

THE FUTURE OF ROMAN CATHOLIC HEALTHCARE CHAPLAINCY

Kenneth Owens

Abstract: This article takes a past, present and future look at healthcare chaplaincy from the perspective of the Roman Catholic(RC) Church in Scotland. It explores the traditions and experiences of chaplaincy in the context of a changing National Health Service(NHS), a multi-faith Scotland, and a changing Roman Catholic community. It offers insight into the future focused on a broad understanding of Spiritual care and chaplaincy. The author concludes with positive advice and encouragement for the RC Church, its bishops, the NHS, and all organisations associated with healthcare chaplaincy. The Editors

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Introduction

Over the past decade the NHS has undergone massive change in order to enable it to respond to the complex issues related to healthcare for the twenty-first century. Chaplaincy within the healthcare system has had to adapt and is still in transition as the reality of the new NHS emerges. Historically in Scotland the practice has been to appoint Church of Scotland ministers as 'official' chaplains to healthcare institutions. In the recent past other religious groups have been able to gain access as part-time, honorary or occasional chaplains. The arrival of the Holyrood parliament and its desire for even-handedness, inclusion and equal opportunities will have an impact on future working practices.

The purpose of this article is to articulate some of the difficulties experienced at present as well as some of the challenges that need to be faced as new models of chaplaincy emerge in the future.

Past legacy

A ministry of presence and sacrament:

The pastoral care of those who are ill has always been and remains a high priority within the Roman Catholic tradition. When those who are sick call upon the resources of the church there is a wealth of different approaches that can be drawn from. The first and the most re-assuring is that of presence -

encouraging people that they are not alone in their moment of pain and vulnerability but that they are supported by the prayer and good will of the community represented by its pastoral minister. Secondly they can receive the consolation of the sacraments. Eucharist which nourishes and sustains their spiritual selves, the sacrament of the sick which heals and soothes those in pain and the sacrament of reconciliation which offers the opportunity of seeking forgiveness from God and from their neighbour.

With the on-set of the dying process there are rituals and prayers to accompany those who are preparing for their eternal destiny as well as bringing comfort and consolation to family relatives and friends present. There are also a variety of devotional practices which help people cope with the deterioration of their illness and preparations to meet their Maker. Each individual believer has unique needs, created as they are to be originals and not copies, in the image and likeness of God. Any pastoral minister needs to be able to work within a fairly broad spectrum of belief that embraces both popular and orthodox belief.

A part-time, denominational chaplaincy

RC Chaplains are appointed by their bishop. Most are part-time. Traditionally they have visited RC patients and said hello to other patients but not been involved in the politics of the healthcare setting. Career and financial remuneration have taken second place to the need for those who are ill and dying to be ministered to.

The expectation for an individual part-time denominational chaplain that s/he is available twenty-four hours a day, seven days a week, three hundred and sixty five days a year breaches both employment law and realistic expectations of what is human. There are wider implications for all chaplains with regard to the issue of on-call. It's interesting to note that in a recent study on hours worked by chaplains according to contract, whole-time chaplains were working 4% over contracted hours where as part-timers were working 32% over contracted hours (Barnes 1999). The advent of the implications of clinical governance within the chaplaincy context means that Trusts can no longer have chaplaincy on the cheap.

Present context

A changing NHS

There has been a growing awareness within healthcare that spiritual, sacramental and pastoral care is not the preserve of the chaplaincy department and many other members of staff make an invaluable contribution to such care. Anecdotal evidence seems to suggest that when people are anxious, in pain and coping with illness their recovery can be significantly improved by drawing from their religious faith or value system.

One of the proposals that will be discussed by new unified NHS Boards is the issue of who takes responsibility for the setting of clinical standards for healthcare chaplaincy. In this project there needs to be a full integration of the different yet complementary approaches to chaplaincy in different denominations.

Within Trust structures whole-time chaplains are often seen as the chaplaincy department. While in some settings there has been an attempt to develop a more comprehensive inclusion of both whole-time and part-time chaplains there has been no allocation of any additional hours to enable a new working approach.

In the recent past much emphasis has been placed on safeguarding patients, respecting confidentiality and working professionally, with other NHS staff as chaplains become more fully integrated into the team approach of the healthcare setting. These advances are to be applauded and encouraged. How-

ever they will only be successful where adequate support structures and remuneration match the demands for professional excellence. It is clearly inadequate to categorise part-time denominational chaplains in such a way as they do not benefit from the same corporate advantages as NHS employees.

There is a new appetite at the present time for a wider and more informed debate on ethical issues in healthcare. Recent controversies with regard to the removal and storage of organs, the conduct of individual doctors and the rapid expansion of genetic technology all demand thoughtful consideration. The different faith communities offer a natural locus for this discussion as they gather together a cross section of the community with a good breadth of experience.

It is significant that in July 2000 that the Scottish Executive called together a steering group to widen awareness and training with regard to spiritual need for all NHS staff.

A changing RC Community

The collaborative model of ministry within the RC tradition has been evolving since the late sixties. Its particular strength is that it offers both a theological framework and a practical model to engage a variety of different individuals in a communal task (Cooper 1993). It seeks to use the theological concept of communion as a way of uniting different individuals to work for the common good. It has spiritual and ecclesial roots in the word of God and places mission at the centre of its activity. As we see healthcare chaplains moving from working as individuals to collaborating in teams it is one more offering to put on the table for further discussion.

Over the last thirty years within the RC tradition there has been a growing appreciation of the priesthood of the baptised. Within the church community this has meant a wider diversity of ministries and an acknowledgement of the multiple charisms which individuals have been gifted with. Just as the medical and nursing professions have had to adopt new working practices at present similar challenges exist for chaplains.

There is beginning to emerge a strong and committed group of lay people trained in spirituality and theology. They can make an invaluable contribution to patients' time in a healthcare setting. This mobi-

lisation of resources means that for RC patients who wish they can have a visit, someone to pray with and, should they wish, they can receive the eucharist more frequently. This frees the priest chaplain to spend more time with those who are seriously ill, those who have been disconnected from the church and want to return and those seeking the sacrament of confession and anointing that are reserved to the priest.

Two important features should be highlighted about this development. It helps to restore the clergy and laity imbalance of the past where chaplaincy was the sole reserve of the priest. It encourages the laity to live out their baptismal vocation in the light of the gospel. The ministry of visiting and bringing the eucharist is a ministry that is open to both male and female which is empowering for the mission of the church as well as personally enriching.

It is worthwhile noting that at St Columba's Hospice in Edinburgh which has thirty in-patient beds there are four hundred volunteers supporting their work and the ethos of the hospice, and they are a complement rather than being detrimental in any way to employed staff.

Interfaith community

The challenge facing healthcare chaplaincy at this time I believe is to move from a fairly monolithic Presbyterian history to be an inclusive inter-faith community. That will not happen overnight. It necessitates an openness and willingness among all participants to seek to develop new models of working which are discerned mutually.

The future of healthcare chaplaincy needs a forum for debate, discussion and evaluation. Previously this has been well-provided for by the Church of Scotland through the Board of National Mission. There needs now to be a new vehicle which expands and develops this work and moves beyond the Scottish Churches Committee on Healthcare Chaplaincy which draws together the Christian communities under the ACTS structures.

There also needs to be a clear endorsement from the inter-faith community of the value and necessity of further training and accountability. As we become more aware of the cultural diversity of modern Scotland and the range of different gifts on offer that

must be reflected on those who work within healthcare chaplaincy.

The Scottish Executive's Health Gain Division has begun this preparatory work with the formation of the Spirituality in the NHS Group and the revision of the previous guidance issued to Trusts with regard to healthcare chaplaincy.

Ecumenical Reality

There is no one definitive model of delivering spiritual care. What we need to better appreciate in Scotland is difference. Difference enriches and widens our horizons as well as inviting us to learn from best practice. The inter faith community along with other interested parties needs to engage in a process of mutual dialogue which can help the new model emerge. There would be a recognition of areas where there is a commonality of approach as well as a respectful understanding of areas of divergence.

Training and development officer

The recent appointment of a full time Training and Development Officer for healthcare chaplaincy means that now is an opportune time for a nationally co-ordinated programme of support for chaplains. One of his core responsibilities will be 'to liaise with and be a resource for faith communities in the provision of religious and spiritual care in the NHIS' (Particulars of Appointment May 2001). Professional development is essential in this fast changing world. It is vital that part-time chaplains feel valued in this training initiative and that their views are sought and acted upon.

Future Hopes

It is very encouraging that healthcare is a stated priority in the present political arena. In the past the RC tradition has made a significant contribution to the founding of religious orders to cope with particular needs, to ministering to the poor and those who are dying, in offering support and help to the vulnerable. For the future we need a more prophetic witness to the belief in God's power to heal. Science has contributed greatly to advances in medicine. Religion can help individuals who have faith to flourish in their potential as human persons. Further thought, reflection and creativity are needed to discover ways in which the RC tradition can make a positive and worthwhile contribution to the devel-

opment of healthcare chaplaincy and not be a fringe partner.

Using the gifts of the RC community

As stated in the opening paragraphs of this article the RC chaplains have at their disposal a variety of pastoral strategies. While wishing to retain and assert the right of RC chaplains to minister to RC patients it would be good to see more varied input into generic chaplaincy, with others benefiting from tried and tested resources. For example, *Ignatian spirituality* (Silf 1998): Adapting and walking with St Ignatius as a guide could help both patients and staff to be more reflective and nourish their spiritual selves. Ignatius was keen to help individuals who were seeking to know God better by reflecting on their experiences of consolation and desolation. His desire was to find God in all things. To know God's will and to try to discern where my desires are for the good. His reflective process has been developed over the centuries to respond to different needs and attempts to help individuals be in touch with their own spiritual journey.

Ignatian spirituality takes the participants on a journey of self discovery in the presence of God. Seeking to enrich the individual by discovering the nature of their deepest desires. Ignatius' ministry of companionship has brought peace and fulfilment to many in the world today as they cope with the pressures of life. His holistic approach confronts the pain of darkness as well as giving practical hints on how to cope. He encourages us to be more self-conscious and aware of the world of feelings and how they shape us as people.

Supportive and reflective accompaniment has been valued increasingly in a number of professions. Again the spiritual traditions and the reflective practices of the RC tradition can be a useful resource. Whether they follow the traditional lines of spiritual direction/accompaniment, silent retreat, vocal or expressive prayer their value is that they nourish the spirit of those in caring professions helping them to replenish their inner selves.

Both as individuals and groups increasingly clergy are finding that pastoral supervision helps them in their ministerial and personal lives (Hawkins & Shottet 2000). Pastoral supervision offers a forum to reflect and affirm work that has been done. It can also act as a stimulus to provide some vision where

the vision has been blurred. It provides a safe environment to challenge professional practice.

What needs to change?

Local NHS Boards need to make better use of the natural communities that already exist and link into schemes already operating at parish level. These include visitors groups, prayer lines, practical help and the reception of sacraments at home. One of the early difficulties experienced in the change of emphasis brought about by the Care in the Community legislation was identifying community resources for this programme. Better co-ordination and appropriate sharing of information could strength the links after a patient has returned home.

Trusts I believe need to learn more about the working practices of the catholic community. Contacts I have had with those who manage chaplaincy services demonstrate a basic ignorance of the variety of duties and responsibilities that individuals have to support. Bishops for their part need information coming from Trusts and NHS Boards about changes in working practices, legal and personnel requirements as well as a drive by all towards a professional patient-centred approach to chaplaincy.

One of the challenges for the Scottish Executive is to begin to investigate how best to train and support the next generation of chaplains whether they be ordained or lay drawing on the experience of the past and in partnership with interested bodies who value chaplaincy.

I believe that the RC church has to be a fuller participant both in time and resource in the development of new models of healthcare chaplaincy. As congregations diminish and the number of clergy decrease there is tendency to withdraw into a defensive stance. We need to assess priorities and find ways of making insightful contributions to the debate. This should involve the whole catholic community and not just bishops and clergy.

I would strongly encourage the RC Bishops in Scotland to promote the training of laity and clergy to encourage specialisation in healthcare chaplaincy while being aware that at grassroots level this is already happening. This growth would be positively accelerated if better co-ordinated and financed. In Scotland we need to see emerge a training programme along the lines of the experimentally based

programmes in America. I would hope that in conjunction with the good programmes already running for other healthcare professionals our educational institutions could enliven ongoing development for chaplains in the Scottish context. There is no shortage of experience and good practice. The Professional Bodies that represent chaplains have already begun some of this work. It would be good to see this work extended further and to be more inclusive.

Conclusion

New and creative ways of working must be sought by all interested parties so that healthcare chaplaincy models the inclusive nature of Scotland today. While change and development are an intrinsic part of the Christian dynamic most people still find them hard. It calls for a concerted effort by all involved to respond with openness and generosity to the changing healthcare environment.

The debate is at the beginning of its life rather than at the end. To those willing to engage the opportunity exists to create a way of responding to those in healthcare settings seeking to satisfy their spiritual needs. Hopefully society as a whole can benefit.

The experience of a divided and polarised past which has often disfigured Scottish society can hasten the imperative of giving better communal witness to a respect for difference that enhances rather than separates.

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- Rev. Kenneth Owens is parish priest in St. John Vianney's in Gilmerton, Edinburgh, and does consultancy work in the healthcare system on behalf of the Roman Catholic Church.*