, patient relatives, and final-year student nurses at SDA Hospital in Ile-Ife, Nigeria. The study was limited to SDA Hospital in Ile-Ife, Nigeria. The scope of this research not encompass all SDA hospitals in Nigeria, it specifically explores the barriers faced by healthcare workers in accessing and utilizing chaplaincy services at SDA Hospital Ile Ife, Nigeria. It delves into other aspects of hospital services or healthcare delivery.

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[30] Kirchoff W. Robert et al., "Spiritual Care of Inpatients Focusing on Outcomes and the Role of Chaplaincy Services: A Systematic Review," *Journal of Religion and Health* 60 (2021): 1406–1422, https://pubmed.ncbi.nlm.nih.gov/33575891/.

[31] Robert A. Dowd, "Religious Diversity and Religious Tolerance: Lessons from Nigeria," *Journal of Conflict Resolution* 60, no 4 (2014): 617-644, https://www.jstor.org/stable/24755888.

[32] Philip Austin et al., "Spiritual Care Training Is Needed for Clinical and Non-clinical Staff to Manage Patients' Spiritual Needs," *Journal for the Study of Spirituality* 7, no. 1 (2017): 50–63, https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2010.03547.x.

The survey utilizes a structured questionnaire or survey instrument consisting of closed-ended questions, rating scales, or Likert-type scales to gather quantitative data.

Limitation

This study is limited to SDA Hospital, Ile-Ife, Nigeria. The factors would be explored, and the results may not be generalizable to other SDA hospitals.

CHAPTER 2

BIBLICAL FOUNDATIONS OF CHAPLAINCY MINISTRY IN HEALTHCARE

This chapter explores the biblical foundations of chaplaincy ministry within healthcare, tracing its roots through the Old Testament (OT) and New Testament (NT). It examines how Scripture has historically guided the principles and practices of providing pastoral care, particularly in times of illness and suffering. By analyzing key biblical texts and examples, the chapter highlights the enduring relevance of these teachings in shaping the role of chaplains in modern healthcare settings.

Chaplaincy Concepts in the Old Testament

Priests were fundamental in the religious and spiritual lives of the Israelite people in the OT. While the specific term "healthcare chaplain" may not be mentioned in the OT, priests did fulfill certain functions that could be considered like the role of chaplains in healthcare setting.[1] Here are some aspects of the priestly role in healthcare:

Ritual Purity and Healing: In the OT, the role of priests was closely associated with maintaining ritual purity and performing various religious ceremonies, including those related to healing. While healthcare chaplains in modern times may have a broader scope of work, we can draw some parallels to understand the involvement of

[1] Maria Colfer, "Maintaining a Biblical Perspective on the Role of Chaplains in the Effective Care and Healing of Hospital Patients" (PhD diss., Reformed Theological Seminary, Global Campus, 2014), 12, 13, https://cdn.rts.edu/wp-content/uploads/2019/05/201403-Colfer-Maria.pdf.

priests in ritual purity and healing. Here are some references from the OT that highlight the priests' role in these aspects:

> (Lev 13–14): This portion of the Book of Leviticus discusses the laws and rituals surrounding the identification, treatment, and cleansing of individuals with skin diseases, particularly leprosy. The priests played a central role in examining and diagnosing the disease, as well as declaring a person clean or unclean. They also supervised the rituals of purification after healing.[2]
>
> (Num 5:11–31): This passage details the procedure for dealing with suspected cases of marital infidelity. The priest would be involved in a ritual where the woman would drink "bitter water" to determine her guilt or innocence. The priest's role was to administer this ritual and invoke God's judgment.[3]
>
> (Lev 21:16–23): Here, the priests are given specific instructions regarding their physical conditions and requirements for purity. Priests were not allowed to approach or perform certain sacred rites if they had any physical blemishes or abnormalities.[4]
>
> (Exod 30:22–33): Priests were responsible for preparing and using specific anointing oils for consecration and healing purposes. This passage describes the formulation of the holy anointing oil and the instructions for its application.

While these references highlight the involvement of priests in healthcare-related matters, it is essential to note that healthcare chaplaincy concept as understood in contemporary contexts has evolved. Modern healthcare chaplains provide emotional and spiritual support to patients, families, and healthcare professionals, regardless of their religious affiliation. The role of healthcare chaplains today draws inspiration from various religious traditions, including the Old Testament priesthood.

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[2] Joey R. Peyton, "Considering a Biblical Mandate for Providing Holistic Pastoral Care to Diaspora Populations," Global Missiology, published October 2017, accessed 14 January 2021, https://www.academia.edu/110481972/Considering_a_Biblical_Mandate_for_Providing_Holistic_Pastoral_Care_to_Diaspora_Populations.

[3] Andrew J. Weaver, *The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry* (London: Routledge, 2007), 3–4.

[4] Jared Wilson, "The Perfect Priest: An Examination of Leviticus 21:17–23" (MA thesis, George Fox University, Newberg, Oregon, 2013), 26–27.

Spiritual Guidance and Support: Priests are instrumental in delivering spiritual guidance and support, a role that has significantly influenced the evolution of contemporary chaplains. Similar to priests, chaplains provide pastoral care and assistance to individuals in diverse environments, including hospitals, military institutions, correctional facilities, and academic institutions.[5] To understand the connection between the roles of priests and modern-day chaplains, let's delve into the historical context and the ongoing importance of spiritual guidance.

Moral and Ethical Teaching: Priests' role as moral and ethical teachers has a long history in religious traditions. Priests are typically seen as spiritual leaders who guide their communities in morality, ethics, and values.[6] Their teachings often draw from religious texts, doctrines, and traditions, providing a moral compass for individuals and communities. They included educating the people about maintaining good health, practicing hygiene, and avoiding behaviors that could lead to illness or harm. The book of Proverbs contains numerous wisdom sayings that address topics related to health, well-being, and virtuous living.

In the context of contemporary chaplains, who often function in several institutional settings such as hospitals, military, and prisons, their role as moral and ethical teachers can be traced back to the historical role of priests. While chaplains may not necessarily be ordained priests, they often fulfill similar functions by providing spiritual guidance, moral support, and ethical counseling to persons in need.

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[5] Paget K. Naomi and R. Janet McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2013), 21–22.

[6] Teresa J. Rothausen, "Integrating Leadership Development with Ignatian Spirituality: A Model for Designing a Spiritual Leader Development Practice," *Journal of Business Ethics* 145, no. 4 (2016): 811–29, https://doi.org/10.1007/s10551-016-3241-4.

Chaplains frequently work in multicultural and diverse environments, catering to people of different faiths or no religious affiliation.[7] Their primary objective is to promote holistic well-being and address the spiritual, emotional, and ethical needs of those they serve. They often act as a source of comfort, offering guidance during challenging times, ethical dilemmas, or moral crises.[8]

> (Lev 13–14): Laws concerning infectious skin diseases and purification rituals.
> (Ps 6; 30; 38): Examples of psalms expressing distress, supplication, and a desire for healing.
> (Prov 3:1–8; 4:20–22): Wisdom sayings related to health, well-being, and virtuous living.
> (Isa 1:17; Jer. 22:3): Calls for social justice and care for the vulnerable.

Chaplaincy Concepts in 2 Kings 5:1-14

In 2 Kings 5:1–14, we encounter the story of Naaman, a commander in the Syrian army, who suffered from leprosy. The passage explores various concepts related to chaplaincy, such as faith, humility, and the role of a spiritual advisor or mentor.[9]

Faith. The story highlights the significance of faith in the healing progression. Naaman, upon the advice of a young Israelite girl, seeks the prophet Elisha for a cure. Despite initially feeling skeptical about Elisha's instructions, Naaman eventually demonstrates faith by following them. Faith plays a crucial role in chaplaincy, as spiritual advisors often encourage individuals to trust a higher power or find solace in their beliefs.

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[7] Doug Oman, "Defining Religion and Spirituality," in *Handbook of the Psychology of Religion and Spirituality*, ed. Raymond F. Paloutzian and Park L. Crystal (New York: Guilford Publications, 2014), 44–45.

[8]Andrew Todd, with Butler Colin. "Moral Engagements: Morality, Mission, and Military Chaplaincy," in *Military Chaplaincy in Contention: Chaplains, Churches and the Morality of Conflict*, ed. Andrew Todd (Cardiff: Aghagate, 2022), 151-168. https://orca.cardiff.ac.uk/id/eprint/29134/.

[9] Mary C. Lindberg, *Jobs Lost, Faith Found: A Spiritual Resource for the Unemployed* (Minneapolis, MN: Fortress Press, 2018), 32.

Ritual and Symbolism. The act of washing in the Jordan River serves as a ritual in Naaman's healing process. This ritual carries symbolic significance, representing purification and cleansing. Rituals and symbols are common tools in chaplaincy, as they can help individuals connect with their beliefs, find comfort, and mark significant moments or transitions in their lives.

Outcome. Naaman's obedience and faith led to his healing. His leprosy is cured, and he acknowledges the God of Israel as the true God. This outcome emphasizes the power of faith and the transformative impact of spiritual guidance. In chaplaincy, spiritual advisors often aim to help individuals find healing, meaning, and a deeper connection to their faith or spirituality.

Chaplaincy Concepts in 2 Kings 20:1-11

In this passage, Hezekiah became severely ill, and the prophet Isaiah comes to him with a message from God, saying that he will not recover from his illness and will die. Hezekiah got distressed and turned to the Lord in prayer. He reminded God of his faithfulness and devotion, and he weeps bitterly. God heard Hezekiah's prayer. Before Isaiah even left the middle court of the palace, God spoke to him and instructed him to go back to Hezekiah and deliver a new message. Isaiah told Hezekiah that God had seen his tears and heard his prayers and that Hezekiah would recover from his illness.[10]

This incident demonstrates the importance of spiritual support and intercession during illness. Hezekiah turned to God in prayer, and God responded by granting him healing and extending his life. While there may not have been a specific chaplaincy role as we understand it today, the presence of prophets like Isaiah who acted as

[10] Gwendolyn Washington, *Faith Healing Ministry: A Christian Education Model for Clergy and Laity* (Meadville, PA: Christian Faith Publishing, 2020), 55–56.

messengers of God provided spiritual guidance and support to individuals like Hezekiah.

Chaplaincy Concepts in the New Testament

Jesus as a Chaplain

The ministry of Jesus serves as a profound biblical foundation for the chaplaincy ministry in health. Jesus' life and teachings provide a model for compassionate care, spiritual healing, and ministering to the whole person.[11] Here are several aspects of Jesus' ministry that directly relate to the chaplaincy ministry in health, along with relevant Bible verses and references:

Compassionate Healing and Restoration: The concepts of compassion and mercy are central to the teachings of Jesus. Jesus demonstrated a ministry of compassion, healing, and caring for the whole person, including their spiritual needs.[12] He ministered to the sick, prayed for their healing, and offered words of comfort and hope. Chaplains seek to emulate Christ's example by ministering to the spiritual desires of patients, families, and healthcare staff. In the parable of the Good Samaritan (Luke 10:25-37), Jesus teaches about loving one's neighbor and showing mercy to those in need. Chaplains extend compassion, empathy, and mercy to individuals in healthcare settings, offering comfort, support, and assistance.

> "When he went ashore, he saw a great crowd; and he had compassion for them and cured their sick." (Matt 14:14)
> "Moved with pity, Jesus stretched out his hand and touched him, and said to him, 'I do choose. Be made clean!'" (Mark 1:41)

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[11] Diane J. Chandler, *Christian Spiritual Formation: An Integrated Approach for Personal and Relational Wholeness* (Peabody, MA: InterVarsity Press, 2014), 12.

[12] Paul Borthwick, *Great Commission, Great Compassion: Following Jesus and Loving the World* (Downers Grove, IL: InterVarsity Press, 2015), 41.

Chaplains, like Jesus, are called to show compassion and offer spiritual healing and restoration to those who are physically and emotionally unwell.

Ministry to the whole person: Jesus recognized the holistic needs of individuals, ministering not only to their physical ailments but also to their spiritual and emotional well-being.

> "And just then some people were carrying a paralyzed man lying on a bed. When Jesus saw their faith, he said to the paralytic, 'Take heart, son; your sins are forgiven.'" (Matt 9:2)
> "And he said to her, 'Daughter, your faith has made you well; go in peace and be healed of your disease.'" (Mark 5:34)

Chaplains aim to provide holistic care, addressing the spiritual and emotional needs of patients alongside their physical health.[13]

Announcement of the Kingdom of God: Jesus' ministry was involved on declaring the advent of the Kingdom of God, which brought hope, healing, and transformation.

> "Jesus went throughout Galilee, teaching in their synagogues and proclaiming the good news of the kingdom and curing every disease and every sickness among the people." (Matt 4:23)
> "The Spirit of the Lord is upon me because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free." (Luke 4:18)

The Good Samaritan as a Chaplain

The scriptural story of the Good Samaritan, found in (Luke 10:25–37) a, is widely recognized. The narrative depicts a traveler who is assaulted, robbed, and left half-dead on the side of the road. A Samaritan, although being an outsider, stops to help an injured man, but other religious authorities do not. The Samaritan cares for the man's injuries, transports him to an inn, and pays for his treatment.

[13] Cambridge University Hospitals, "The Role of the Chaplain," accessed 4 April 2024, https://www.cuh.nhs.uk/our-services/chaplaincy/role-chaplain/.

Emulating the Good Samaritan means going beyond the boundaries of religious, social, or cultural differences to help others. It involves a genuine concern for the well-being of individuals and a willingness to provide aid when needed most. A chaplain who models themselves after the Good Samaritan aims to serve as a compassionate presence, offering comfort, understanding, and a listening ear to those hurting or in distress.[14]

Healthcare and Chaplaincy Concepts in Ellen G. White's Writings

Ellen G. White (1827–1915), a key figure in the early SDA Church, wrote extensively about a variety of themes, including health and spirituality. While she did not use the term "chaplaincy" in her writings, her teachings included elements of holistic health and pastoral care that are relevant to the concept of healthcare chaplaincy.[15] White emphasized holistic care for the full individual, including body, mind, and spirit. She advocated for a holistic approach to health, acknowledging the interconnection of various factors. She promoted healthy living choices, such as a plant-based diet, regular exercise, fresh air, and sufficient relaxation. White's writings highlighted the significance of spirituality in health and well-being. She believed that true healing involved speaking not only physical symptoms but also spiritual and emotional needs. She highlighted the power of prayer, faith, and trust in God as essential components of a person's healing journey. White's teachings emphasized the importance of compassionate care and service to others. She encouraged individuals to extend kindness, empathy, and support to those in need, particularly the sick and

[14] Neil Holm, "Toward a Theology of the Ministry of Presence in Chaplaincy," *Journal of Christian Education* 1, no. os-52 (2009): 14.

[15] Ellen G. White, *Testimonies for the Church* (Berrien Springs, MI: Center for Adventist Research, Andrews University, 2013), 4:205.

suffering. Her teachings accord with the essential objectives of healthcare chaplaincy, emphasising spiritual and emotional support for patients, families, and staff. Ellen G. White's book, *The Ministry of Healing*, examines the relationship between bodily and spiritual health.[16] This book covers healthcare subjects such as spirituality, preventive care, and the impact of a supportive environment on health and rehabilitation.

While Ellen G. White did not explicitly develop the concept of healthcare chaplaincy as it is understood today, her teachings on holistic health, pastoral care, and compassionate service provide a foundation that can be related to the principles and practices of chaplaincy in the healthcare setting. Her writings continue to influence the beliefs and practices of SDAs, many of whom are involved in healthcare ministries around the world.

Summary

It is impossible to dispute the religious and biblical underpinnings of chaplaincy work, particularly considering how urgently needed it are in healthcare facilities. Even though the words "chaplaincy" and "chaplain" are not mentioned in the Bible, the idea is nonetheless present. The best chaplain in the Bible is God, who constantly sets out in pursuit of a man who has been mired in sin, illness, pain, etc. Jesus became human to identify, relate to, and console man for losing everything that would have been available to him had he not fallen. Regarding chaplaincy and caregiving ministries both inside and outside of churches, Ellen White did not remain mute.

[16] Lehel Somogyi, “The Nature and Role of Health Laws in the Writings of Ellen G. White,” PhD diss., Adventist International Institute of Advanced Studies, Silang, Cavite, Philippines, 2023, ProQuest Dissertations & Theses, https://gateway.proquest.com/openurl?res_dat=xri%3Apqm&rft_dat=xri%3Apqdiss%3A31635859&rft_val_fmt=info%3Aofi%2Ffmt%3Akev%3Amtx%3Adissertation&url_ver=Z39.88-2004.

CHAPTER 3

REVIEW OF RELEVANT LITERATURE

This chapter involves a comprehensive examination and analysis of existing academic, scholarly, and other relevant sources pertinent to the field of chaplaincy. This critical review aims to identify, summarize, and synthesize the key findings, methodologies, theories, and gaps in existing literature, providing a foundation for the new research being undertaken.

Literature Review

Chaplaincy is indeed a broad field that encompasses various aspects of pastoral care and support. While chaplaincy has not developed as much as it has in other areas, it is crucial to remember that these locations do have chaplaincy services, albeit with certain differences and difficulties. Providing pastoral care and assistance in a diversity of institutional contexts, including; hospitals, prisons, the military, educational institutions, and workplaces,[1] is commonly referred to as chaplaincy. Chaplains are trained professionals who offer guidance, counseling, and religious or spiritual services to individuals and communities in need.

Through their review, authors of published literature locally and globally identified several recurring themes in the literature, including the significance of

[1] Jolanda van Dijke, "Receptive Empathy: The Role of Empathy in Good Care from a Care Ethics and a Humanist Chaplaincy Perspective" (PhD diss., University of Humanistic Studies, Utrecht, Netherlands, 2021), https://research.uvh.nl/ws/portalfiles/portal/62017606/Definite_PDF_Proefschrift_Jolanda_van_Dijke.pdf.

spirituality in healthcare, the need for chaplains to be trained and certified professionals, the challenges of providing pastoral care in diverse and secular contexts, and the evolving role of chaplains in addressing the holistic needs of patients and families.

The article also highlights areas where further research is needed, such as the efficacy of pastoral care interventions, the impact of chaplaincy on healthcare outcomes, and the development of best practices for integrating chaplaincy into the healthcare system.

Sub-Saharan Africa

Literature sheds light on the challenges and opportunities facing chaplaincy services in Sub-Saharan Africa.[52] By examining the function of chaplaincy in the setting of Sub-Saharan Africa, where religious and spiritual beliefs frequently play a major role in people's lives, this study fills a substantial gap in the literature. The study's main conclusions focused on the particular difficulties faced by chaplains in Sub-Saharan Africa in contrast to those in other parts of the world.[2] These challenges may include limited resources, cultural differences, and the diverse religious landscape present in the region. For example, in Ghana, where Christianity and Islam are the dominant religions, chaplains may need to navigate interfaith dynamics while providing spiritual support to individuals from various religious backgrounds.[3]

Furthermore, the study may highlight the opportunities for chaplaincy services to make an impactful impact on the well-being of individuals and communities in

[2] Ajibola Olusogo Fayeshile, "The Chaplain's Role in Improving and Simplifying the Advance Care Planning Workflow on the Heart Failure Unit" (PhD diss., Lancaster Bible College, Lancaster, Pennsylvania, 2023), 34.

[3] Gabriel N. Yidana, "The Dilemma of Chaplaincy to Chieftaincy in Ghana for Pentecostal Denominations" (PhD diss., University of Chester, Chester, England, 2020), 8–10, https://chesterrep.openrepository.com/handle/10034/624317.

Sub-Saharan Africa. Chaplains often serve as pillars of support, providing spiritual guidance, counseling, and comfort during times of crisis or distress. By understanding the cultural and religious contexts of the communities they serve, chaplains can effectively address the spiritual needs of individuals and contribute to holistic healing and wellness.

Given the unique challenges and opportunities present in the Sub-Saharan African region, there may be a need for tailored training programs that equip chaplains to respond to the needs of people. The efforts between religious institutions, healthcare facilities, and academic institutions could play a crucial role in strengthening chaplaincy services in Sub-Saharan Africa.

Nigeria

In Nigeria, while formal chaplaincy programs may not be as extensively developed as in some other parts of the world, there are religious leaders and individuals who provide pastoral care and support in different contexts.[4] For example, in hospitals, one may find pastors, priests, imams, or other religious leaders who offer prayer, comfort, and guidance to patients and their families. Similarly, in educational institutions or the military, there may be individuals fulfilling chaplaincy roles, although their training and formal recognition may vary.

One reason for the relatively limited development of formal chaplaincy programs in Nigeria and some other parts of Africa may be the diverse religious landscape and the historical influence of indigenous spiritual practices. Nigeria is home to a wide range of religious beliefs, including Christianity, Islam, and African traditional religions.

[4] Ike, "Organizational Improvement of Nigerian Catholic Chaplaincy in Central Ohio," 34.

These factors can contribute to variations in the structure and organization of chaplaincy services. However, there is an increasing recognition of the importance of professional chaplaincy services in Africa, including Nigeria, and efforts are being made to develop and strengthen these services. Some educational institutions and religious organizations are offering specialized training programs for chaplains to enhance their skills and knowledge in providing pastoral care.[5]

It is worth noting that the development of chaplaincy in Africa, including Nigeria, is a dynamic process influenced by various factors such as cultural traditions, religious diversity, and resource availability. As the need for pastoral care and support continues to be recognized, there is potential for further growth and formalization of chaplaincy services in these regions.

Meaning of the Term Chaplaincy

The term "chaplaincy" comes from the Latin word "capella," which means "cloak," and is related with the renowned Saint Martins of Tour.[6] During the cold winter of the fourth century, there was a massive death in Northern France due to a lack of proper clothing and exposure. One day, as a regiment of soldiers marched through the gate of the city of Amiens, a poor man clothed in rage and shivering from the cold extended his hand for charity. Other cops passed him by without offering him a dime or showing concern for his needs. Martin, a young soldier riding through the gate, noticed a poor man in the cold but could not just pass by. He grabbed his blade and slashed his military coat in half, while one-half still hung from his shoulders,

[5] Fiona Kate Jones et al., "The Content, Teaching Methods and Effectiveness of Spiritual Care Training for Healthcare Professionals: A Mixed-methods Systematic Review," *Journal of Pain and Symptom Management* 3, no. 62 (2021): e261–e278, https://pubmed.ncbi.nlm.nih.gov/33757893/.

[6] Paget and McCormack, *The Work of the Chaplain*, 2.

while he delivered the second half to the first and stated to him "This is all I have to give, I have no money." And he moved on with his battalion.[7]

Martin had a dream in which Jesus Christ appeared to him, wearing part of the cloak given to the beggar and asking him whether he recognised it. The radiant visitor turned and addressed those who accompanied Him, saying: "Martin, though only a catechumen, has clothed me with his garment."[8]

Chaplaincy refers to a specialized field within chaplaincy services that focuses on providing spiritual and emotional support to individuals and communities in various institutional settings. A chaplain is typically a religiously ordained or appointed individual who serves as a pastoral caregiver, offering guidance, counseling, and religious services to people of diverse religious and non-religious backgrounds.[9]

Healthcare Chaplaincy

Healthcare chaplaincy, a specialized field within pastoral care, has a rich history and has evolved to meet the diverse spiritual needs of patients and healthcare professionals. This article explores the origin and development of healthcare chaplaincy, drawing insights from various philosophers and thinkers who have contributed to its growth. The roots of healthcare chaplaincy can be traced back to ancient civilizations, where pastoral care was an integral part of healing practices. The philosopher Hippocrates emphasized the holistic nature of healing, acknowledging the

[7] Chaplainemergen, "The Origins of Chaplaincy," posted April 3, 2019, accessed 4 April 2024, http://stmartinoftoursparish.org/st-martin-bio.

[8] Martins of Tours Parish, "The Life of St. Martin of Tours," accessed 4 April 2024, http://stmartinoftoursparish.org/tempfiles/1968%20Parish%20Directory.pdf.

[9] David Todres, A. Elizabeth Catlin, and Martha Mary Thiel, "The Intensivist in a Spiritual Care Training Program Adapted for Clinicians," *Critical Care Medicine* 33, no. 12 (2005): 2733–2736, https://www.proquest.com/docview/2871497586.

importance of addressing spiritual dimensions alongside physical ailments (Hippocrates, c. 460 – c. 370 BCE).[10]

Existential philosophers, such as Søren Kierkegaard (1813-1855) and Jean-Paul Sartre (1905-1980), have significantly influenced the development of healthcare chaplaincy.[11] Kierkegaard's emphasis on individual subjective experience and the search for meaning in the face of suffering and Sartre's exploration of the human condition and the role of freedom have informed chaplains' approach to providing existential support to patients. Transpersonal psychology, championed by thinkers like Carl Jung 1875-1961) and Abraham Maslow (Maslow, 1908-1970), has contributed to the understanding of spirituality and its role in health and well-being.[12] Jung's concept of individuation and the integration of the spiritual self (Jung, and Maslow's exploration of self-actualization and peak experiences) have influenced the pastoral care practices within health care chaplaincy.[13]

The recognition of diverse religious and spiritual traditions within healthcare chaplaincy can be attributed to the works of philosophers who advocated for religious tolerance and pluralism. John Locke (1632-1704), an Enlightenment philosopher, argued for the separation of church and state, promoting religious freedom and

[10] Nilufer Demirsoy, "Holistic Care Philosophy for Patient-centered Approaches and Spirituality," IntechOpen, accessed 23 June 2024, https://www.intechopen.com/chapters/54224.

[11] Patrick M. Whitehead, *Existential Health Psychology: The Blind Spot in Healthcare* (London: Palgrave Macmillan, 2019), 22.

[12] ScienceDirect, "Transpersonal," accessed 23 June 2024, https://www.sciencedirect.com/topics/nursing-and-health-professions/transpersonal.

[13] Edward Hoffman, "The Social World of Self-actualizing People: Reflections by Maslow's Biographer," *Journal of Humanistic Psychology* 60, no. 6 (2020): 908–933, https://journals.sagepub.com/doi/abs/10.1177/0022167817739714.

toleration.[14] His ideas laid the foundation for inclusive pastoral care that respects the beliefs and practices of individuals from different faith traditions. Viktor Frankl (1905-1997), a Holocaust survivor, and existential philosopher emphasized the search for meaning as a fundamental human motivation.[15] His work has influenced chaplains in helping patients find purpose and meaning in their healthcare journey. Paul Tillich (1965- 1965), a theologian, and philosopher explored the relationship between religion and existential questions.[16] His concept of the "ultimate concern" and the existential dynamics of faith have shaped the pastoral care practices within health care chaplaincy.

Richard Cabot (1868-1939) and Russell Dick (1956-2021) argue that the Bible presents a perspective on healthcare provision that is akin to chaplaincy services.[17] Chaplains facilitate religious accommodations for service members, ensuring that their religious rights and practices are respected. They advocate for religious freedom within the military and help resolve conflicts related to religious practices. In the biblical context, priests were responsible for addressing the spiritual and physical impurities of the people. Specifically, when individuals displayed symptoms of leprosy, the priests would diagnose the condition and isolate those affected through quarantine measures.

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[14] Diego Lucci, "Separating Politics from Institutional Religion: The Significance of John Locke's Theory of Toleration," *Dialogue and Universalism* 31, no. 2 (2021): 70, https://www.pdcnet.org/du/content/du_2021_0031_0002_0067_0087.

[15] Hanan Bushkin, Roelf van Niekerk, and Louise Stroud, "Searching for Meaning in Chaos: Viktor Frankl's Story," *Europe's Journal of Psychology* 17, no. 3 (2021): 233, https://ejop.psychopen.eu/index.php/ejop/article/download/5439/5439.html?inline=1.

[16] Borthwick, *Great Commission, Great Compassion*, 19.

[17] Richard Cabot and Russell Dick, *The Art of Ministering to the Sick* (New York, NY: Macmillan, 1936), 128.

Despite their role as priests, they also provided care for the sick. While this may not be traditionally perceived as an act of chaplaincy, in modern times, the priest's work aligns with helping the sick restore emotional and physical well-being from a spiritual standpoint. In times of crisis, such as during combat deployments or natural disasters, chaplains play a crucial role in providing pastoral care and emotional support. They offer comfort, conduct memorial services, and assist in grief counseling.[18] Chaplains work closely with other military personnel, including commanders, medical staff, and mental health professionals, to address the holistic needs of service members. They collaborate in creating a supportive environment.

In the United States, the history of healthcare chaplaincy can be traced back to the mid-19th century. During the Civil War, chaplains were appointed to serve in military hospitals, providing pastoral care and support to wounded soldiers.[19] Their presence and services were valued as they offered comfort, prayer, and religious rituals to those in need. This recognition of the importance of pastoral care in healing led to the development of chaplaincy services in civilian hospitals as well.

In the early 20th century, the profession of hospital chaplaincy began to formalize. The first professional organization dedicated to healthcare chaplaincy, the College of Chaplains, was founded in 1931.[67] It aimed to establish standards and provide training for chaplains working in healthcare settings. Over time, the field of healthcare chaplaincy expanded, incorporating a broader understanding of spirituality, and addressing the needs of patients from various religious and cultural

[18] Fiona Timmins et al., "Providing Spiritual Care to In-hospital Patients during COVID-19: A Preliminary European Fact-finding Study," *Journal of Religion and Health* 61, no. 3 (2022): 2212–2232, https://pubmed.ncbi.nlm.nih.gov/35511386/.

[19] Tiia Liuski, "The Finnish Military Chaplaincy: A Double Bonded Profession in a Changing Operational Environment: A Multi-method Study" (PhD diss., University of Eastern Finland, 2023), https://www.researchgate.net/publication/371324959_The_Finnish_military_chaplaincy_-_a_double_bonded_profession_in_a_changing_operational_environment_A_multi-method_study.

backgrounds.[20] The role of healthcare chaplains evolved beyond providing solely religious services to include emotional support, counseling, and advocacy for patients and their families.

In recent decades, chaplaincy associations and organizations have emerged to provide resources, education, and professional support to healthcare chaplains.[68] These associations, including the Association of Healthcare Chaplains and Ministry Advisors, work to promote best practices in chaplaincy, advocate for the inclusion of pastoral care in healthcare settings, and provide a platform for chaplains to network and exchange knowledge.[69]

He proceeded to describe the evolution of what is now recognized as a hospital, stating that hospitals are a relatively recent advancement.[21] In 1872, there were merely 178 hospitals in the United States. However, by 1910, the number had increased to over 4,000. In 1989, there were more than 6,800 hospitals in the USA, but by 1995, the count dropped to 6,467. In 2007, the USA Hospital Directory listed 6,245 hospitals.[22] It is important to note that hospitals emerged later in history, with the primary establishments for tending to the wounded and ill-being inns during the earliest times.

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[20] DorAnne Donesky, Emily Sprague, and Denah Joseph, "A New Perspective on Spiritual Care: Collaborative Chaplaincy and Nursing Practice," *Advances in Nursing Science* 43, no. 2 (2020): 147-148.

[21] Marco Gola and Stefano Capolongo, "Who Says Hospitals Are Ugly? Evolution and Trends of Architectures for Health," in *The City of Care: Strategies to Design Healthier Places*, ed. Anna Anzani and Francesco Scullica (New York: Springer International Publishing, 2022), 96-98.

[22] Waldemar Głusiec, “Hospital Chaplains Are Ethical Consultants When Making Difficult Medical Decisions,” *Journal of Medical Ethics* 48, no. 4 (2022): 3.

Gibson also theorized that before World War II, community hospitals were regarded as peaceful places located on hills.[23] These hospitals were run by dedicated individuals who were relatively underpaid, yet admirably fulfilled their duties and were highly respected by the community. They lacked facilities such as the intensive care unit, dialysis units, open-heart surgery capabilities, nuclear medicine, and advanced laboratories. However, they offered extensive personal care and often faced financial difficulties. Patients who could afford it ended up paying more than the actual cost of their care to ensure that care could be provided for everyone.

Research indicates that in 1946, the Hospital Survey and Construction Act brought about a significant change in the healthcare landscape.[24] With high tax rates and the conclusion of the war, Congress sought avenues to allocate surplus revenues. One such area was hospital construction, leading them to establish a substantial subsidy program aimed at promoting hospital development.

Requirement for Healthcare Chaplains: Clinical Pastoral Education

It is valuable to be aware of the progress and advancement of contemporary clinical pastoral education, which plays a crucial role in the growth and transformation of healthcare chaplaincy. A significant query that has emerged is: "How did healthcare chaplaincy evolve?" The Association of Healthcare Chaplains and Ministry Advisors offers a response. The Clinical Pastoral Education Initiative

[23] Nathan McClintock and Amy K. Coplen, "'Helping Each Other to Help Ourselves': Viviane Barnett, the Green Fingers Program, and Black Agrarian Upbuilding in Albina," *Oregon Historical Quarterly* 124, no. 2 (2023): 120–122, https://muse.jhu.edu/pub/432/article/900726/pdf.

[24] Christi A. Grimm, *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020*, U.S. Department of Health and Human Services, Office of Inspector General, PDF file, April 2020, https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf.

was initiated in Massachusetts on the East Coast in 1925, while the Healthcare Chaplains Ministry Association originated on the West Coast in California in 1939.[25]

Chaplaincy services, which are already available to everyone in the acute care setting,[73] Improved patient experience, reduced stress for surviving family members, and reduced distress with end-of-life decision-making and advance care planning, and reduced distress with end-of-life decision-making and advance care planning. [74] Addressing religious and spiritual needs improves decision-making, reduces end-of-life expenses, reduces in-hospital mortality and increases hospice enrollment,[76] raises patient satisfaction metrics, and improves social health, coping, and health behaviours.[77] In a variety of healthcare settings, people are interested in discussing existential issues (such as what is most significant and cherished), which emphasises the significance of having these kinds of discussions with the care team. Since chaplains are qualified and trained for this kind of work, they are ideally suited to address these requirements. The patient's language and values inform the chaplain's approach and terminology.

Currently, Nigeria is increasingly adopting the concept of holistic care, which involves addressing physical, emotional, psychological, and spiritual needs. In today's hospitals, pastoral caregivers are receiving professional training to align with the professional standards of healthcare, like medical personnel. While Nigeria still has progress to make, the practice of healthcare chaplaincy is gaining traction in the country, particularly within hospitals affiliated with religious institutions.

[25] Joseph Richard Jeffries, "The Role and Function of a Hospital Chaplain in an Interdisciplinary Team" (PhD diss., Liberty University, Lynchburg, Virginia, 2020), https://digitalcommons.liberty.edu/doctoral/2676/.

Summary

Chaplaincy services are evolving at different rates globally, with some countries seeing rapid expansion into various sectors like healthcare and education. In contrast, Nigeria's chaplaincy services are growing more slowly, influenced by cultural and religious factors. Despite the slower pace, there is increasing recognition of the value of chaplains in providing holistic care. Efforts are underway to enhance and integrate these services more widely across the country.

CHAPTER 4

METHODOLOGY

This section describes the methodology for conducting the research work. It explains the research design, area, population, instrumentation, sample size, and analysis. It also specifies the ethical considerations binding this research work.

Research Design

This research work used a descriptive quantitative method. It helps to include a wide range of participants, such as hospital staff, administrators, patients, patient relatives and final year nursing students. Allowing for the identification of different perspectives and barriers across these groups. This design is efficient in terms of time and resources, making it practical for assessing the prevalence of issues without follow-up. The findings from this study highlighted key barriers. Offering immediate insights that can be used to inform policy changes or interventions to improve chaplaincy services at SDA Hospital, Ile-Ife, Nigeria.

Criteria for Selection

The criteria for the selection of the sample size is based on the availability, willingness to participate, and data collection feasibility. The individuals are educated on the research question and the purpose of the theses for the outcome which is be beneficial and improve wellness of the patients, patient families and the staff.

Population and Sample Size

We conducted a total survey of all members of the core medical team (Consultant physicians, nurses, resident doctors, and house officers) and final-year student nurses of the SDA Hospital, Ile-Ife, Osun State, Nigeria. The core medical team includes 53 medical staff (18 nurses, 20 doctors - Consultants, residents, and house officers), and 15 ward maids) because they are the core medical service provider. 30 of the inpatients because they are the core recipient of the chaplaincy services and 20 of their family members because of the emotional crisis they may be going through. A 57 of the final year nursing students (26 in arm one, and 21 in arm two) were enrolled to participate in the study. It was expected that the final-year students had completed more than two-thirds of their clinic postings and are prepared to transition into the core medical team soonest. It is important to include the final-year nursing students and house officers because they are the future of the core health workforce and will be a useful resource to promote the visibility and functionality of chaplaincy services in the hospital settings in the long run. Overall, the sample size is 150 respondents. Table 1 presents the study's population distribution alongside the corresponding sample sizes.

Table 1. Population and Sample

Category	Population	Sample Size
Nursing Staff	28	18
Doctors (Consultants, Residents, House Officers)	30	20
Inpatients	96	30
Patient Relatives	–	20
Ward Maids	30	15
Nursing Students (Final Year - Arm One)	72	26
Nursing Students (Final Year - Arm Two)	49	21
Total	301	150

Note: Researcher's Field Design, 2025; cf. Saunders, Lewis, Thornhill.[1]

Instrumentation

A semi-structured questionnaire was used for data collection. Interviewers provided guidance and clarity. The questionnaire was configured electronically on Google Forms. The questionnaire has three sections.

Reliability and Validity

To conclude the dependability and cogency of the instrument the scores recorded was based solely on the data collected. In order to determine if construct validity has been achieved, the scores need to be assessed statistically. The drafted copy of the training guide together with the questionnaire was be validated by two experts. They were requested to read through the draft training guide, and the questionnaire, and collaborative reviewers to meticulously scrutinize and validate data and advise appropriately on any area of ambiguity or disarrangement of the structure noticed.

[1] M. Saunders, Philip Lewis, and Adrian Thornhill, *Research Methods for Business Students*, 5th ed (London, UK: Pearson Education 2009), 16-18.

Data Collection Procedure

Permission was sought from AUA Ethics Committee, the Chief Medical Director, and the principal school of nursing. Data collection takes place only in hospital settings. Lunch break was leverage or the end of shift hours for data collection to ensure that the exercise does not disrupt respondents' duties.

Step One: Obtained approval to proceed with the research tool and data collection from the supervisor.

Step Two: Requested permission to proceed with data collection from the AUA ethics committee.

Step Three: Obtained permission from the Chief Medical Director, and the principal school of nursing.

Step Four: Recruited research assistants. Hence, in determining the research assistant, the following were put into consideration while appointing research assistants; attention to detail, time management, communication, data collection, communicate fluently, understand and interpret the questions to a non-English person.

Step Five: Conducted a two-day training of research assistants on research ethics, objectives, and instruments for data collection.

A practical session was be held on the second day of training to ensure that research assistants are conversant with the process of administering the questionnaire and obtaining informed consent.

Step Six: Data collection begins. A research assistant approached each ward, and first meets with the Head, describing the study, and its benefits in providing integrated care for patients, their relatives, and healthcare staff. Next, he/she presented the approval letters issued by the AUA Institutional Scientific Ethics Review

Committee and describes the study population. He await permission to proceed with data collection from the Head.

Next, the research assistant approached each eligible respondent and administers the informed consent form, after which he administered the questionnaire. Afterward, the research assistant appreciated the respondent for their participation and approaches the next eligible respondent.

The research assistant expressed gratitude to the Head of the ward once data collection from consenting respondents is completed.

Training of Research Assistants

Six (male and female) research assistants who have obtained at least a bachelor's degree, demonstrate fluency in English (speaking, reading, and writing), and have at least two years' experience conducting surveys were recruited for the data collection exercise. Each practical training session had a discussion period. Each trained volunteer chaplain undergone a 2-day training focusing on research ethics and respect for persons. The training ended with a mock demonstration of the data collection procedure. Suggestions were provided on strategies for improvement to ensure that volunteer chaplains are competent to conduct the research procedure ethically.

Inclusion and Exclusion Criteria

This research captured adults only from age 15-65 who are either patient, medical worker or final year student. While the exclusion are patient with mental disabilities, critical illness (which was be ascertain by the medical team), and those above the age of 65.

Ethical Considerations

The AUA Institutional Scientific and Ethics Review Committee (AUA-ISERC), which oversees AUA's research, provided ethical approval. Every person who wanted to take part in the study got a consent form. Every eligible participant was given the assurance that participation in the study was entirely voluntary and that they were free to leave at any moment if they so chose. Additionally, users were guaranteed that the data they submitted would only be utilised for the study and would never be shared for any other purpose. No identifying information was gathered from participants in order to maintain their anonymity. Participants were fully informed of any risks or potential harm so they might make an informed decision about taking part in the study. Patients who qualified were shielded from both mental and physical discomfort. They were followed attentively for any unwanted consequences. The researcher was mindful of their concerns, respected their privacy and bodily autonomy, and ensured rigorous data confidentiality. The researcher also made an effort to convey findings that are truthful, trustworthy, and legitimate, and precautions were taken to prevent plagiarism of any kind. Every qualified respondent was asked for their informed consent. The study did not include respondents who were in too much pain or discomfort to answer the questions.

Data Analysis

Data collected will be checked for completeness and accuracy of responses. Data will be analyzed using SPSS version 27.0. Frequency tables and bar charts would be used for data summaries. Six questions will be used to elicit respondents' sociodemographic. The maximum obtainable awareness score for general chaplaincy services will be "9". Respondents who score less 50% (score below will be defined as having poor knowledge of chaplaincy services 50-70% (at least a score of 5 – 6 out of

9) of the knowledge score will be said to have a fair knowledge of chaplaincy services, while those with 70% (greater than or equal to 7) will be said to have good knowledge of chaplaincy services.

For knowledge of chaplaincy services at SDA Hospital, Ile-Ife, the maximum knowledge score would be "52". Respondents with aggregate scores <50% (<26 points) will be categorized as having poor knowledge of chaplaincy services at SDA Hospital, and those with scores between 50 - 70% (26 – 36 points) will be defined as having fair knowledge of chaplaincy services at SDA Hospital, Ile-Ife. Respondents with scores >70% (>36 points) will be said to have good knowledge of chaplaincy services at SDA Hospital, Ile-Ife, Nigeria.

We will rank the factors in order of agreement (from strongly agree to strongly disagree) to identify the pertinent factors hindering chaplaincy services. We will also stratify knowledge by the core health team and student nurses. This subgroup analysis will provide more detailed information and will be useful in designing possible interventions.

Data Analysis and Discussion of Findings

This section presents the analysis and interpretation of the findings from the 109 completed questionnaires. Data were first meticulously checked for completeness and accuracy before being imported into SPSS version 27.0. A descriptive quantitative method was employed to capture a snapshot of the current awareness and knowledge regarding chaplaincy services among various stakeholders at SDA Hospital, Ile-Ife.

Demographic Characteristics of Respondents

Figure 1 illustrates the age breakdown of all survey participants.

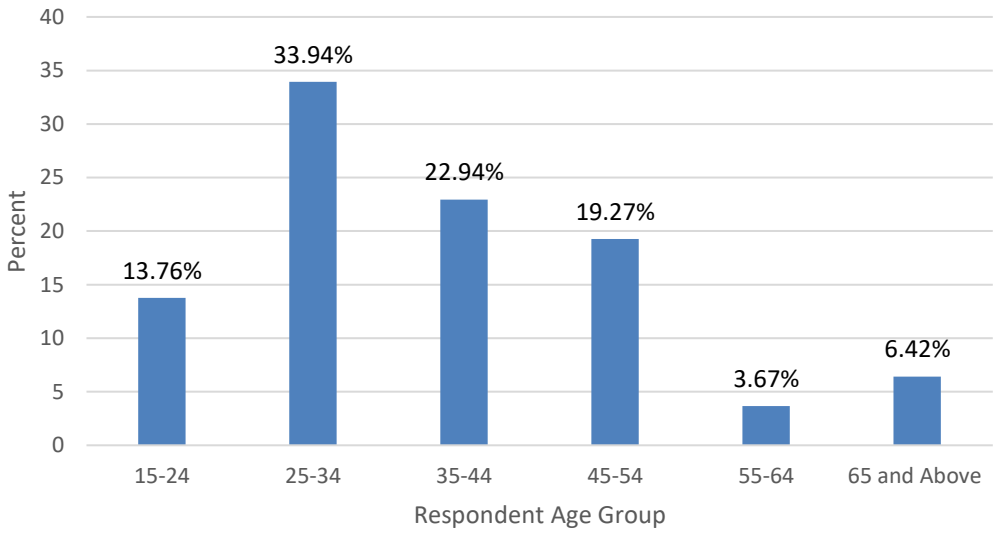

Figure 1. Age Distribution of Respondents

The age distribution of respondents in the study showed a balanced participation of qualitative respondents, mostly adults within the 18-65 age cohorts, with strong concentration in the 25–44 year range. This group includes early to mid-level professionals in addition to final year students who are relatively more active in the healthcare system. This cohort is likely to be more responsive to changes in the form of new care delivery models, including chaplaincy services. However, due to structural constraints, their actual contact with chaplaincy services is very limited, which most likely explains the low awareness levels reported in the survey.

These findings indicate that professional development at younger age levels offers the highest potential to integrate chaplaincy education and increase its prominence. Junior professionals in the survey raised the most stimulating points for improvement and, if properly guided, are in a good position to influence positive culture change across institutions. Cadge et al. support this by stating that this ideology about the integration

of pastoral care works best when these systems are introduced to institutions at the start of a career in order to sustain attitudinal change.[2] Figure 2 displays the gender composition among respondents.

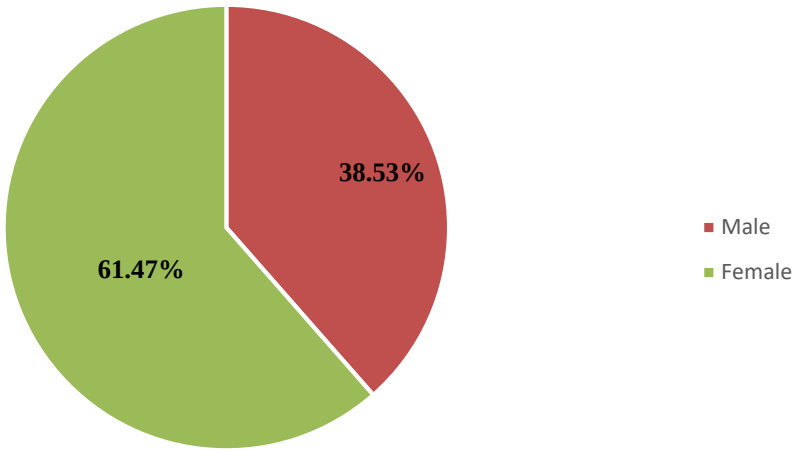

Figure 2. Gender Distribution of Respondents

The bar chart shows that female respondents outnumber their male counterparts, with 61.47 percent identifying as female and 38.53 percent as male. This indicates a notable skew toward female participation in the study and may reflect differences in availability, willingness to participate, or other demographic factors influencing the sample composition. Figure 3 shows the professional roles held by the study participants. Figure 3 illustrates the professional roles of those surveyed.

[2] Wendy Cadge et al., "Training Chaplains and Spiritual Caregivers: The Emergence and Growth of Chaplaincy Programs in Theological Education," *Pastoral Psychology* 69, no. 3 (2020): 187–208, https://doi.org/10.1007/s11089-020-00906-5.

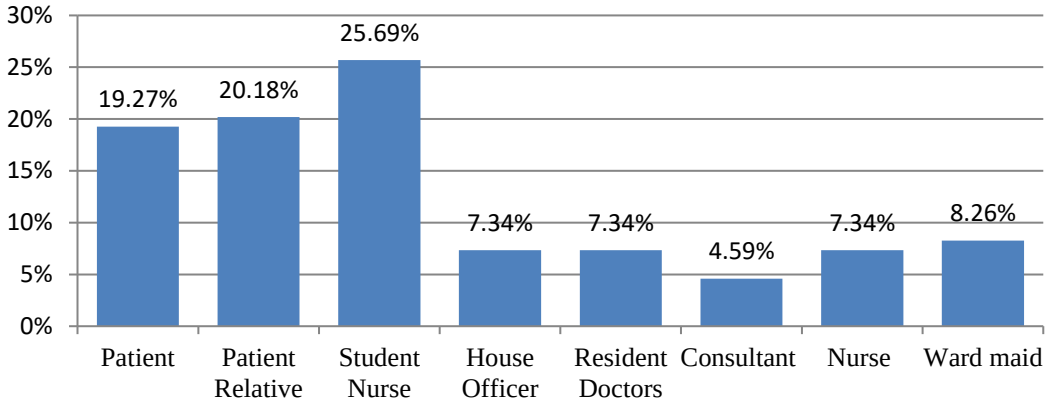

Figure 3. Distribution of Respondents by Professional Cadre

The bar chart reveals that the largest proportion of respondents consists of student nurses at 25.69 percent, followed by relatives at 20.18 percent, and patients at 15.27 percent. Ward maids account for 8.26 percent of participants, while house officers, resident doctors, and nurses each represent around 7 percent. Consultants comprise the smallest segment at 4.58 percent. This distribution indicates a substantial presence of student nurses and patient relatives among the respondents, alongside a more modest representation of healthcare professionals and support staff. Figure 4 depicts the ethnic makeup of the sample population.

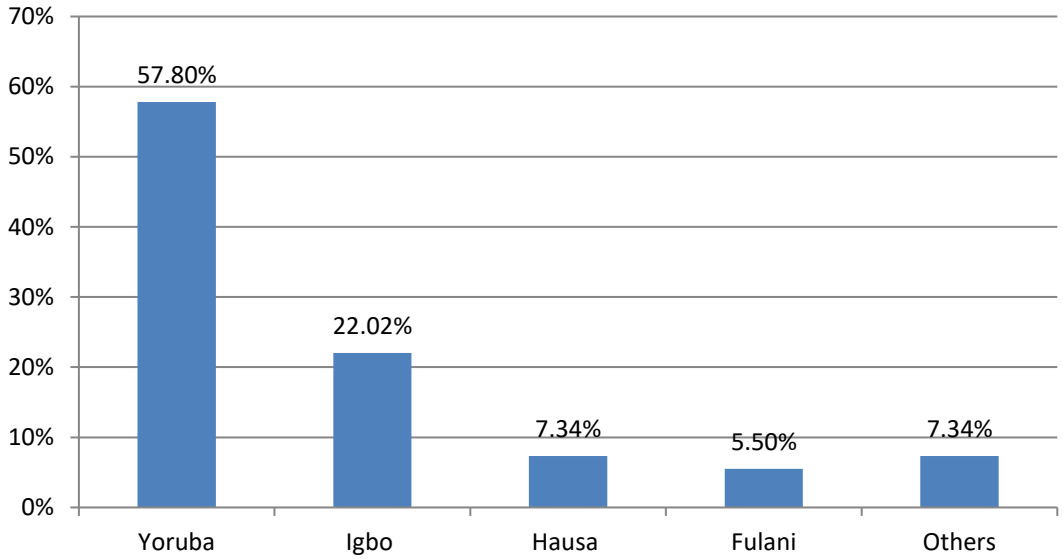

Figure 4. Ethnic Composition of Gender

The bar chart shows a strong majority of respondents identifying as Yoruba, at 77.82 percent, while Igbo participants make up 20.13 percent. Hausa and "others" each stand at 7.33 percent, and Fulani accounts for 5.50 percent. Overall, these figures indicate that most respondents are Yoruba, with smaller but notable representation from other ethnic categories. Figure 5 presents respondents' religious affiliations.

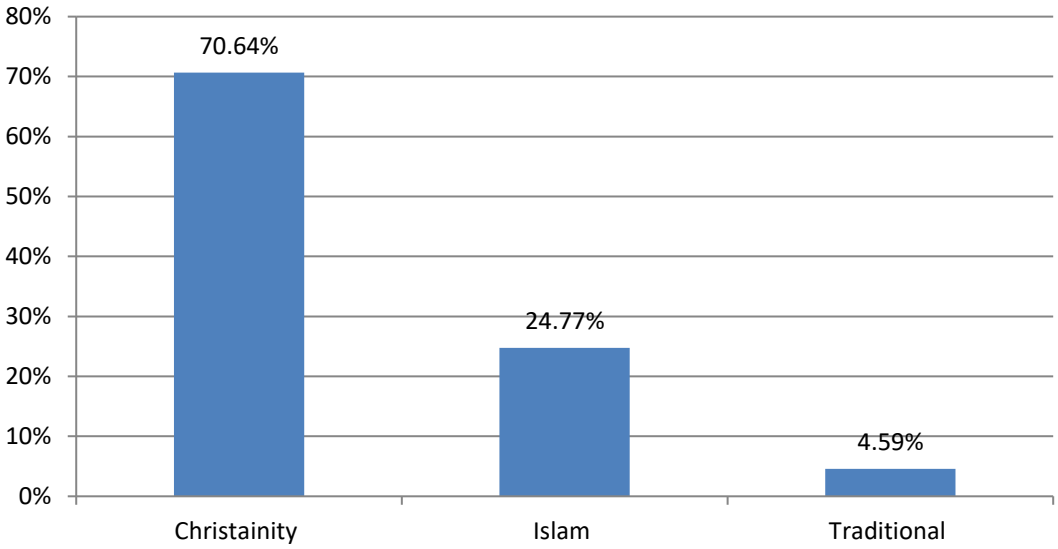

Figure 5. Distribution of Respondents by Religion

Figure 5 indicates that 70.64 percent of respondents identify as Christian, while 24.71 percent follow Islam, and 4.58 percent adhere to traditional religious practices. This distribution demonstrates a clear Christian majority, a smaller yet significant Muslim representation, and a minority of individuals who practice traditional beliefs. It is therefore important for chaplaincy programs to strive for an interfaith and inclusive approach, this will ensure while the core values may align with Adventist beliefs, the services are accessible to individual from various religious background. Figure 6 outlines the highest educational qualifications attained by participants.

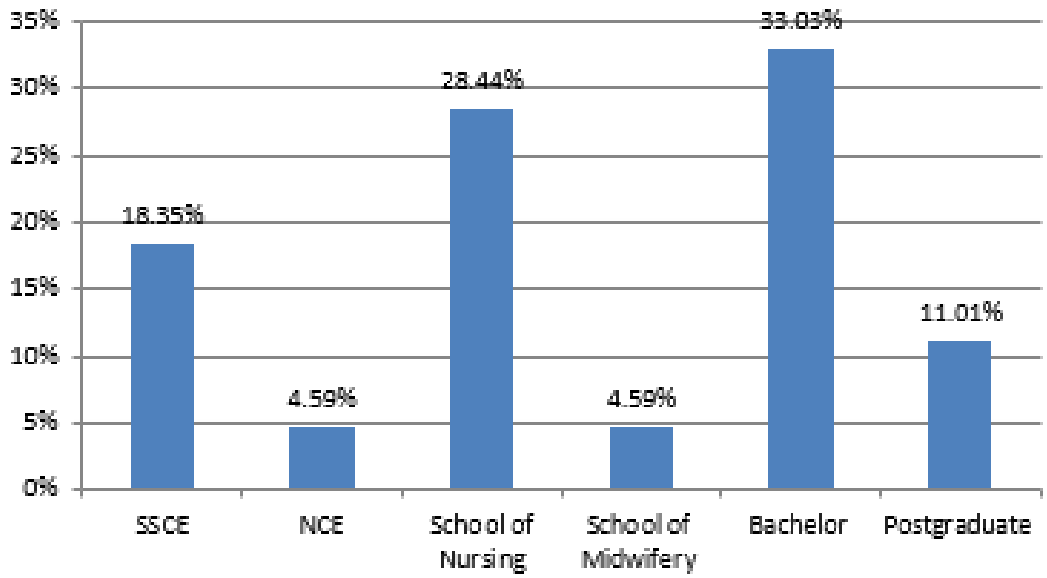

Figure 6. Educational Qualification of Respondents

Figure 6 show that 33.03 percent of respondents hold a Bachelor's degree, making this the largest group. School of Nursing graduates follow closely at 28.44 percent, while those with only an SSCE qualification constitute 15.84 percent. Respondents with postgraduate degrees stand at 11.00 percent, and the smallest proportions are those who completed NCE and the School of Midwifery, each at 4.58

percent. Overall, the data suggest that a significant number of participants have received tertiary-level education, with Bachelor's holders representing the single biggest category.

Awareness of Chaplaincy Services at Seventh-day Adventist Hospital, Ile Ife

Table 2 summarizes stakeholders' awareness levels of chaplaincy services at SDA

Table 2. Awareness of Chaplaincy Services at Seventh-day Adventist Hospital, Ile Ife

S/N	Awareness	Yes (%)	No (%)
1	Chaplain contribute to holistic healing	86.2	11.9
2	Chaplain is a trained professional	92.7	7.3
3	Chaplaincy is a specialized field	92.7	7.3
4	Chaplain undergo chaplaincy training before certified	91.7	8.3
5	Chaplain responds to emotional needs of patients, relatives, and staff	92.7	7.3
6	Spirituality is important in the provision of healthcare services	92.7	7.3
7	Chaplain offer guidance, counseling and religious or spirituality services.	93.6	6.4
8	Chaplain provides services to people of all faiths and no-faith	95.4	4.6
9	Chaplain is a member of healthcare team and support pillar	93.6	6.4
10	Institution provides resources, education, and professional support to chaplains	92.7	7.3

Source: Field Survey, 2025

Table 3 categorizes participants according to their overall awareness scores.

Table 3. Classification of Awareness Level

Classification	Score Range	Approx. Percentage Range of 9
Poor Knowledge	<5	<50%
Fair Knowledge	5–6	50–70%
Good Knowledge	≥7	≥70% of 90

Source: Researcher's Threshold Framework, 2025

Results of the study indicate high awareness and appreciation for chaplaincy services among respondents at the Seventh-day Adventist Hospital, Ile-Ife. Statistics collected via the structured questionnaire indicate high awareness among the majority of the respondents, comprising employees at the hospital, inpatients, their visitors, and final-year students of nursing, about the significance of chaplaincy in this kind of environment. In particular, as seen in Table 2, 95.4% of the respondents agreed that chaplains offer service to people irrespective of their religious affiliation or otherwise, reflecting deep awareness about the chaplain's universal role at the institution. Likewise, 93.6% agreed that chaplains provide spiritual support, emotional support, as well as religious services, to patients as well as employees at the institution. Another high proportion agreed that chaplains are professional workers who are able to assist in holistic healing as integral parts of the healthcare team.

In addition, 92.7% of the participants agreed that chaplaincy is a professional area that needs professional schooling and certification, while 91.7% agreed that chaplains should be trained in chaplaincy before taking up duties. Another 92.7% stressed the significance of spirituality in healthcare provision, in effect affirming the important role of pastoral care in healing patients as well as staff wellness

Such level of awareness among hospital staff, patients, and students means that the problems faced by chaplaincy services in the hospital are not due to ignorance or non-acceptance. In fact, findings indicate an explicit recognition of the chaplain's value, showing that chaplaincy is seen as an integral part of holistic care. The implication of these findings is significant: they uncover that what is hampering chaplaincy services is quite often structure-oriented rather than perception-oriented. The identified obstacles in the study such as the deployment of untrained chaplains, absence of institutional support, ineffective collaboration between chaplains and

medical staff, and inadequate resources are system-oriented problems. What this means is that what is required is immediate policy and administrative changes that would pave the way for professionalizing and integrating chaplaincy services into the healthcare system of the hospital.

Also, the findings indicate that there is a strong foundation that can be built on in terms of reinforcing the chaplaincy department. Wide awareness and positive perception of chaplains among stakeholders provide a ground for implementing reforms like the hiring of professionally qualified chaplains, the inclusion of Clinical Pastoral Education (CPE), and the provision of institutional resources towards chaplaincy growth. It implies that educational and advocacy campaigns may not have to be based on raising awareness but can focus on turning goodwill into implementable institutional support and capacity building.

These are consistent with the literature that emphasizes the importance of professional chaplaincy intervention in healthcare. Having skilled chaplains in healthcare environments enhances patient experience, treatment decision-making, and relations of patients with the healthcare team.[3] Likewise, Nuhu, during his evaluation of professional chaplaincy in Jengre SDA Hospital, Nigeria, established that skilled chaplains enhanced patient outcomes in terms of healing significantly and promoted the overall well-being of hospital client.[4] In their research, Agbiji and Agbiji, call for pastoral care as one of the most important means for holistic healthcare growth, particularly in the African environment, in keeping with the respondents in this

[3] Annelieke Damen et al., "What Do Chaplains Do: The Views of Palliative Care Physicians, Nurses, and Social Workers," Abstract, *American Journal of Hospice & Palliative Medicine* 36, no. 5 (2019): 396, https://doi.org/10.1177/1049909118807123.

[4] Nuhu, "The Impact of Professional Healthcare Chaplains on Patients' Recovery Nature in Jengre Seventh day Adventist Hospital, Nigeria," 52.

present research.[5] Moreover, the above research confirms Rushton's argument that obstacles at the institutional level such as minimal training and unfair treatment rather than unawareness are the key deterrents for the full actualization of chaplaincy intervention in healthcare units.[6] In brief, findings of this research not only confirm the validity and perceived worth of chaplaincy services at SDA Hospital, Ile-Ife, but indicate an important gap between awareness and institutional action as well. Implications for this research are a call toward redirecting energies toward capacity building, professionalization, and systematization of chaplaincy within the hospital care system. As literature suggests, professionalization of chaplaincy in conjunction with institutional support makes it an integral support structure in holistic healing touching not only the physical, but the spiritual as well as emotional states of patients as well as caregivers.

Knowledge of Chaplaincy Services at Seventh-day Adventist Hospital, Ile-Ife

The knowledge section of the questionnaire comprised 15 Likert-scale items designed to assess respondents' understanding of the roles and functions of chaplaincy services at SDA Hospital. Each item was scored from 1 (Strongly Disagree) to 4 (Strongly Agree), yielding a maximum possible total score of 60 (15 × 4). Data were analyzed using SPSS version 27.0, and the overall knowledge score for each respondent was computed by summing the 15 items. In our dataset (N = 109), the observed scores ranged from 20 to 48, with a mean of 39.13 and a standard deviation of 4.52. Table 4 details the knowledge scores of respondents regarding specific chaplaincy roles and functions.

[5] Agbiji and Agbiji, "Pastoral Care as a Resource," a3507.

[6] C. H. Rushton, "Moral Resilience: A Capacity for Navigating Moral Distress in Critical Care," *AACN Advanced Critical Care* 27, no. 1 (2016): 111–119.

Table 4. Respondents Knowledge on Chaplaincy Services at Seventh-day Adventist Ile IFE
Source: Field Survey, 2025

Variable	Mean (M)	Standard Deviation (SD)	Scaled Response	Verbal Interpretation
Spiritual support to patients	2.42	1.091	Disagree	Moderate
Emotional support to patient relatives	2.79	0.944	Agree	High
Emotional support to student nurses	2.82	0.925	Agree	High
Spiritual support to staff	2.82	1.131	Agree	High
Emotional support to staff	2.63	0.978	Agree	High
Emotional support to patients	2.65	1.022	Agree	High
Connects to people needing spiritual support	2.83	0.848	Agree	High
Assists staff struggling with crises	2.65	0.854	Agree	High
Attends to emergencies	2.43	0.936	Disagree	Moderate
Counsels patients on request	2.76	1.053	Agree	High
Counsels patients' relatives	2.31	0.889	Disagree	Moderate
Provides end-of-life ministry	2.08	0.851	Disagree	Moderate
Navigates interfaith dynamics	2.77	0.878	Agree	High
Assists patients struggling with life	2.87	0.829	Agree	High
Participates as a healthcare team member	2.29	0.955	Disagree	Moderate

Scoring system: 1.00-1.99=Strongly Disagree=Low; 2.00-2.49=Agree=Moderate; 2.50-3.49= Agree=High; 3.50-4.00=Strongly Agree=Very High

These results in Table 4 showed that respondents broadly appreciate the chaplaincy as a source of spirituality and emotional care but don't fully recognize its other functions or they might be oblivious to its other functions. High scores for supporting relatives (mean = 2.79, *SD* =1.091), Student nurse (mean = 2.82,

SD = .944), and staff (mean = 2.82 *SD* =1.131) confirms that chaplains are seen primarily as counselors. However, end-of-life ministry (Mean = 2.08, *SD* =.851), emergency response (M = 2.43, *SD* =.*936*), and formal collaboration with health teams (M = 2.29, *SD* = .955) fall into "Disagree/Moderate", indicating a significant gap in awareness of the chaplain's full clinical role. This limited view may stem from the fact that many hospital chaplains in Nigeria lack formal clinical training and are therefore perceived chiefly as conduits for routine prayer and devotion rather than as holistic care providers.

These findings in Table 4 echo existing literature on chaplaincy services. While several studies highlight the chaplains' role in providing consolation, counseling, and crisis intervention,[7] their participation in end-of-life care, emergency calls, and multidisciplinary care planning remains peripheral.[8] Insufficient professional training and lack of institutional support have been identified as barriers to fully integrating chaplains into healthcare teams.[9] In the absence of systematic policy, clinical education, and supportive policies, chaplaincy is poorly supported and remains somewhat hidden. To provide truly holistic pastoral care, it is necessary to develop comprehensive chaplaincy training programs and integrate them into hospital policies and team-driven care frameworks.[10]

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[7] Agbiji and Agbiji, "Pastoral Care as a Resource for Development," a3507; Nuhu, "The Impact of Professional Healthcare Chaplains on Patients' Recovery Nature in Jengre Seventh day Adventist Hospital, Nigeria."

[8] Blethen, "Cross-Cultural Management in Healthcare."

[9] Jones et al., "The Content, Teaching Methods and Effectiveness of Spiritual Care Training for Healthcare Professionals."

[10] Puchalski et al., "Improving the Spiritual Dimension," 650.

Hindrance Factors Affecting Chaplaincy Services

Table 5 ranks the key factors perceived by respondents as influencing effective chaplaincy service delivery.

Table 5. Respondent Perspectives on Factors Affecting Chaplaincy Service
Source: Field Survey, 2025

Variable	Mean (M)	Standard Deviation (SD)	Scaled Response	Verbal Interpretation
Inadequate knowledge of chaplain's role	2.90	0.850	Agree	High
Students' different religious beliefs	2.73	0.845	Agree	High
Patients' different religious beliefs	2.54	0.938	Agree	High
Patient relatives' religious beliefs	2.47	0.987	Disagree	Moderate
Students' cultural beliefs	2.38	0.910	Disagree	Moderate
Staff cultural beliefs	2.24	0.901	Disagree	Moderate
Patients' cultural beliefs	2.34	0.964	Disagree	Moderate
Patient relatives' cultural beliefs	2.51	1.300	Agree	High
Insufficient training opportunities	2.33	0.974	Disagree	Moderate
Insufficient collaboration with healthcare providers	2.20	0.950	Disagree	Moderate
Limited resources limiting chaplain's efficiency	2.10	0.912	Disagree	Moderate
Few chaplains	2.22	0.916	Disagree	Moderate
Lack of healthcare workers' cooperation	2.55	0.938	Agree	High
Insufficient knowledge about chaplaincy services	2.49	0.939	Disagree	Moderate
Patients misunderstanding confidentiality	2.58	0.954	Agree	High
Patient relatives misunderstanding confidentiality	2.50	0.949	Agree	High
Staff misunderstanding confidentiality	2.39	0.892	Disagree	Moderate
Student nurses misunderstanding confidentiality	2.32	0.921	Disagree	Moderate

Note: Scoring system: 1.00-1.99=Strongly Disagree=Low; 2.00-2.49=Agree=Moderate; 2.50-3.49= Agree=High; 3.50-4.00=Strongly Agree=Very High

The results on Table 5 above showed that respondents had high levels of inadequate knowledge of chaplains' role (M = 2.90, SD = .850), students' different religious beliefs (M = 2.73, SD = .845), and patients' misunderstanding confidentiality (M = 2.58, SD = .954). This signifies that healthcare settings were severely lacking in integrating the definitional as well as role assumption facets of understanding chaplains - definitional neglect, trivialization of pastoral care, systemic exclusion neglect, and role assumption neglect within care teams. Lack of education about chaplaincy functions under mapped service delivery, underscore under-served areas. Moreover, respondents reported challenges concerning religion - the mismatch between the religious identity of the chaplains and the students or patients was substantially service inhibiting. Higher scores on confidentiality concerns as barriers portray constructs of trust. Patients who participated in the study had significant headspace challenges because they believed that their sensitive data would not remain confidential. Respondents further disclosed inadequate cooperation from healthcare professionals (M = 2.55, SD = .938), patients of various religious denominations (M = 2.54, SD = .938), and relatives of patients who were non-religious or who misinterpreted confidentiality (M = 2.50, SD = .949). The data obtained indicates that patient diversity, including religion, family confidentiality issues, and interdisciplinary collaboration inefficiencies were barriers complicating the effectiveness of chaplaincy. Other moderate factors of concern such as inadequate training (M = 2.33, SD = .974), patients' cultural beliefs (M = 2.34, SD = .964), and staff cultural beliefs (M = 2.24, SD = .901) indicate these were considered lesser obstructions than the knowledge barriers stemming from religious diversity.

This suggests that insufficient role definition, training in multi-faith respect, and explicit confidentiality policies eroded the effectiveness of chaplaincy services,

and their absence led to critical vulnerabilities in chaplaincy services. Inadequate trust, which must exist for effective pastoral care, severely minimizes chaplaincy impact. Outcomes were in agreement with chaplaincy literature who suggested ineffectual service delivery stemmed from poorly defined roles, emphasizing well-defined roles facilitated effective service delivery.[11] Higher understanding, collaboration, trust, and confidentiality fostered stronger pastoral care systems and better patient outcomes.

[11] Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago, IL: University of Chicago Press), 45; Koenig, *Handbook of Religion and Health*, 88; Pargament et al., *Spiritually Integrated Psychotherapy*, 120.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

In the evolving landscape of healthcare, chaplaincy services have increasingly become the focus of attention as institutions strive to offer holistic care that attends not just the physical but the emotional as well as the spiritual requirements of patients. The outcomes garnered from the quantitative analysis of the 109 completed questionnaires at SDA Hospital, Ile-Ife have shed light into the awareness, knowledge, and perceptions of chaplaincy services within the stakeholder's framework. The demographic profile shows a predominance of respondents between the ages of 25 to 44 years, which constitutes mid-career healthcare professionals and nursing students in their final year. This group is likely to be more open to new innovative approaches to care, which chaplaincy services can be categorized under. It was also seen that females made up 61.47% of the sample as opposed to males who accounted for 38.53%. There appears to be a gender imbalance which could affect the general view on the need for and provision of pastoral care.

In this research, student nurses (25.69%) dominated the professional makeup of participants followed by patient relatives (20.18%) and patients (15.27%), which left lesser portions to medical personnel such as consultants (4.58%), resident doctors (7%), and house officers (7%). This shows that the perception of chaplaincy services is largely shaped by trainees and care receivers as opposed to those who have actual experience as healthcare practitioners. An overwhelming majority who are Yoruba also show ethno-cultural gaps in education background (77.82%), with lesser numbers

as Igbo (20.13%), Hausa (7.33%), and Fulani (5.50%) groups, reflecting the regional demographic characteristics of Ile-Ife. Religious affiliation data showed a Christian majority (70.64%), with Islam followers comprising 24.71%, and traditional religious practitioners representing 4.58%, underscoring the necessity for an interfaith approach to chaplaincy services.

The distribution of all attained educational qualifications showed that the largest percentage, 33.03%, comprised of Bachelor's degree holders, followed by School of Nursing graduates at 28.44%, suggesting that the sample population is somewhat educated, and can possibly engage in critical thinking associated with holistic caring concepts. This particular demographic profile sets the stage for young, educated professionals, especially trainees, as they emerge with strong educational investment that enables them to become active participants whom the contemporary restructuring of chaplaincy systems integrate them into the organizational paradigm changes intended for hospital services in the near future.

Concerning recognition of chaplaincy services, evidence from the study shows extremely high rates of recognition across various spheres. The vast majority, 95.4%, indicated knowledge that chaplains extend their services to people of all faiths and those who have no religion. As well, 93.6% acknowledged that chaplains provide some form of counseling and religious or pastoral care, and equally, that chaplains form an essential part of the healthcare team. Moreover, 92.7% of respondents showed knowledge that chaplaincy is a vocation that requires professional qualifications and that chaplains address a number of emotional issues from different stakeholder groups and that spirituality is one of the dimensions of healthcare services.

The knowledge assessment regarding specific chaplaincy functions revealed more nuanced understandings. Respondents demonstrated high knowledge levels regarding chaplains' roles in providing spiritual and emotional support to various stakeholders, including student nurses (Mean = 2.82, SD = 0.925), staff (Mean = 2.82, SD = 1.131), and patients (Mean = 2.65, SD = 1.022). Respondents also strongly recognized chaplains' functions in connecting people needing spiritual support (Mean = 2.83, SD = 0.848) and assisting patients struggling with life challenges (Mean = 2.87, SD = 0.829). However, knowledge scores were considerably lower for specialized chaplaincy functions, including end-of-life ministry (Mean = 2.08, SD = 0.851), participation as healthcare team players (Mean = 2.29, SD = 0.955), counseling patients' relatives (Mean = 2.31, SD = 0.889), and attending to emergencies (Mean = 2.43, SD = 0.936). This pattern suggests a conceptualization of chaplains primarily as providers of routine spiritual support rather than as comprehensive pastoral care specialists integrated into the healthcare team.

The analysis of hindrance factors affecting chaplaincy services yielded critical insights into barriers impeding optimal service delivery. The highest-rated barrier was inadequate knowledge of chaplains' roles (Mean = 2.90, SD = 0.850), followed by challenges related to students' different religious beliefs (Mean = 2.73, SD = 0.845). Additional significant barriers included patients' misunderstanding of confidentiality (Mean = 2.58, SD = 0.954), lack of healthcare workers' cooperation (Mean = 2.55, SD = 0.938), and patients' different religious beliefs (Mean = 2.54, SD = 0.938). Factors rated as moderate hindrances included insufficient training opportunities (Mean = 2.33, SD = 0.974), patients' cultural beliefs (Mean = 2.34, SD = 0.964), and staff cultural beliefs (Mean = 2.24, SD = 0.901). This hierarchy of barriers suggests that structural and institutional factors particularly those related to role definition,

religious diversity, and interdisciplinary collaboration pose more significant challenges than cultural beliefs or resource limitations.

The juxtaposition of high awareness levels with moderate knowledge of specialized chaplaincy functions and identified institutional barriers reveals a critical gap between theoretical appreciation for chaplaincy services and practical implementation within the healthcare environment. This discrepancy indicates that while stakeholders value the concept of pastoral care integration, structural impediments prevent its full realization. Particularly noteworthy is the finding that junior professionals demonstrated the highest potential for embracing enhanced chaplaincy integration, suggesting that targeting educational interventions toward early-career healthcare providers may yield substantial long-term benefits for pastoral care integration.

Conclusion

Thorough analysis of data from SDA Hospital, Ile-Ife documents a multifaceted reality of chaplaincy service where there is high theoretical esteem but is bounded by powerful structural and institutional constraints. When there is near unanimous appreciation of the value of chaplaincy with more than 90% of the respondents reporting appreciation of the professional status as well as contributory role of the chaplains to holistic healing, there is significant gap in implementation between this conceptual appreciation and actual integration into systems of healthcare. The gap indicates that obstacles to optimal chaplaincy service are not attitudinal resistance but systemic limitations to delivering the best pastoral care.

The results indicate an alarming lack of understanding about the whole-person clinical role of chaplaincy by stakeholders. Although respondents affirm strongly the overall functions of chaplains to offer spiritual support and emotional care, they

express much weaker awareness of competencies like end-of-life care (Mean = 2.08), emergency response (Mean = 2.43), and formal healthcare team integration (Mean = 2.29). Such limited understanding actually limits chaplains to routine spiritual comfort providers, rather than whole-person specialists in clinical pastoral care who contribute measurably to salient comprehensive patient outcomes. The category system is representative of the region's widespread deployment of chaplains without undergone Clinical Pastoral Education, leading to the conventional way of pastoral service provided in the healthcare system affecting chaplaincy intervention.

Institutional and structural factors arise as the leading hindrances to effective chaplaincy, eclipsing attitudinal or resource-based impediments. The largest barrier is found to be insufficient knowledge about the roles of chaplains (Mean = 2.90), closely followed by religious diversity issues and lack of interdisciplinary cooperation. The results thus point toward the necessity for systematic organizational change to integrate chaplaincy, beyond efforts to raise awareness or appreciation levels of stakeholders. Also, the finding of "lack of healthcare workers' cooperation" (Mean = 2.55) as a major hindrance implies that even if present within the healthcare system, the chaplains tend to be functionally isolated from care teams, significantly reducing their input toward whole-person care.

Religious diversity presents a particularly complex challenge with both students' different religious beliefs (Mean = 2.73) and patients' different religious beliefs (Mean = 2.54) identified as significant barriers to effective chaplaincy service delivery. With approximately 30% of respondents identifying with non-Christian faiths, there exists a pressing need for interfaith approaches to chaplaincy that maintain the institution's Adventist foundation while ensuring inclusive pastoral care. The challenge is compounded by confidentiality concerns (Mean = 2.58 for patients'

misunderstanding of confidentiality), undermining chaplaincy confidentiality leading to non-disclosure of the patients and patient relatives concern during crisis.

Notably, the research identifies junior professionals and healthcare students as demonstrating the greatest potential for embracing enhanced chaplaincy integration, aligning with evidence that early professional development offers the optimal opportunity for instilling attitudes favorable to holistic care approaches. The argument is that targeting educational interventions at early-stage health workers has the potential to drive enduring institutional change toward pastoral care integration. The high student nurse representation as the largest professional group included across the study (25.69%) underlines the strategic importance of engaging this group with both education and collaboration efforts related to chaplaincy services.

Cumulative evidence suggests that although SDA Hospital, Ile-Ife has a strong foundation of stakeholder support toward the use of chaplaincy services, ensuing theoretical appreciation must be converted into effective practical application by overcoming significant structural, education, and collaboration barriers. The way to better integration demands structural changes in the policy of healthcare over attitudinal changes, with specific concern for professionalization of chaplaincy practice through clinical pastoral education, clear definition of roles and expectations, transparent confidentiality practices, active interdisciplinary collaboration, and the application of interfaith practices that are respectful across diverse religious tradition while upholding institutional identity. By these multifaceted reforms, the hospital can address the gap between aspirational appreciation of the value of chaplaincy and actual integration into comprehensive healthcare deliverance.

Recommendation

Knowing the findings of this study, it is safe to conclude that there are several measures that can be taken to improve the integration and functionality of chaplaincy services in healthcare institutions.

1. Set up a formal chaplaincy program that develops specialist competence in pastoral care, end-of-life care, crisis management ministry, and collaboration with healthcare providers. The knowledge deficit we identified was specifically with end-of-life ministry scoring only 2.08 on our scale. Adequate training, provision of materials and other resources may be of help towards improving chaplains' competency. In this way, the chaplains can step beyond rudimentary pastoral care to become competent specialists who are fully embedded in the patient care team.
2. Implement formal policies that explicitly establish roles, duties, and collaboration with healthcare teams for chaplains and making it assessable to the chaplain and healthcare workers and monitor its implementation. These policies have to involve regular assessments. Such as, formal referral procedures to use the services of the chaplaincy, appropriate recording on medical charts, regular team meetings with spiritualcare considerations, etc. These enhancements will bring the work of the chaplain into the fabric of patient care.
3. Create an adaptive model of chaplaincy that respects the hospital's Seventh-day Adventist heritage yet is shown to be effective across people of diverse religion (2.73 among students, 2.54 among patients). Chaplains should receive training in different religious traditions, develop resources for various faith practices, build relationships with local religious leaders, and create

welcoming prayer spaces for all faiths and no faith. Additionally, establish clear confidentiality guidelines to address patients' privacy concerns (2.58) by clearly explaining how information is shared, protected, and documented. These improvements will build trust and make pastoral care more accessible to everyone.

4. Incorporate chaplaincy awareness and collaboration into education for healthcare students, particularly nursing students who made up the largest group in our study (25.69%). This should include rotations with chaplaincy services, mentoring relationships between chaplains and students, joint learning sessions about spiritual aspects of healthcare, and volunteer opportunities in chaplaincy. Since our research shows younger professionals are most open to chaplaincy integration, this approach targets those most likely to embrace pastoral care as an important part of comprehensive patient centered care.
5. Create concrete methods for measuring the effectiveness of chaplaincy and collecting evidence for continuous development. These must involve measuring patients' spiritual and emotional wellness, feedback about pastoral care from families, evaluation of collaboration by the healthcare staff, and consideration of the impact of pastoral care on treatment outcomes. Regular monitoring of this data will lead to areas of excellence and areas for development, drive resource allocation decisions, offer proof to administration for support, and assist in continually sharpening chaplaincy practices. By doing so, this process will change the method of evaluating the value of chaplaincy from largely anecdotal to one rooted in outcome measurement and systematic development.

APPENDIXES

APPENDIX A

CONSENT TO PARTICIPATE IN THE STUDY

You are being asked to participate in a research study entitled: Factors militating against chaplaincy services at Seventh-day Adventist Hospital, Ile-Ife, Nigeria.
The information below talks about what is involved in this research, what you will be asked to do, and the potential risks and benefits of participating in this study. You will be asked questions and you are expected to seek clarification about the nature of the study.

The purpose of this study: This study will help students develop confidence in chaplaincy services and consult duly, thereby making the chaplain and his role more visible.

Participation: To participate in the study, you will be asked to fill out a questionnaire that has 39 items. Finishing the questionnaire should take approximately 15 minutes.

Voluntary Nature of Participation: Your participation in this study is voluntary, and by signing the questionnaire, you are giving your consent. If you choose not to take part, simply refrain from starting or completing the questionnaire or engaging in other research activities. You won't face any consequences for opting out, and your questionnaire will not be utilized.

Benefits and Risks: Your participation in this research will enhance our understanding of chaplaincy services, potentially aiding in better meeting patients' needs and improving health outcomes at the Seventh-day Adventist Hospital, Ile-Ife. There are no identifiable risks associated with participating.

Confidentiality: Your details will remain confidential. Please refrain from including your name on the questionnaire, as this form is distinct from it, guaranteeing anonymity. Only the researcher(s) will have access to the data, which will be securely stored on a password-protected computer.

Questions about the Study: Please feel free to reach out to the researcher with any questions you may have about the study. You can contact them now by emailing or calling using the contact information provided at the bottom of this letter.
If you have any ethical concerns about your participation in this research, contact the Institutional.
Scientific Ethics Review Committee, Adventist University of Africa<ethics@aua.ac.ke>

I have read and fully understood the statements on this form. All my questions were answered satisfactorily. I voluntarily agree to participate in this study.
Researcher's Signature Date _____
Contact the supervisor of the research if you need more information or have questions:
Dr. MahlonJuma
Email address: jumamn@aua.ac.ke

Thank you.
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APPENDIX B

QUESTIONNAIRE

Factors militating against Chaplaincy Services at the Seventh-day Adventist Hospital, Ile-Ife, Nigeria

Questionnaire

1. Respondent's age (as of last birthday): 15-24 { } 25-34 { } 35-44 { } 45-54{ } 55-64{ } 65---
2. 2. Sex at birth: Male { } Female { }
3. 3. Highest level of education: Senior School Certificate { } National Certificate in Education { } School of Nursing { } School of Midwifery { } Bachelor { } Postgraduate { }
4. 4. Cadre: Student nurse { } House officer { } Resident doctor { } Consultant { } Nurse { } Ward maid { }
5. Ethnicity: Yoruba { } Ibo { } Hausa { } Fulani { } Others (specify): _____
6. Religion: Christianity { } Islam { } Traditional { } Others (specify): _____

Awareness and Knowledge of Chaplains

The following questions will assess your awareness and knowledge of the requirements for chaplaincy services. Respond with either Yes/No

1. Chaplain contribute to holistic healing	1. Yes 2. No
2. Chaplain is a trained professional	1. Yes 2. No
3. Chaplaincy is a specialized field	1. Yes 2. No
4. Chaplain undergo chaplaincy training before certified	1. Yes

	2. No
5. Chaplain is trained to respond to emotional needs of patient, patient relative and staff.	1. Yes 2. No
6. Spirituality is important in the provision of healthcare services	1. Yes 2. No
7. Chaplain offer guidance, counseling and religious or spirituality services.	1. Yes 2. No
8. Chaplain provides services to people of all faith and no-faith.	1. Yes 2. No
9. Chaplain is a member of healthcare team and support pillar	1. Yes 2. No
10. Institution provide resources, education and professional support to healthcare chaplain	1. Yes 2. No

Knowledge of Chaplaincy services provided at Seventh-day Adventist Hospital, Ile-Ife

Please rate your knowledge about the existence of chaplaincy services at the Seventh-day Adventist Hospital, Ile-Ife.

Strongly Disagree (1), Disagree (2), Agree (3) and Strongly Agree (4).

Questions	1	2	3	4
At Seventh-day Adventist Hospital, Ile-Ife, Chaplains….				
1. Provide spiritual support to patients.				
2. Provide spiritual and emotional support to the patient's relatives.				
3. Provide spiritual and emotional support to student nurses.				
4. Provide spiritual support to staff.				
5. Provides emotional support to staff.				
6. Provides emotional supports to patients.				
7. Connect to people who might need spiritual support.				
8. Assist staff members struggling with a crisis.				
9. Attend to emergencies				
10. Counsel patients on request				
11. Counsel patients' relatives				
12. Provides end-of-life ministry				
13. Navigate interfaith dynamics while providing spiritual support.				
14. Are called in to assist patients who are struggling with life.				
15. Are health team, player				

Factors that Hinder the Effective Provision of Chaplaincy Services
Please rate the following factors that hinder the effective provision of chaplaincy services at the Seventh-day Adventist Hospital, Ile-Ife. Kindly rate the factors.

Strongly Disagree (1), Disagree (2), Agree (3) and Strongly Agree (4).

Factors hindering chaplaincy services	1	2	3	4
1. There is inadequate knowledge of the role of chaplains in the hospital community.				
2. Students' different religious beliefs				
3. Patients' different religious beliefs				
4. Patient relatives' religious beliefs				
5. Students' cultural beliefs				
6. Staff's cultural beliefs				
7. Patients' cultural beliefs				
8. Patients' relatives' cultural beliefs				
9. Insufficient training and professional development opportunities for chaplains				
10. Insufficient collaboration with healthcare providers				
11. Limited resources may limit chaplains' efficiency.				
12. Few chaplains				
13. Not having other healthcare workers cooperation.				
14. Insufficient knowledge of other healthcare workers about chaplaincy services				
15. Patients' misunderstanding about chaplains maintaining the confidentiality of shared information				
16. Patients' relatives' misunderstanding about chaplains maintaining the confidentiality of shared information				
17. Staff's misunderstanding about chaplains maintaining the confidentiality of shared information				
18. Student nurses' misunderstanding about chaplains maintaining the confidentiality of shared information				

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VITA

GABRIEL OLASUPO ODEDEJI
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A highly motivated individual and experienced minister with keen interest in providing spiritual guidance and support to my congregations. Adept at leading worship services and providing pastoral care. Passionate with a deep commitment to helping others through compassion. Proven track record of developing programs to foster spiritual growth and engaging members in church activities.

WORK EXPEREIENCE
Chaplaincy Director, Oyo Conference (SDA) Church, Ibadan, Oyo State, Nigeria, August 2023 - July 2024
Church/District Pastor, West Nigeria Conference/Oyo Conference (SDA Church), Aradagun, Ilogbo, Orogun, Oke-Bola, Iwo-Road, and Airport, Ibadan, May 2005 - July 2024
Pastor/Campus Chaplain, West Nigeria Conference/Oyo Conference (SDA Church), Orogun, Ibadan, Oyo State, Nigeria, July 2011 - October 2015
Healthcare Chaplain, Babcock Teaching Hospital (Internship), Ilisan Remo, Ogun State, Nigeria, 2018, 2019, 2021 and 2023

SKILLS
Outgoing with strong and effective organizational and leadership skills. A confident problem solver with a logical, enthusiastic and creative approach.

MINISTERIAL ORDINATION
Ordained January, 2016

ENDORSEMENT
Healthcare chaplain, 2023

EDUCATION
MChap Candidate, Adventist University of Africa, Nairobi, Kenya.
BA. Theology, Babcock University, Ilisan Remo, Nigeria

INFORMATION AND COMMUNICATION TECHNOLOGY
Microsoft office (Word, Excel), CompTIA Project, Ec-council customer Relationship Management, New Horizons (certificate of completion), 2009 – 2011

PROFESSIONAL QUALIFICATION
Data Security Awareness (NHSD) - March, 2025
Clinical Frailty scale session - April, 2025

Clinical Pastoral Education, Adventist Chaplaincy Institute, June 2023 - August 2023
Clinical Pastoral Education, Adventist Chaplaincy Institute, February 2021 - April 2021
Clinical Pastoral Education, Adventist Chaplaincy Institute July 2019 - November 2019
Clinical Pastoral Education, Adventist Chaplaincy Institute June 2018 - August 2018

CONTINUING EDUCATION

Continuing Education (Chaplaincy), Adventist Chaplaincy Institute, 2023
Continuing Education (Chaplaincy), Adventist Chaplaincy Institute, 2022
Continuing Education (Chaplaincy), Adventist Chaplaincy Institute, 2021
Continuing Education (Chaplaincy), Adventist Chaplaincy Institute, 2020