

THE LOCATION AND IDENTITY OF CHAPLAINS:

A CONTEXTUAL MODEL

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Abstract: The place of chaplaincy in healthcare is endorsed by current guidance in the NHS, but chaplains are also recognised as belonging to other communities. This can be both advantageous and problematic for chaplains. The identity of chaplains is intrinsically social and the communities they are associated with are important sources of determining identity and location. A contextual model provides a way of understanding this identity through three principal communities: the healthcare community, the disciplinary community and the faith community. The model explains why chaplains provide a valuable contribution to healthcare.

Key words: chaplaincy, social identity, community, social context

Introduction

I am standing in front of a large group of fresh-faced pre-registration house officers as part of their induction programme. I have an hour on the subject of spiritual care and chaplaincy, and I ask them if they have ever met a chaplain before, or if they know what one is. Invariably the response is discouragingly small and at best I elicit the comment that a chaplain is some form of vicar. The session therefore begins with a sense of incongruity: the new doctors recognise the chaplain as someone who is within healthcare but who also seems out of place particularly in a programme concentrating on medico-legal topics and essential clinical practices and procedures.

This encounter raises interesting questions about the place of chaplains in healthcare and how they are located. Historically religion and medicine have been closely interrelated, but healthcare today seems far removed from the flourishing monastic hospitals of the Middle Ages, not least because of social shifts and their impact upon religion (Davie 2002). But whilst in general many people have a nominal relationship to religious institutions, the expression of the spiritual is prevalent (Woodhead & Heelas 2000). This is particularly evident in healthcare, where the official documentation of the NHS explic-

itly endorses and validates spiritual care and chaplaincy (Scottish Executive 2002, NHS 2003). In addition there is evidence to suggest Trusts have high expectation of chaplains:

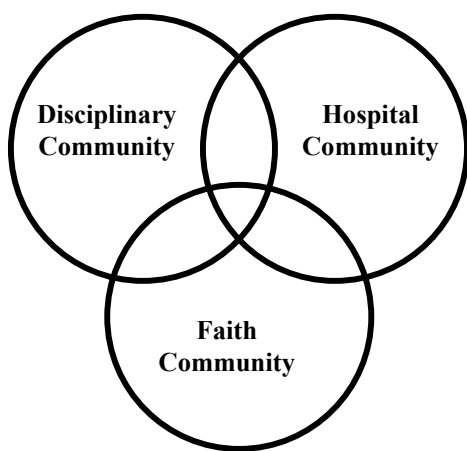
“There was ample interview evidence from all sites of staff from a variety of disciplines saying how much they valued chaplaincy. Some were effusive, referring to it as “absolutely critical”, “essential”, of “vital importance” with an “amazing, staggering role”. Others were more understated, feeling it was “useful in the nicest possible sense”. Negative comments were very unusual.”(Orchard 2000:120)

Identity and location

One way of understanding the place of chaplains in healthcare is to consider their identity, not individually but collectively shared by those holding a similar role, public office or ministry. What is it about being a chaplain that causes them to define themselves as similar to one another; and what is it that causes others to recognise or attribute common characteristics in them by which they can be categorised as chaplains? Where are chaplains located on the “social map” and how do we identify them? We can answer this by using both internal and external sources of reference but we must recognise that they

interrelate by a process in constant dialogue. What it means to be a chaplain is realised in relationship to others and therefore the identity of chaplains is intrinsically social and one in which “the collective and the individual occupy the same space.” (Jenkins 1996:26)

Chaplains cannot simply go around claiming a particular identity; the communities they relate to and deal with must validate it. Equally chaplains cannot guarantee that the identity they think they have is the one that others perceive or understand. One way to understand something of what it means to be a chaplain therefore is to consider their social context and in particular the communities they feel they belong to in some way or other. Communities, as the sociologists remind us, are important sources of collective identity; and for chaplains I want to suggest that there are three particular communities which shape their understanding of who they are. These are communities that chaplains consider themselves associated with, and participants of, to a significant extent. They are therefore communities which represent important aspects of the identity and meaning of chaplaincy within the social context.



Contextual Model of Chaplaincy

1. The healthcare community

Chaplains in healthcare share with others a commitment to promote wellbeing and to care for the ill and injured. This moral commitment is the bedrock of the healthcare community and enables vulnerable and suffering individuals to trust their health and

lives to designated strangers who can work with them, or when necessary act on their behalf. The sick and suffering approach the healthcare community because they need assistance and help to restore an equilibrium in their lives that illness or injury has disrupted; and where this is not possible to find relief from suffering and the assurance of continuing care. The community of healthcare is therefore a community of service that seeks to promote the common good of health and wellbeing which is the profession – literally the public declaration or promise – of most healthcare organisations and disciplines. This is the ground of trust and the ethical basis for practices and interactions, which in other relationships we may consider immoral or illegal.

The fidelity of members of the healthcare community to the particular good of health for particular people is formally expressed in codes of conduct and ethics. For example the Health Professions Council states that “*as a health professional, you must protect the health and wellbeing of people who use or need your services in every circumstance*” and they go on to describe standards of conduct performance and ethics required of registrants (HPC 2003a). Much of this is familiar to chaplains who vocationally, professionally and contractually share this moral orientation. The Scottish Association of Chaplains in Health Healthcare and the College of Health Care Chaplains have a Code of Conduct (CHCC:2003) which from an ethical perspective stands on similar grounds to those of other health professionals.

What is more distinctive about chaplains in this respect however is that they care not only for patients and their carers, but for staff, students and typically whoever constitutes the healthcare organisation or institution they serve at any given time. For chaplains the good of health and wellbeing is located within community, it happens within relationships; therefore this brings into view carers and all those involved in serving the needs of others. If chaplains serve both organisations and the individuals involved in them – whether as users or providers - then there is likely to be a perceived or real ambiguity both internally and externally as to who they are representing. Consequently, chaplains may feel themselves to be working on the edge of their faith communities or in the dim recesses of the healthcare community; they may be an integral and valued part of the healthcare organisation or they may find

themselves excluded and marginalised; they may consider themselves advocates of the vulnerable and powerless (staff or patients) or they may count themselves as equals among their fellow professionals with a seat at the most important meetings.

This suggests that one of the challenges for chaplains in the context of the healthcare community is being able to understand and work with questions of power (Forrester 2000:73-89). These questions arise from a number of different angles including: the structures of authority and responsibility which permeate healthcare organisations and faith communities; the relationship between care and power in the context of health and illness; and the social structures that constitute the human community. Religion and medicine are both systems of authority, and whilst we should be critical of authority that is derived and depends on human weakness, there is a legitimate case for the authority necessary for the pursuit of the common human good. In a passage about the practice of medicine which could easily be about the practice of chaplaincy, Hauerwas argues that:

"Physicians have authority because they draw on the wisdom we have in common as bodily beings [not simply a physical body but a "lived body"]. Specialization, or, preferably, the calling of some members of the community to become physicians, is justified by the community's need to have some of its members committed to learning and practicing the skills of health and the means to care for the ill." (Hauerwas 1988:50)

And so we return to the notion of the healthcare community as a community of service which shares a vision of human well-being and health with the wider human community in which it is placed. It is out of this wider community and not professional enclaves that the public offices of healthcare should derive the content of their authority. If chaplains are understood as public office holders then they exercise legitimate authority in so far as the wider community considers it a valuable moral good that their learnt spiritual wisdom and practices contribute to care and human wellbeing.

2. The disciplinary community

Chaplains constitute a disciplinary community in the sense that they do similar work and share common intellectual and practical interests. Professional bodies such as the Association of Hospice and Palliative

Care Chaplains, the Scottish Association of Chaplains in Healthcare and the College of Healthcare Chaplains exist because of the need to maintain a social grouping which can focus upon developing the knowledge and skills required to practice as a competent chaplain. In order to protect the integrity of this endeavour, professional associations maintain certain boundaries that define membership. The sociologist, Eliot Freidson, argues that this form of social closure is necessary for a discipline:

"The development of a specialized body of formal knowledge and skill requires a group of like-minded people who learn and practice it, identify with it, distinguish it from other disciplines, recognize each other as colleagues by virtue of their common training and experience with some common set of tasks, techniques, concepts, and working problems, and are inclined to seek out each other's company, if only to argue with each other... If it did not exclude from membership those who lacked any consciousness of common experience, interest, and commitment, it would be an entirely different kind of group, perhaps not a group at all." (Freidson 2001:202)

I have worked alongside nurses, I have supervised research undertaken by nurses, I have studied some nursing theory, and I have undertaken some interdisciplinary training with nurses. But I cannot be counted as a member of the disciplinary community that constitutes nursing. I do not have the competencies required to nurse proficiently and safely and I would therefore fail in my moral commitment to care because I would not be trustworthy. If the RCN was happy to accept people like me as a member then it would no longer be a disciplinary body but some form of nursing club for people who share an interest in nursing, and this I suggest would clearly be to the disadvantage of both nursing and patients.

Disciplines need boundaries or closure to nurture and form practitioners, to focus on the development of particular skills and knowledge and to identify and monitor what standards of practice can be expected of members. Consequently disciplinary communities can be understood negatively as monopolies that protect the interests of members, restrict competition, promote elitism and maintain occupational control. Freidson reminds us that a monopoly to an economist is a conspiracy against consumers and that closure to a sociologist is a form of exclusion dependent upon inequality. However, he contends that these objections do not survive

critical scrutiny for a profession in which they serve the legitimate purpose of supporting the refinement of the discipline and the quality of its practice.

It is generally accepted that a claim to constitute a disciplinary community is derived substantially upon there being a formal body of knowledge and skill. The Health Professions Council, for example, considers that a profession must cover “*a discrete area of activity displaying some homogeneity*”; *apply “a defined body of knowledge”* and have “*standards in relation to conduct, performance and ethics*” (HPC 2003b). It is not difficult to appreciate that the activity of chaplains is circumscribed, despite its breadth, and involves a substantial core of tasks that is not undertaken by any other occupation. In order to fulfil this role, chaplains require certain knowledge and skills that must be learned and practiced and these can be standardised into a syllabus and elaborated into a disciplinary discourse. In the USA the canon of knowledge and skills for chaplaincy finds its clearest expressions through Clinical Pastoral Education, but in the UK where this tradition has never taken hold to any extent, the canon is less organised and more nascent. Examples include the university courses on offer to chaplains, and the work of individual Chaplaincy departments who have developed their own competency frameworks (Kerry 2001). However, whilst I would argue that there are particular skills and knowledge required to practice as a healthcare chaplain, we should acknowledge that one of the distinctive characteristics of chaplains is that they are representatives of another community in which they will have already undergone some type of formation and training; a community which is grounded typically in a tradition of faith and practice, and in body of theological knowledge. In this sense healthcare chaplains can be considered specialist practitioners of what is typically a well developed clerical or ministerial profession.

3. The faith community

It remains the standard practice in the UK to appoint chaplains to healthcare posts who are authorised and licensed members of the major faith communities and their constituent parts. In the terms of the NHS guidance for England and Wales: “*suitable and authorised persons are appointed to chaplaincy-spiritual care posts in partnership with representatives of the appropriate faith community*” and “*faith community representatives ensure that the candi-*

dates hold the authority of the faith community and can be empowered to act as its representative within the healthcare setting.” (NHS 2003b:8-9) It is the clear expectation of these guidelines that chaplaincy services are appropriate to users including staff. They are therefore sensitive to the diverse nature of the communities that are served - a key principle of the modern NHS.

The representation of a faith community by a chaplain is expressed in relationship to the healthcare and disciplinary communities and with a critical sensitivity to the people who use the chaplaincy service. Religious belief-systems have varied and distinct forms of social structure and community within which particular roles are identified and authorised. Consequently there may not be an existing community role or specialist that is analogous to a chaplain and a proximal role has to be developed that can be recognised within the healthcare community (Gilliat-Ray 2001). One example of this is the Certificate in Muslim Chaplaincy programme offered by the Markfield Institute in Leicester validated by the University of Loughborough. Healthcare serves a diverse society and requires a pluralistic chaplaincy in terms of belief-systems. This forms the basis of a valuable resource to the healthcare community and one which can enrich the discipline and practice of chaplaincy. For the individual chaplain, being a representative of a faith community means having a rich tradition to draw upon, and this enables a distinctive contribution to healthcare.

This is most evident to other healthcare professionals when chaplains are carrying out rituals, ceremonies and corporate functions. Less tangible is the pastoral care that occupies many chaplains and which is basic to many faith communities. The pastoral theologian, Charles Gerkin has described this as a narrative hermeneutical process that locates pastoral care in the dialogical space between the particular life story of the individual and the story of the faith community and its tradition. The significance of the location is that it facilitates “*a serious, open dialogue between the two sides of the equation, a dialogue that will include sharing of feelings, stories of past experiences, mutual questioning, and search for authentic connection between the two poles.*” (Gerkin 1997:112) This dialogue can only be facilitated by those who are capable of hearing, interpreting and responding to the stories of individuals, the faith community and the human story.

Inevitably this involves some form of tension: it requires the discernment to know where best to be located. I suggest it also requires an active form of practical theology that enables theory and practice free exchange.

It is this theological skill which is at one level the most implicit aspect of the chaplain's skill and art. Practical theology is both an academic and community discipline that is grounded by the chaplain in the pastoral context of healthcare. According to Stephen Pattison pastoral theology is inevitable, for he claims, "anyone who does anything and who is involved in a world of ultimate meanings, values and beliefs that impinge on life and practice already has some kind of working theology." (Pattison 2000: 223) But he goes further and asserts that pastoral theology is the underpinning knowledge and method of ministry, and the place where, "religious belief, tradition and practice meets contemporary experiences, question and actions and conducts a dialogue which is mutually enriching, intellectually critical and practically transforming." (Pattison 2000: 227) Theology is a unique and valuable resource in healthcare because it enables chaplains to engage in matters of belief and faith, of values and meaning, of purpose and destiny. The chaplain is also symbolically a reference point in this task for the chaplain is a lived expression of belief and faith.

Conclusion

Chaplaincy does not exist in a vacuum; it is embodied in particular individuals, takes shape in particular contexts and is expressed in distinct social forms. I have suggested that one way to understand this is to consider a contextual model. Models are not reality but they are a way of representing aspects of reality in a simplified form that allow us to explore and safely try out features of the world we live in. I have aimed to explain something of the context of healthcare chaplaincy in terms of three principal communities each of which contribute to substantiating and determining the location and identity of chaplains. This could be the reason that chaplains are something of an enigma to fellow professionals, for they have complex identities and associations, but perhaps this is why chaplains can make such a unique and creative contribution to healthcare.

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