

Church Involvement in Community Service: thoughts, Ideas, and Solutions through Hospital Visits in Muara Enim

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ABSTRACT

The church is frequently trapped in exclusive internal activities, ignoring the social isolation and deep existential crises experienced by people in public medical environments. Therefore, the active engagement of the faith community through public diaconal ministry is highly required to bring holistic healing and hope amidst modern human suffering. This study employs a qualitative descriptive approach combined with a structured pastoral action research method. Data were gathered through intensive participant observation and clinical interviews across three distinct case studies at RSUD Dr. H. Mohamad Rabain Muara Enim. The results demonstrate that integrating targeted healing prayers with practical physical blessings, such as meals, effectively reduces anxiety and psychosocial burdens on caregivers. Furthermore, restructuring theological perspectives combined with direct social advocacy to government agencies provides sustainable solutions for vulnerable families.

INTRODUCTION

The Church does not in essence exist for herself, but is sent into the world to manifest the signs of the Kingdom of God through holistically transformative action. Ecclesiologically, the church's vocation is summarized in three main pillars, namely *kerygma* (preaching the Gospel), *koinonia* (fellowship), and *diakonia* (ministry of love). However, in contemporary ecclesiastical dynamics, there is often a reduction in which church activity tends to be centered within the walls of exclusive sacred buildings, thus ignoring the sociological screams that occur in the surrounding environment. In fact, true Christianity is characterized by a willingness to step out of the comfort zone of cult rites towards radical involvement in the midst of the concrete struggles of society. When the church limits itself to the teaching of the internal pulpit, it is experiencing amnesia towards the historical example of Jesus Christ that never separates His preaching from real acts of healing and social concern. This call to be an active agent of change is explicitly affirmed in the theological mandate of Matthew 5:16, which states that the light of the church must shine before the multitude, so that through these good works, the world may see and glorify the Father in heaven. This verse imperatively demands the existence of orthopraxis or harmony between the doctrine believed in and the actual actions implemented in the public sphere. The Christian light is not designed to be hidden under a bushel of passivity, but rather must be emitted in places where the darkness of human suffering lies, including in the quiet corridors of public medical institutions.

This far-reaching dynamics of ministry requires pastoral leadership that is prophetically sensitive and spiritually mature. Rev. Rubin Adi Abraham, in his construction of his thinking on theological leadership, affirms that in every trajectory of history and generation, God has always raised up His chosen individuals to become an extension of His hand on earth. The main characteristic of these responsive pastoral agents is their willingness to accept the "*divine burden*." This divine burden is not an abstract intellectual discourse, but a keen inner sensitivity in capturing, seeing, and feeling the real needs and sufferings that are plaguing the congregation and the surrounding environment. This agency of ministry that has been transformed by the divine burden will not choose to be passive, to escape reality, or simply to throw theological rhetoric from the pulpit. Instead, they will devote all of their existence, time, and resources to concrete acts of service in order to actively do God's will on earth. Thus, the church's involvement in community service is no longer seen as an optional program or merely a complementary (charitative) activity, but rather an ontological necessity that defines whether the church is truly alive as a moving Body of Christ or merely a static religious organization. It is this manifestation of the divine burden that drives the awareness that the local church must be physically present in the midst of the space of suffering, one of which is through a structured hospital visit service program.

Sociologically and psychologically, hospitals are a critical locus where human physical fragility meets acute existential crises. When an individual is diagnosed with an illness and has to undergo hospitalization, he or she experiences a temporary disconnection from his or her social environment, work, and domestic routine. This condition triggers what is called medical social isolation. Research in the field of pastoral mental health shows that social isolation in hospitals is often followed by increased anxiety, helplessness, and even *masked depression*, which if left unchecked will worsen the body's biological response to medical therapy. This psycho-spiritual problem not only tests the patient's resilience, but also hits the family that accompanies them. Caregiver families bear a double burden, which includes physical fatigue due to irregular on-call hours, anxiety about the patient's medical prognosis, and financial stress due to treatment costs. In intensive care units such as *the Intensive Care Unit (ICU)*, very strict restrictions on visits for the sake of medical sterilization create a dividing block that exacerbates the isolation of the companion family. They often sit in the cold corridors of the hospital in a fragile mental state, without an adequate *support system* to greet or simply strengthen their emotional side. This vulnerable condition in the medical realm unfortunately often goes unnoticed by the local religious community. This gap in religious community engagement triggers a void of holistic mentoring. Many local churches are stuck in an "*in-church ministry*" paradigm, where pastoral programs are geared only to members of the congregation who are actively present on Sundays. As a result, when there is a community or even a congregation in a regional general hospital, institutional pastoral presence is often absent or only incidental if there is a formal request. Medical institutions such as regional public hospitals are often seen as secular areas that are beyond the scope of the church's sacred responsibilities. In fact, hospital *chaplaincy* is the largest contribution that the church can make to fill the psychosocial void that cannot be filled by biological medical treatment. Doctors and nurses focus on physical healing, while the church is called to bring about healing through empathetic presence, prayer, and tangible moral support.

The urgency of the presence of religious institutions in the public sphere is supported by various international and national scientific literature in the last fifteen years. In the global discourse, Carey and Cohen's research confirms that spiritual mentoring in hospitals has a very significant positive correlation with reduced stress levels and increased patient cooperation in the medical recovery process. Medical pastoral care is no longer seen as a complement to ritual, but rather as part of scientifically recognized *holistic care*. In Indonesia, the Church has an important role in the sociological-medical field because pastoral ministry is not only oriented to the spiritual needs of the sick, but also covers the social and economic problems faced by patients and their families. Kusmaryanto emphasized that healing services are part of the church's pastoral work and evangelization work. Thus, service to the sick becomes a tangible form of Christ's presence and love for people. Furthermore, in the context of a post-pandemic society, Kardi, Hermanto, and Abraham underlined that the church is required to redefine the pattern of its presence in society by prioritizing acts of mercy that touch the domestic realm and public facilities. This thinking is in line with the

views of international practical theologians such as John Swinton, who argue that the church should be a welcoming community capable of presenting the "*suffering presence of God*" in isolated places such as hospital wards. This ministry requires the church to take off the mantle of theological comfort and dare to feel the wounds of the world directly.

On a practical scale, the implementation of this service should not be stagnant on the plain of theoretical concepts or abstract prayers, but must be manifested through ideas and solutions that touch on the psychosomatic aspects of human beings. Furthermore, Urbaniak emphasized that the contribution of theology in the public sphere needs to be directed at the fulfillment of social and economic rights, taking into account its impact on the most vulnerable groups of society. Thus, the involvement of the church in social life does not stop at theological discourse, but needs to be realized in concrete efforts to fight for justice and human dignity. One tangible form of implementation of this concept is the integration of spiritual support (in the form of healing prayers) and practical material support (such as the sharing of the blessings of ready-to-eat meals). For the patient's accompanying family, especially from the middle to lower socioeconomic class, the provision of simple food in hospitals has a very high theological and practical value. This action breaks down the line between the sacred and the secular. This is supported by the sociologist of religion Inger Furseth's analysis of social capital in religious communities. Furseth points out that religious communities can be a source of social capital through networking and the provision of various resources, including assistance in obtaining employment, shelter, and support for members in need. In Indonesia, the church's ministry to people who are sick needs to be understood holistically. Simanullang, Depari, and Marmidi show that pastoral ministry in hospitals is not only concerned with the spiritual needs of patients, but also includes attention to social, emotional, and financial aspects. The presence of a caring pastoral minister who is compassionate, compassionate, and *compassion* is a concrete form of God's love for patients, families, and health workers.

Specifically, the reality of the need for holistic assistance is clearly recorded in Muara Enim Regency, South Sumatra. As a developing area, major health service centers such as the Dr. H. Mohamad Rabain Muara Enim Regional General Hospital (RSUD) every day accommodate hundreds of patients from various corners of the village with heterogeneous socio-economic backgrounds. Based on initial observations, many families accompanying patients at Rabain Hospital experienced mental fatigue and limited access to psychosocial support systems. The ICU waiting room and the corridor of the third-grade ward are silent witnesses of how great the need for a sincere humanitarian greeting is. Students of the Kharisma Bandung Theological College (STT) who carry out the Community Service (PKM) program in this area captured the phenomenon as an emergency call to service. However, in order for the service carried out to be more than just a charitable social action that just passes, an in-depth scientific study is needed to map the intervention model, the subject's response, and the theological significance of the service action in the field.

This research has a very crucial topic of significance, both theoretically and practically. Theoretically, this article enriches the treasures of practical theology and contextual ecclesiology in Indonesia, especially regarding the model of non-institutional hospital chaplaincy ministry carried out by the theological academic community. In practical terms, this article provides strategic guidance and a replicative model for local churches in Muara Enim and its surroundings on how to develop, execute, and evaluate hospital visit service programs that are effective, inexpensive, but have a great impact on the psychosocial well-being of the community. Based on the background and literature review that has been presented, the formulation of the problem in this study is formulated as follows: First, what is the form of implementation of hospital visit services carried out by STT Kharisma students at Dr. H. Mohamad Rabain Muara Enim Hospital? Second, what are the psychological, spiritual, and social impacts of prayer interventions and the sharing of practical blessings for patients and accompanying families? The purpose of writing this article is to analyze in depth the effectiveness of the hospital visit service model at Rabain Muara Enim Hospital as a tangible manifestation of church social involvement, as well as formulate a transformative and applicable pastoral framework for community service in the future.

IMPLEMENTATION AND METHODS

This study uses a qualitative approach with a theological-pastoral descriptive method to map the dynamics of spiritual and social interventions in the medical field. The qualitative approach was chosen because it focuses on understanding subjective experiences, emotional responses, and subjects' psychosocial transformations that cannot be measured numerically. This research integrates the principles of *pastoral action research*, in which the student service team of STT Kharisma Bandung is actively involved as a service agent (volunteer chaplain) who intervenes, records responses, and conducts theological reflection on the phenomena that occur.

The location of the study was deliberately (*purposive*) at the Dr. H. Mohamad Rabin Regional General Hospital (RSUD), Muara Enim Regency, South Sumatra Province, as the main health referral center with a sociological background of multiple patients. Operational restrictions focus on Intensive Care Units (ICUs) and third-class general care wards that have the highest levels of vulnerability. Primary data was obtained directly through three main case studies, namely Mr. SY's family, Mrs. WT's family, and Mrs. DW, in the form of informal verbal communication transcripts and non-verbal behavior records. Secondary data were obtained from documentation studies of PKM paper drafts, visit registration books, and relevant practical theological literature.

Data collection techniques are designed through three main instruments: participatory observation to directly observe the real conditions and indications of mental fatigue of the patient's companions; pastoral clinical interviews with *active listening* techniques to build rapport (*building rapport*); and *field notes* in the form of a post-visit reflective note. Intervention procedures in the field include the licensing stage with medical management, psychosocial mapping in the hospital corridor, the implementation of holistic interventions (healing prayers and the distribution of ready-to-eat meals), and the termination stage in the form of providing long-term practical solutions.

The data analysis technique adopts an interactive analysis model that includes three streams: data reduction to simplify field data into case clusters; narrative-descriptive presentation of data; and conclusion drawing through theological dialogue between empirical findings and the theoretical framework of public diakonia and the theological leadership concept of Rubin Adi Abraham. The validity of the data is ensured through source triangulation techniques and triangulation methods to minimize the subjectivity bias of researchers in the field.

RESULTS AND DISCUSSION

The implementation of the community service program by STT Kharisma students at Dr. H. Mohamad Rabain Muara Enim Hospital reveals the complex reality of psycho-spiritual burden and social isolation experienced by patients and accompanying families. Based on the mapping of the situation in the *Intensive Care Unit* (ICU) and third-class general inpatient ward, the service team identified an urgent need that went beyond biological medical treatment. The empirical data collected during the field intervention is grouped into three main case study clusters as follows:

Case 1: Visiting Service to Mr. Sy's Family (ICU Room)

The first subject in this intervention was Mrs. SY, who was accompanying her husband, Mr. SY, who was being treated in critical condition in the ICU room of Rabin Hospital. Based on preliminary visual observations, Mrs. SY showed significant indications of physical and mental fatigue, characterized by tense facial expressions, blank gazes, and lethargic body gestures while sitting in the waiting room corridor. When the service team took a personal approach (*building rapport*) through warm greetings, Mrs. SY responded openly and began to narrate her inner struggles verbally. She expressed acute anxiety regarding the prognosis or uncertainty of the future health of her husband who was in the medical isolation room.

Furthermore, this informal communication revealed that the psychological pressure experienced by Mrs. SY had been physically manifested (psychosomatic). Sy's mother admitted that she suffered from a recurrence of gout which caused pain in her joints. This condition is exacerbated by a very poor rest pattern and neglect of her own health condition in order to take care of her husband. Mother Sy's response to the joint prayer intervention given by the team showed drastic emotional changes; She wept emotionally, clasped the hands of the service team, and stated that her mind felt much lighter. The team also provides practical health education on the independent handling of gout symptoms in the hospital environment.

Case 2: Visiting Service to the Family of Mrs. WT (ICU Room)

The second case study focused on the companion family of Mrs. WT who was also undergoing intensive care in the ICU room. In contrast to the general treatment area, the regulations of the ICU room of Rabain Hospital that restrict access make the family forced to spend days in the outer corridor area and open waiting room. The team found that Mrs. WT's companion family experienced acute social medical isolation due to saturation, uncertainty of medical information, and a lack of emotional *support systems* around them. In addition to grappling with emotional anxiety, Mrs. WT's foster family has been found to neglect their basic nutritional needs. This is due to their reluctance to leave the area around the ICU room because they are afraid of an emergency call from medical personnel at any time, as well as the limitation of daily financial budgets during the waiting period. When the service team was present to provide a practical solution in the form of sharing the blessings of ready-to-eat food (nasi wrapkus) accompanied by pastoral greetings and prayers of strengthening, the subjects showed a verbal response in the form of deep gratitude. The physical intervention in the form of food was consumed directly on the spot, and the subjects stated that the simple act made them feel cared for in the cold atmosphere of the hospital corridor.

Case 3: Visiting Services for Mrs. DW (General Care Room)

The third case study was conducted in a third-grade general care ward, involving a female patient named Mrs. DW. Based on in-depth pastoral clinical interviews, the team found that Mother DW bears the burden of multidimensional suffering. On the one hand, he had to struggle with physical weakness due to illness that made him hospitalized. On the other hand, Mrs. DW experienced very heavy mental pressure because she thought about the domestic condition of her household, where she was the main caregiver of her child who has a disability.

During the light counseling process, Ms. DW expressed guilt, despair, and existential questions about the justice of her life. The presence of the student team was responded to as an emotional cathartic channel for Mrs. DW to shed all her tears and complaints. The post-intervention response to prayer shows a reconstruction of the inner paradigm in Mrs. DW, which is characterized by her commitment to return to gratitude and to view her disabled child as a precious gift, not a burden of curse. As a long-term practical solution, the service team ended the visit by carrying out social advocacy actions, namely providing contact information and facilitating directions so that Mrs. DW could connect with the Muara Enim Regency Social Service to get a special assistance program for children with disabilities.

Psychosomatic Analysis and the Burden of Accompanying Families in Hospitals

Field findings at Dr. H. Mohamad Rabain Muara Enim Hospital confirm that health crises never only have an impact on the patient's physique, but also collapse the psychological stability of the family that accompanies them. The case of Mrs. SY, who experienced a recurrence of gout due to stress and chronic fatigue while caring for her husband in the ICU room, is a clear example of a psychosomatic phenomenon in the medical field. Psychosomatic is a condition in which emotional burden, anxiety, and mental distress manifest into a real physical illness. In the literature of health theology and pastoral psychology in the last ten years, this condition is known as the *caregiver burden*. When a person focuses on caring for a critically ill family member, they tend to neglect their own rest hours, diet, and health. This build-up of inner pressure stimulates a biological stress response that ultimately lowers the immunity of the companion body itself.

Suparman Rustam and Chaidir explained that the families of critical patients experienced psychological distress while accompanying their family members in the ICU. They found that some families experience maladaptive coping mechanisms and affirmed that critical patient conditions can cause anxiety, fear, and stress in families. The findings were strengthened by the discussion of the condition of critical patients who can cause psychological burdens in the form of fear of death, confusion, fear, and feelings of helplessness because the family feels unable to help their family members who are undergoing intensive care. This condition shows that the family not only plays the role of a patient's companion, but also a party that faces emotional pressure during the treatment process. Extreme physical fatigue that is intertwined with the burden of the mind has been proven to trigger somatic health disorders on the part of the family. Therefore, the interventions carried out by STT Kharisma students in the form of *active listening* and light pastoral counseling in the ICU corridor are very crucial. Through this approach, the patient's family is given a safe space to vent their negative emotions (*catharsis*). When the mental burden is successfully reduced through sincere humanitarian greeting, the tension of the subject's nervous system decreases, which in turn helps to relieve the symptoms of psychosomatic physical illness that they feel.

The Urgency of Integrating Prayer and Practical Blessings as a Solution to Social Isolation

In Case 2 of Mrs. WT's family in the ICU corridor, the team found that the companion family often experienced social isolation and neglected basic nutritional needs (hunger). Their decision to stay in the cold corridor without eating was not only due to financial problems, but also triggered by psychological panic if at any time an emergency occurred to the patient in the ICU. In crisis situations like these, abstract words of motivation or prayer often feel distant and unearthed if their stomach is hungry. Therefore, the practical solution offered by the team through the distribution of ready-to-eat meals (packaged rice) combined with healing prayers has a very massive impact. This act of combining physical nourishment and spiritual strengthening is in line with the concept of holistic service. According to a study conducted by Simanulang,

et al said that pastoral assistance in hospitals is not just providing verbal comfort, but a form of holistic presence that involves deep empathy and understanding of the existential suffering of patients and their families. The Church must realize that man is a whole union between body, soul, and spirit. When a person is at the lowest point in his life, practical attention in the form of simple food is the most tangible form of the senseless presence of God's love. The act of distributing rice wrappers to patient guards in the hospital corridor succeeded in breaking down their walls of isolation. This approach proves to the people in Muara Enim that the church is not only concerned about the salvation of the soul in the hereafter, but also sensitive to the needs of the stomach and physical endurance of humans on earth.

The Evolution of Theological Perspectives and Social Advocacy for Vulnerable Communities

Case 3 experienced by Mrs. DW in the general care room reveals a much more severe multidimensional challenge, namely the combination of physical pain and the burden of caring for a child with a disability. In the midst of despair, Mrs. DW was trapped in a crisis of faith and viewed her son's condition as a burden or curse. The pastoral intervention of the students here succeeded in reconstructing the theological perspective, helping Mrs. DW to change her inner perspective to see the child as a precious gift entrusted by God. This restoration of the inner paradigm resurrected a positive spiritual coping mechanism, giving Mrs. DW new resilience to face her suffering.

However, contemporary pastoral reflection affirms that the ministry of the church should not stop at prayer or a change in the patient's way of thinking. The church must go further in the direction of concrete social advocacy. The steps of the student team who facilitated and directed Mrs. DW to the Muara Enim Regency Social Service are a clear example of a living public theology. This view is reinforced by the thoughts of Enoch Adijaya and Daniel Martin Tamera that Christian theologians affirm that the existence of people with disabilities is within the framework of sovereignty and obedience to the plan of the Most Perfect God, so that the form of social advocacy must be realized through respect for rights, dignity, and equal participation in the public sphere. Prayer provides the heavenly power to endure, while social advocacy opens a systematic earthly way out. Through this integration model, hospital visits by the church are transformed from mere charitable social action (temporary assistance) to transformative diakonia ministry that brings long-term solutions to the welfare of the general public.

CONCLUSIONS AND RECOMMENDATIONS

From the entire series of services carried out by STT Kharisma students at Dr. H. Mohamad Rabain Muara Enim Hospital, we can see a very clear reality that hospitals are not only a place for sick bodies, but also a place where the human soul is tested to the lowest point. When someone lies weak in a care room, or when a family is forced to sit for days in the cold corridors of a quiet ICU room, they are not only fighting the disease medically. More than that, they are fighting against loneliness, anxiety about an uncertain future, extreme physical exhaustion, and feelings of isolation from the outside world. Through a real case study that we found in Mr. SY's family, Mrs. WT's family, and Mrs. DW, this study proves that the presence of the church in the midst of the space of suffering is no longer just a program of choice or a side social action, but a moral obligation born of true love.

Results on the ground show that the most touching solution and brings real recovery is when the ministry is carried out in its entirety, touching both spiritual and physical needs at the same time. Words of comfort or prayers of healing offered in the corridors of the hospital certainly provide extraordinary inner strength for those who are in despair. However, the prayer becomes much more alive and grounded when it is accompanied by simple concrete actions, such as distributing a packet of warm rice to families who faithfully care for patients without having time to think about their own stomachs. That physical food turned into a symbol that they were not walking alone and that there were others who cared about their humanity. This visitation service also proves its strength when it is able to lead someone who is disappointed in their life situation like Mrs. DW experienced to rediscover gratitude and see her child with disabilities as a precious gift. In fact, this service becomes even more meaningful when the team does not just stop at prayer, but goes further by helping to connect people in difficulty to related social services for long-term assistance.

In closing, the important message that we want to convey through this article is that the church must dare to step out of its comfort zone. The church should not be a passive institution, which is only preoccupied with worship activities in the building and waiting for the injured to come for help. Instead, the church must be proactive in picking up the ball, present in secular places where tears flow, one of which is in the corridor of the regional general hospital. It is highly recommended for every local church in Muara Enim to start forming a regular and scheduled love visit team. For future researchers, the scope of pastoral ministry in the medical field is still very broad to be developed, especially in building inclusive interfaith cooperation in order to provide a warm embrace of humanity in the midst of the cold medical world.

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REFERENCES

- Adijaya, Henokh, and Daniel Martin Tamera. "Memahami Disabilitas Dari Perspektif Teologis." *Alucio Dei* 8, no. 1 (2024): 50–61. <https://doi.org/10.55962/aluciodei.v8i1.131>.
- Carey, Lindsay B., and Jeffrey Cohen. "Religion, Spirituality and Health Care Treatment Decisions: The Role of Chaplains in the Australian Clinical Context." *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 25–39. <https://doi.org/10.1080/08854720802698491>.
- Carolus Boromeus, Kusmaryanto. "Health Pastoral Care." *Jurnal Teologi* 5, no. 1 (2016): 91–104. <https://doi.org/10.24071/jt.v5i1.483>.
- Chaidir, Reny, and Junaidy Rustam. "Spiritualitas Dan Mekanisme Koping Keluarga Pasien Di Ruangan Intensive Care Unit: Studi Korelas." *Jurnal Ners* 7, no. 2 (2023): 1327–32. <http://journal.universitaspahlawan.ac.id/index.php/ners/article/view/17257>.
- Furseth, Inger. "Social Capital And Immigrant Religion." *Nordic Journal of Religion and Society* 21, no. 2 (2008): 147–64. <https://doi.org/10.18261/issn1890-7008-2008-02-02>.
- Kardi, Sherley Astuty, Yanto Paulus Hermanto, and Jessica Elizabeth Abraham. "Pastor and the Congregation Survive In This Pandemic Time." *International Journal of Research and Scientific Innovation* 08, no. 11 (2021): 57–61. <https://doi.org/10.51244/ijrsi.2021.81103>.
- Simanullang, Gonti, Firdaus Depari, Fransiskus Xaverius Marmidi, Fakultas Filsafat, Universitas Katolik, and Santo Thomas. "Logos, Jurnal Filsafat-Teologi, Vol. 23, No.1 Januari 2026 145." *Pengalaman Pelayan Pastoral Care Orang Sakit Di Rumah Sakit* 23, no. 1 (2026): 145–59.

Simanullang, Gonti; Depari, Firdaus; Marmidi, Fransiskus Xaverius. "Pengalaman Pelayan Pastoral Care Orang Sakit Di Rumah Sakit: Sebuah Penelitian Fenomenologis." *LOGOS* 23, no. 1 (2026): 145–159.

Swinton, John. *Raging with Compassion: Pastoral Responses to the Problem of Evil*. Grand Rapids, MI: Wm. B. Eerdmans Publishing Company, 2007.

Urbaniak, Jakub. "Probing the 'Global Reformed Christ' of Nico Koopman: An African-Kairos Perspective." *STJ | Stellenbosch Theological Journal* 2, no. 2 (2016): 495–538. <https://doi.org/10.17570/stj.2016.v2n2.a23>.