

EDITORIAL

chaplains must first plumb the depths of their own souls and experience before they can accompany others to the depths of their own. Robert Mundle

As NHS employees, chaplains are subject to all that is expected of NHS staff and that includes clinical governance. This means that just thinking the needs of patients are being met is not good enough – services are intended to be audited, researched and reviewed continuously. Aldridge et al.

These two comments sit in conscious contradiction in this volume of the journal. Between them lies the tension of modern chaplaincy. How does a professional individual offer the depth of their own soul's experience while living and working in a highly regulated authority structure? How do chaplains hold on to the depth of the soul when number crunching, verbatim analysing and auditing are all required of their service by the NHS at large? The current issue offers varying answers to these questions, and I hope that might stimulate debate about what it is chaplains offer, what we measure and why, and whether research and the depths of the soul are in harmony or in conflict.

Aldridge *et al* look at what chaplains actually discuss with patients. They gather first an idea of what it might be and it is no surprise that 'death and bereavement' is a hot topic - a hot topic, perhaps, but not as frequently discussed as the team expected. The telling of story is another area which chaplains know from experience is a common theme but to have it recorded and delineated is very useful, and I hope will reinforce the link between story and good chaplaincy. When is a story spiritual? Is all personally told story spiritual? Does non-spiritual or not clearly religious content diminish the value of chaplaincy contacts? Or is there nothing which is not spiritual? Or is non-spiritual content just necessary scene setting? This was a small study and it raises some interesting questions, hopefully it will inspire further work into patient contacts. There is much more that can be done in the future to build on this useful work.

Mundle too raises potentially contentious questions of consent and of religious boundaries. Can chap-

laincy, by its nature pluralist and spiritual in emphasis, challenge religious boundaries? Is it part of the nature of human experience to do so? What is the role of the patient's own request in asking for boundaries to be challenged? Where does boundary challenging become evangelism or proselytising? And there are further questions surely to be answered about the interface between chaplains and faith group leaders, imams, clergy, those who hold the traditions and boundaries of the faiths and also work daily with the challenges that those boundaries meet and absorb.

The boundary between chaplain and faith group leader is viewed from the perspective of co-operation in Cavannah *et al's* work on Trauma and Faith Group Leaders, significantly looking at the level and intensity of experience brought to the door of the minister, priest or belief group leader by those who have suffered traumatic events. Here the boundaries between chaplain and faith group leader are challenged and the similarity of the pastoral and spiritual care work done by both groups is emphasised. Much that chaplains may normally feel is distinctive to their role becomes shared endeavour in this piece.

The shared endeavour could be said to be the theme in both Lumsdaine and Mulligan's article on Organ Donation and Beth Seymour's article on nursing students and their own views on spirituality. The co-operation between clinical and spiritual care is rarely straightforward and the interaction between spiritual and physical illness is certainly not direct. Both these pieces bring to the fore the need for individual insight and respect for individual opinion as an underpinning principle of all care, religious, spiritual or clinical.

Readers will also find a new section in the journal entitled 'Reflective Practice'. Following the practice of some journals to include a 'Views and Reviews' section, or to print letters to the editor, the board have decided to create a dedicated section in each issue for views, opinions, and reflective pieces, of 500-1000 words. Those involved in the delivery of Spiritual Care, Religious Care, or Healthcare Chaplaincy are invited to submit short

pieces which are grounded in their experience of practice by way of reflection, case study, discussion of current issues or response to previous articles. An invitation to contribute to this section will replace the previous call for letters to the editors.

In order to inaugurate this new section, Tom Gordon writes of the last boundary of life and he reflects on the finality and liberation of death and some common misconceptions of healing and cure, and of suffering, which he has encountered while working as a chaplain. The depths of the human experience are again brought to the surface as a

Church of Scotland committee discusses health and healing.

This volume has much within it to stimulate thought and debate. It seems to me that the questions raised, relating to the relationship between research and the active work of pastoral and spiritual care, may be carried forward for some issues to come. As boundaries are breached, and yet also respected, the interaction between chaplaincy and the professional disciplines with which chaplains work ought to produce more research questions for the profession to examine.