

EDITORIAL

Chaplains, by the very nature of our work, come into contact with suicide. We listen to those whose despair is such that they contemplate or have attempted to take their own lives; we counsel those who have been bereaved by it, and know well how far reaching and destructive a thing suicide can be. We have a lively sense that we are all diminished by it. We have our stories of our attempts to care for those who have been affected by suicide, and our reflections as to how such stories and such caring have affected us. Reading and reflecting upon Harriet Mowat's article, I relate, in brief, one of my own stories.

'Key to chaplaincy's 'distinctive role' is its availability, over and above other organisations/professionals who offer pastoral support' says Anne Aldridge. I began to wish that I had been *unavailable* on the particular Friday afternoon when one of our psychiatrists looked into the office. It had struck him that I might be just the person to help out with a situation involving a patient whose state of mind he had been asked to assess, after what he described as a well planned and considered suicide attempt. The patient, whom I shall call A., suffering from a progressive debilitating illness, had been admitted to an acute medical ward after an overdose of prescription drugs. He was now expressing a desire to draw up an advance directive, which would deal specifically with a future suicide attempt which he claimed the freedom and autonomy to choose to make, and which would specify that he was not to be given life saving treatment in these circumstances. The psychiatrist's mental examination led him to conclude that A. was competent; an adult with the capacity, in law, to refuse medical treatment – for reasons good, bad or absent. Would I help A. draw up the advance directive? I felt as though I had been handed a hot potato, but at the same time, recognised that I was as well placed as any in the health care community to handle it.

But how strange and uncomfortable it felt. At a superficial level, I could say that I was adopting an advocacy role vis a vis A.; that I was enabling him to exercise his autonomy, to assert his control, in circumstances in which advancing illness threatened autonomy and control in so many areas of life. At a

deeper level, though, my feelings of discomfort had to do with having to cope with a person's clear eyed and considered resolve that, if life became for him intolerable, he would end that life by his own hand. The isolation and estrangement from community which lie behind such a stance foster an acute sense of personal and communal failure. Harriet Mowat speaks of suicide as 'a challenge to normative values', an act which 'confronts us all with questions of meaning, hope and social cohesion, and challenges us to acknowledge the possibility of suicide for each of us in particular circumstances.' My meetings with A. confronted me with these things and more. In A's shoes, would I wish to claim the same ultimate freedom? If A. were to do the deed at some later date, could this be called a 'rational suicide', that most challenging of concepts? Was I, as chaplain, failing A. by not trying to work on him, to persuade him out of his fixed intent? At times, during our meetings, I sensed in him an anger, an unspoken warning not to try that with him, not to try to ease my own discomfort by saying the conventional things. Was I, on the other hand, by listening, by putting myself at his disposal, by trying to make some sort of human, pastoral relationship with A. –was I actually doing my job?

I will cut short a longer story, and say only that with some expert ethical and legal guidance, we managed to find a form of words which captured the essence of A.'s wishes, without compromising myself or the other signatory to the document. But my sense of discomfort and of sadness lingers. Clifford Hughes writes inspiringly of finding meaning, purpose, even joy, in a potentially devastating experience of illness and loss. Yet as chaplains we encounter those for whom the struggle with illness turns life into an existence devoid of these things, an existence which some might even wish to bring to an end. This is a tragedy for an individual, for a family, and for the wider community. I am struck by Harriet's findings about 'disconnection' and its relationship to suicide. Disconnection as the absence of support, friendship, acceptance; as the person's losing 'place and space in the social fabric'; as dislocation, isolation, estrangement. Many of the definitions of spirituality stress the opposite. For example 'spiritual wellbeing is the affirmation of life in a relationship with God,

self, community and environment that nurtures and celebrates wholeness'(Ellison 1983).

If spirituality has to do with connectedness and integration at many levels, then the suicide which arises out of the experience of *disconnection* be-speaks, among many other failures, a failure at the level of the spiritual. It is of particular interest then that Harriet investigates the ways in which faith communities can promote the kind of connectedness

which holds the vulnerable within community, and which can provide 'a counter cultural view of the world and an alternative set of values and criteria for being human and for living humanly.'

Reference

Ellison, C.W.(1983) Spiritual Wellbeing: Conceptualisations and Measurement. *Journal of Psychology and Theology*. Vol 11p.33

Apology

The editors apologise for the omission of Stephanie Morrison as co-author of *The Janki foundation: A values based approach to spirituality and health* in Volume 8 No. 2, 2005. The on-line version of the article has been amended however please add the following details to your copy of Volume 8 No 2:

Page 29: Authors should read: ***Astrid Bedomir and Stephanie Morrison***

Page 34: Final sentence should read: *Astrid Bedomir is Janki Foundation co-ordinator Scotland, Stephanie Morrison is , lecturer, school of health sciences, The Robert Gordon University, Aberdeen.*

Standards NHSScotland for Chaplaincy Services

In Volume 9 (2) 2006 we expect to publish an article by Chris Levison and Katy Bullock reporting on the findings of the Report of the Scoping Study Group on the Provision of Spiritual Care in NHS Scotland and the development of Chaplaincy Standards for NHSScotland. One of the key recommendations in the scoping report encouraged the Healthcare Chaplaincy Training and Development Unit to convene a group to work on chaplaincy standards for NHSScotland and prepare for future work with NHS Quality Improvement Scotland.

That standards group has convened and draft standards for NHSScotland chaplaincy services have been prepared and are available for viewing on the

Healthcare Chaplaincy Training and Development Unit website. In addition a consultation will take place in late June, details of which are also on the Healthcare Chaplaincy Training and Development Unit website (www.chaplains.co.uk).

The editors would encourage all our readers to access the standards and consider attending the consultation. In addition we would welcome your comments and reflections in the form of 600–800 word articles or letters to the editor of up to 500 words which should be submitted by 30th June 2006 by e-mail to journal@sach.org.uk

The Editors