

CLARITY AND COST EFFECTIVENESS IN CHAPLAINCY

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Abstract: The need for chaplains to articulate their speciality and distinctiveness is vital. Such self-definition aids our working with others, as they more fully understand our role and function. This will increase the confidence and skills of the pastoral practitioner and thereby enable the chaplain to demonstrate more effectively the worth and benefit of chaplaincy involvement in healthcare.

Key words: Chaplaincy, self definition, role, function, pastoral care, cost effective

Introduction

We live in a diverse society where supermarket spirituality is the order of the day. There are no boundaries to spirituality; indeed there is a great enthusiasm to diverge into the mystical, supernatural and the 'other'. In line with this general revival of interest in spirituality, chaplaincy has seen a significant period of growth and development in the 1990's at a local level.

This growth and development brings its own particular challenges. As chaplains, are we able to articulate our speciality and distinctiveness? What is it that is distinctive or characteristic of Chaplaincy i.e. what is it that we do which is unique? I would want to contend that clarity of thought and understanding of our role and function would enable us to articulate our position more effectively within the context of healthcare. This is a crucial issue for Chaplaincy today. It is that sense of self-definition, which seems to be lacking. One senior Chaplain in a major teaching hospital in 1999 mused, 'As to our role – it is difficult to say precisely what it is. It is something to do with alerting the organisation that we are here, we have a variety of skills within the team, and it's about saying 'yes' to a multitude of things and seeing what is relevant and what can be discarded.' (Rivers 1999) While another commented: 'My basic ministry is to listen – if I could do that for people I feel I would be doing my job'. (Mitchell 1999) Definitions of this kind are in danger of seeming vague, woolly, diffuse, and lacking in substance.

The Orchard Report

It has been fascinating that while the Orchard Report, 'Hospital Chaplaincy: Modern, Dependable?' was published in 2000, and a day hosted on it, which allowed Church Times to malign Chaplaincy, there seems to have been silence from central Chaplaincy bodies about many of the issues it raises. By that I am not saying that I necessarily agree with what the report contains; nevertheless, the silence disturbs me. The issues that Orchard raises must be of grave concern for those chaplains on the ground. Let me briefly sketch three areas highlighted by Orchard which, among others, cause me concern.

1. It concerns me when colleagues will provide comments to an external researcher that they find pastoral care, 'boring and irritating'. Others speak of an anonymised colleague, 'who boasts he's never seen a patient' and another 'I've heard of a chaplain who said 'I hate the patients''. It is one thing to let off steam and feel worn down or burnt out by pastoral engagement, but I wonder how professional it is. The old jibe at a vicar only working one day a week comes back in the guise of the chaplain finding anything to do other than care for and visit people.
2. Another senior chaplain's aspirations were as follows – 'I think I would make it much more managerial so that I did very little, even less pa-

tient support because it's so exhausting... To make the job bearable, pastoral support would be given by volunteers.' (Orchard 2000, 128). I'm not for one minute suggesting that all chaplains should be confined to long hours of bedside visiting – there are limits to the amount of 'exhausting', 'boring' patient contact work any one person can or should do within Chaplaincy. The counselling profession suggest it is not physically possible to spend more than 40% of working time in face-to-face contact and remain a functioning practitioner. Consultant anaesthetists spend 50% of their time in theatre or at the clinical interface. There are parallels for us to consider and while I would not wish in any sense to diminish the demands of pastoral care, I would say that it is another thing to talk openly about creating a role, which deliberately avoids and delegates patient concern.

3. Finally the Orchard report highlighted the use of volunteers. Some carry the bleep, perform funerals and provide the majority of pastoral cover for the hospital. I would want to ask, in the light of these comments what is the chaplain's self-perception as a professional? What are they saying about their own expertise? What place is being given to their formal training and qualifications? The logical consequence of this use of volunteers would be always to management's advantage. It's much more cost effective to employ 1 full-time chaplain and 150 volunteers than 4, 6 or 8 full-time chaplains; so if there is no difference between a volunteer and a chaplain in terms of providing pastoral care, surely the more volunteers the merrier.

I am not saying I agree with all that is written by Orchard, but there needs to be a grappling with the issues.

The Chaplain's role and the need for clarity

Swinton (2001) comments, 'Chaplains have a vital role to play in the spiritual care and the discernment of spiritual experiences. They bring specific expertise of religions and spirituality and as such, are in a perfect position to make a major contribution to the process of care assessment.' He goes on to highlight his reasoning behind this statement; firstly, chaplains are in a position to provide multi-disciplinary

teams with vital information; secondly, chaplains can and do spend long periods of time with service users, and finally, Chaplaincy is a conduit into appropriate religions or faith communities.

Reflecting on what she offers as a constructive critique of Chaplaincy, Orchard (2000) comments that serious efforts 'need to be expended in demonstrating to other health-care professionals what chaplains are bringing to the bedside that is therapeutically effective rather than simply edifying'.

I would wish to argue that clarity of thought and an ability to articulate adequately our contribution is vital. This seems crucial if as a profession we are to survive. Such self-definition and articulation not only provide others with an understanding of our role and function, but also serves to validate for ourselves what we are about. A crucial element in sustaining ongoing pastoral engagement is the awareness of our own motivation. Recent work in handling stress and burn out or compassion fatigue invites individuals to revisit their primary motivation for entering this work – to maintain the value base for what is done. If we are unable initially to articulate our role, what hope is there to do so when we have been exposed to prolonged periods of pastoral engagement?

I am not suggesting that there is or should be one clear model of what Chaplaincy is. There are numerous possibilities open to chaplains, with particular tasks and duties specified, but a great deal left unexpressed. As a chaplain one is placed in a healthcare setting with a particular agenda. That setting is made up of many different groups from patients, families, professionals, and politicians etc who have a distinct point of view and self-understanding in this complex world. The role, function, mission or ministry of the chaplain may be clear or unconventional or mysterious. It is not enough to utilise the experience of any particular chaplain in order to shape a model of chaplaincy which fits all...especially since few chaplains have the opportunity to engage in the process of rigorous reflection upon their practice from which major principles for practice and definitive models emerge.

As chaplains our focus of attention are issues and spiritual concerns, which may be regarded as peripheral by other clergy. We no longer function merely as priests or ministers of religion in a hospi-

tal context. It has to be said that even that engagement must have had an effect on the essential character and self-definition of the minister. Part-time chaplains are perhaps those who are most acutely aware that they are different in the local church to what they are in the hospital.

To be a chaplain in such a setting is to expect some change in oneself – as a person, in spirituality, in outlook, service and survival. I do not want to spend time exploring those tensions that such changes cause. Nor would it be appropriate here to document some of the differences. Rather I would want to contend that there is something distinctive and particular about healthcare Chaplaincy. What is it?

My concern is to know whether we are able to articulate that distinctiveness or particularity, so that it is understood both by others and ourselves. Chaplains are rarely lost for words – silence is the main problem, but I am concerned lest a volume of words should disguise a lack of quality of articulation. The major challenge is whether we can describe or articulate in a reasonable and adequate sense what it is that we do that is unique and special. It could be suggested that such a concern is so that chaplains can bolster or defend their own positions and not feel threatened in a competing culture. However if we are able to describe and tabulate that specific something which makes up Chaplaincy then we shall be able to more consciously and deliberately refine the skills that we have so that we may be ever more proficient and professional.

What is required is not a remote and alien religious language, but a communication that others within the healthcare scene can understand and engage meaningfully with and perceive it as a contribution to the collective partnerships. Adequate articulation, I would suggest, is challenging, difficult and demanding – but should not be avoided. It is a never-ending quest where concepts will be framed and reframed over the years.

A perspective on the chaplain's role

The task of meaningful engagement is a crucial one, but scarcely a simple one. It is rather a challenge for chaplains to work at for themselves. My own meagre offering at this point is to propose:

- Chaplains are pastoral practitioners who seek to build a relationship of trust through compassionate presence and thereby offer help and support to a diversity of people.
- Such support might focus on the emotional/spiritual adjustment to illness, or a search for meaning and purpose during illness. Help in crisis situations including family/relational issues as well as bereavement care are regular areas of Chaplaincy involvement.
- Chaplains work along side other health care professionals collectively and collaboratively to provide for the psycho-social-spiritual needs of their patients.
- The Chaplain's specialty is to possess a particular understanding of the relation between faith, illness, and emotional and mental conflicts that arise, and seeks to motivate and initiate meaningful use of each individual's beliefs and attitudes in the management of their problems.
- The Chaplain's role is supportive as well as functional within the interdisciplinary team. The Chaplain serves as a counsellor and guide to the psycho-spiritual needs of the staff and patients.

Of course such understandings need to be developed and channelled so they shape the words and ethos of our work and are reflected in licensing or commissioning services for chaplains.

Let me return to my theme. Doyle (1992) gave five reasons why doctors do not address 'spiritual' issues.

1. They do not see spiritual issues as their responsibility – however much they recognise the existence of spiritual issues, they feel they have neither the time nor the skill to tackle them.
2. In an age of well-defined disciplines and professional speculation, they leave spiritual matters to those who are trained to deal with them.
3. While many recognise the existence of a spiritual dimension in life, they feel hesitant to become involved because of a profound sense of inadequacy. They feel inexperienced, untrained, unsure and all too aware of their own spiritual doubts and questions.
4. Their sense of amateurism in the spiritual realm is in stark contrast to their day-to-day profes-

sional confidence in their own discipline or speciality.

5. An even larger group, when challenged, has to admit that they are not quite sure what spiritual issues are. Are they the same as religious ones or cultural ones?

Here Doyle is speaking to doctors and reveals an assumption that chaplains are the specialists who know the business. I would suggest that so far from exhibiting the confidence of the specialist, many chaplains share the uncertainties expressed by the doctors to whom Doyle is speaking.

But it also poses the problem most acutely, to ask whether there is any difference between a chaplain and a medical social worker? What is it that we bring that is different into that setting that a social worker would not bring? We need to be able to articulate that so we can demonstrate that our work is cost effective.

Benefits of chaplaincy

This leads me on to my final strand, which is to raise the question of the benefits of chaplaincy. If we are able to define what it is that we do then the next step is to tabulate its benefits and then demonstrate in the current climate of evidence based practice that what we claim is true.

It is possible to describe these under three main headings:

1. Institutional

One of the distinct benefits of chaplaincy in the modern healthcare system is to place a priority on pastoral care in the context of a physically obsessed and medicalised culture. We have the opportunity at many levels in the organisation to raise the whole agenda of the psycho-social-spiritual. The range of this depends on the scene of activity and whether that is the ward round or the clinical ethics forum, the chaplain is one of the few people who are able to raise those concerns across a broad base. It should be noted that I choose to use the concept of pastoral care since this is something, which I feel is important in our work. Ideologically many of the other world faiths and traditions would not comprehend or identify with us but that should not diminish our defence of such a concept.

In view of our employment by the organisation we are able through a variety of means to continue to ensure that spiritual care remains on the main high way of healthcare delivery. It is not sufficient that we stand back and meekly accept the transitions within our society and not defend the importance of the spiritual as an integral aspect of life within the post-modern world. Goodliff is especially good in his profile of post modern society where the spiritual aspects are revisited, "the past is revalued and aspects of culture which, modernism rejected - magic, myth, cosmology and feeling - are absorbed into the post modern melting pot". There needs to be an advocate for that agenda if there is to be health in a full sense.

2. Operational

One of the benefits of chaplains being involved in patient care is that patients are able to express their feelings and explore the meaning of their experience.

Sometimes this will mean that patients explore in greater depth the whole question of spiritual resources, which can be utilised in terms of their own rehabilitation, and personal growth.

Sometimes the engagement with the patient is accompanied by the chaplain also working with the family and friends. In that atmosphere where support and care and positive solutions are created that will be conducive to patient outcomes.

Another area where chaplaincy can have a significant impact is in the area of staff support and morale. The chaplain will work with staff to support patients and their relatives. They can also provide appropriate support for the psycho-social-spiritual needs of the staff themselves as they face many of the challenges in healthcare.

The educational and facilitation of programmes around issues of bereavement, ethics and multi-faith are fairly well recognised in many hospitals.

3. Community

There is a great deal of concern over patient and public involvement in the NHS. The chaplaincy team in a hospital already relates to a significant segment of society by virtue of the relation with the local clergy and their respective communities. Such involvement allows chaplains to provide educational and support programmes for congregations on specific issues and in particular the interface of faith with sickness and healing. This was the impetus for

the creation of the workbook; "In Search of Wholeness" produced by St John's College, Nottingham that sought to provide a Christian theology of healing and practical training for church and medical settings.

Cost effective

Finally I would want to argue that the day will come when we shall be able to prove that pastoral care is cost effective because it shortens length of stay in inpatients facilities because patients are motivated to respond to their particular situation.

That episodes of pastoral care will reduce the need for pain medications and the treatment of conflict related stress in-patients. It will reduce demands on staff and enhance client satisfaction as well as reducing the number of complaints. That happens to be a large agenda that needs addressing!

In conclusion I would suggest that a greater clarity about the role of the chaplain would lead to a greater degree of professional engagement by the practitioner. This will in turn permit a strong and more robust case to be made for the worth and benefit of chaplains within the field of healthcare.

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Editorial note

This article contains the substance of a talk which Revd Dr Derek Fraser delivered to the chaplaincy conference 'Valuing Spiritual Care' which took place at Carberry in September 2002. Dr Fraser speaks from the perspective of a chaplain working south of the border, but his reflections have a broader relevance.

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