‘No abiding city’: where do healthcare chaplains belong, and where are they heading?

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Although Methodist ministry has changed immeasurably since its beginnings, the notion of ‘travel’ remains a powerful image, not least because it resonates with the biblical understanding that there is an unsettledness appropriate to the life of faith. We are pilgrims on a journey, with nowhere permanent on this earth to belong, ‘no abiding city’, as Hebrews puts it.

Healthcare chaplains cannot claim to be itinerant, but they can talk with some authority about feeling constantly ‘on the move’; and the journey has not been a straightforward one, either for the institutions where they are employed or for their own role. To understand where we are now, a brief outline of where we have come from is needed; and I use personal experience by way of illustration.

When I first became a part-time chaplain in the 1990s, I was designated as ‘Free Church’. At the time, most full-time chaplains were Anglicans; and my Anglican chaplaincy colleague could remember the days when she and the Senior Chaplain would walk through the wards first thing every Sunday morning, giving Holy Communion to any patients who showed the remotest inclination to receive it. Those days have long gone. Now, most chaplains in the acute hospital sector work in multi-faith teams, and regular services in the chapel (or more likely, the multi-faith sanctuary) will include worship from many different religious traditions. Moreover, there has developed within healthcare a widely accepted distinction between ‘spiritual’ and ‘religious’ needs, recognizing that many patients who do not subscribe to a particular religious faith may still find themselves struggling with existential questions. This means that most Methodist chaplains, whether full- or part-time, will employ a generic approach, spending a fair proportion of their time with people who may not regard themselves as religious, but who still need spiritual support.

In many ways, the core elements of my work have remained the same over the years: being alongside patients and families in crisis, responding to emergencies, conducting worship, training and supporting staff. Yet there have been profound changes in the way healthcare activity is assessed and measured, with huge stress placed upon efficiency and cost-effectiveness. In a world of relentless financial pressures and limited resources, chaplaincy is no longer taken on trust, and is increasingly being challenged to prove its usefulness by measuring activity. The effects have been far-reaching. Even in the part of my work centred on a small Specialist Palliative Care Unit (an environment traditionally supportive of chaplaincy) I have had to keep exhaustive records over the past year of how many patients and families I have seen, how many funerals conducted, how many home visits made. I can now produce some impressive graphs. Yet the limitations of the exercise are obvious: the statistics cannot measure *quality*. I could be doing dreadful spiritual damage to people, and if no-one complained, no-one would know. This is a reminder that spiritual care is extremely difficult to define (though we may have no problem in describing anecdotally when we've seen it done well); but perhaps we should not be surprised if, in an environment committed to measurable outcomes, chaplaincy services might seem to some hard-pressed hospital managers like an optional extra. One thing is certain: as Harriet Mowat observes: 'We can no longer assume that people will see healthcare chaplaincy as a social good.'[2] This is the situation in which we find ourselves.

So where do we go from here? Well, on one level, chaplaincy has already responded to the challenges of the present climate by seeking to demonstrate its credentials as a healthcare *profession*, with its own standards, competencies and training programmes, and moves towards professional registration; this process will no doubt continue. But if chaplaincy is to retain its distinctiveness in a secular environment, this has to be accompanied by ongoing theological reflection on where chaplains belong, and what they are *for*.

First, it is important for chaplains to recognize that the marginality that makes them feel insecure may paradoxically be their strength. To return to the metaphor with which we began, the patients we meet in the course of our work are also travellers. The language of healthcare acknowledges this, with reference to the 'patient journey' and 'care pathways'. But such language breaks down when patients find themselves in situations where all the familiar landmarks have disappeared. Dr Sheila Cassidy has written eloquently about this in the context of palliative care:

> The dying are people on a journey. They are uprooted people, dispossessed, marginalised, travelling fearfully into the unknown . . . So the spirituality of those who care for the dying must be the spirituality of the companion, of the friend who walks alongside, helping, sharing and sometimes just sitting, empty-handed, when he would rather run

> away. It is the spirituality of presence, of being alongside, watchful, available; of being there.[3]

This is the essence of the chaplain's role. It is not for a moment to suggest that other disciplines do not also listen. But as Aldridge et al. point out, clinical staff, by explaining and delivering treatments, 'have input' into the patient narrative, whereas the chaplain simply 'responds to the need of the patient as the patient presents it'[4]. In other words, we listen because we literally *have nothing else to do.*

This is not always a comfortable place to be. Tom Gordon writes about the need for chaplains to avoid the temptation of imposing their own route map upon the patient:

> There are no ready answers or pat solutions which will rescue the desert traveller and whisk them off to safety. The outcome of the journey together *may* be a sense of purpose or direction, or even some answers to big questions. But it . . . should not be the initial purpose. To meet the traveller with a solution already worked out is to offer them *my* journey and not to help them find their own.[5]

Chaplains who are able to accompany patients in this way are sharing in Jesus' ministry to the outsider. We deal for the most part with people whose opening gambit may well be: 'Thank you, I'm not religious.' These are often the same people who later want to ask profound spiritual questions; but in terms of belonging to the Church, they will usually remain outsiders. Indeed, as I reflect upon my time in chaplaincy, I can only recall conducting two funerals in a church in the last 10 years; yet funerals are a significant part of my ministry, mainly baby funerals, and those of patients who don't feel they belong anywhere. Here the image of Jesus in Hebrews, crucified outside the city boundary, is a powerful one. I have long believed that the seven last words from the cross of our Good Friday liturgy encapsulate the needs of all dying people: to know forgiveness, offered and received; to be remembered; to make provision for loved ones; to have longings heard and understood; to endure feelings of abandonment; to find a sense of completion; and to commend the self into the hands of God. Christians down the centuries have been comforted by those last words. I have found in my work as a chaplain that many who would not consider themselves Christians at all have nevertheless felt drawn to this haunting figure on a cross, and have found in him some courage and hope with which to face their own dying.

This experience of being 'on the margins' also extends to the liturgies that chaplains create in situations that stretch the pastoral imagination to the limit – blessings of retrieved tissue samples, in the wake of the Alder Hey scandal; the request by devastated parents to baptize their dead teenager in Accident & Emergency. These hardly qualify as 'fresh expressions', but they may keep people who are in great pain tenuously linked to a source of meaning and hope that the chaplain represents for them.

So in terms of pastoral encounter, be it with patients, carers or staff, the chaplain's place on the margins can be a theologically significant one. But in the current climate chaplains need also to develop effective ways of communicating what they do to employing organizations that do not always understand them. Harriet Mowat argues strongly that there is a moral imperative for chaplains to be engaged in research, in order that they can share practice, explain their role and ultimately improve quality of care.

What is clear is that, in a secular healthcare environment, chaplains need to remain theologians. They have to be able to explain themselves to a system obsessed with what is measurable – if they do not, they will not survive as a profession. But if chaplains don't reflect theologically upon their work, and upon the culture of their workplace, they will lose what makes them distinctive and, paradoxically, what makes them valuable to the healthcare organization, which needs to hear alternative voices. Walter Brueggemann (2008) identifies the prophetic role as being *uncredentialled* and *called by God*,[6] and thus free to speak from outside the boundaries of the dominant culture. There are practical difficulties involved in seeking to be prophetic within a dominant culture that is responsible for your employment. But the opposite danger is to fail to criticize the prevailing culture at all, and to adopt what Al McFadyen has termed 'post-it label theology, where God-talk is appended to secular discourse and can be peeled off without even leaving a mark'[7].

How to communicate all this to the Church is another matter. Here, the formal opportunities for dialogue and mutual support feel frustratingly limited; but it would be helpful if more opportunities could be found. Full-time chaplains, who operate entirely outside ecclesiastical structures and whose daily work is shaped by encounters with a great number of people for whom religion is an irrelevance, have an experience of liminality that the Church might benefit from hearing. What is more, the theological and emotional challenges involved in occupying this territory are such that it might be of help to chaplains and the Church to reflect on them together.

What of the future? Undoubtedly, these are uncertain times. Healthcare organizations looking to save money will continue to want proof from chaplaincy services that they are cost-effective. The National Secular Society maintains its attack on NHS funding, arguing that faith communities should be paying for chaplains to meet the needs of ‘the small number of patients who are religious’, blithely ignoring the links between spiritual well-being and health, and seemingly unaware of the service chaplains provide to people of all faiths and none who simply want someone to be with them, listen to their stories and help them find meaning in their experience. Meanwhile chaplains themselves often seem caught between two worlds – the secular employer and the Church – trying to explain themselves to both. Yet whatever the uncertainties, Christian healthcare chaplains continue to trust that God has called them to this work, and that in doing it they are responding to the words of Jesus: ‘I was sick, and you visited me.’

NOTES

1 Judy Davies is a full-time NHS Chaplain in Reading, specializing in palliative care.
2 Harriet Mowat, *Scottish Journal of Healthcare Chaplaincy* Vol.13, 2010.
3 Sheila Cassidy, *Sharing the Darkness*, DLT 1988.
4 A. Aldridge, D. Fraser, K. Morrison, ‘What do people talk to chaplains about?’ *Scottish Journal of Healthcare Chaplaincy Vol.12:2*, 2009.
5 T. Gordon, *A Need for Living*, Wild Goose Publications, 2001.
6 W. Brueggemann, *Old Testament Theology* Abingdon, 2008.
7 A. McFadyen, ‘What is a person? A theological Interpretation’ *Journal of Health Care Chaplaincy* 1999: 3,1.