**TEN HARMFUL THINGS**

**in Hospital Visitation**

**The Negative Golden Rules in Hospital Visitation:**

**“Don’t do unto others as you would not have them do unto you.”**



Here are ten harmful things we should not do when we visit someone who is ill. These guidelines apply to visits in hospitals, nursing homes as well as with people who are frail and sick at home. Please reflect on these guidelines. These directions are given in short form with minimal clarification. Therefore, if you have additional suggestions, please respond with your ideas. We want to learn from each other so we can share God’s love and grace in the most effective and caring way possible.

**1. Attitudes**:

Avoid carrying your own worries, problems, frictions, tension and crises into a sick person’s room. Our attitude will be perceived by the patient and his/her family. A calming presence is necessary!!

**2. Entering:**

Be perceptive when a door is closed. In a care home we will want to knock and then quietly enter the room. In a hospital knocking is not wise because a patient may be sleeping. Check with the staff.

If there is any notice regarding not having visitors, then we need to contact the medical staff with our questions. We cannot go against the medical staff. A pastoral call may be needed, even urgent, but at certain times it may be impossible. We must honour the directions of the medical staff and the patient’s wishes. The door may be closed for medical reasons or because some people prefer to have their doors closed all the time.

At times there will be a notice by the door saying that we cannot enter the room without specific items such as - a gown, gloves, possibly a mask. We need to comply with the directives that are posted. These items may be uncomfortable, but we need to comply with the medical directives. Check with the staff.

**3.** **Visiting Position**:

Never sit or lean on the patient’s bed. Avoid jarring or bumping the bed.

If possible, we should never remain standing as we visit. We should do all we can to get a chair (or chairs if we are visiting as a couple) so that we can visit on the patient’s level. Even if the visit is brief the patient will sense we are considerate when we sit on their level.

The one exception may be when a group is visiting one person, particularly if the person is in a critical condition, such as in a Cardiac Care Unit. Again, we want to be sensitive as we gather around a person.

**5. Relationship with medical staff**:

We should never set the patient against the physician, nursing staff, hospital or nursing home. We may sense the person we are visiting is angry at or disappointed with the medical people.

How should we respond to his/her anger?

We need to be clear of our role. Our role is certainly not to evaluate the medical people. We do not know all the facts. And even if we did, what would it help? It may be easy to take sides. Certainly we must feel with and validate the patient’s emotions. But, this does not mean we should agree, or disagree, with them.

The following may be what is actually happening when a person is angry with a doctor or the medical people. The person may have received some difficult news - maybe about a terminal illness. As a result, the person feels they need someone to blame because the news is too devastating. The best is to feel with the person, walk with him, listen to his feelings and assure him you are present in the difficult valley.

Never let any unresolved feelings we may have with medical staff cloud what is happening. When a person shares anger or frustration, never say, “Well, let me tell you about what happened to me when I was in the hospital.” Never tell about an unfortunate situation we have heard about another patient. Stay with the person in front of us - and don’t shift the focus on to ourselves - or give other stories.

**6. Visitor’s Health**:

Do not make hospital calls when we have a cold or the flu. If we believe we need to make a visit but have a minor cold - then follow deliberate steps such as having no physical contact and wear a mask. What would make the need to visit so great that we had to visit while fighting a cold?

**7. Sharing Information**:

If ever the Apostle James’ command is relevant, it is here, “My dear brothers, take note of this: Everyone should be quick to listen, slow to speak.” - James 1:19

Be **very slow to speak** about a patient’s diagnosis even if we know it. It is not our business to tell the patient how sick he/she might be. Information about the patient’s illness will be given by the physician. Do not carry information about patients to other people, particularly to other patients in the hospital. Be thoughtful in sharing medical information with others. Even when we ask other people to pray for a patient, we need to be careful what we share. Patients have trust and confidence that we will not share their information.

**8. Arguing**:

Never argue with a patient. The purpose of an argument is to win over one’s opponent; not to give insight or encouragement. If we disagree, then just disagree and let it go at that. The patient does not need to know that we disagree. Will it help the patient when we argue with him?

**9. New Babies**:

Do not ask a new mother if she received what she wanted. It is important she wants what she received. If we are asked to comment about the looks of an infant that we think is not particularly beautiful, we may use words such as, “That sure is a baby.” Find some encouraging element to mention. Look at the delicate (or strong) features.

**9. Scent free**:

Sick and shut-in people are extremely sensitive to perfumes, colognes, and after shaves. **No scents** makes **good sense**. The hospital asks all people to respect their scent-free environment, and this includes flowers.

**10. Medical Information & Terminology**:

True or False: We should ask a patient what his/her sickness is?

There are several items to consider when we think about the medical information of a person. We begin with the principle that medical information is very personal and often sensitive. We need to be very sensitive when we ask questions. Ask yourself:

* Why do I need to know? Often, individuals will think they have good reasons to know. But, we must evaluate whether these are really valid reasons, considering our purpose for visiting.
* If I were the patient, would I want others to know the details of my condition?
* If I know the technical issues about the sickness, what will I do with this information?
* What benefit is it to the patient that I know?
* Place yourself in the place of the patient. What if I were the patient, and had just received some discouraging news, would I want other people to know? What people should know - and who should tell them - and what should they tell?

Understanding of Medical Information:

Never pretend that we know what a term means if we do not know its meaning.

Do not assume that the patient fully understands what it means. Often the medical people use technical language that people do not clearly understand. And sometimes people are ashamed to ask the medical professionals about their condition. They may be embarrassed to ask to have it explained in “lay language”. This really means, people will often not know with clarity what is happening to them. When other people are told about a patient, and then come to visit, they might “know” more than the patient does. At least the patient may feel that way.

Ask yourselves, what is the role of the visit? If a patient is unable to speak and tell us medical information, does it change the purpose of our visit?

**Five Items to consider regarding medical information**:

**1st** **What is our role?**

Our role is to care and listen.

Will knowing medical information help us to care for a person?

Will telling other people be caring or might it just be gossiping?

**2nd An Intellectual Discussion or Caring from the Heart?**

Is there a temptation that we will remain on an intellectual/factual level and discuss medical issues but not care for the person? By this I mean, we can discuss facts, at least as far as we know them, and use these facts to keep from looking deeply in a person’s eyes and sensing their heart’s cry.

**3rd** **Expressing Jesus’ love - not impressing**

We begin with the premise that our purpose is to express Jesus’ love and compassion - and not to impress people of our knowledge of medical terms. And, actually this is very limited.

**4th** **Making comparisons**

We should never use our knowledge of people’s medical condition as a means to compare the patient’s to other people. This means, we cannot let our minds make comparisons with other people we know. When the person we are visiting has told us, “I have colon cancer (or any other medical condition),” it is neither helpful, nor caring, to say something to this effect, “Well, when my aunt had colon cancer she had these treatments and these operations and lived this long.”

Whenever we speak about another person - after the person we care for has shared her/ his condition - we are in effect ignoring the person before us. We need to stay with the person and feel his/her emotional pain. It is tempting to provide comparisons as a way of demonstrating our medical knowledge and impress the person that we understand what she is experiencing. But this will do the opposite. **No comparisons!!**

**5th** **Making Predictions**

Whenever we hear a diagnosis we must never respond back with any statement like, “Therefore I believe you only have three months to live.” We need to feel the full impact of difficult news - and then we must respond with assurance and commitment that we will remain faithful in our caring and praying - walking together with our loved one, no matter how long or how short. Again, it is tempting to provide stories of people who lived beyond their prognosis. **No predictions!!**

Our purpose is to care for people - not to analyse medical issues.

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