SPIRITUAL CARE AND CHAPLAINCY: A RESEARCH PROJECT

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Abstract

During the 1990's Spiritual Care has featured prominently in nursing and palliative care journals. However, virtually nothing has been contributed by chaplains. Why? This article reports the findings of a research project considering whole-time health care chaplaincy in Scotland, as presented to the Scottish Association of Chaplains in Healthcare, at the Annual Conference in May1999. The findings are positive. There is a clear understanding among chaplains of their role and a continuity of practice. Spiritual care is clearly understood to be more than religious care, with chaplains readily acknowledging that all Health Care Professionals can provide it. The report highlights the importance of education and training for health care professionals to increase their understanding of spiritual care, and areas for further research needing to be examined. The debate on spiritual care is happening now, chaplains need to ask some questions, research what they do, and join the debate.

Key Words: Being there, Chaplaincy, Education & Training,Palliative care, Person centred care, Spiritual care

Hospitals and hospices appoint chaplains to provide spiritual care for their patients, visitors and staff. However, what is understood by `spiritual' and how the chaplains role is perceived is not always clear. A research project was undertaken asking the question: How do whole-time health care chaplains in Scotland understand and practice spiritual care? The research question was formulated taking into account: personal experience as a chaplain, knowledge of an increase in whole-time chaplains appointments, and awareness of a growing debate around spiritual care in nursing and palliative care journals. The following is an extract of the research as presented to the annual conference of the Scottish Association of Chaplains in Health Care in May 1999.

The desire to carry out this research was based on personal experience as a chaplain first in a general hospital and then a hospice. Experience showed there was a general confusion among Health Care Professionals (HCPs) between `spiritual' and `religious', with many HCPs using the terms synonymously. Attendance at several UK wide chaplains' conferences raised awareness that chaplaincy in Scotland was different from the remainder of Great Britain. Chaplaincy conferences held in England would invariably spend time discussing sacraments and anointing, which were clearly an important element of the care provided by chaplains. However, they were not a significant part of the Scottish experience of chaplaincy. This is not surprising since most chaplains in Scotland are `contracted in' from the Church of Scotland which is Presbyterian in tradition, and in nature less sacramental in function, than other Christian denominations.

A raised awareness of things Spiritual is also evident in the increasing number whole-time chaplains appointments being created. The Church of Scotland's Board of National Mission has also seen a marked increase in representation by Hospital Trusts making appointments, with some trusts and most hospices making a move away from the traditional contracted appointments to local appointments.
However, the most significant factor influencing the research was an awareness of the increasing focus on spiritual care seen in nursing and palliative care journals in particular during the 1990's. The World Health Organisation, WHO(1990), in its definition of palliative included `spiritual' alongside the physical, psychological and social aspects of care. Since then, various working groups and guidelines have included spiritual care in their framework, including: The Scottish Health Service Advisory Council Working Group (1991), the Scottish Partnership Agency with the Clinical Resource and Audit Group's Palliative Care Guidelines(1994), and the National Panel for the Care of the Dying and Bereaved(1994 and 1996). In nursing journals in particular there has been a consistent

rise in the number of articles seeking to explore spiritual care with the International Journal of Palliative Nursing(1997) devoting a whole issue to the subject.

An example of the debate is in the exploration of the distinction between spiritual care and religious care by O'Brien(1995) and Wright(1997). O'Brien sees the problem as symptomatic of religion and science being seen as adversaries, while Wright suggests that the debate has moved on from that with nurses in particular seeking to explore the care they give. When linked specifically with `hospices' the confusion and temptation to equate spiritual care with religious care increases. The religious nature of some hospices was noted by Hawkett(1997) and Walter(1997). Hawkett acknowledges that the roots of the hospice movement are entwined in Christianity and go back more than a thousand years. Walter acknowledges that along with HCPs, most members of the public equate spiritual with religious, which inevitably affects the general understanding of spiritual care.

At present there is no definitive document in Scotland on Spiritual Care. The Patients' Charter (1994) did include spiritual care in its statements. However, all responses from the Scottish Office Department of Health have been by Management Executive Letters. These letters are limited to commenting on the availability of chaplaincy services and making provision for worship. Perhaps the fullest and most helpful publication on Spiritual Care in Health Care was that provided as National Association of Health Authorities and Trusts (1996) which gave a full and clear understanding of spiritual care in its widest sense and acknowledged the relationship of religious and spiritual care. However the document has no official status in Scotland.

Method

The research took the form of a descriptive survey (Mitchell 1998). The study population comprised chaplains working whole-time in hospitals and hospices in Scotland. The Church of Scotland's register of whole-time hospital and hospice chaplains gave a sample frame of 28, three of which were included in the pilot study and ten in the main study. The sample was selective including two psychiatric hospital, two hospice, and six general hospital chaplains, with respondents drawn from the major population centres and health boards in Scotland.

Data collection was by a self-completed questionnaire/diary and a single semi-structured interview. The questionnaire sought factual information about the chaplain's appointment, including size and type of hospital, any palliative care component, religious expression, sacraments and funerals. The diary, completed over one week, sought to find how much time was spent with patients, visitors, and staff, together with education, meetings, call-outs, and other areas identified by individual chaplains. The diary data was not reliable since chaplains on joint hospital/hospice appointments tended to complete the diary for one part of their appointment only. Secondly, one week was too short a time to be useful since not all elements of the chaplains' work were practised in any one week. Respondents found the diary difficult to complete. However, they felt it was useful in raising their awareness of how their time was spent, and how varied each day and hour could be. Both of which informed the interview discussion.

The interview explored the following areas: chaplaincy in practice, spiritual care, palliative care, teamwork, education, and the chaplains' own areas of concern. The interview data was analysed using a computer word processing programme based on Burnard's framework for analysis (1994). Validation of the data was achieved by returning to three respondents to confirm that the process and content were accurate. A computer spreadsheet programme was used to compile and analyse the questionnaire data.

Objectives

The study aimed to explore the following objectives:

- how chaplains understand spiritual care

- how chaplains practice spiritual care
- do chaplains distinguish spiritual/religious
- has palliative care influenced chaplaincy
- what factors are important to the delivery of good spiritual care.

Findings

Over all there does not appear to be a clear definition of spiritual care. Respondents were reluctant to attempt a definition of spiritual care. In contrast however, they were very clear in their reasoning against a definition. Spiritual care was described as being individual to everyone. It involved exploring an individ-

ual's meaning of life: past memories, present thoughts and feelings, future hopes and fears. It involved facing up to the WHY questions, and the feelings and experiences that often brought these questions to the surface. To be precise in definition was felt to be less helpful. Spiritual care is about people, all people are individual, all people are different, therefore spiritual care needs to be more open, or all inclusive, rather than precise.

There was also a clear understanding of the place of religious care within spiritual care. Religious care was an important part of spiritual care. However, the degree of importance depended on the other person. There was a common frustration expressed by respondents who felt many HCPs did not make the same distinction and thought spiritual and religious to mean the same thing.

One essential element for chaplaincy was a personal faith. Such a faith gave chaplains a place to return to after journeying with someone else, a place they could restore their sense of meaning and draw personal strength. There was also a measure of authenticity from being ordained. Sometimes the patient needed to talk to and hear the words from the right person: God's representative.

It was readily acknowledged that when understood in its widest sense spiritual care could be provided by all HCPs and was not the sole remit of the chaplain. Those chaplains who were involved in new staff induction programmes, staff training and education, reported less confusion of their role and greater understanding of spiritual care in a broad sense.

Person Centred Care

Spiritual care was offered to all patients, visitors and staff, regardless of their faith or no faith. The focus is centred on the individual: approaching with no assumptions, and following their agenda. The practice is to meet people where `they' are, to get alongside them, and to share their journey. An example of the focus on the individual is in the chaplains' reluctance to use patient records/notes. It was felt to be more helpful to ask the patient and get their interpretation of what they knew or had been told.

Being There

`Being there' was the essence of the person centred care: being there for the individual. It was also about the chaplain's physical presence: being seen in and around the hospital. It was clearly felt that the more the chaplain was seen, the more they would be used and the better understood. Chaplains make a determined effort in being there:

- regularly visiting particular ward/units where they might expect greater spiritual need e.g. acute psychiatric wards, oncology, intensive care and maternity units.
- using dining rooms and coffee lounges: areas where staff meet.
- visiting at the right time: fitting into the routine of the ward, knowing when to visit to see the patient alone or with visitors.

Building relationships with staff was the focus of much of this area. The multidisciplinary team was an important factor for chaplains and being recognised and used as part of the team. Increasingly chaplains were receiving referrals from other HCP's, and were also being used for staff support. Both areas not only required an understanding of the chaplains' role, but depended on a good relationship and spirit of trust that can only be developed by being seen and known.

A popular phrase used many respondents to describe this art of being there was to describe chaplaincy as `loitering with intent'. The ability to appear to be there for no particular reason but often at the right time: when needed.

The influence of palliative care

The palliative care influence was strong. 70% of chaplains had palliative care experience with four hospital appointments having a joint hospice element. In exploring the difference between palliative care and ordinary hospital care, respondents saw no difference in the care they give in either setting. There was, however, a difference in other HCPs. In palliative care the patient and their family/carers are seen as part of the team. The same was not true of hospital care, the inclusion of families/carers in hospitals was not so prevalent

Palliative care was naturally embraced by all respondents. Its principles were clearly understood and seen as the natural elements of care that chaplains have always understood though by a different name: pastoral care.

A Local focus

Chaplains tended to concentrate on their own local setting. While each individual setting had its own priorities and differences, there was, however, a national continuity of care and practice in the provision and understanding of spiritual care. The focus of care in each location was an extension of the `person centred approach' with chaplains asking "What is needed here?" The down side of local thinking is that chaplains seem unaware of the wider debate surrounding spiritual care. The reason is straightforward: Chaplains don't read nursing journals.

Conclusions

Chaplains have a very clear understanding of their role: to provide spiritual and religious care. They are not the sole providers of spiritual care. When understood in its widest sense, all HCPs can provide spiritual care and often do so without thinking about it. With religious care it was about being the right person for the patient. Although other members of staff could listen and say the same things, sometimes others needed to her the words from the `right person' and that was the chaplain: God's representative.

Multidisciplinary team working is embraced by chaplains and seen as the way forward. Because of their experience and expertise chaplains do have a distinctive role within the team. Chaplains are comfortable with loose boundaries and there is no sense of threat from other HCPs providing spiritual care. While there is a need to increase other HCPs understanding of spiritual care and the role of the chaplain there is no need to defend the professional status of chaplaincy. Instead there was a clear desire from chaplains to `fit in' to their local setting.

As hospitals in particular move towards shorter patient stays there is a recognition that the traditional model of the chaplain visiting all wards is being replaced by a model that depends more on referrals from other members of staff. However for referrals to work staff have to have a clear understanding of the role of the chaplain, hence the importance of the chaplain in `being there': the more the chaplain is seen, the better he or she will be known, and the more they will be used. Taking part in HCPs' education and training is essential. However, the initiative to be involved will need to come form chaplains. Induction programmes for new staff, continuing education and training, and the training of nursing and medical students were all areas chaplains should be seeking to participate.

Although there is clear evidence from the increasing number of whole-time chaplaincy appointments being made that spiritual care is being taken seriously, there is a danger that the agenda for the provision of spiritual care could be overtaken by other professions. Chaplains need to engage in the debate prevalent in the nursing and palliative care journals. If not, the result could be assessment tools for spiritual care that are at odds with chaplaincy understanding and practice, tools which could limit and routinise rather than enhance the provision of spiritual care for patients and their families.

Further Study/Research

The study has highlighted areas that need further research. For example: respondents noted a significant amount of their time was spent on staff support. How much time is spent on staff support? What is the nature of the support? And why do staff choose the chaplain? These are questions that need answered through further study. This study was of chaplains working whole-time in health care. Would the same results be true of part time chaplaincy? What of denominational chaplaincy: those appointed to minister to a particular faith group? The common sense answer is no, whole-time chaplaincy is different! Research needs to be carried out to discover the nature of other forms of chaplaincy to confirm or deny such a conclusion.

A Final Comment

This research project was never meant to be the definitive study of chaplaincy and spiritual care. It was designed to discover how the professionals appointed by hospitals and hospices to provide spiritual care to patients, visitors and staff understood and practised spiritual care. Whole-time chaplains in Scotland have a clear understanding of their role and the spiritual care they seek to provide. There is a general consistency in that understanding and practice despite the local focus of their appointments.

Its hoped the chaplains who read this article will:

- start asking themselves some questions.
- follow the questions up and develop some research into the different areas of chaplaincy and spiritual care
- start writing about it.

The debate on spiritual care is out there and happening now. Where is the voice of chaplaincy?

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