

SPIRITUAL CARE IN THE N.H.S.SCOTLAND

THE PERSPECTIVE OF A HOSPITAL PHYSICIAN

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Abstract: A retired hospital physician considers the practical implications of the Scottish Executive Health Department (SEHD) Guidelines on Spiritual Care in the NHS Scotland. Whilst welcoming the move toward the recovery of a spiritual dimension in health care, and the recognition of the specialist role of hospital chaplains, he expresses two concerns. The first is the danger of too superficial and ill-defined an attitude to the spiritual need of patients. The other is whether the rank and file of healthcare workers will be prepared to give time to this additional burden, or feel equipped to do so.

In October 2002, the Scottish Executive Health Department issued Guidelines on Spiritual Care in the NHS Scotland. The Health Minister (Chisholm 2002) accepts that *spiritual awareness is biologically built into us*, and that research demonstrates *clear benefits in health outcomes when an individual's religious needs are met while they undergo hospitalisation or treatment*. He expressed his determination to *make spiritual care a central element of the way the NHS cares for people*, and that such care should be undertaken by *the whole health care community*.

Chaplains are to have a central role, covering all faiths, and being able to request a visit from a local representative from the patient's own faith. NHS boards are to be asked to provide quiet rooms or sanctuaries designed for multi-faith worship. A Spiritual Care Coordinator has been appointed, along with an assistant, to provide training, pastoral support and supervision to chaplains and spiritual care providers.

The limitations of scientific medicine

This new initiative is an exciting development for those of us who are concerned for the total welfare of our patients. I am encouraged that The Health Department has decided to emphasise that medical care involves more than care for the body and mind. For long, the accepted view has been that technical excellence is all that matters. The argu-

ment has been that when you have a burst appendix, all you want is a plumber who knows his job! It is now recognised that human beings are not simply machines that have gone wrong! It has long been evident that the best and most up-to-date medical science frequently fails to meet the total need of patients. Many patients today are leaving scientific medicine and turning to alternative medical practitioners, and one of the main reasons for this lies in the fact that their non-medical needs are not being met by the NHS.

Definition of spiritual need

So, I am all in favour of paying more attention to the spiritual needs of patients, and it is natural that the chaplain should be given a *central role* in this initiative.. This is encouraging, and must be taken as a recognition of the importance of their work. They are specialists just as much as the hospital consultants, and should meet them on terms of equality.

But I have two problems. The first concerns the definition of spiritual need. I fear it may be too superficial. The impression I form by reading the Guidelines is that catering for the spiritual needs of patients could be equated with what the health profession has long known as *holism* - caring for *the whole person*. including the emotional and social needs. The best general practitioners have long regarded this as the essence of being a good doctor. Is all that is proposed in the new initiative a reminder

of these duties? Or is there more to spirituality than mere holism?

Spirituality has traditionally been linked with transcendence. In a recent issue of the BMA News (Harper and Troughton 2001) spirit was equated with *the part of us that resonates with God and which has to do with purpose and destiny*. Patients often ask: *Why me? Where is God in all this?* It is remarkable that the Guidelines manage to say so much about spirituality without actually mentioning God! Such an attitude would be incomprehensible in most countries of the world.

In Christian (and, I believe, Jewish eyes) this longing for the transcendent finds its answer in a personal relationship with God. In the teaching of Jesus Christ, a personal relationship with God is the gateway to eternal life. Holism is fine, and healthcare staff should strive to take on board the emotional and social needs of their patients much more than we have in the past, but spirituality must surely include the transcendent - the concept of a relationship with the Creator and Sustainer of the universe. Even the psychiatrist, Carl Jung (1933), found it was almost impossible to help patients, especially over the age of 35, who did not possess some kind of religious background. My fear is that this element will be lost in the *broadening understanding of spirituality* which underlies this initiative.

A hospital specialist (Lloyd-Jones 1957), who transferred to the Christian ministry because he found that medical science was unable to reach the fundamental needs of his patients, wrote: *It cannot be emphasized too much that every view of man which omits from its consideration such a major factor as man's relationship with God, is doomed to partial measures. It can never fully and finally solve the crucial problem which lies at the root of humanity's unrest and dis-ease. There is a major element in the very nature of man, which can be catered for in one way, and only in one way. As Augustine said 'Thou hast made us for Thyself, and our heart is restless until it finds its rest in Thee.'* So that is my first problem with this initiative: it adopts too superficial a definition of spiritual need.

The role of healthcare workers

My other problem is the doubt whether many ordinary doctors, nurses and other healthcare workers

will be prepared to give time to this additional burden, or feel equipped to do so. Doctors in Britain are constantly – and in my view justifiably – complaining that they do not have enough time to undertake all the duties expected of them. It is unrealistic to envisage a change of attitude on the part of a large number of NHS staff so that they suddenly discover that they are not so busy as they thought, and find the non-medical and spiritual needs of their patients becoming attractive. I cannot see it happening.

The same applies to chaplains. I have a serious concern that they will be swamped by administrative duties and lose almost all face-to-face contact with patients. Worse still, since their duties will cover all faiths, I fear they may come to see themselves merely as facilitators, and soon cease to have any convictions of their own. In my view, chaplains should not attempt to specialise in social work or psychology, but develop experience as spiritual diagnosticians and therapists. For this, they need to spend time in prayer and the study of God's Word.

Spiritual care in practice

If, as the Minister of Health accepts, there are *clear benefits in health outcomes when an individual's religious needs are met while they undergo hospitalisation or treatment* it is pertinent to attempt to identify the elements which convey this benefit. In other words, what aspects of spiritual care actually work? An editorial in a recent BMJ (Foster 2001) singled out prayer and Bible reading as being the most important factors in one group of problem patients in the USA. The experience of my family would endorse this. Both my mother and my son were patients in the Aberdeen Royal Infirmary and both were extremely grateful for the prayers of the chaplain at their bedsides.

Statements about God from the Bible are also of proved value. Some years ago, we had an anaesthetist in the ARI, who was a convinced Christian. A frightened young woman was wheeled into the anaesthetic room, struggling with the porters. The doctor quoted the verse from the Book of Deuteronomy (33:27): *The eternal God is your refuge and underneath are the everlasting arms*. Hearing this familiar Scripture immediately quietened her. But it did more. According to her mother, it radically changed her life.

It may be objected that I am arguing for religion rather than mere spirituality. So be it. Chief Rabbi, Jonathan Sacks (2002), recently made the gnostic statement: *Spirituality changes our mood, religion changes our life*. I would suggest that most of the enduring benefits that have been reported as a result of spiritual care have actually been due to the religious dimension. For church members, religious commitment carries the additional value of a supportive church fellowship.

Evidence of persisting demand by patients

Much is made of the decline in religious observance. Nevertheless, it is a fact that patients in hospital still warm to an invitation to a Christian service. Despite the fact that so many patients are nowadays discharged before the weekend, Sunday services in the chapel at Aberdeen Royal Infirmary still attract an attendance of 20-40 patients, and this, in spite of all the difficulties – the long corridors, the wheel chairs, the intra-venous drip stands and the fact that many patients who would have liked to attend are prevented by the need to wait for a doctor's visit or nursing attention. So there is evidence that, even today, many patients find help from the Word of God and prayer.

The danger of proselytisation

If lay spiritual co-operation is encouraged, there is a danger of insensitive ministrations and proselytising. This should be largely avoided, however, if in the training sessions that are envisaged, it is made clear that any spiritual help which is offered must be in response to the patient's expressed need and with due sensitivity to their state of health and mind.

It would be a mistake to prohibit all lay religious action because of the misguided enthusiasm of a few. Healthcare workers should not turn a deaf ear to the questions which preoccupy many patients, particularly those who are seriously ill or elderly - the meaning of life, the fear of death, and the mysteries of the hereafter. As C.S. Lewis (1940) observed memorably: *God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is his megaphone to rouse a deaf world*. Chaplains will never have time to meet all spiritual need, and it is a matter of fact that in many

instances, patients have found outstanding spiritual help from their ordinary carers.

Inter-faith relations

It is entirely right that there should be spiritual provision for those who do not belong to the Christian faith. But their needs must be met without downgrading the historic provision for Christians. Any idea that adherents of fundamentally different faiths can worship together must be rejected. It is as repugnant to sincere Jews and Moslems as it is to true Christians. It must be accepted that there are real and irreconcilable differences between faiths. Faith is a relational term. It implies belief and adherence to something or Somebody. To the Christian, Jesus Christ is all-important.

Discussion

A recognition that the needs of patients go beyond the physical, mental and social must be applauded. It is good to highlight the spiritual aspect of patient care, provided its true nature is acknowledged, and it is good to involve doctors and nurses as well as chaplains. Increasingly, student doctors in the USA are being taught to take a *spiritual history* of their patients. Healthcare workers need to be trained in this field. It would be interesting to see the response of staff to an invitation to assist the chaplaincy team in this sphere of service. I would suggest focussing on long-stay institutions in the first instance; offering patients a visit from a member of the team and giving them an opportunity to request spiritual books. Every patient should have a Bible (or a New Testament) by the bedside

Summary

The spiritual needs of patients are important - vitally important - and the meeting of these needs is beneficial to the healing of body and mind. But the nature of the spiritual need must be correctly diagnosed and this is, in essence, a right relationship to God. This ministry is not the province of healthcare workers in general. No one can help anyone else to enter into this relationship unless he, or she, has entered into it themselves.

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