

HOLISTIC MEDICAL CARE – THE ROLE OF CHAPLAINS IN A MULTI-DISCIPLINARY TEAM

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Abstract: Having previously looked at the need for doctors to begin to engage with a spiritual agenda with patients, and having identified that there is huge potential, but significant constraints, the unique contribution of healthcare chaplains is here considered in more detail, before examining ways in which the medical role in spiritual care can be developed, alongside closer collaboration with chaplains

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Pastoral Practitioners - an available compassionate presence

An area where the chaplain could be regarded as being unique is that the primary role is about being present to focus on spiritual needs, whether that be of the patient, the family or carer, the staff, or the hospital or healthcare institution as a whole.

Chaplains are unique among the health professionals in that their caring task is primarily focussed upon religion and spirituality (Caring for the Spirit 2003 parag.32 p. 12).

Chaplains function within a team framework in healthcare settings, but do not have the other tasks that nurses, doctors and other workers have, but are able to

work along side other health care professionals collectively and collaboratively to provide for the psycho-social-spiritual needs of their patients (Fraser 2004, p.28).

They 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 (Fraser 2004, p. 28).

The phrase *compassionate presence* is important, as for many patients and staff the presence of someone whose role is primarily to give support is

unique. They are the only people throughout a healthcare organization who are potentially in touch with everyone – from patients and relatives to doctors and nurses, from porters, cleaners and orderlies, to the chief executive. There is an unusually high level of availability: 24 hours a day, 7 days a week, which is open to all, regardless of religious affiliation, being available to those of all faiths and none, but, importantly, without proselytising. This is not the way chaplains have always worked, which may explain some of the confusion, as doctors look back to the more distinctly religious and denomination-based chaplains of the past, but it does reflect the current situation, and it does need to be communicated clearly, so that there is likely to be a greater willingness to refer to the chaplaincy team by other members of the healthcare team.

Spiritual and religious experts

But what is it about spiritual care that makes it any different from other good patient-centred holistic care? Is being available to listen all that being a pastoral practitioner means? What is distinctive about the pastoral care that chaplains can bring? What does it mean to be the ‘spiritual and religious expert’? Cobb’s definition may be helpful here:

Pastoral care is the practical embodiment of belief in humanity within a theological framework that is critically sensitive to context and disciplined in its response.... It also has a wealth of resources at its disposal including the wisdom of faith traditions and their contemplation of the human condition; a chal-

lenging theological methodology, it strives for truthfulness and authenticity and religious narratives, myths, symbols, images, and rituals that can open up a larger world in which people can discover meaning and hope.” (Cobb 2005 p. 43)

With the more widely acknowledged recognition that no form of counselling or psychological care comes value-free – each has its own underlying values, dogmas and assumptions – there has come a greater confidence in what pastoral care can bring.

It is not client-centred counselling or Freudian analysis, or whatever other psychological theory might be in vogue in counselling (Goodliff 1999 p. 87, 98). The practice of chaplaincy has moved from being expressed primarily in a religious framework, through a time in the 1960s and 70s when the focus was more on models taken from socio-psychological disciplines, but now there seems to be a recovery of the distinctiveness of pastoral care. For any chaplain there is a need for awareness of their own identity as a member and representative of their community of faith, but this is expressed within a multi-faith environment, so that there is care not to impose, assume or coerce, yet still somehow retain an authentic identity. There is an ongoing need for self-awareness and disciplined theological reflection, and a sensitive appropriation of the wisdom and resources of the faith traditions.

This can find expression in three areas:

- a) the search for meaning;
- b) matters of life and death;
- c) where there is a felt need for religious ritual.

Helping with the search for meaning

When a person becomes ill or is hospitalised it is often a time for questions of identity, role, purpose, meaning. “Why has this happened? Why to me? What have I done to deserve this?” These questions have no easy answers and are unique to each individual, and can lead to a greater depth of spirituality or faith or to a loss of whatever beliefs sustained previously. In the hospital environment social structures are removed that support and sustain, and there can be a greater vulnerability to the breakdown of psychological defence mechanisms. Adjustment to losses of health, independence, fam-

ily members, life itself are a significant challenge. These are important yet often very private issues, which may not be raised with family and friends,

the patient (may be) alone with these fundamental doubts and concerns at a time when they most need to share them - a challenge to all members of the health care team to be open to discuss these issues. (Stewart et al 2003, p. 60)

In a recent discussion with final year medical students in a seminar on issues around death and dying the students were comfortable answering questions from simulated patients about euthanasia and the process of death, but were very uncomfortable with questions about meaning such as: “Why has this happened to me? What happens to ‘me’ when I die?” Doctors could, with appropriate training, explore these issues further with patients, but this may be where there is an indication for referral to chaplains:

(whose) speciality 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. (Fraser 2004, p.28)

Sometimes care can be given by acting as ‘interpreter’, a metaphor which has often been used of chaplains, at a basic level of helping where there is a miscommunication because of medical jargon/language, between patients and their medical carers, and sometimes where there are areas of miscommunication between patients and family and friends, but also crucially in this whole area of helping people to make sense of what is happening to them. Here there is the very real *compassionate presence*, coming alongside, listening to the patient’s story, and embodying acceptance, affirmation and a broader perspective, helping them to understand their story and reshape where the old story no longer fits.

As chaplains they will come with their own story, integral to their identity as a person representing a faith community, and shaping their values. In a multi-faith chaplaincy context there will be different themes that arise from the different perspectives. For the Christian chaplain there may be themes such as embodiment and wholeness, relationship and interdependence, redemption and resurrection, faith, hope, love. These larger themes can, with respect for the

patient's beliefs and preferences, and due care and sensitivity, be a resource in helping to give a broader and deeper perspective, to help shape a new story.

For some, simply to be able to voice their anguish may be enough. Barry Bub, a Jewish physician who later trained as a chaplain writes about recognising and acknowledging the 'lament' in people's telling of their stories:

suffering is the one narrative theme that permeates the entire healthcare system and, as such, spares few patients and professionals. Trauma (and illness is a trauma) results in suffering and people who suffer cry, mourn, wail, complain, moan, i.e., they lament. (Bub 2006 p. 97)

and he writes that what is needed above all else is to listen to and acknowledge the cries of pain in the suffering.

'Narrative based' care is a particular model of consulting in primary care, drawn from family systems theory and from the work of practitioners at the Tavistock clinic in London. What is interesting and relevant to this discussion is that the main aims of narrative-based consulting are to listen to patients' stories and enable them to form a new story, but John Launer, a key proponent writes:

Primary care in many places is besieged. Where the pressure is great, and the support systems inadequate, it may be impossible to provide conditions that satisfy both the patients' need for meaning and the practitioners' need for personal survival. (Launer 2002 p.222)

This would seem to be a heartfelt admission that there is a need for those whose role is to spend time with people helping in this search for 'a new story', but a painful acknowledgement that the reality of current medical practice is that this is an ideal which is not always possible, even in general practice, where these values have long been held to be important and vital to patient care. Chaplains in hospitals are in a position to come alongside and listen to stories in a way that physicians are just not free to. It is also perhaps an indication of a need to seriously consider the role of chaplains in primary care. Of note in this respect Rev'd Deborah McVey, a URC minister in Cambridge, has worked

as a chaplain in primary care and is currently researching the feasibility of a model for chaplains in primary care contexts.

Experts in matters of life and death

Probably the hardest challenges faced by most people are about dealing with death: their own and that of their loved ones. For the medical team who are faced with dealing with death on a daily basis it can be very hard to maintain compassion and sensitivity. Different people cope in different ways but there can often be distancing, use of ironic humour, and denial, or just that it all becomes 'routine'. Much of the modern medical environment is about striving to overcome death by any possible means, rightly seeking to combat illness, but ultimately 'health' becomes only associated with absence of illness, with cure of disease, and anything else is feared, with no room for an understanding of health that could encompass disability, brokenness, disfigurement and ultimately death.

A very sobering observational study was conducted by Murray, interviewing two groups of patients, in Scotland and in Kenya, both with terminal cancer. The group from Africa had well-developed belief systems which sustained them through their illnesses, but had significant physical distress because of lack of availability of treatment, while the group from Scotland had far more sophisticated treatment possibilities, but experienced more unmet spiritual needs (Murray et al 2003a). Nobody would ever wish to make the lack of treatment normative, and yet the experience of faith and spiritual wellbeing in the presence of death is also highly significant.

Is this again where there can be a particular role for a chaplain who can embody a dimension of 'otherness' – this is not all there is - there can be a different story – hope in suffering, wholeness even in the midst of brokenness, and resurrection in death?

Experts in religious ritual

One important aspect of the chaplain's role is in the ability to represent both the spiritual and the religious embodiment of faith for other people. Such an embodiment leads the observer to project on to the chaplain their views and expectations. These may be simple or complex, confused or clear, placid or angry. Without compromising his/her integrity, the chaplain is expected to express the spiritual needs of

the individual in a meaningful and relevant way (Caring for the Spirit parag 35 p. 12).

Many people retain residual religious beliefs and feelings about religion, and in the UK, about the Christian Church and its representatives, but their only contact with religious leaders will be at the times of the rites of passage of birth & baptism, marriage, death.

The chaplain is therefore in a unique position of being available and visible to the general public in away that parish clergy are no longer – they are “*in the front line*”, going where they are called, with a responsibility for the whole community (Finlay 2006).

For those who belong to a religious group the role of the chaplain is well established in providing for their needs, which might include prayer, confession, reconciliation, anointing, marriage and funerals, and particular rituals specific to a particular group, such as Holy Communion and Baptism for the Christian.

For those with some faith or none there can still be a profound need for ritual of some kind, for the ‘right words’ to be spoken, sometimes reflecting a kind of residual folk belief. Carefully constructed ritual and liturgy can

create the space in which we confront truths we dare to speak or glimpse the people we dare not imagine we are called to be. The words and actions of liturgy and ritual care create an environment of meaning that can nourish and restore. They can contain the unbearable, express the unimaginable, and point us beyond the mundane to the holy (Cobb 2005 p. 122).

Can medical staff be involved in these aspects of spiritual care?

This is probably the area that is most contentious: nurses and doctors without a religious faith understandably report feeling ill at ease if called upon e.g. to pray, and ethical concerns have been raised about whether it is appropriate for doctors to pray with patients, because of confusion of roles and alteration of power dynamics, although this is something that studies have found that some patients would value.

Until recently the official GMC position is that doctors should not use their professional position to proselytize, but “*the profession of personal opinions or faith is not of itself improper*” except where patient care was compromised, or distress was caused by “*inappropriate or insensitive expression of their religious, political or other personal views.*” (GMC 1993). In 2007 the GMC undertook an on-line consultation on Personal Beliefs and Medical Practice the results of which are awaited. (GMC 2007).

In one American report it was suggested that if a patient wants prayer then they should pray and the physician could wait in silence (Post et al 2000 p. 581).

Chaplains are in a position where there are important ethical and moral obligations to respect the autonomy of the patient, but there is much more of an expectation that prayer is appropriate and welcomed. Where doctors may feel constrained by their medical role, chaplains have a role which has permission to ask the God questions: ‘...and do you pray?’, but it is important that consent is given to the chaplain’s visit in the first instance. Patients should be given a choice and the power to say ‘no’.

For a chaplain to engage meaningfully in this kind of situation there needs to be a critical reflective sensitivity to the culture and beliefs of those who request their help, and to the context, whether that be grieving parents with a stillborn baby, a frightened dying man anxious to know some kind of absolution, a family waiting at the bedside of their brain-dead relative for the transplant team to arrive, while still retaining integrity and authenticity in their own identity and story.

The Future – Doctors and Chaplains Working Together?

What has become clear is that there are very definite limits to what doctors and nurses can deliver in the provision of spiritual care, but they could be doing more than they are, though there are organisational constraints, lack of time, training needs and ethical dilemmas. Chaplains do have a unique position in healthcare settings, with a significant potential contribution to patient care, but there are areas where chaplains could, and should, be clearer and more upfront about their contribution to spiritual care. There is room for much more dialogue and collaborative

working, and there are three main areas in which this could be accomplished.

a) Teaching & training

Koenig, McCullough and Larson conducted an extensive overview of over 1000 research studies looking at relationship between spirituality and religion and health care, and made some recommendations about the role of physicians in addressing the religious or spiritual needs of patients. They felt that doctors could at a basic level enquire about, and support religious beliefs by aiding access to chaplains, and could include chaplains as members of the healthcare team. They also suggested that medical students and chaplaincy students should take some courses together so that they learned early on in their careers the unique contribution that each can make to the whole team (Koenig et al 2001 p. 445).

The authors write from a North American context so that some recommendations may be less transferable than others, but there are moves to make the 'spiritual history' a part of the story elicited by doctors of their patients, with standard formats proposed, and inclusion of a 'Spirituality in Healthcare' module into the curriculum of several medical schools in UK. Other recent developments include a multi-disciplinary conference in 2007 organised by the Higher Education Academy on 'Integrating spirituality into the undergraduate medical curriculum.' (see http://www.medev.ac.uk/show_past_workshop?entry_id=88) This is clearly an area where there is much to be done, but there are encouraging signs of ongoing development of the curriculum in a number of medical schools. One key message seems to be that, as a minimum, doctors should be discovering whether spiritual or religious issues are important to patients, whether they have the support they need, and if they would like further support or care.

Psychiatrist Larry Culliford has produced an assessment tool for use by physicians (Culliford L 2005). Christian Medical Fellowship authors suggest some simple screening questions, like "Do you have a faith that helps you at times like this?" (Vaughan K 2005). Murray proposes some basic level enquiry questions about where patients derive support (Murray 2003b).

Chaplains already play a role in teaching and training in bereavement care, teaching of breaking bad news etc, but this role could be much greater, in helping doctors to learn how to undertake a basic level of spiritual care, promoting the inclusion of a spiritual dimension. It would also raise their profile and credibility within the healthcare setting.

b) Teamwork

Better understanding of their role and viewing the chaplain as the Specialist in Spirituality would lead to more readiness to refer where appropriate.

Kliewer & Saultz recommend that

when it comes to spirituality, the role of the health-care clinician is, primarily, as a catalyst. Thus, the art of referral is one that should be nurtured (Kliewer & Saultz p. 187)

Ethical issues of consent & confidentiality are important, and a best practice guide was published in 2003 (DoH 2003), and a Code of Conduct produced by the chaplaincy regulatory bodies (AHPCC, CHCC & SACH 2005) which seeks to put in place appropriate safeguards. An expanded role for chaplain is explored by Koenig et al based on evidence from research that there are positive effects on health and clinical outcome for patients where spiritual and religious needs have been addressed. Reduced length of hospital stay has been found where there have been chaplains' visits (Bliss et al 1995- quoted in Koenig et al 2001, p. 420).

Rather than reducing chaplaincy provision it would seem to be more helpful to consider enhanced roles for chaplains which might involve fuller integration into the multidisciplinary team in primary and secondary and involvement in offering spiritual support to patients and their families at all stages of an illness or a hospital stay, and availability to offer support to staff in all departments. (Koenig et al 2001 p.453).

c) Developing credible evidence-based research

The prevailing culture of the medical world is of 'evidence-based medicine'. Increasingly for the work of chaplains to be accepted as valid in this climate there will be a need for research into efficacy. There are a considerable number of studies which have now been published concerning the positive effects of spirituality and religion on health, listing

benefits in the areas of psychiatric, emotional and physical well-being. The Handbook of Religion and Health brings together over a thousand studies and concludes that there is considerable beneficial effect.

There are some difficulties in applying this work in the UK in that virtually all of the studies were conducted in USA, and the context is very different with considerably higher background levels of faith and church involvement than is the case for the UK. There are also significant questions about methodology, for instance an article by Sloan et al which is quite sceptical about the alleged benefits (eg Sloan et al 1999), but for an alternative perspective see Koenig's 'Rebuttal to Skeptics' (Koenig et al 1999). Space precludes fuller discussion, but in 2006 *The Caring for the Spirit* initiative commissioned a comprehensive review of relevant research, the results of which are awaited. Swinton also reports on an overview of research evidence in his book (Swinton 2001).

How is research to be conducted? There are inherent difficulties with measuring what can be seen as immeasurable – spiritual wellbeing, but research into the effects on patient care of inclusion of a spiritual dimension would be valuable.

Clearly double-blind placebo randomised control trials would not be possible, but qualitative research methods could be used such as patient self-reporting questionnaires, case reports, discourse analysis, surveys of providers and users. There may well be objective outcome measures that can be used: shorter hospital stay, use of medication, morbidity and mortality. None are without their problems but this is not a new issue, but chaplains will need training and resourcing in order to be able to work in this way, alongside medical staff: Peter Speck published *A Standard for research in health care chaplaincy* in 2004.

Other possible areas for research could include looking at knowledge and attitudes of healthcare team towards inclusion of a spiritual dimension, and the specialist role of chaplains.

Final Remarks

Spiritual care is a vital component of truly holistic patient care, and research indicates positive benefits

on health outcomes. Even the most patient-centred models are incomplete without a spiritual dimension, and training of doctors could incorporate a spiritual component to the consultation. As Larry Culliford, psychiatrist put it:

Many see religion and medicine as peripheral to each other, yet spirituality and clinical care belong together. The time is thus ripening for doctors to recall, reinterpret, and reclaim our profession's sacred dimension (Culliford 2002 p. 1435).

Chaplains are uniquely equipped to be the Specialists in Spirituality, and with greater provision of personnel, evidence-based research and on-going training for all healthcare staff there could be valuable increased recognition and inclusion of their contribution to holistic care.

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