

PUTTING SPIRITUAL CARE AT THE CENTRE OF THE NHS

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*The author presents a report as an overview of the **Spirituality in Health and Community Care** conference at Stirling Management Centre, Scotland, on 15-16 November 2001*

Background

In November 2001, hospital chaplains, representatives of faith communities, and members of NHS Boards gathered to discuss the report of the Working Party revising the guidelines on chaplaincy and spiritual care in NHS Scotland. This discussion was framed by papers exploring the wider context in which these guidelines had been developed. The Working Party's report had been revised in the light of comments on an earlier version received from NHS Trusts, Health Councils, faith communities and chaplaincy professional bodies. The next stage is that this report will be circulated to NHS Boards who will be required to develop a plan for spiritual and religious care in their local context over the next twelve months.

A Different World

Since 1948, the commitment to catering for the spiritual needs of patients has been a feature of the NHS. But today's world is very different from the one in which healthcare chaplaincy was first established. That was a world of strong institutions, which structured people's identities. Over the years, people have changed. We are now witnessing the rise of "sovereign individuals" who "make themselves up as they go along" and who want to experience rather than to believe or think. They no longer accept grand narratives which give an over-arching order to their lives.

This is how Desmond Ryan introduced the wider context in which we must understand the changing pattern of spiritual and religious need within the community. He traced the way in which the "glue" in social bonds was becoming less effective, resulting in people being more isolated and often have a greater feeling of fragmentation. He noted that hospitals have changed too. The emphasis on the need for efficiency, along with the various structural

changes which have attempted to deliver this, have made it increasingly difficult for staff to be fully attentive to the whole-person needs of their patients.

Part of the response to these developments towards more atomised individuals has been the rise of new integrative approaches, both through a greater emphasis on spirituality and in complementary therapies. Much of the attraction of complementary therapies both for the practitioner and for the patient is the more intimate person-to-person nature of the engagement. Can care be offered in hospitals so that it goes with the grain of these developments, rather than against them? And what role do chaplains play in this?

This is the challenge that the guidelines try to meet. In a world of more diffuse identities and more scientifically sophisticated medical care they aim to craft a service that is honest about, and sensitive to, people's changing needs and that is integrated into the professional culture of a modern hospital.

A Multi-faith Scotland

In exploring how the nature of people's spiritual needs and the resources they have for expressing them has changed since the start of the NHS, it is important to recognise that Scotland is more multi-faith than it used to be. Indeed, given the increase in migration at a global level, it is likely to become more so. Chaplains have to be clear-sighted about the pattern of religious belief in their part of Scotland.

They need to be familiar with many of the cultural expectations of people of other faiths, expectations which mean a lot to people particularly under the stress of illness. Roger Cressy offered delegates to the conference a chart of how faiths differed in various cultural practices, which could be important in medical care. Christians, Hindus, Jews, Muslims and Sikhs have different needs when considering diet,

ablutions, modesty and protocol on death, with which chaplains should be familiar. They should also be aware of the main religious festivals and any special observances which these entail.

The guidelines recommend that Trusts should ensure that proper arrangements are made for the spiritual care of those who belong to the smaller faith communities and that each faith community should be able to have its own chaplain or spiritual caregiver if it wishes. Chaplains should therefore be in close touch with the spiritual caregivers in their local situation who minister to people of these faiths. Trusts or Boards are required to provide accommodation, accessories and facilities which can be used for worship by people of various faiths. Ensuring that this provision is appropriate takes considerable sensitivity, so that religious symbols, precious to one community, do not intrude offensively on the worship of others.

Non-religious Spirituality

However, in the experience of many chaplains, the most dramatic change over the last fifty years will not be the multi-faith nature of Scottish society but rather the dramatic decline in church membership and the attendant drop in knowledge about Christianity.

Over the same period, however, the spiritual experience and spiritual needs of the wider population tells a more interesting story. David Hay told the conference about the research he had been doing into the spirituality of adults in Britain. Recently, partly at his instigation, the BBC commissioned a national survey which found that 76% of their sample reported having had personal experiences which could be described as spiritual. The experiences included being aware of the presence of God, recognising a sacred presence in nature, and noticing and seeking a pattern of meaning in events in their lives. Hay noted that the figures for Scotland might well be higher than for the national sample. What was intriguing was that a similar survey in 1987 had found that only 48% admitted to recognising a spiritual dimension in their lives. Did this represent an increase in people's spirituality, or just a greater willingness to talk about it?

Hay had also carried out more detailed research. He selected people for his study who never went to

church but nonetheless recognised a personal spirituality as part of their experience. Following a focus group session, each person was invited to have a relaxed conversation with the researchers. The transcripts of these conversations showed that their sample seldom used overtly religious language to express this spirituality, in some cases actively distancing themselves from anything to do with institutional religion. On the whole, they were also remarkably timid about talking about this subject. Hay interprets these findings as indicating that there is still a taboo about talking about spirituality but, on the basis of the national surveys, that the taboo is getting less.

This conclusion was strengthened by work that Hay had done along with Rebecca Nye on spirituality in young children. They asked six and ten year olds to comment on pictures which had been designed to elicit awareness of the here-and-now, awareness of mystery, and awareness of values. They found that the children were well capable of demonstrating this awareness in their comments. Hay interpreted this as giving support to the views of the zoologist, Alister Hardy, first proposed in his Gifford Lectures in 1966, that spiritual awareness has a biological underpinning because of its survival value.

This research, then, gives the lie to the assumption that spiritual experience, and so felt spiritual need, is diminishing in an increasingly secularised population. However, it also indicates that being articulate about this area of experience is often difficult for people. Moreover, the language of traditional religion is not only alien to many people, but can block access to the expression of their spiritual experience. Exercising spiritual care therefore involves the challenge of ministering to people whose needs are real and palpable, but who may not share a common language with the caregiver.

What are spiritual needs?

The guidelines recognise that there are many definitions of spirituality current and, wisely, do not pin their proposals to any one. They do, however, offer a useful distinction between spiritual and religious care, which emphasises the person-centred nature of spiritual care. "Religious care is given in the context of the shared religious beliefs, values, liturgies and life-style of a faith community; spiritual care is given in a one-to-one relationship, is completely

client-centred, and makes no assumptions about personal conviction or life orientation”.

Roger Cressy reported to the conference about his work on identifying the spiritual needs of patients. He observed that often, despite good medical care, patients were still left with feelings of isolation, fragmentation and despair, which were related to the onset and progression of their illness. The distress which this engendered hampered their ability to fight their disease. He identified ten areas of potential distress in patients' experience: being valued; finding meaning; having hope; emotions; having dignity; truth and honesty; good communication; death, dying, bereavement and loss; religion; and culture. Other areas more specific to the patient's circumstances, such as sexuality, may also contribute to their distress. It was also his view that all healthcare workers, not just chaplains, offer spiritual care to the extent that they attend to their patients with compassion and empathy, without pre-judging.

What is expected of chaplains and spiritual caregivers?

To operate in this context, chaplains need to have very special qualities. They need to be skilled and sensitive listeners, who can identify and encourage spiritual gifts within their patients. The report finds various ways to express the need for impartiality, openness, mutual respect, proper valuing of diversity, and encouragement. The chaplain must never impose or proselytise, should work closely with other NHS staff, and should be a unifying presence in an NHS Trust. To satisfy these expectations, training of Trust and faith community chaplains is important. The report envisages that this should be an integral part of the Trust's strategy. In addition, however, the Executive has funded the post of a whole time Healthcare Chaplaincy Training and Development Officer, Rev Chris Levison. They also intend to second an experienced member of the NHS to work with him.

Scope of the Task

The model of chaplaincy and, indeed, of healthcare in general, which is promoted by the report is patient-centred. However, it acknowledges that chaplains work not just with patients but also with their carers and increasingly with members of staff. Their spiritual needs are also important because they, too,

are under strain in the changing and demanding environment of today's hospitals.

The report tries to give a realistic assessment of the workload of chaplains, relating the expected number of sessions both to the number of beds in a unit and the type of care (maternity, intensive care, etc.) that is being delivered. It also indicates other areas in which chaplains have to be active, such as teaching, informal advocacy, providing information and advice, liaison with faith communities and serving on committees within the hospital. Trusts are reminded that, in calculating the number of chaplaincy sessions required, they must also respect the Working Time Directive! As healthcare is moved more into the ambit of the community, the work of community mental health chaplains is given a brief mention.

However, the extent of the need for continuing care when people leave hospital is considerable and goes largely unaddressed. Bob Devenny gave a paper on the spiritual needs of stroke families. The Scottish Borders Stroke Study followed patients over a six-month period and measured outcomes at one week, three months and six months. The tests given included studies of quality of life, spiritual well-being, and the strain on care givers. Two-thirds of the patients felt that their spiritual health was important to their well-being, consistent with the figures reported by Hay. Just over one per-cent (1.4%), however, felt that they received spiritual support from health care professionals, although 28% had been given support by a minister.

This study clearly uncovers an unmet need in an important population. Stroke is the main cause of disability in Scotland and it happens so suddenly that the life of the patient and their family is turned completely upside down, leading to interesting reflections on trust, worry and confidence by the patients. The paper indicated the degree of upheaval and spiritual distress caused by this experience, poignantly expressed by one patient who commented “I used to be a husband, father, provider”.

One category of spiritual experience which was commonly noted was the importance of the nurturing effect of the environment. This raises questions about whether the normal clinical environment is sufficiently therapeutic. This observation led Devenny to argue for placing the Stroke Recovery Ward in Borders General on the ground floor, with

access to a garden. The Stroke Study is now being extended to a Muslim community in Glasgow.

Structural Considerations

Our National Health lays out several themes for healthcare, namely, that national standards should be delivered locally, that there should be increased accountability, streamlined bureaucracy and integrated planning and decision making. Many of the detailed proposals for the organisation of chaplaincy aim to bring it under this scheme. In addition, it is recommended that a local Chaplaincy Committee, whose membership includes representatives of the Trust, the main faith communities, the religious and spiritual care staff and two lay people, would be valuable in integrating the planning and delivery of the services.

It will be the responsibility of the Health Boards to adapt the suggestions in the report to their local situation. In each case, however, they will be expected to ensure that the Chaplaincy and Spiritual Care services are adequately resourced; to integrate the chaplaincy services in such a way that they are seen to be central to how the NHS cares for its patients; and to promote partnership between the various services which come under the Trust, so that spiritual care of comparable clinical quality is provided by all of them.

The accountability of the chaplaincy service is highlighted by the need for chaplains and spiritual caregivers to be people in good standing with their local faith communities. Within the hospital context, the proposal that a Trust Department of Spiritual and Religious Care be set up and that the Chaplaincy should be line-managed by senior management staff also should increase accountability. It is also suggested that the chaplaincy services should be monitored and reviewed by the Trust.

One area of bureaucracy that requires careful attention is that of noting a patient's religious affiliation and passing on this information to the appropriate spiritual caregiver. Reference was made at the conference to the importance of how the question of religious affiliation is framed. Concern was also expressed that there had to be sensitivity to respect the wishes of the patient in passing on this information to particular people.

Unresolved Issues

The Working Party was aware of differing views about how much access chaplains should have to patients' medical records. Some felt that, as a member of the care team, the chaplain should know as much as everybody else about the patient's history. Others felt that the pastoral dynamic may be adversely affected if the chaplain knew certain things. The Working Party proposed that the chaplains should have access to information on a "need-to-know" basis. At the heart of this dilemma, is a question of confidentiality and it was emphasised that patients should be made aware when they give information who is likely to have access to it and why.

There was also disagreement about how chaplains and spiritual caregivers should be appointed. The Working Party was unable to agree on a single system of appointment and recommends that each Board or Trust should make its own decision as to which system of appointment is more suitable. Two routes are used at present. Either a chaplain is appointed directly by a Trust in consultation with the local faith community or the chaplain is appointed and employed on an agency basis by the faith community in consultation with the Trust. The report notes that, in either case, it is important that both the Trust and the faith community should work together on the appointment. It is important, however, that, whatever route is used, the appointment should be seen to be impartial. It was noted that there was concern that the present system where the Church of Scotland appoints chaplains did not result in a more balanced denominational distribution of appointments. They note that on the Appointment Board there should be a practising chaplain with not less than three years' experience.

Two comments and some pictures

It is in the nature of a conference or a report that it leaves the impression of being wordy. At times, it seemed that the guidelines characterise a person's spiritual needs as the process of asking the questions to which religion has traditionally given answers. That is part of the picture but, particularly in the light of the difficulties Hay's people often had in articulating their spirituality, it is important not to forget the healing value of the comfortable silence, or quiet music, or looking at something beautiful.

Doubtless chaplains know this, but perhaps it needs more explicit acknowledgement.

There is an interesting tension in the guidelines between opening up the task of spiritual care more widely among the hospital staff and making the role of the chaplain more professional, even anticipating the possibility of registration. Keeping these two understandable aims in balance will be an important part of the task of the Healthcare Training and Development Officer as he designs appropriate training for each group. But it will be important to ensure that these areas of spiritual care develop in a complementary way and not competitively.

Many of the words at the conference were used to paint rich pictures. The dramatic observation of Roger Cressy that "Auschwitz is the antithesis of hospice". Or the poignant vignette of the recovering

patient who threw out five batches of scones before she baked ones good enough to take with her to the Stroke Club. And the revealing comment by the other stroke patient who recognised he had focused too much on his arm and neglected the more difficult spiritual journey he had to make.

Here's another one, courtesy of Blair Robertson. It's the image of the chaplain from Chaucer's Canterbury Tales, who accompanied the pilgrims on their journey and carried the sacred things. Different journeys and a richer array of spiritual and religious resources, but still a good image for chaplaincy today.

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