

Health Care Chaplaincy: A Reflection on Models

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Health care chaplains are engaged in precarious work astride two very different worlds – the Church and the National Health Service. Both worlds bring to bear on chaplaincy particular concerns, pressures and questions.

The aim of this reflection is to explore a broad framework within which chaplaincy understands itself. It arises out of my own experience as a chaplain in the Queen Elizabeth Hospital, which became first the South Birmingham Acute Unit, and then the University Hospital NHS Trust, between 1990 and 1996; though the reflection adopts a wider perspective. It is my aim to highlight the areas that require further thought and action.

I intend to be explicit about two basic considerations: The first concerns the culture of the Church in relation to the world, in particular its lack of appreciation and understanding of the work of chaplains in the health service. It is a regrettable trend that the Church has become increasingly sectarian in its outlook. The symptoms of this trend are its narrow concern with numbers in churches on a Sunday and the general reluctance to engage in ministry which does not have some immediate relevance to getting people into church. It follows that there has been a loss of the vision of non-stipendiary ministry (except as a supplement to the parish clergy), a continued failure to empower and affirm lay ministry and a largely negative attitude to sector ministries like that of hospital chaplains. Further symptoms of this sectarianism are the institution's desire for certainty and its concern for clear boundaries in a number of areas. Not surprisingly, financial stringency accentuates these attitudes. This loss of vision has disabled the churches in empowering their structures and members to accept and engage its shared calling as a priestly body - an institution of society which has the whole of society to serve through its ministry. Some established theological traditions, both Catholic and Protestant, explicitly discourage any such view of the Church's nature and primary responsibility.

The second consideration concerns the security of chaplaincy in today's Health Service. While it is important to affirm that the chaplains have ably provided much spiritual care for many years, the future of this provision is curiously uncertain. Chaplaincy arrangements in NHS Trusts in England and Wales are unevenly distributed. Although there are some areas where there have been innovative developments and improvements, current trends in NHS management make it unlikely that these improvements will be widely sustained. The pressures in this area are not only financial. The NHS serves a pluralist world of various cultures and faiths. The Establishment of the Church of England is unlikely to provide sufficient reason for employing Anglican clergy. It would be surprising if some Health Authorities and Trusts do not examine the funding of chaplaincy and ask challenging questions of the churches, especially about their responsibility to finance this kind of work. It may seem unreasonable to expect or demand the NHS to fund improved chaplaincy arrangements. This point relates to the ways in which chaplaincy

works; its models, roles and functions. Specifically it depends, in part, on how chaplaincy has adapted or shaped itself in the radically transformed culture of the Health Service. It is worth asking: 'How does chaplaincy fit into the process by which hospitals think about the process of delivering health care? Is the service measurable, effective and an efficient use of money? What are chaplains for and what do they do?'

Finally, engagement with these realities depends on what models of chaplaincy the NHS chooses to promote amidst the changing patterns of health care over the next decade. While the Department of Health has affirmed the importance of meeting the spiritual needs of patients and staff, there is no statutory requirement for Health Authorities to fund chaplains. While there has been a gradual increase in the appointment of chaplains to acute hospitals in recent years, the present and future situation is far from stable. Patterns of the provision of health care have changed in the Mental Health Sector from residential to community care; similar trends seem likely for Acute Care. This care will be given in alternative settings, driven by the understandable desire to have health delivered more effectively and efficiently.

It follows that in mapping out a framework within which to understand the changing nature and scope of chaplaincy, the two broad considerations will affect the shape of possible models.

What Model of Chaplaincy?

The following model of chaplaincy undergirded the development of teamwork within my Acute chaplaincy work in South Birmingham. While there was some degree of ownership within the chaplaincy team of this model, it is fair to point out that putting the model into action was fraught with challenges and difficulties. One of the significant factors that the team confronted at many levels in the work was the assumptions and stereotypes that many patients and staff held about the role and function of the chaplain.

The model might best be described in the following way: health care chaplaincy is a ministry at a number of distinct but overlapping and interlocking levels of engagement with the institutions and experiences of disease, healing and health. Visualised in this way the model can be seen as a number of concentric circles, with each circle relating to a dimension of the chaplaincy work.

The focus - the centre - the patient

The focus of the work of any hospital and chaplaincy team is the delivery of care to the patient. One of the priorities of chaplaincy is ensuring that patients have the appropriate support they need during their illness.

Illness, whether serious or not, can be a critical time that serves to confront those who live and work with it with their mortality and vulnerability. It may lead to a re-evaluation of the

direction of life, work, relationships and beliefs. Religious faith and practice support some people through illness; others, with no formal religious faith, may seek new meaning and purpose in changed circumstances. Chaplaincy aims to meet the spiritual needs which include religious needs where appropriate, and to allow patients, within the context of a supportive relationship, to reflect on their illness and its meaning, and how this experience may lead to greater wholeness.

The patient's family, carers and friends

The second level of contact and work is chaplaincy with and to the patient's family and friends. Their involvement in the patient's life is intimate and precious. They need to understand what has happened to their loved one, and how illness has affected their life. They may have had to deal with considerable amounts of anxiety and isolation. Their ongoing presence and support is a significant part of any patient's experience during the incapacities of illness. Sensitive, skilled listening and support at this level can empower them to participate in their loved one's care.

The professional carer - health care workers

The third dimension of chaplaincy work has increased in significance as the average stay of patients in Acute Care has decreased. Put simply, if staff feel supported and motivated then they are more likely to be able to deliver the best possible attention and care to patients. There are pressures on staff to sustain costly personal involvement with acute illness. Chaplaincy needs to be alert to how its staff can grow in wholeness.

Many different kinds of staff relate to the patient, and so chaplaincy should aim to be aware of and co-operate with a wide variety of them. These include porters, cleaners, physiotherapists, doctors, managers, social workers, nurses, caterers and pharmacists.

The community and institution of the hospital

The fourth dimension of chaplaincy work is engagement with the organisation or structures that constitute the being of the hospital. This aspect of the work is complex and multi-dimensional. It may mean challenging the way decisions are made or reflecting back to those with responsibility and power the effects of decisions and changes on the life of the hospital. More positively, it may mean building bridges of good communication between people, encouraging good practice, and giving much-needed positive feed-back. Chaplaincy should play its part in building a community where staff feel listened to and valued. Some of this work is done on an informal basis in the dining room and in corridors; some of it during formal meetings with other departments and managers.

The wider context of the hospital

The fifth and final dimension of the work involves relating the hospital to its wider setting of the community in which it is placed, and encouraging that community in its responsibilities to and for the hospital. The assumption here is that we cannot build a healthy hospital community without attending to the context within which it exists. Further, there are many resources in the community that a hospital can draw upon to support individuals and groups who face their illness. The community can resource all kinds of ways of making hospitals more accessible and less difficult to use. A knowledge of how hospitals work and of what goes on in them can help the community feel that their hospitals belong to them. This ownership can empower them to take some responsibility for good health and wellbeing. This work of breaking down barriers and providing simple and straightforward education and information is part of the hospital's responsibility.

As more health care is delivered in the community more thinking and action needs to be facilitated in this area.

Developing an Understanding of Health Care Chaplaincy Through the Variety of its Roles and Functions

Pastoral care

As I have described above, the activity of the Health Care Chaplain is focused on pastoral care. This activity has been described in the following way.

To enable individuals and groups in a health care setting to respond to spiritual and emotional need, and to the experiences of life and death, illness and injury in the context of a faith or belief system.'

It follows from this core mission statement about the pastoral practice of chaplains and from the description of the model given above, that five things can be affirmed about the nature of pastoral care. These are:

1. That pastoral care is a shared activity. Clearly chaplains co-operate with others in the process of listening and supporting.
2. That pastoral care is a distinguishable activity. Some work has been done by chaplains in describing the methodology whereby the activity of pastoral care can be distinguished from other activities and its outcomes monitored and audited.
3. That this belief that pastoral care is a specialised activity demanding particular skills and training, is an important factor in the development of professionalism amongst health care chaplains.

4. That pastoral care is a time-consuming activity that places particular demands upon the health care chaplain. This has been a particular argument in the development of resourcing health care chaplains, and in the discussion of issues of professionalism and accountability.
5. That the disciplines of counselling and psychotherapy may play a part in the promotion of the chaplain's distinctive role of empathy within the process of care.

This section contains descriptions of the roles of chaplaincy that emerged during my ongoing reflection with chaplains in Birmingham from 1990 to 1996.

Chaplain as interpreter

Coming into hospital as a patient is for most an experience which raises a series of unfamiliar and perhaps uncomfortable experiences. Individuals have to cope with their loss of control - giving over power to experts in a very different environment from that of ordinary life. Fundamental concepts of security and hope for the future bear upon the person's world of meaning and truth. The chaplain is amongst those who can help interpret and listen to these experiences. The issue of language is fundamental here. While some people may have a language within which to express these experiences, often individuals lack a conceptual framework within which to understand what is happening to them. Thus patients, staff and relatives may be grasping and searching for some form of meaning for their experiences, but doing so without any particular framework of language or reference. A whole host of undigested and, at times, unhelpful theological concepts, bible stories from childhood and other truisms may surface, and the chaplain may be in a position to help construct both a language and possible interpretation. The interpretation may emerge not only between two or more people, but also between the various aspects of the same person's struggle to come to terms with what is happening to him or her.

There will always be some patients who have a distinct religious agenda, from whatever world religion or faith community they come, but there may still be a role for the chaplain as interpreter. Good interpreters hear not only the words but also the nuances and subtleties within the voice; for example, people may speak of their tremendous faith but may be indicating that they are asking for some kind of space within which to acknowledge their doubts and fears. The *anchor* faith is just as capable of dragging people down to the ocean depths as providing a secure basis in reality.

There is also the need to interpret theological language and concepts. Few aspects of life seem to expose our basic instincts and insecurities more than illness, and a chaplain may have a role in developing and interpreting a theological understanding of health, healing and suffering. The request most asked during my own experience of chaplaincy was 'Will you pray for me?' This request reflects not only the image of the chaplain as a representative of God, but also the perception that the chaplain can forge a link between the human and the divine.

Chaplain as intermediary

Many health care chaplains today realise that the majority of the population neither attend church on a regular basis nor have had any experience of a pastoral ministry from the church or faith community. Some chaplains therefore believe it is their role to promote and present a positive view of the Church through the relationships they make. This often involves the breaking down of stereotypes and correcting misinformation, or talking through past negative experiences. In this regard a chaplain can also act as an intermediary or bridge between local churches and individuals or groups. This may have a practical focus in, for example, relieving the isolation of the elderly or providing a supportive network for those whose process of rehabilitation requires extra support.

The chaplain may often join with others in trying to draw people closer together, particularly if family relationships are strained or have broken down. The chaplain may also operate at the level of being an advocate for the patient. Often if the patient is so disempowered in the health care process, then questions or views need to be represented to other members of staff. At a basic level chaplains may support the patients in the formal process of complaint.

Chaplains may also be able to operate as *neutrals or go-betweens* in an institution that is often divided into the doctors, the nurses, the managers, the auxiliaries, etc. Thus the possibility arises of mediating between groups without being seen as attached to any.

Where is God in all this - to whom are hospital chaplains accountable?

Many health care chaplains have responded positively to the reforms of the NHS during the 1990s. The language of business is impressive: performance review, business plans, audit, quality initiatives, objectives, change management and organisational missions. This language is now part of the everyday life of the Health Service, and each professional group has been forced to work out its response to this culture.

There is a particular history to hospital chaplains' response to the task of professional development. Two years after the implementation of the reforms, chaplains gathered at their annual conference in Ripon (1992) to formulate their response to the task of professional development in chaplaincy. It is interesting to note that at this conference the main thrust of the reflection, which no doubt was shaped by particular experience of the changed NHS culture, was a concentration on the processes by which the job of chaplaincy is done and the skills needed to accomplish it. Further, what was interesting from my own theological perspective was the relative absence of theological critique. There was an embracing of the language of the health care business without any significant theological questioning. My own thinking is clustered around three interrelated and overlapping questions:

- What kind of God?
- Are pastors professional?
- Is all authority good?

What kind of God?

All of us have our own unique stories to tell about how God has got hold of us. The minister is a vocational professional in the sense that one of the undergirding questions which motivate work and perspective is 'What does God want of me?' The combination of personality experience and context leaves the individual group with a variety of understandings and perceptions of God. These perceptions of our models of God can and do give rise to all kinds of patterns of belief. Despite, or perhaps because of, our theological education, there is a curious lack of awareness and articulation of the sheer variety of models of God and patterns of belief, both inside and outside the churches. Absent from the discussion about professionalism of health care chaplaincy referred to above was any direct reference to conceptions of God, and there was no explicit exploration of either the patterns of belief or the models of pastoral practice that follow from these theological understandings. It was as if the fundamental knowledge base of theology which makes health care chaplaincy distinctive, was a useless tool in the attempt to move the ministry of the health care chaplain to an acceptable professional base within the Health Service.

The accenting of different aspects of Christian belief would result in different approaches to chaplaincy; for example, accent God's activity in all life and all truth, then you immerse yourself in the institution. In other words its concerns become your concerns. Accent God's being encountered chiefly or normatively via the Church, then you accent mission from the ark of faith to the institution and the chaplain as bringing Christ to people there. Accent the Church as part of society then you try to influence the place in a Christian spirit.

Are pastors professional?

In this context the need to be professional and the negotiation of freedom in controlling the content of the work is important but there are certain dangers in the ethos of professionalism. There may be some uncertainty or confusion about what 'professional' means in this discussion.

It is partly to do with being efficient and co-operative in relation to the hospital structures, and this understanding is to be encouraged, but it is deficient. The issue is in part about a chaplain's understanding of identity and role within the hospital. As suggested above, there will be some chaplains who hold the hospital's secular structures and value systems at arm's length while they continue the real activities of being a Christian pastor and

evangelist. This approach too is deficient if pursued in isolation. It is true that chaplains need to have the broad objective of articulating, questioning, and sustaining moral and religious values, and there should be an appreciation of this aspect of the chaplain's role by the hospital: they are paid to be a presence within the community, promoting values that sustain healing. Theologically the hospital could be understood as an anonymous Christian community by virtue of its healing task. The role of the chaplain would involve him or her being a person who asks questions of the institution about its deeper assumptions, questions of meaning and purpose. The chaplain can be a resource in shaping priorities on various assumptions regarding God, healing, disease, health and wholeness. In certain circumstances, the role might extend to sharing in the analysis of even the more technical problems in medical ethics that now beset the therapeutic world. In other words the chaplain needs to unite the strengths of the two kinds of professionalism described. Alone, neither is satisfactory: combined in the way described means the creation of a valid model of Christian presence and work.

Health care chaplaincy has no option but to organise and develop a professional approach to its key tasks and roles; within the present culture of the NHS there are many options and possibilities, but what are the dangers? The role in the organisation is often an ambiguous and ambivalent one. There is a need to get the feet under the organisational table, but it is easy to remain on the edges and margins and feel impotent as a result, whether the fault is their own or that of others in the system - perhaps through the sheer weight of older models of the chaplain's role as benign pastor or dispenser of religious rules. In the light of this, refuge may be taken in clear tasks and roles in order to cope with the feelings of threat and insecurity: the chaplain as academic; the chaplain as manager; the chaplain as therapist. Perhaps a chaplain needs to be critically reflective about where self-validation comes from. It will not necessarily come from the attempt to be professional in the narrow sense. In this debate and in the business planning process, what is the role for the intangible, the immeasurable and the transcendent?

Is all authority good?

One of the areas where I perceive a major theological crisis is in our critique of the new culture of which we are a part. The chaplain seems reluctant to take on the role of saboteur, mole or whistle-blower. In what way are we free to work in the way that we may feel we should? If God is the Chief Executive, the ultimate rubber stamp of the system, then is this because all authority is good? We need to question the assumption of the implicit goodness of the organisation and culture and to ask ourselves how institutionalised we have become. Put another way - do we tell people what they want to hear? With whom, or to whom, do we as chaplains need to belong?

There are barbaric and wicked aspects of a culture which sees illness and disease as commodities whose provision is to be treated as a business in the market. This originates, in part, from the temporary eclipse of the idea and ideal of a caring society. Is it true that today altruism has become a private hobby? Has the publicly accepted moral assumption

that resources should be used for the common good been eroded? What about the social and moral dimensions of our political and social life? Above all, are these ultimately issues about God?

These are not narrowly political issues but profound theological ones. For at the heart of our faith is the matter of simple and ultimate reality - a God whose concern is for promoting and sharing holiness, justice, peace and love. There is therefore, an inescapable link between our human togetherness and the Kingdom of God. Does our experience in the Health Service and society lead us to believe that the fabric of society is alerting and promoting people to care for their neighbours and share with their neighbours?

Who is going to guard, cherish and promote essential human wellbeing within society? Who has the vicarious task of judgement so that the pseudo-divinities dominating culture and reducing human beings to functions are revealed for what they are? Chaplains (as indeed all health care professionals) have the privilege of meeting people in their flesh and blood, their living and dying, their suffering and recovering. This is inescapably sacramental - it has to do with the sacredness and hallowing of ordinary things in ordinary people. Professionalism alone will not necessarily organise a life which the world can sustain and human beings can both endure and enjoy. Our authority as Christians comes from our common sense of calling and as human beings loved by God. How does that work out in our chaplaincies as a commodity worth purchasing?

We are confronted by a pagan proletariat . . . the mentality of their surroundings completely conquers them.... Our mission must aim, not to organise those who already are practising Catholics ... but to penetrate the different milieu with the Spirit of Christianity

As, with our colleagues, we think through these issues in the context of our own workplaces, we need to be reassured, challenged, and drawn back to the metaphors that set us free - above all, to the significance of the cross and resurrection of Jesus and to see that all human culture, including Christian culture has to be revalued anew in their light.

Notes:

1. *Health Care Chaplaincy Standards* published by The College of Health Care Chaplains The Free Church Hospital Chaplaincy Board, The Hospital Chaplaincies Council, The Roman Catholic Hospital Chaplaincies, September 1993.

2. Abbé Michonneau, *Revolution in a City Parish* (Blackfriars, 1949), pp. 2, 7.

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