

## SPIRITUALITY – A SCOTTISH HEALTHCARE ISSUE

*Desmond Ryan*

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In this paper I try to put the conference on Spirituality in Health and Community Care into context, suggesting some reasons why it is both important and timely. While the conference is about extending spiritual care throughout the Scottish health care system, in support of patient-centred care as a primary value, it has the potential to be of wider social benefit, as contributing towards the step-change in Scotland's health promoted at the recent *Healthy Scotland Convention 2001*. I hope that the chance to see the present moment in its historical, health care system, and organisational contexts may help both the discussion and the policy-formation processes to be approached in a maximally constructive way.

### **Spiritual care: the historical context**

The essential preliminary is to remember the driver for the emphasis on spirituality: *person-centred care*. The NHS in Scotland is seeking to move away from a healthcare system operated according to the clinical and technical priorities of the providers towards a system which is more responsive to the needs of users, seen holistically as physical, psychological, emotional and spiritual beings: in short, as persons.

This increased emphasis on the personhood of the healthcare user has not come from nowhere. It has been prompted by sensitivity to the general social process under way in British society since the 1960s wherein most individuals have experienced an increasing degree of detachment from the established structures of family, neighbourhood, place of work and place of worship, and also a greater degree of independence in moral and cultural matters. Britain as a whole has moved in one generation from being an industrial society with strongly socially structured identities and a readiness to accommodate to what was expected in the way of public behaviour to being a post-industrial society from which recog-

nised authority has all but disappeared, whose only effective integrator is a volatile economy largely based on services, and where people are much more concerned to assert their rights. In Scotland the scale of change has been if anything more extreme, given the historic dependence of whole sections of the population on exports of manufactured goods.

This transition is often described as the end of 'modernity'. As modernity gives way to post-modernity, more and more of us pass into a cultural state in which the one-time 'grand narratives' of our society (e.g. Empire, motherhood, Queen and country, temperance and thrift, honour and service, religious loyalty, class solidarity) lose credibility for us. Not only this, but we find it difficult to understand those for whom such narratives are still sufficiently real and binding to give an overarching order to their lives.

As 'post-moderns' we increasingly live in multiple parallel stories and fragments of stories which we compose ourselves, which are really only about us and the people close to us, and which have no 'closure' except that which we can ourselves provide. Seen positively, this is the assertion of individuals finally liberated from oppressive structures to live lives of their own making, consumers surfing today's multiple markets on the board of the appropriate form of capital. Seen negatively it is the triumph of hedonistic consumerism, the erosion of social solidarity and the creation of highly resistant pockets of socially excluded poor people. Whichever view one takes, there is no doubt that more people live alone, that we are each required to be more responsible for our own self, that in an era when the average British job lasts just six years we are more reluctant to take on lasting commitments, and that we seem to be less successful than earlier generations in maintaining relationships long-term. For good or ill, the traditional structures of society are in retreat, the glue in

the social bonds is less effective than before, the individual self is held to be sovereign.

Faced with so massive and so sudden an accession of liberation and choice, responses trying to emphasise integration and harmony were inevitable. And in fact the same period has seen a great efflorescence of movements and outstanding individuals whose aim has been to offer to unify experience and counter the fragmentation and disorientation brought by fundamental economic, political, technological and social change. This emergent culture goes under several names, but there is always a good deal of overlap between the different currents: New Age, New Religious Movements, 'Body, Mind and Spirit', the Human Potential movement, Alternative/Complementary therapies, etc.. For our purposes there are two significant features about these movements:

- their concern to provide integrating structure, even discipline, for the isolated individual self (e.g. through meditation, yoga, tai chi);
- their acknowledgement that this self is spiritual.

It has been pointed out that the new religious and the new health/healing movements share a common world-view. It has also been pointed out that such movements are commonly sympathetic to some world-views which are far from being new, but which are almost always outside the dominant Western mind-set: oriental religions, Celtic spirituality, native American spirituality, shamanism, witchcraft and paganism, etc..

It is hard not to see these commitments as representative of a profound revolt against the tendency to break things apart of the analytical Western mind. The more dominant Western science becomes in the public world, the more impelled many Westerners themselves appear to be to try to resist it in their private worlds. The historical irony here is that movements within Western culture which long considered themselves polar opposites (science and religion, e.g.) now find themselves in the same camp, both condemned by the new movements for their over-emphasis on the intellect, obsession with competing truth claims and indifference to the experiential dimension of being human. Empty seats in university science departments, empty pews in Christian churches, and the strong drift to complementary health services are evidence that, though actual membership of New Age movements may be

small, they do to no small degree express the spirit of the age. In market terms, we have moved into the age of the Experiential Economy: rather than to believe or to think, above everything else, people want to *experience*.

As I have tried to suggest, this search for experience has become unavoidable for many individuals, disoriented by the loss of the traditional structures of social control and of the grand narratives they carried, socially inclusive discourses with which large numbers of people were helped (sometimes to excess) to make sense of their lives. But such moments can be opportunities for development as well as occasions of loss.

The historical context for the increased emphasis on spirituality in health care is therefore one of highly dynamic and profound change in our post-industrial, post-imperial society. The Scottish spiritual environment has been totally transformed from when the NHS was set up, and with it the environment for delivering spiritual care in today's NHS.

### **Spiritual care: the health system context**

Given the importance New Age attaches to a holistic view of human being and to the inclusion of the spiritual as an essential element of right living, it can be no surprise that the *general* culture shift of the last forty years has fed a parallel healthcare culture shift, signalled by the addition of the word 'spiritual' to the World Health Organisation's definition of health in the late 1980s. But there are two as yet neglected aspects of the integration of the spiritual into the healthy which I think need to be emphasised:

- the relocation of the ideal healthcare relationship out of mainstream healthcare into the complementary care sector;
- the importance of considering spirituality as a possible public health issue in today's Scotland.

Lack of space means that discussion of the public health aspects will need to be deferred to another occasion. But the question of the ideal relationship in healthcare deserves more attention than it has so far received, even though continuing to neglect it can only lead to more problems for recruitment, retention and staff morale in the NHS. There was a time when the model practitioners of health care

were those who were most central to the system people actually experienced: the good doctor, the selfless nurse. But it is now widely reported by doctors and nurses that it has become increasingly difficult to practise according to the ideals they had presented to them during their training. The reasons given for this difficulty are largely related to the changes in organisational structure and process imposed by successive governments on the health service in the last thirty years. The inner logic of bureaucratised bio-medicine continues to make it difficult for health care workers to be all they would like to be for their patients. They do in fact often succeed; but success seems to require considerable investment of self out of personal goodwill and respect for the powerful tradition of wholehearted service in the NHS, rather than to be an outcome of managerial facilitation.

There is a key spiritual question here, and it has nothing to do with patients, everything to do with staff. If the NHS is to establish as normative the principle of person-centred care, the principle has logically to include 'person-aware' staff policies. Healthcare personnel often come into the sector because they want to care for people, to work in a personal relationship with others, rather than with paper or machines. Which poses the question: what kind of relationship do they have to the organisation? Are they seen as whole persons, deserving of respect on a level with patients? Or as impersonal functions in a system?

The take-up of complementary/alternative therapies has made available the experience of a different kind of working relationship. Leaving aside the questions of these services having to be purchased in the market, and being of limited, even doubtful efficacy for serious diagnoses compared with mainstream medicine and surgery, the key question is the 'demonstration effect' of the relationship between practitioner and client. It is person-to-person, it is open to wider exploration of seemingly contingent aspects of the client's lifestyle and relationships – and it is congruent with the self-oriented cultural shift discussed above. As such it provides satisfaction to both parties: irrespective of measurable health gain, the client may feel their needs to have been fully addressed; and the practitioner gets the satisfaction of having been able to implement their knowledge and skill to the full.

Not only is it increasingly the case that people are undertaking complementary and mainline health care at the same time, mainline practitioners are themselves acquiring qualifications in complementary therapies (1500 UK doctors are qualified in acupuncture). Sometimes these are practised in parallel, but sometimes a qualification in a complementary therapy becomes an exit ticket from the NHS into private practice, occasionally accompanied by such remarks as 'Now I am giving the kind of care I became a nurse to give, but found impossible under the understaffed conditions of a typical ward'. In this phenomenon we see that spirituality in health care is not just an issue for good patient care, but has become an important issue for both the job satisfaction and the retention of highly trained staff. As long as it was the monopoly employer, the NHS could be indifferent to the working culture prevailing within its walls. The growth of a market for independent practitioners, though directly competitive in only a fraction of patient conditions, means this is no longer the case. Complementary therapies have been holding up an evaluative mirror to NHS human relations practices, stimulating them to move with the times.

### **Spiritual care: the organisational context**

The main obstacle to developing a holistic policy for spiritual care for health delivery systems is taking too practical an approach. Without theory, without vision we have no model but the present one to guide our plans and projections. If we have no model but the present we will surely end up with what we already have, not capable of delivering the qualitative innovation, the 'step-change' we need.

Theorising how to deliver spiritual care in healthcare organisations requires us to make some distinctions with regard to the potential divisions of labour for the task. Spiritual care could be delivered by three distinct routes, alone or in combination:

#### **1. via the socio-cultural system**

where the patient is followed into the organisation by family and other members of their faith community, who carry out the prescribed ritual and support tasks on their behalf, requiring no involvement from the organisational staff;

## 2. via a specialist role

devised by the organisation or via a specialised agent deputed from an outside body, in either case absolving organisational staff of any requirement for engaging with spiritual needs.

## 3. systemically, via the organisation as a whole

where the organisation resources itself to deliver the greatest part of the appropriate spiritual care, through training of staff members.

The empirical referent in **option 1** is a fully integrated socio-religious system, where the sacred is actively present in all aspects of political, social and personal life. This kind of healthcare system has not been dominant in modernised, pluralist societies. They are still to be found where Christian denominations (or other faith groups) run their own hospitals for their co-religionists, or where ethnic minorities have secured the right to fully support their own patients. It is a system in tension: two medico-scientific worldviews and two sources of authority are in competition, to wit, those of scientific healthcare and of traditional religion.

**Option 2** is predicated on the assumption that spiritual needs are distinct from health care needs, that not every patient has these needs, and that those who do can have them met by being referred by the clinical staff to chaplaincy personnel, be they hospital-appointed religious specialists or deputed to the role by external faith communities.

**Option 3** is a somewhat notional beast, logically required but not (yet) widely to be found. It is the system one would expect to see in a health-care system which attended to spiritual needs as an aspect of the holistic health care delivered by the organisation, as against making recognised external bodies free to meet their own members' needs in virtue of their membership of that spiritual body. The evolutionary jump from Option 2 is from a situation where an external religious organisation secures the right for one of its appropriately qualified (e.g. theologically trained) members to work in a public healthcare setting to a situation where the healthcare organisation secures an appropriately qualified (e.g. 'hospital-aware') spiritual professional to deliver spiritual care to its members (staff as well as patients). The role in the organisation may keep the same name, it

may even continue to be the same physical individual playing the role; but there would be a subtle shift in the objectives. What was incidental (health) is now of the essence; what was essential (spiritual comfort, relief of distress, reconciliation and renewed faith) is now instrumental.

While this system is beginning to exist, notably in North America, it is rare, for the reason that non-religious healthcare systems have been rare, in a global perspective; but even rarer is the case of a non-religious system seeking to include a spiritual dimension, but as an aspect of health rather than of religion. Rare though it may be, it is also, it seems to me, the system logically implied for a society which has largely said goodbye to formal religious membership and attendance at worship, but which is at the same time experiencing the kind of boom in spiritual search and experience detailed e.g. by David Hay and John Drane. As my overdrawn contrast may have already suggested, the actual quality of spiritual care possible in this system will be crucially dependent on how it is defined, how fully it becomes accepted as an intrinsic (i.e. not extraneous) component of healthcare, and how well personnel get prepared to work with spiritual needs. If spirituality is reductively defined, what patients receive will likely not be spiritual care.

In the health care arena, we are at a moment of dialectical tension: the broad cultural transition towards ever greater individual self-determination is in tension with a health care system which has long been home to two distinct grand narratives: the 'heroic quest' story of Western scientific medicine, and the 'redemption' story of Christianity. What the new holistic individualism is seeking is to overcome such mutually exclusive separations, such a marked feature of Western modernity, and which one sees materialised in the floor-plan of hospitals where spiritual care is a separate functionally specialised department, analogous to renal medicine or orthopaedics. As chaplaincy moves from being an extension of a religious organisation into a healthcare organisation to becoming a 'naturalised' part of the healthcare organisation, it confronts this dialectical tension between the two world views. Chaplains themselves are concerned lest the increased professionalism of their service should be institutionalised in an assimilation of their work into just one more expert contribution to the multi-professional team. And they are right to be concerned: such a response

is the usual way a complex organisation 'bolts on' another service.

The fact that the spiritual and the physical are different dimensions of being human, requiring different approaches, is not in itself a protection. Organisations can assimilate such differences without changing their base design. 'Loose coupling' is the term organisational theorists invented for the way in which turning different parts of the organisation into semi-autonomous units allowed inconsistent programmes to co-exist in the one organisation. The payoff from this is that the organisation's survival chances are enhanced by being enabled to respond to contradictory environmental pressures. The question is again the fundamental one: is spiritual care a property of the entire organisation? Or is it a specialist service, available on referral?

## Conclusion

These reflections on the form to be taken by a spiritually enhanced health service are necessarily conjectural. But conjecture is essential at moments of transition. . The chaplains are enthusiastic to move

towards new more collegial models of spiritual care. The NHS Executive has indicated that it has no intention of shoehorning every healthcare organisation into a one-size-fits-all approach to delivering spiritual care. This leaves the developers of the local policies freedom to be original, space to look around, time to discuss different possible approaches. It is a big challenge, but it is also a societal challenge – the partners in healthcare should have lots to say. In my view the central issues of this new crucial moment in Scotland's history are spiritual: relationship or alienation, meaning or anomie, fulfilment or frustration, sharing of gifts or privatistic retreat... Healthcare is the setting where we happen to be working now; but spiriting Scotland is a challenge for everyone.

*Desmond Ryan is co-founder of Spirited Scotland and Senior Research Fellow, Department of Nursing Studies, University of Edinburgh. The work leading up to this paper received funding from the NHS in Scotland. The views expressed are entirely his own.*