

SPIRITUAL CARE IN NHSSCOTLAND

A NON-RELIGIOUS PERSPECTIVE

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Abstract: 'Spiritual Care in NHSScotland' seeks to differentiate between religious and spiritual care. Yet the latter is not adequately addressed as a separate concept, and the definition which is given of it is unduly dependent upon established psychological theories. The author poses the question as to whether the education of staff in spiritual care, as opposed to religious care, ought necessarily to be the province of the chaplaincy at all

Introduction

Spirituality is a complex issue currently considered to be very much a part of the rhetoric of health care at both interpersonal and political levels. In 2000, the Department of Health Gain of the Scottish Executive set up the Spirituality in the NHS Steering Group'. Taking cognisance of the policy document 'Our national health', in October 2001 the group recommended that Health Boards and Trusts should accept spiritual care as an integral part of NHS provision, and encouraged them to include it in their policies, fund it adequately and ensure it meets the standards set for it. Subsequently, in October 2002, the Scottish Executive Health Department produced the document Spiritual Care in NHSScotland supporting and endorsing these recommendations. This paper is a personal response to that document and will focus in particular on the spiritual dimension of health care, the 'non-religious' expression of this, and the implications for education and practice.

On the one hand there is religion; on the other....

Spiritual Care in NHSScotland seeks at the outset to differentiate between what it refers to as 'Religious care' and 'Spiritual care' by providing brief definitions as follows :

Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community.

Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.

Leaving aside the interesting issue as to whether one can be religious without being spiritual, of more immediate concern is the fact that the notion of spiritual care as opposed to religious care is not adequately addressed within this document, in fact by the end of the document 'spiritual' has become coterminous with religious Non-religious spiritual care is lost within the text, which seeks to primarily establish the role of the chaplain, including referral criteria, lines of responsibility, accountability and communication, personal qualities, professional qualifications and experience, representation on decision making bodies, the role in relation to non-christian faith communities and crucially, developing training and education for staff. Crucial, because given the harmonising of the terms one can only assume that the responsibility for the education of nursing staff regarding the spiritual as opposed to the religious, will also fall within the role of the Healthcare Chaplaincy Training and Development Officer.

A nursing perspective: education on what basis?

Spirituality is prominent in many nursing theories and it is thought that paying attention to spiritual

needs and spirituality plays a major part in healing and therefore in health care (Burkhardt & Ngai-Jacobson 1994, Ross 1994, Pullen et al 1996, Dyson et al 1997, O'Neill & Kenny 1998, Wright 1998, Golberg 1998, Narayanasamy 1999). However, much of the response to the challenge of spirituality has come from educators and theorists determined to develop theories on and of spirituality with a view to 'clinicalising' this aspect of health care based upon (of course) the thorough assessment of spiritual needs (see for example Narayanasamy 1991). Unfortunately, the majority of the research and published work capitulates to absorb spirituality into religion, Swinton (2001) is a good example of this, citing religious research in support of his representation of spirituality.

Insights into the spiritual are currently theory driven and this obscures the obvious; that mapping the spiritual is a complex endeavour and the efficacy of spiritual activity has proven very hard to determine (Nelson 2000). Spirituality is problematic to define, psychological elements such as locus of control, coping, resilience, hope or well being have to be delineated and examined separately. Thus, the concept becomes ever-more complex and, while interrelationships between elements are frequently demonstrated, global effects are difficult to establish with it being impossible to adequately control social, psychological and clinical variables (Nelson 2000). There is no end to the theoretical and methodological snags that frustrate the investigation of the spiritual.

But the desire to develop concepts of spirituality to underpin spiritual care might have obscured an alternative viewpoint, that perhaps "*It is entirely and radically above and prior to any form of conceptual elaboration. It is strictly unqualifiable*" (Wilber 1996). Furthermore, central to personal experiences of spirituality is a relationship with the numinous, that is, the sense that there is a higher power outside of the self with which one can commune. Consistent with Wilber's view of the spiritual, the numinous is also considered to be non-rational, irreducible – a primary datum, which cannot be defined, only evoked and experienced. The primary experience constitutes the source of all cathartic spirituality and as such cannot be reduced to some current psychological theory. Sickness, calamity, failure, dying, death, among many other phenomena, are capable of rendering individuals vulnerable to the sense of their

own limitations, which may be acute in times of instability and uncertainty. The question of meaning that comes to the fore in extreme situations where there is suffering or death and dying is most likely to receive a subjective, an individual response. This will find voice in an inarticulate language whose communicability is essentially expressive and poetic – a 'meta-language' that does not lend itself to research of any paradigm (Hervieu-Leger 2000). Significantly, the definition of spirituality in the document points strongly towards established psychological theories using as it does phrases such as 'one-to-one relationship' and 'person-centred'. The likelihood then is that these will be used to guide education and practice and most likely in the guise of counselling models.

Models and theories seek to impose order and rationality upon experiences and worlds that are in reality ambiguous, chaotic and problematic and perhaps none more so than the spiritual dimension. In denying the primacy of experience by its re-framing within the counselling culture to match the theories and models, we are in serious danger of alienating our patients. Ordinary human qualities are replaced with skills to be attained within the counselling technologies, ordinary human qualities such as empathy. But within a technology, empathy does not mean authenticity and contact does not mean connection. Counselling theories may be well grounded, but they are incongruous with spirituality

Studies have shown that in both education and practice, too little attention is paid to the spiritual aspects of health care (Ross 1994, Bradshaw 1995, Oldnall 1996, Dyson et al 1997). Problems emerge when spirituality is not part of the nurse's worldview. However the means by which we might educate nurses regarding spirituality is contentious. The provision of effective spiritual care is dependent on the nurse having insights regarding their own spiritual beliefs and practices and how these impact upon their own lives. The ability to comprehend an individual in their wholeness is an imaginative and creative act – to look at an individual and see a life saturated with meaning and connections (including the meaning of their illness and hospitalisation) – is an aesthetic endeavour equal and superior to most. It is this ability that needs to be nurtured. This is a highly specialised undertaking and should not fall within the remit of the Healthcare Chaplaincy Training and Development Officer.

Conclusion

Hospital chaplains have a vital role to play in educating and guiding staff in the particular requirements of the various manifestations of religious observation unique to each faith community – for example prayer, meditation, diet or attending the deceased. They also have a vital brokerage role in their connections with the various faith communities and in particular knowing who to call upon and when. By extension they have a central part to play in educating staff in the role of the chaplain and when and how to access the service. Religious care is a very important aspect of health care and an effective chaplaincy department is essential. However, whether they have a role in providing spiritual care (as opposed to religious care) rests entirely with the individual in need and will most likely be based on the nature of any one to one relationship and interpersonal qualities.

What we must never lose sight of is the fact that this is about patient care and it is the patients wellbeing and recovery that underpins any intervention in the health care arena. Collaboration and co-operation in this most complex and delicate area can only enhance patient care while improving our own knowledge and experience. This is crucial, as all we know for certain is that religious and spiritual practice and experience are far from static or stable and are constantly shifting and evolving. This is abundantly clear from reports surrounding the recent census and throws up the next big challenge: who will care for the Jedi?

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