

PROACTIVE OR REACTIVE CHAPLAINCY

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Abstract: In November of 2003 a more proactive approach to Chaplaincy was instigated in a Renal Unit. Rather than wait for referrals, the Chaplain visited round the unit, asking patients about their experience of renal care and dialysis. The result was a hugely increased number of patients and staff involved in spiritual care, and a greater awareness on the part of the staff of the work of the Chaplaincy Team. This article is an examination of the process whereby Chaplaincy became an integral part of the care given on this unit and reports the results of a survey of staff regarding this process. This also contributes to current debate about the professionalizing of Chaplaincy and the allocation of spiritual care resources.

Keywords: *Chaplaincy, Renal Unit, Spiritual Care, Dialysis, Holistic Care*

Introduction

In the course of 2002, a Chaplaincy Department received three referrals from the Renal Unit of its hospital. In each case the patient was extremely ill, either on the point of death, or deeply unconscious. The Staff initiating the call for a Chaplain clearly felt that this was the right thing to do in these circumstances. The Chaplain, when he arrived, was able to support staff and, in two of the cases, the patient's family, but wondered why Chaplaincy referrals seemed to be seen as a last resort, or kept for extreme situations. This situation was not helped by the fact that the Renal Unit is, in effect, a day case unit, and in this particular hospital, referrals to Chaplains are usually from in patients, and are given to the Chaplaincy Department on the second day of the patient's stay in hospital.

In October 2002, HDL 2002 76 was published, heralding a new development in Scottish Chaplaincy. Each Health Board region was required to develop its own Spiritual Care Policy in response to the HDL, following the adoption of this Health Board's policy in September of 2003, the Chaplain sought an initial meeting with the Medical Directorate General Manager and the Ward Manager for the Renal Unit. What was proposed at that meeting was a more proactive form of Chaplaincy whereby the Chaplain himself would visit each of the patients in the Renal

Unit, and ascertain from them whether further visits would be welcomed or required.

An opportunity was given for the Chaplain to speak at an in-service training session of staff from the Renal Unit, explaining what he hoped to do, and asking for the staff's co-operation in this venture.

Immediate Results

Straight away, the numbers of people on the Chaplain's visiting list in the Renal Unit went from 3 in one year to 55 in one month. (At that time, the Renal Unit was treating 72 patients.) Patients expressed to the Chaplain a clear willingness to talk to someone who would simply sit down with them and listen. There was a huge range of issues raised, very few of which might be described as specifically religious, but all of which fell into the category of spiritual, as people articulated various needs they experienced while undergoing the prolonged and regular treatment that is dialysis.

This confirmed the basic tenet of the HDL, which asked Health Boards to recognise the important distinction between religious and spiritual care, a distinction which was also reflected in this Health Board's own Spiritual Care Policy.

Simultaneous Research

As this work was being developed in the Renal Unit, Harriet Mowat was conducting an important piece of research throughout Scotland, asking the question 'What do Scottish Chaplains actually do?'

This research concluded that Chaplains are engaged in a three-stage process of seeking out the needy, identifying their needs and responding to these needs. Mowat further concluded that 'the needy' would comprise patients, their relatives and carers, and members of staff. The needs of these groups of people varied considerably, but Mowat identified several areas including specific religious need, existential need, teleological need and practical need.

These findings were certainly validated by the experience in the Renal Unit. 'Seeking' implies that there is to be some pro-active effort on the part of the Chaplain in looking for people for whom he is to care. 'Identifying' implies awareness on the part of the Chaplain of a broad range of needs that could be described as spiritual and not just religious. 'Responding' implies a particular knowledge and skills framework in spiritual care and a willingness to be part of a multidisciplinary team, referring on to other members of that team if the Chaplain is not the appropriate source of help.

Seeking

Although, in the first month, 55 patients in the Renal Unit self-referred to the Chaplaincy Department as a result of more pro-active visiting on the part of the Chaplain, others were soon being referred by members of staff. Increased contact with the Unit meant that the Chaplain was becoming a recognised face and that members of staff were contacting the Chaplaincy department on their own account. Increased contact with patients inevitably led to a greater contact with their relatives and carers too.

These areas of contact had already been anticipated in the HDL and in the Board's own Spiritual Care Policy as well as being identified in Mowat's research. The inter-connectedness of these people was obvious to the Chaplain. Increased visibility on the Unit generated many more patient contacts, which in turn brought the Chaplain into contact with their relatives and carers. Staff, observing a new kind of pro-active Chaplaincy, grew in confidence with the

service, referred more people to the Chaplain and used the service themselves.

Identifying needs

The two broad categories of 'Patients and Relatives' and 'Staff' will be examined in analysing the kind of needs encountered by the Chaplain. In looking at the Staff's issues, the process has been enlightened and greatly helped by a Staff survey conducted on the Unit by the Unit Manager.

(a) Patients and Relatives

Several of the patients raised moral or ethical issues with the Chaplain. These often fell into one of two categories; those associated with transplant issues, and those associated with end of care decisions.

In terms of transplant, patients often talked of the moral problem of anticipating someone's death in order that a kidney would be donated. Some patients also felt uncomfortable about the issue of 'living donor' transplants, and about having to approach a relative in order to ask for one of their kidneys.

Another moral/ethical issue faced by patients was in relation to their withdrawal from care. Some patients who had been on dialysis for a long time, and who had developed strong emotional attachments to the staff on the unit, felt uncomfortable about stating their wish to withdraw from care, thinking that this sounded ungrateful. Others expressed the thought that it felt like suicide. In all of these issues, a discussion with the Chaplain helped to clarify the moral and ethical issues the patient faced, and assisted in the patient coming to his or her own conclusion.

The Chaplain often found himself involved in a discussion about existential issues. Facing a radically changed lifestyle which contained three sessions of dialysis each week at four hours each time, patients raised the question of their own identity, now that this had happened to them. For some, who had lived very active, and even athletic lives, the question 'Who am I now?' was one with which they needed help. The Chaplain, through listening to and engaging with the patients, could help them come to new understandings of themselves in continuity with the persons that they had been.

The Chaplain was of help to patients on several occasions following the death of a fellow patient. This also raised into focus several existential questions and real existential anxiety on the part of some.

The Chaplain found himself involved in discussions relating to compliance with diet and fluid intake which are so much a part of the life of someone on dialysis. Similarities could be drawn to the twelve-step program of recovery from addiction, as the Chaplain encouraged patients to be in touch with their inner or true selves, and their higher power in order to comply with strict dietary regimes. On one occasion, a patient asked the Chaplain to pray for her in order to help her be compliant with her diet.

Although, as has been noted, the general approach of the Chaplain moved from addressing the specifically religious to more spiritual concerns, there were several instances of the Chaplain still meeting religious needs. Several of the patients asked for prayers to be said by the Chaplain, either for them in the hospital Chapel or with them in the Unit. Several patients asked for the sacrament. Some patients wanted to discuss their funerals with the Chaplain, especially those patients withdrawing from care. The Chaplain himself noted how helpful this was to family and to friends when subsequently conducting these funerals, not just because he had come to know the person who had died, but because he could deliver the kind of service specifically requested by the patient.

Mowat notes that sometimes the Chaplain addresses practical concerns like, 'Did I remember to put the cat out?' On several occasions, the Chaplain had small practical tasks like this to fulfil on behalf of the patients, and on one occasion was involved in finding care for a patient's cat.

Relatives and friends of patients bring still further needs with them. The Chaplain found that they often needed some help in accommodating the lifestyle changes brought on by the patient's dialysis. They too struggled with issues of transplant, especially by live donor. In one case, an anxious partner talked of the dilemma of offering a kidney for the patient, or keeping it in case one of their children needed it in the future. Relatives also needed help in the general communication of thoughts and feelings arising from a loved one's treatment. Family always appreciated help at the time of the death of a patient.

(b) Staff

The Staff, at first, were a bit sceptical of the Chaplain being more pro-active around the Renal Unit. Questions arose as to whether he was really part of the multi-disciplinary team. Some Staff may even have felt that there was a confusion of roles, seeing it as part of their duty to provide spiritual care. (In fact, the need for all Staff to address spiritual needs was highlighted in the HDL and the Board's Spiritual Care Policy.) Part in fun, but partly serious, some Staff asked if they were going to have to watch their behaviour and their language when the Chaplain was about. One member of Staff is quoted as saying, 'We've gotten on fine without God in the Renal Unit up until now!'

A protocol was adopted at an early meeting with the Staff, agreeing that the Chaplain would always report to the nurses' station on arriving on the Unit. He would receive news of patients and be directed towards any priority visits. He would report back to the nurses' station before leaving the Unit, reporting any major issues that the patients wanted him to convey to the Staff.

Several months later, the Unit Manger observed that the Chaplain was fully accepted as one of the multi-disciplinary team. He had helped in the discussion and handling of difficult times, he had helped patients, Staff and relatives through times of personal loss and sadness, he was skilled in pastoral counselling and could offer valued support to the Unit and he was both impartial and objective. Any concerns the Staff may have had at the outset of this venture had been allayed.

It was decided to survey the Staff and to ask them to identify what they perceived to be the benefits for the patients and benefits for the Staff of the Chaplaincy service. They were also asked if they wanted the service to continue. Out of 32 survey forms circulated, 30 were returned (a response rate of 93%).

Only three members of Staff stated that they were not aware of the chaplaincy service on the Renal Unit. Possibly these were new members of Staff or, perhaps, members of the Peritoneal Dialysis team who worked mainly outside the Unit. Whatever the case, this was seen by Chaplaincy as an opportunity to revisit Staff and make them aware again of the service.

100% of those who were aware of the service noted clear benefits for the patients. Among these benefits were listed:

- Someone to talk to – non-nursing
- Neutral, impartial person
- Spiritual and emotional support
- Support when facing difficult times or death
- Frequent visits – not just in times of crisis – ‘normalised’ a Chaplain’s visit.
- Discuss anxieties and ethical issues
- Holistic approach
- Mental health needs – not just spiritual
- Not judging or teaching
- One to one without interruption
- Discussed concerns related to condition
- Helped with life-changing decisions and fears
- Prays with patients and gives religious support to those who require it.

96% of those who were aware saw clear benefits for Staff (only one was unsure). These benefits included:

- Impartial, someone to talk to
- Support for staff when a patient dies
- Someone to talk through issues, grieve with, pray for Staff
- Someone to discuss moral issues for patients with Staff
- Staff attend funeral services for patients knowing they are conducted by someone who knew the patient
- Support with personal sadness or difficulties at home
- Someone to talk through issues difficult to discuss with immediate colleagues

100% of respondents wished the service to continue.

In reviewing the increased service, the Unit Manager sees that it has had an extremely positive impact on the Unit. It is invaluable and informal (and invaluable because it is informal). The Chaplain is now an important member of the multi-disciplinary team and gives support to patients, Staff and relatives. He adopts and encourages an holistic approach. One nurse summed up the value of having a Chaplain on the Unit by writing on her survey form, ‘Sometimes the real meaning of life gets lost in the

day to day business and the chaplain is there to remind us what life is really about.’

Responding to these needs

As these needs have been encountered, the Chaplain and Staff together have responded in different ways. They have worked as a spiritual care team, first and foremost listening to what the patients, relatives and other members of Staff are really saying. This is never to be diminished as ‘just listening’. In truth, it is through listening to what is really being said that so many of the issues can be resolved. In particular, the Chaplain can echo the thoughts of Simone Weil who describes the task of listening as helping the other person to describe what they are going through. The Chaplain, although not there to insert needles or diagnose problems can be of huge help to an individual simply by sitting down beside that person and asking, ‘Tell me how this is for you. Tell me what you are going through now.’

The Chaplain also empowers others, and in turn they empower still more people, in the telling of their stories. In this way, the Renal Unit becomes not first and foremost a place of medical healing but a place of truth, to borrow Michael Wilson’s definition of hospital. The task of the Renal Unit is then seen properly, not as a place where people will necessarily get better and recover from their kidney disease but as a place where people can find the truth about themselves and their various conditions and learn to live with that truth. To this end, people are helped to draw their own conclusions about what really matters in their lives.

Partly, this is facilitated by specific religious interventions such as prayer, bible reading and the sacraments. Partly, this is facilitated by putting the cat out for a patient. Always this is encouraged by making the Renal Unit a community of patients, relatives and Staff, where spiritual values are recognised and promoted, where interdependence, vulnerability and multi-disciplinary working are shared realities, and where spiritual care is seen as the work of all, not just the Chaplain.

Matters arising: Proactive or Reactive Chaplaincy?

Is this, then, a success story for Chaplaincy? For sure, this could not be replicated in other wards

throughout the hospital where it took place, because of current Chaplaincy team resources. When the increased work load became clear, a Chaplaincy Team Volunteer (a trained lay visitor) was enlisted to help in the area but, even with this extra help, resources are still stretched. Trying this more proactive approach to Chaplaincy throughout the hospital would need a much larger Chaplaincy team or would lead to burn out among the Chaplains.

This raises the question of how Chaplaincy sessions can be calculated. A considerable part of the Chaplain's work in this Unit involves sitting with the patients and listening to their stories. Some of these conversations can be quite long and about nothing in particular, and then become very significant as the patient gains confidence in the Chaplain and says what is really on his or her mind. But the conversation would not have become so significant unless the Chaplain had been prepared to stay there for the previous twenty minutes.

How then are Chaplains to behave as healthcare professionals? Should they actually go round the hospitals, looking for clients? No other healthcare professional behaves in this way. Other healthcare professionals work in multidisciplinary teams, offering to the work of these teams their own specific areas of knowledge and skills. Why should we expect the Chaplain, alone among Healthcare Professionals to have to find his or her own clients? Indeed, if Chaplains were to do this, the results would be similar to those found on this Renal Unit. Referral rates would rise to such a level that Chaplains would not be able to meet the demand for visits.

It could also be argued that a money-conscious NHS cannot afford to have its employees behaving in this way. From the point of view of 'value for money' the NHS would surely want its employees to be seeing and treating only those who need to be seen and treated. Chaplains should, therefore, only react to clear and specific calls to particular people in specific situations, perhaps where spiritual need is acute.

Yet, this example of pro-active Chaplaincy clearly resulted in better team working, fuller involvement of the Chaplain and better spiritual care for the patients and staff. It began with the assumption that everyone has spiritual needs and sought to deliver

spiritual care appropriate to the level of need encountered. It resulted in a busier Chaplain, for sure, but one who felt greater job satisfaction particularly in this area of his work because it was using his range of knowledge and skills more fully. He felt that Chaplaincy works because it involves one human being sitting down beside another and simply asking, "How are you?" and "Tell me what you are going through?"

Conclusion

It is understandable when Chaplains call for greater professionalism in their practice, but it would be regrettable if such professionalism meant an end to the Chaplain proactively looking for those in need. If by 'professionalism' what is meant is invulnerability, with clear and informed calls to specific interventions in particular cases then Chaplains would be wise to resist this. 'Professionalism' must mean something else for the Chaplain.

It must, as Mowat suggests, continue to contain the element of 'seeking'. If not, then Chaplaincy and Spiritual Care run the risk of becoming yet another part of care to be added to the list of boxes ticked, so that care of the whole person can be said to have been delivered. But Spiritual Care is not just another form of care to be added on to other areas of care such as 'physical care' or 'mental care'. Spiritual Care is more like the glue that keeps all the care together and that does not allow the human being to be compartmentalised into the bits that can be treated by differing healthcare professionals. It permeates all care and is expressed through all care, making it holistic. Otherwise our care is simply the mechanical treatment of a bit that has gone wrong.

This implies that one of the most important skills that should be looked for in Chaplaincy is the ability to relate to people generally, but also the gift of being able to engage at deeper levels with those who need more time and pastoral attentiveness at that particular occasion. In this, it could also be suggested that the Chaplain would be emulating the example of Christ whose busy ministry was full of daily demands upon him, yet he could respond quickly in order to attend specifically to the deeper needs of the particular individual who needed him most at that time.

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