

CHANGE AND CHALLENGE: THE DYNAMIC OF CHAPLAINCY

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Abstract: Healthcare and spirituality both address the question of what it means to be human. In answering the question both are committed to enquiry, discernment and discovery. This is the contextual space of chaplaincy and it provides a stimulating environment for understanding and practice. Part one of this paper will review some of the factors and conditions that have resulted in chaplaincy developments over the past decade. I shall consider what these changes might say about chaplaincy and what they might say about the wider contexts of healthcare and spirituality. In part two I shall outline some of the challenges that may shape the future of chaplaincy and I will be asking how chaplains may respond.

Keywords: chaplaincy, health service, religion, research, spirituality, theology

Introduction: Chaplaincy in an environment of Change

Chaplains work in a remarkable context in which change exists on all levels. As we come face to face with patients, their carers and staff, we come face to face with the living and dying and we are challenged to understand who these people are and how we should respond to them. The process of healthcare is one which is primarily related to change: of restoring people's health, or enabling people to adapt to impaired physical functioning, or supporting people as their irreparable bodies fail and die. In the midst of all this the chaplain also has a distinctive sensitivity and attention to the spiritual journey, to the transformative change of our encounters with the sacred and the search for meaning and hope. Change is also a prominent feature of the organisation and delivery of healthcare services where the redesign and reconfiguration of services serves the aim of progressive change towards improvement.

Another way of framing a discussion about the changes and challenges of chaplaincy is to consider the theory of evolution and its application to chaplaincy. Leaving aside whether or not chaplaincy is the product of evolution or intelligent design, the concept of evolution asks us to engage with the environmental context in which chaplaincy exists and

to recognise how this bears upon the form and function of chaplaincy. Therefore, in terms of natural selection, it could be suggested that changes to the conditions that support the life of chaplaincy will require innovations in chaplaincy to benefit from these conditions and thus survive. Darwin's biological theory has been adapted and stretched for many purposes, but I only want to suggest that we use it in a limited and analogical way to help us understand how chaplaincy has adapted to its environment and the modifications and changes this may have caused or has the potential to influence.

Part I: Changes in critical environments

1. Spiritual environment

I begin with the changes that follow the path of modernity as a mode of social life that many sociologists claimed would inevitably lead to the decline of religion. Anthony Giddens, for example suggests that "...most of the situations of modern social life are manifestly incompatible with religion as a pervasive influence upon day-to-day life." (1990:109). Steve Bruce, Professor of Sociology at Aberdeen, has written extensively on the subject,

ten extensively on the subject, and he argues that “...modernity undermines religion except when it finds some major social role to play other than mediating the natural and supernatural worlds.” (1996:96). Bruce argues that belief is largely dependent on practice, and therefore it is only a matter of time until the statistics of religious belief follow those of practice into decline. Others, most notably Grace Davie, consider belief to be an independent and persistent variable that suggests people ‘believe without belonging’ (Davie 1994). On both these counts chaplaincy finds a favourable environment because it seems that religion has maintained a significant role in healthcare, primarily because of the prevalence of life-transitions and their existential demands, but also that patients are disembedded from their communities and their belonging matters less than their beliefs.

David Voas and Alistair Crockett (2005) argue that belief declines at the same rate as practice, and they conclude that generational change is the key to religious decline in modern Britain. They found that young British adults are half as religious as their parents concluding that chances of passing on belief seem to be much the same as for attendance and affiliation. Whilst this is a convincing argument about the personal inheritance of a faith, it has little to offer about those who discover or accept a faith regardless of their inheritance. It also takes no account of social and cultural inheritance and of religion which remains a social presence through such things as language, values, rituals and sacred places – what might be called the deposit of faith. Is chaplaincy a beneficiary of this inheritance or a vicarious repository for it?

The secularisation theory has become considerably more nuanced and complex over time and religion has not followed the terminal trajectory of the sociologists. The early theories failed to account for the ambiguities and contradictions that many people are prepared to live with and the new religious forms and mutations that have appeared. Davie suggests that traditional religion is not being abandoned for either a coherent secular or religious alternative:

Far more significant are the growing numbers of British people who have indeed lost their moorings in the institutional churches, but not their inclination to believe – as a result belief becomes individualised, detached, undisciplined and heterogeneous...

Outbreaks of this type of spirituality perplex the secularist just as much as the Christian believer... In contrast, secular liberals remain a minority, despite a noticeable increase in number and confidence – reinforced by their clustering in prominent places in modern society. (Davie 2000:120)

The impact of secularisation on the spiritual environment is significant but not the only influence, and I shall briefly consider three more. The first is religious pluralism and the increase in different religious populations particularly as a result of immigration. These populations are present to a varying extent within the NHS which is expected, as a public service, to find ways of accommodating religious differences and their diverse needs. Hence we see the development in chaplaincy of the provision of prayer rooms and worship spaces for particular religious groups, and the employment of chaplains of different faiths.

The second element is the growth of subjective spiritualities or spiritualities of life (Woodhead & Heelas 2000) which recognise the divine within the human and the personal authority of the individual in matters of belief. Spiritualities of life are closely related to self-fulfilment and personal wellbeing, therefore there is likely to be much less consensus among people who “*put their own packages together out of whatever cultural materials seemed to serve their own personal preferences.*” (Martin 2005:23) This form of spirituality has become prominent in a growing literature within healthcare, a literature that is authored by a wide range of healthcare professionals. Spirituality is no longer difficult to find even within official publications and the idea of spiritual care has become adopted by the NHS most recently being recognised as a competency in the Knowledge and Skills Framework (Department of Health 2004).

In contrast to the heterodoxies of subjective spiritualities we must consider a third element of the spiritual environment which is a move to define and defend a distinctive literalist orthodoxy by religious fundamentalists. Resisting the impact of modernity fundamentalist movements claim an inerrant interpretation of scripture through which they reject pluralism and diversity and seek to establish a utopian society of strict religious conformity and morality. (Ruthven 2004) This is evident in ethical debates, such as those concerning euthanasia and stem cell

research, but it may also be present in the identity politics of religious groups who attempt to gain exemptions or demand special group privileges which chaplains may be called to advise and arbitrate on.

2. The healthcare environment

The second environment that we need to consider in relationship to chaplaincy is that of healthcare and its distinctively Scottish characteristics. The Scotland Act 1998 sets out the statutory framework of the devolution settlement and under its authority the Scottish Executive and the Scottish Parliament came into being on 1 July 1999. Our National Health (2000) set out the core aims, national priorities and strategy for NHSScotland. Whilst it contains much that was specific to the Scottish context it also incorporates the approaches of more general health strategies such as increasing public and patient involvement, the setting of national standards to be delivered locally, and improving the patient journey through fairer access to services. In addition it also set out more condition specific aims related to cancer, coronary heart disease, mental health and care of the elderly. There is one reference to spiritual issues in relation to palliative care (2000:74) but otherwise the document is devoid of any mention of chaplaincy or spiritual care.

Three years later this was followed by the White Paper, Partnership for Care, which includes a single reference to religion in relation to equity of access to health services whatever the individual circumstances of people's lives (Scottish Executive 2003:20). The Paper has a strong emphasis on seeing, "...patients and national standards as key drivers of change in the health service and frontline staff as leaders of the change process" (2003:7) It therefore re-affirms a commitment to patient-focussed care, and the participation of patients, carers and local communities which "...should mean that their views are actively sought, listened to and acted on; and treated with the same priority as clinical standards and financial performance." (2003:18) This is supported in the Paper with a commitment to major service redesign and systematic progress with improving the quality of services – the modernisation agenda.

Healthcare services around the world are faced with demand exceeding available services coupled with limited resources and (in the UK) an ageing popula-

tion. Consequently the Paper contains a well-known model of healthcare that promotes services in the community as the norm with high-cost institutional services (hospitals and specialist centres) restricted to a small proportion of patients. There is also reference to the need for service reconfiguration to ensure that some clinical services (for example angioplasty or maternity services) are concentrated sufficiently to achieve good outcomes and maintain patient safety.

Whatever the undoubted achievements of the NHS there is a growing concern that health services have become illness services and are increasingly incapable of promoting and fostering a healthy society. One reason for this was that the NHS is an historical institution that reflects the concerns of the past rather than the needs of the present which include chronic diseases, mental health problems and unhealthy lifestyles. A recent report therefore observes that:

...a health system shaped by nineteenth and twentieth century issues about contagion and acute disease, now has to cope with a very different kind of epidemic, but without having yet developed the means of coping. It means that much of the contemporary health policy debate – with its focus on building ever bigger hospitals, more choices of treatment and expensive technology – often misses the point. (Boyle, Mulgan, & Ali 2006:5)

Let us now consider some of the implications of this environment for chaplaincy. Firstly, a health service that seeks to be responsive to patients and recognise their total needs must be able to respond in some way to the religious and spiritual needs of people, however defined. Secondly, whatever the service being provided it has to conform to the general ethos of the health service: in other words accessible, patient-centred, responsive to different needs, accountable, high quality and so forth. It is logical therefore that chaplaincy requires some form of operational framework, guidelines and resources. Thus we have Spiritual Care In NHSScotland requiring "...NHS organisations to develop and implement spiritual care policies that are tailored to the needs of the local population." (Scottish Executive 2002)

We have thus seen the greater ownership of chaplaincy by the NHS, not only through the direct employment of chaplains in Scotland, but also in their place within Agenda for Change which recognises

chaplains as equivalent to many of the allied health professions in terms of job evaluation and job profiles (NHS Employers). In addition NHSScotland resources the small but highly significant Healthcare Chaplaincy Training and Development Unit which has worked effectively within this environment and provided an important interface between chaplains and the NHS. All this assumes that chaplaincy can be made to fit clinical and management systems, that chaplains are capable of fulfilling roles equivalent to other health professions, and that the role of chaplains is not that of the parochial clergy who visit their community members exiled in hospital, but that of a professional members of the care team and embedded in the institution.

Finally, we need to recognise that the healthcare environment is slowly adapting to the wider ecology of health and wellbeing, driven by such things as changing epidemiology, demographics, social trends, healthcare innovation and the health economy. Healthcare chaplaincy, like the NHS, was not created out of nothing and built upon existing health services and their institutions. As the delivery, organisation and understanding of healthcare changes this will impact upon chaplaincy and its form and function. What is perhaps most exciting for chaplains is that the broader social agenda of health and wellbeing recognises patients as people within contexts, something which chaplains should be well resourced to understand and respond to.

Part II: Changes in critical environments

In Part I have looked at the two prevailing environments that chaplains operate within, that of the spiritual and that of healthcare. In many ways both have formed an ecology that chaplains have adapted to with some ease and in some respects thrived in. But I have also tried to recognise the way that these environments have shaped chaplaincy and favoured particular ways of being chaplains. In part two I am going to continue with my evolutionary theme but now I turn my attention to future matters and to three of the important challenges that chaplains face.

1. Role and Identity

One of the consequences of modernity identified by Anthony Giddens is that much of the time we interact with strangers in anonymous settings. We therefore have to find ways of trusting in representatives

(for example doctors) of abstract systems (such as the NHS) and this requires evidence of their reliability and displays of their trustworthiness. Thus we have specialised environments, codes of conduct and professions who claim specialist knowledge. This theme of trust was the subject of Onora O'Neill's 2001 Gifford Lectures in which she examines how trust is undermined in healthcare. One familiar example she provides is how the patient "...now faces not a known and trusted face, but teams of professionals who are neither names nor faces, but as the title one book aptly put it, strangers at the bedside." (2001:20) Establishing relationships of trust with patients, their carers and staff, is pivotal to the effectiveness of chaplains and their survival in the environment of strangers in which they work. But from the patients' point of view who is the person designated a chaplain and how can they be trusted? Indeed even the title 'chaplain' is under question, for what does it mean to a generation in which many have had no contact with organised Christianity, or who may be from different religious communities?

One answer to this is to ensure that we are clearly identified as healthcare professionals, so that although a patient may not know what a chaplain is, in the same way that a patient may not know what say a clinical psychologist is, chaplains are trustworthy because they conform to the behaviour and standards expected of professionals. But just as chaplains appear to be gaining a place at the professional table, the very idea of being a professional is subject to public scrutiny and questioning. Clearly patients still trust healthcare professionals, but as a respondent to a recent consultation on medical professionalism suggested, "... *trust is not the same as blind faith. It has to be earned and demonstrated. The demand for openness, transparency and accountability is articulated more frequently nowadays, not because the public is less willing to trust professionals, but because they are more educated and critically aware.*" (Picker Institute 2005)

Chaplains can no longer expect patients or their carers to understand who they are and they can rely much less on the social capital of religion. In acute settings contact with the chaplain may be confined to a single encounter. So in order for people to trust in chaplains they must be able to demonstrate their competence to do the job, their commitment to the ethical values that foster relationships of trust, and that they are accountable for what they do and how

they behave to a regulatory body that can protect the public if necessary. This is a framework of trust not only in the individual chaplain but in the institutions of chaplaincy. At present the most chaplaincy has are the varied systems of some of the religious organizations to whom chaplains belong. But these are not consistent and they are sometimes unreliable. In addition what qualifies someone to be a chaplain remains indeterminate beyond a local appointment and we have no system that examines the knowledge and skills of chaplains according to consistent criteria.

All this brings us to the issue of the identity of chaplains, something which is complex and multifaceted. For example, there is no doubt that over the past ten years a more coherent professional identity has formed which is evident through chaplaincy journals, professional associations and some of the social and institutional apparatus of a nascent chaplaincy profession. But to what extent is this necessary adaptation and what for example does this mean about the relationship of chaplains to their religious communities, where they exist? Will there, for example, be a demand for the theological purity of chaplains in order to maintain a clear distinction between a faithful orthodoxy of the religious community and the wider secular world, or can chaplains maintain a theological realism that is sensitive to the beliefs, experiences and practices of those they encounter in healthcare? These are just some of the difficult questions that chaplains must explore and find a way to answer in clarifying their identity.

2. The research agenda

One of the delights for me of working in healthcare is that it is an environment of curiosity and questions about being human, about the nature of health and wellbeing, about life coming into being and the life coming to an end, about hope and despair, about care and compassion and healing. These are all questions that have the potential to become research, but in healthcare research has been dominated by medical research and in particular the development of drugs. This scientific agenda has for a long time kept to its own line of enquiry but increasingly it is beginning to turn its attention to the field familiar to chaplains: that of religion and spirituality. For example, the Oxford Centre for Science of the Mind (OXCSOM) is undertaking research into the physical basis of beliefs and investigating whether

people cope with pain differently depending on their faith.

This research agenda is a challenge to many chaplains who have no scientific training or education in research methodology. Scientific research can also be daunting in its apparent claims to provide explanations even of matters of faith. But whilst science maybe able to provide explanations about the intrinsic physical properties of the human body, scientific reductionism has to neglect the many others aspects of what constitutes a person such as the social and historical context. Whereas a scientist may account for a smile in terms of muscles and their stimuli, we account for it personally in terms of the meaning of the experience through our interaction and empathy. We may therefore distinguish between two types of explanation of spirituality: firstly, naturalistic explanations that reinterpret or reduce the spiritual discourse to that of the empirical (for example the neurological); secondly, theological or philosophical explanations that take the sacred and transcendent as a primary phenomenon that cannot be subject to further reduction. Further, scientists may be able to demonstrate the neurological mechanisms related to spiritual experience, but this natural approach cannot prove it false, as one philosopher has commented, *"you have to do more than explain something in order to explain it away."* (Baggini 2006)

Chaplains should be aware of the research going on around them and the conclusions people are drawing from it. Chaplains need to develop a critical understanding about how they access and use research conceptually and practically, and they need to be developing the capacity for research within chaplaincy departments and the profession. Let me take one aspect of this challenge as an example, and that is the concept of evidence-based practice which is well established across many healthcare professions. There are a number of important reasons why practice should be supported by evidence, not least the ethical justification that we should practice in ways that are beneficial rather than harmful to patients. The challenge here is what does evidence look like for chaplaincy and how do we obtain it? This is relatively easy if elements of chaplaincy practice are the discrete cause of a phenomenon that easily measured. But what is the evidence of the benefit of commending a dying person to God?

Attempting to answer this sort of question requires us to attend to research methodology. It is important to acknowledge that whilst natural science provides many of the research methodologies used in health-care, social research is also an important source of information and evidence for chaplains. Another approach is to follow the humanities, such as history or philosophy, whose research and explanations rely more on verifiable claims. Finally, whilst chaplaincy can use a range of research methodologies to develop its knowledge in particular ways it should also remain confident that experiential knowledge is just as necessary to good practice.

3. The theological task

The third challenge facing chaplains concerns the theological task of chaplains. A primary theological task of ministry is the confessional task, or the articulation of the faith, beliefs and practice of the religious community. Another is the liberational task that seeks to transform the world by releasing people from all that prevents them from becoming fully human. The theologian Edward Farley identifies a third task, which he considers is usually absent from practical theologies, that of the critique of religion itself. This task is a necessary corrective to the evident problem that people have in translating the spiritual into human terms and grasping the mysteries of the sacred. Farley considers that this impulse may lead a religious community to distortions or heresy and that, "...one of the dynamics at work in the religious community's tendency to discriminate and perpetuate injustice is the ethnocentric and even narcissistic impulse of (popular) religion." (Farley 2003:45)

This theological task is one that is often lacking in chaplaincy discussions, and yet most chaplains are trained theologians, and chaplaincy promotes reflective practice, of which theological critical thinking is a part. Two questions follow for chaplains: firstly, what critique do they offer the religious communities of which they are a part or work with, and secondly, how do chaplains critique their own narrative of chaplaincy? Without engaging in this third task it is likely that chaplaincy will be shaped and formed by the most powerful prevailing narratives and consequently chaplaincy will become less rigorous and authentic in the process.

Let me offer two examples. The first was the focus of pastoral care in the latter part of the twentieth century on the individual. This was influenced by the development of counselling and psychotherapeutic models and their ready adoption by pastoral practitioners. However, this movement paid little attention to the wider social and political contexts that people lived in and a theological critique eventually developed that alerted practitioners to the wider social, economic and environmental concerns that needed addressing. The second example is the developing practice of chaplains in relation to parents who have suffered a pregnancy loss. Chaplains have pioneered ways of supporting parents in situations where a pregnancy has ended and we are now familiar with chaplains performing various rites in which a foetus or unborn baby is named or blessed, funerals are conducted and remembrance services are held. However, there has not been much evidence of how this practice relates for example to the theological traditions concerning the state of unborn children or life after death. In both these examples it is easy to construct a compassionate rationale for the practice of the chaplain, but we must remain alert to the theological task of self-conscious critical thinking, inquiry and interpretation. Theory, practice and theological tradition must be in dialogue, and chaplaincy should be a very conducive environment for the reflective discipline of theology.

Conclusion

Chaplains live within a dynamic ecology that has shaped and influenced the nature of chaplaincy over the past years and will present challenges for its survival in the future. What is critical is that chaplains are aware of this dynamic, understand its impact and are confident to respond from a position of authenticity, theological rigour and spiritual depth.

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