EDITORIAL

Looking back over the editions of the journal which have appeared to date, I am impressed by a sense of gathering momentum. This has not to do solely with the process by which a new journal gradually defines its identity and finds its feet, although hopefully this has indeed been happening, and will continue to happen. The momentum which I detect has more to do with the gathering pace of change within chaplaincy itself, of which none of us can be unaware, especially since the publication of HDL (2002) 76. There is a new urgency about the asking of questions, the defining of identity within a modern healthcare system. There is a need for focus, precision, communication, not only among ourselves, but also with those who do not share our language and must be persuaded of the worth of chaplaincy. There is a felt need for secure status, defined role, the respect of the health professionals alongside whom we work. And yet at the same time, room must be found for those most precious aspects of the chaplain's role which are often the least amenable to precision, explanation, evidence and proof. Chaplains are not yet experiencing a crisis of identity, and are to an extent cushioned by the sense of good will and respect which many in healthcare still have towards us, even if they only have the vaguest idea of what we are really 'for'. Yet there is a growing awareness that chaplains must be ahead of the game in asking of ourselves the hard questions which will inevitably be put to us by others. 'Reflect and Survive', may be the motto here. But this is not, or should not be, our primary motivation for doing the hard thinking about the identity of chaplaincy; we do it so that we may with confidence and integrity provide meaningful spiritual care within the NHS of the 21st century.

'Chaplaincy for tomorrow' is not only the name of a recent conference; it is the focus of the majority of contributions over recent editions of the journal, including this one. The scene is set by John Swinton's thought provoking article, which sets out the issues involved if chaplains are to become 'health care professionals' in the same sense as others. His plea is that chaplains reflect upon ways of articulating the uniqueness which we claim for ourselves, even if this means finding the courage to assert that we cannot in many respects fit into the 'evidence based' model of healthcare. The challenge is to establish chaplaincy on its own terms, and that requires a sensitive assessment of both the common ground that we share with others in healthcare, and of the ways in which we must of necessity be different. Noel Brown strikes a similar note when he calls upon chaplains to find the confidence to make our distinctive voice heard in the spirituality debate.

Other contributors take up in their various ways the issues involved in chaplaincy for tomorrow, issues of evidence, training and support, role and identity. This edition is broadened and enhanced further by reflections on SARS, and by a consideration of the difficult subject of failure in palliative care, And from a very different perspective, Jordan Vuchkov gives us an insight into a healthcare system from which chaplaincy has for years been largely absent, and where the need for a 'doctor of the soul' is being rediscovered.

A 'doctor of the soul' for a new century, understanding the need for both skill and love, both knowledge and wisdom, both evidence and intuition; operating confidently in a culture awash with information, and yet at the same time preserving space for precious aspects of human experience which are too deep for words. To quote David Mitchell's closing question, 'How will it all develop?'

A QUESTION OF IDENTITY: WHAT DOES IT MEAN FOR CHAPLAINS TO BECOME HEALTHCARE PROFESSIONALS?

John Swinton

Abstract: What does it mean to be a healthcare chaplain? The recent introduction of the chaplaincy guidelines has taken chaplains into the heart of the healthcare system and ensured that the National Health Service in Scotland has to think about and perhaps re-think the role of chaplaincy and its place within the system of healthcare delivery within Scotland. This presents a challenge not only to the National Health Service but also to chaplaincy. Chaplains will be called to account for who they are and what they do in a way that they have not previously had to. The question of the professional identity of the chaplain is thus crucial. This paper reflects critically on the identity of chaplaincy as a healthcare discipline and offers some reflective comments on the pros and cons of what it might mean for chaplains to develop an identity as "healthcare professionals."

Key words: chaplaincy, professional identity, professionalism, professionalisation, spiritual care.

These are interesting times for chaplains. The recent introduction of the new chaplaincy guidelines has taken chaplaincy into the heart of the healthcare system and ensured that the National Health Service in Scotland has to think about and perhaps re-think the role of chaplaincy and its place within the system of healthcare delivery within Scotland. This is indeed a significant step forward for chaplaincy in Scotland. However, it has also raised an important discussion as to precisely what chaplaincy is and how it fits into our current evidence based healthcare system. How are chaplains to identify themselves and what evidence base will they be required to draw on if they are to "prove" the continuing significance of their work? In this paper I want to raise some issues and ask some questions about the identity of chaplains and the future of chaplaincy. I do so not in any sense to criticise chaplains or the discipline of chaplaincy. Quite the opposite, chaplaincy is a discipline within which I spent some of my most fulfilling working years and it remains dear to my heart. I believe that chaplaincy offers not only a vital healing conduit which is crucial for the sustenance of a genuinely person-centred health care system, but also a powerful prophetic challenge to the church in terms of the way in which it defines and practices ministry. It is for that reason that I think that hard and perhaps awkward questions need to be asked at this stage of the development of chaplaincy.

The changing status and perception of chaplaincy raises some important issues that chaplains must begin to reflect on if they are to retain both their integrity and the authenticity of their place within a constantly changing and often uncertain healthcare system. The points presented below are intended to stimulate debate and to open up what I believe is an important dialogue around the nature and identity of healthcare chaplaincy. In this way I hope my thoughts can play a small part in enabling chaplains to focus in on issues that the new guidelines highlight as important and which in the long run may be crucial to the future of chaplaincy.

What does it mean to be a professional?

It is clear that many healthcare chaplains feel that the direction they should be moving in is towards the development of a professional identity as 'healthcare professionals.' In itself this is not an unworthy goal. If being a professional means that chaplains see the importance of performing their role in a way, which is professional, i.e. informed, knowledgeable and complementary to the other disciplines, then this is something worth striving for. If chaplains are to be taken seriously, it is vital that they are viewed by other professionals as engaging in forms of practice which are relevant, efficient and

credible. In order to achieve this they must be seen to be acting in a manner that is professional in the broader sense of the term. However, if being a professional chaplain means striving to achieve an accredited status that is equivalent to the way that professional status is attributed to other healthcare workers such as doctors and nurses, this raises important questions and potential difficulties.

Professionalism or professionalisation?

What I want to highlight here is the difference between 'professionalism and professionalisation.' It is clear that professionalism is very important. My friend and colleague Alison Elliot suggests that the beginning point of professionalism is "the existence of a system and structure which ensures that chaplains have the resources to do a professional job." It seems clear that the recent guidelines point towards ways in which such a structure could be put in place and sustained within a Scottish healthcare context. Elliot suggests that in order to do a professional job, chaplains require the following:

- *Integrity* – This can be maintained by the provision of some sort of code of conduct such as that which is largely outlined in the chaplaincy guidelines.
- *Autonomy* – The ability to work unsupervised in a way which makes a distinct contribution to the practice of healthcare.
- *Back-up* – Being able to keep up with colleagues in things like giving PowerPoint presentations, efficiency and so forth.
- *Support* – From other chaplains, the church, people who know what chaplains are going through etc.

To Elliot's list we might add one further dimension of professionalism which is:

- *Respect* both for oneself and for the dignity, autonomy and personhood of the other, 'the other' being understood as both patients and fellow healthcare workers.

At this level, becoming a professional is vital for any chaplain and a central dimension of good practice. This would seem to be a wise and worthy goal for chaplaincy.

Professionalisation

However, if becoming a professional means the professionalisation of chaplaincy, that is, developing chaplaincy in line with other healthcare professions such as nursing or medicine, then other questions have to be raised and answered. Before we can decide whether or not this might be a good or a bad thing we need to reflect clearly on what it might mean to become a 'healthcare professional' in this second sense of the term We might describe the five primary components necessary for a discipline to have professional status as:

1. A body of knowledge that supports and underpins their practice.
2. A code of professional ethics.
3. An occupational organisation controlling the profession.
4. Substantial intellectual and practical training.
5. Provision of a specialised skill or service.

Let us take each of these dimensions in turn.

1. A body of knowledge which support and underpins their practice.

The Cambridge dictionary defines a professional as *a person who has the type of job that needs a high level of education and training, e.g. health professionals. This education provides the professional with the necessary body of literature that underpins and sustains its practices* (Cambridge online). At first glance one might think that chaplains clearly meet this criteria. Full time chaplains are normally ordained ministers who are educated to the level of university education and sometimes to postgraduate level. However, a deeper reflection reveals a potential problem. Historically chaplains have been ordained Christian ministers who do specific training within the field of Christian theology in order to attain their status as ordained ministers of word and sacrament. This being so, the body of literature which has traditionally underpinned their practice has been the Christian biblical and theological tradition. However, it appears that some chaplains do not want to have their practical and theoretical resources limited to Christian scripture and tradition (Barcley 2003). Rather they want to be seen in more generic terms as 'spiritual carers,' who are able to cater for the spiritual needs of *all* people of all faiths and none. Becoming a spiritual carer in this sense is not in itself problematic insofar as chaplains within a secular healthcare context are called to care for all

whom they encounter and not simply those with an expressed religious commitment. Current research would support the suggestion that all human beings have spiritual needs if spirituality is defined in broad terms which include but are not necessarily defined by religion (Newberg and Aquili 2202) (Hay 1994). Some manifest these needs through religious structures, but many express them in varied ways which do not include religion or even a concept of a deity. If this is so, becoming a 'spiritual carer' in this generic sense is an important dimension of the chaplain's role; spiritual needs need to be catered for and chaplains are a group of people charged with the responsibility of caring for this dimension of human beings.

However, in distancing themselves from the Christian tradition as its primary body of *professional* knowledge, it becomes unclear what body of knowledge actually underpins the practice of chaplaincy. Is it psychology, counselling, psychotherapy? If so what is it that makes the difference between a counsellor trained in these disciplines with an interest in spirituality and a professional chaplain? Could we not just get rid of chaplains and employ spiritually oriented counsellors at less cost? These, I suspect are the types of questions that, in the long term, managers and accountants may well begin to ask. Chaplains will more and more be called to offer an account of what it is that makes them unique and indispensable? Do chaplains have answers to such questions that can justify their existence and status as healthcare professionals?

Now it might be argued that chaplains use their training and experience in the Christian tradition and indeed their personal faith position as a crucial beginning point for the spiritual caring that they deliver. It is their motivation as Christian ministers which moves them to provide spiritual care to *all* people. If this is so, then chaplains need to articulate much more clearly what this actually means in terms of identity and practice and explain the implications and *professional* relevance of such an approach within a secular healthcare system. Chaplains, as a body, need to be clear where they stand on this foundational issue.

2. A code of professional ethics; 3. an occupational organisation controlling the profession; 4. Substantial intellectual and practical training

Let me take these three points together. These three dimensions of the professional role appear to be relatively uncontroversial, at least in principle. Chaplaincy is a discipline which is deeply implicated in issues of value and meaning. Its daily encounters with people on an intimate and deeply trusted level combined with the primary task of caring for the person's spirituality, a dimension of experience which is inherently caught up in systems of meaning and belief, means that ethics and moral principle provide some of the implicit grammar of chaplaincy. A code of ethics would enable the development of ethical standards and assumptions that would provide important guidance for chaplains as they wrestle within the complex ethical environment of the healthcare system. Such a code of ethics is vital not only to enable chaplains to practice ethically, but also to ensure that patients are protected from potential abuse or malpractice.

Similarly having a unified occupational professional body which oversees the profession is a vital dimension in terms of setting boundaries, establishing professional qualifications and training, dealing with disciplinary issues, setting standards and so forth. However, even here some critical thinking may be required. Take for example the issue of training and dedicated chaplaincy qualifications. All of the healthcare professions, medicine, nursing, social work, occupational therapy etc, have specific courses with particular qualifications which it is necessary to acquire before a person can practice within any given area. For chaplains to become healthcare professionals in the way that the other healthcare disciplines understand this term, a similar dedicated training qualification will have to be developed. Presumably, if it were to hold any credibility, the chaplaincy qualification, the nature of which would be decided by the organising body, would have to be at a similar level to that of other healthcare professions.

All of this is fine, but it raises two important questions. Firstly, will everybody have to do this qualification? For example, will a chaplain who has been in post for a substantial length of time be forced to do this qualification if he or she is to continue prac-

tising? This would of course be the case with the training qualifications attached to the other healthcare professionals. Alternatively, would such a qualification only be compulsory for those coming in fresh to chaplaincy? If so, would there be real credibility in running a two tier chaplaincy training system wherein some are trained professionals and others are not, the newest chaplains being healthcare professionals, in the narrow/technical sense, and the more experienced not? Also, if such training was to become a significant dimension of being a healthcare chaplain, and if it is ultimately made compulsory by whatever means of delivery, are we happy to live with the fact that some people, for a number of reasons, may find themselves unable to gain the qualification and therefore not considered fit to practice? Have we reflected on the pastoral implications of such a situation? These are not simply questions for chaplaincy educators to reflect on, they are questions which any organising body with responsibility for certification *must* think about very carefully. I would suggest that issues such as this need to be thought about now rather than catching chaplains off guard in the future when the issue may raise itself in a much more intense and negative form.

5. Provision of a specialised skill or service

Healthcare professionals are called upon to provide a specialised skill or service. But what is that skill or service? Chaplains claim to be experts in spiritual care. It is this claim that provides them with the right to claim to have a specialised skill and to provide a unique service within a healthcare context. In a questionnaire prepared for a recent conference on chaplaincy in Crieff, Rev. Iain Barclay (2003) asked chaplains what they thought were the main skills that chaplains had to offer to people in terms of spiritual care. The main skills highlighted by chaplains were:

- Being with the patient
- Showing empathy
- Listening
- Treating them as whole people
- Loitering with intent/Hanging out

Each of these highlighted points is of course vital for holistic, genuinely person-centred care. However, one is still left with the question of what it is that makes these skills 'specialised?' With the exception of loitering with intent, could not any of the caring professions claim these as central to their practice and professional identity? In the same study chaplains described their role as relating to the provision of "a professional expert resource?" If chaplains are not really adding anything new then why would they be seen as "a professional expert resource?" If I were a nurse with twenty years experience, why would I need a chaplain to teach me these things? Now it may of course be that the sample on which this study was based was skewed or unrepresentative. Alternatively, it could be that chaplains need to seriously reflect on the precise nature of the specialised skills they have to offer and the uniqueness of the service they seek to provide. In an evidence-based healthcare culture such reflection may become crucial for long-term survival.

Evidence based chaplaincy

In a healthcare system which has a tendency to favour technical solutions over and against the significance of persons, chaplains have the potential to fulfil a crucial role in reminding all of the disciplines of hidden dimensions of care which are crucial for holistic healing. And yet, as I have suggested what spiritual care actually means is not at all clear. Combine this lack of clarity with the difficulty of having to *prove* the worth of chaplaincy to management and accountants and we have another tricky problem. I recently attended a conference on spirituality and healthcare at Harvard University in Boston. It was fascinating to see where the Americans were on the issues I am trying to highlight. Spirituality is in some ways more embedded within certain dimensions of their healthcare system than our own. However, that brings with it its own difficulties. One chaplain gave an interesting example that will help to illustrate the difficulty. In outlining the specific competencies that make a professional healthcare chaplain he took great pains to point out that "no one should pray with patients except chaplains. You see, prayer is a professional competency for chaplains…a mark of our identity." Now we have to ask ourselves if this is a paradigm of the direction we want to go as we try to establish the meaning of 'professional' within chaplaincy. Do we simply want to try and squeeze the uniqueness of chaplaincy into a mould in which it simply will not fit? How will we gauge the measure of our practice? Do we want spiritual disciplines to become competences that are judged in the same way as giving an injection or drawing blood? How do we gauge our

worth within an evidence based culture that demands forms of evidence which simply may not be available to or appropriate for chaplains?

Buckets and waterfalls

Let me try and illustrate the difficulties in assessing and understanding the meaning of spiritual care within a healthcare context that has a radically different way of looking at the world. I will borrow an analogy used by Marc Cobb at a recent meeting on spiritual care in Edinburgh. Imagine yourself walking through a deep, dense wood. You are surrounded by beautiful, luscious foliage; the constantly changing aromas of the rich shrubbery makes your head swirl. Suddenly you reach a clearing. Right in the centre of the clearing is a beautiful stream headed up by a magnificent waterfall. You stand and watch in awe at the mystery and wonder of the waterfall. Multiple rainbows dance across the glistening surface of the water. The sound of the water, the taste of the spray the sight of the magnificence and power of the waterfall touches you in inexpressible places and brings you into contact with a dimension of experience which you can't quite articulate, but which you feel deeply and meaningfully. Eventually, your gaze of wonder begins to change as your curious side clicks into action: "What is this thing called a waterfall?" What is it made of?" "Why does it have such an effect on me?" So, you pick up a bucket and scoop up some of the water from the falls. You look into the bucket, but something has changed. The water is of course technically the same substance in each setting: H2O. It remains a vital constituent in your life; you need it to live and without it you will perish. Yet, something has been lost in the movement from waterfall to bucket. In your attempts to break it down, analyse and explain what it really is, the mystery and awe of the waterfall has been left behind. Which is more real? The mystery of the crashing waterfall or the still waters of the bucket?

I think this word picture reveals an important dimension which sits at the heart of the current debate over the role of the chaplain within a professional, evidence based, scientifically driven healthcare system. On the one hand, chaplains are called to be spiritual healers and carers. They are called to mediate and care for a person's spirituality: that dimension of humanness which is unquantifiable, mysterious, individual and unique. On the other hand, they are called to justify their existence within a healthcare context which places great emphasis on that which is quantifiable, generalizable and universally applicable. The distinction between the waterfall and the still waters of the bucket symbolises the difficulties that chaplains are faced with when they begin to consider their role the healthcare system. In terms of professional development and chaplain's long-term role within the healthcare system this tension requires to be reflected on sensitively and thoughtfully in order that the uniqueness of chaplaincy can be fully recognised and effectively and meaningfully worked out.

Square pegs in round holes

The truth is that in significant ways chaplaincy does not fit within the standard model of the health professional…and that is a very good thing! Chaplaincy is a unique discipline with a unique role within the healthcare system and it has to establish itself on its own terms. Chaplaincy is a prophetic discipline which challenges many things within the healthcare system and forces it to begin the process of lateral thinking. One of its challenges may be to begin to redefine the meaning of 'health professional' and expand the boundaries of precisely what evidence base should underpin the practice of chaplains. In a system which is inherently death denying chaplaincy calls us to notice that death and illness may have meaning beyond the understandable but ultimately unrealistic desire to avoid both. Chaplains are called to enable the system to redefine health and healing in ways which will enable it to realise that illness has meaning beyond the technical language of pathology and that healing and health relate as much to the restoration of that meaning as they do to the elimination of suffering and pain, a goal which in reality will never be achieved. Chaplaincy is the critical voice that makes holism possible.

Intuitive based chaplaincy

In a context which demands empirical evidence based on the methodologies of science and empiricism, chaplaincy is called to reclaim the significance of such "hidden" dimensions of the healing process as they are revealed in such things as narrative and intuition. Most of what chaplains do relates to the listening to and the telling of stories. Stories reveal a form of knowledge that is not only grasped with the mind but also with the heart. Stories demand interpretation, intuition, imagination, all gifts which are

fundamental to chaplaincy when people are practicing well. As in their day to day encounters with human pain, suffering and joy, chaplains struggle to understand the human spirit and to translate that into understandable forms of spiritual practice which can enhance the healing process within the structure of the National Health Service, they are called to reclaim the significance of intuition and empathetic imagination as a legitimate dimensions of professional practice; intuition which reaches into the depths of the experience of suffering people not to *explain* their illness, but to try passionately to *understand* the meaning of what people are going through and to draw on the spiritual traditions to enable forms of deep healing which include but are not defined by particular religions. Such a practice of intuitive, narrative based chaplaincy when it is embodied and worked out may offer a beginning point for the establishment of an identity of chaplaincy that retains its integrity without losing its relevance (Greenhalgh 1999). But, chaplains need to be sure and confident of who they are and how they fit in before they can effectively challenge anything.

Catalytic chaplaincy

Chaplaincy is a catalyst which has the potential to transform the way in which we do healthcare within Scotland and beyond. This is an important point. A catalyst changes things not so much by what it *does* as by what it *is*. A catalyst only changes things by being itself. If a catalyst becomes something other than itself it cannot function and there can be no change. That is why the questions surrounding the professional identity of chaplains that I have tried to highlight in this paper are of such importance. Chaplains can transform healthcare practices only if they are certain of who they are and are confident enough to act accordingly. If chaplains are unsure about who and what they are, or unclear about the uniqueness and specific value that they bring to healthcare practices in Scotland, nothing will change and they may well find themselves swallowed up by cheaper alternatives.

Conclusion

My intention within this paper has been to try and raise some critical issues for chaplains as they seek to establish their enduring identity amongst the various healthcare professions. A vital dimension of this process is the necessity for chaplains to be very clear and confident about their identity. Chaplains need to think clearly about what it is that gives them the right to claim a unique place within the healthcare system and to work through the critical tension between professionalism and professionalisation. Chaplaincy holds great relevance for the practice of contemporary health care. As I have tried to point out, it deals with a dimension which is vital for holistic healing, but highly problematic to "prove" in the way that the other healthcare disciplines seek to prove the worth of their practises. However, this relevance could quickly dissipate if chaplains, in their quest for credibility and a professional status simply copy from the other professions and don't reflect on the uniqueness of their own discipline and its relationship to other healthcare professionals. Reductionism is alive and well within the healthcare system and it would be all too easy simply to reduce chaplaincy to within the boundaries of the "acceptable," "credible" disciplines such as psychology or counselling and forget about the uniqueness of the human spirit and the chaplains firm calling to offer care of the spirit. The suggestion that chaplains are catalysts for transformative healthcare practices is crucial. To lose that dimension of the chaplaincy role is to risk losing a vital dimension of the process of healing from the National Health Service in Scotland. I hope that as people pick up on, reject and develop the questions and suggestions that I have made that we can begin to open a dialogue that will take seriously an issue which has vital implications for chaplaincy now and in the future. The stakes are too high for us not to take the time now to reflect on the future.

Acknowledgements

Alison Elliot is the Associate Director of the Centre for Theology and Public Issues at the University of Edinburgh. Mark Cobb is a Senior Chaplain at the Sheffield University Teaching Hospitals NHS Trust.

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STANDARDS AND COMPETENCIES FOR SPIRITUAL CARE AND CHAPLAINCY IN PALLIATIVE CARE

David Mitchell

Abstract: Spiritual care and chaplaincy have come under considerable focus in recent years in Scotland and especially so within the field of Specialist Palliative Care. A combination of National Guidelines, Clinical Standards, Professional Standards, and a Competency Framework have come together to engender considerable discussion and an impetus for developing a framework for spiritual care, religious care and chaplaincy services and practice. The author reflects on the development of the standards and competencies, their format and integration and considers their impact on chaplaincy & spiritual care services in palliative care in Scotland.

Key words: chaplaincy, competencies,palliative care, religious care, spiritual care, standard.,

Introduction

Spiritual care and chaplaincy have been the focus of considerable attention and development in Scotland in recent years. The publication of the Guidelines on Chaplaincy and Spiritual Care in the National Health Service (NHS) in Scotland has engendered considerable debate and planning in all NHSScotland Trusts (NHS HDL 2002 76). They encourage consideration of the breadth of spiritual and religious care in a multicultural society, the depth of experience, professionalism and provision of chaplaincy services, and encourage consideration of the practical resources required to offer a consistent approach to spiritual and religious care. The perceived impact of the guidelines has been widely explored in the Scottish Journal of Healthcare Chaplaincy (SJHC 2003). However, it will not be until 2004 and beyond that we will be able to assess what practical impact the guidelines have had as Trusts seek to implement the plans they are currently preparing in response to the NHS Health Department Letter (2002) 76.

Within the field of Specialist Palliative Care many of the elements of the new NHSScotland Guidelines have been common practice for a considerable time. However, within the specialty, spiritual care and chaplaincy have seen considerable recognition and development with the formation of national standards and competency frameworks for specialist palliative care, chaplaincy, and spiritual care. In this process, hospice chaplains have contributed to the development of three significant documents:

1. **Clinical Standards for Specialist Palliative Care**. These are now mandatory for Hospices and Hospital Specialist Palliative Care Teams and are audited by the independent group NHS Quality Improvement Scotland (CSBS 2002).
2. **Standards for Hospice and Palliative Care Chaplaincy.** These seek to define the role of chaplaincy within the multidisciplinary palliative care setting and have been published by the Association of Hospice and Palliative Care Chaplains (AHPCC 2003).
3. **Competencies for Spiritual and Religious Care.** These are currently in press within Marie Curie Cancer Care, and are likely to be launched in partnership with other palliative care organisations (MCCC 2003 a).

Although each document stands on its own merit and has a particular area of focus, put together they show a consistency of approach that helps elucidate a profession and area of care that is often criticised for a lack of clarity and definition. While readily acknowledging and supporting the belief that spiritual care can be provided by all healthcare profes-

sionals, all three documents enable a greater understanding of the particular gifts of chaplaincy and help define and distinguish the role of all in the proper provision of spiritual care.

Clinical Standards for Specialist Palliative Care

The Clinical Standards for Specialist Palliative Care (CSBS 2002) were launched in June 2002 and are now mandatory for all Specialist Palliative Care Units and Hospital Palliative Care Support Teams in Scotland. The standards were published by the former Clinical Standards Board for Scotland, now incorporated into NHS Quality Improvement Scotland (NHS QIS).

There are eight standards in total, each accompanied by a standard statement, a rational, and a list of criteria. At first reading the inclusion of chaplaincy and spiritual care is not obvious, there being no individual standards for spiritual care or chaplaincy. This, however, reflects the holistic approach to the standards set out in the opening philosophy statement which includes the basic assumption that Specialist Palliative Care is by nature multidisciplinary, and is as a consequence discerning and respectful of religious and cultural needs and traditions. However, on closer reading, chaplaincy and spiritual care are integrated throughout the standards. Examples of this inclusion are seen in the following standards:

Key Elements of Specialist Palliative Care (2a)

This standard defines the range of integrated service components and facilities required of a palliative care unit. Included in the list of facilities that comprise a dedicated environment are:

- quiet/private areas
- chapel/prayer room

Both must be in place for the standard to be met.

Managing People and Resources (3)

The multidisciplinary team is clarified in this standard. A core team is identified with this team having ready access to a number of other professionals. In a Specialist Palliative Care Unit the core team includes seven professions (and its alphabetical listing makes the order interesting):

- chaplain
- doctors
- nurses
- occupational therapist
- pharmacist
- physiotherapist
- social worker

In a Hospital Palliative Care Support Team the core team is doctors and nurses with chaplaincy included in the list of professions to which the core team of doctors and nurses should have ready access. However, the chaplain should have a specialist interest in palliative care and an agreed service level input (dedicated time).

In addition, all Associated Health Professionals (AHPs) should be active members of their profession's specialist interest group (for chaplaincy this is the Association of Hospice and Palliative Care Chaplains), and the professionalism of the AHPs is further supported by the recommendation that all AHPs should have a post graduate qualification in palliative care.

Professional Education (4)

Each unit must provide an evidence based programme of education for professionals addressing the physical, psychological, social and spiritual aspects of palliative care, ethical issues, and communication issues.

Inter-professional Communication (5)

This standard gives further detail on the working of the multidisciplinary team which should meet regularly and review the care of all new and existing patients. All members of the core team (including chaplains) should attend these meetings. It also states the importance of professionals recording their patient and family contact in the patient's records.

Therapeutic Interventions (7)

This standard contains a specific reference to spiritual care and sets a standard for Spiritual Intervention. The criteria of intervention are:

- Evidence exists that patients and those important to them have had the opportunity for their spiritual needs to be assessed and addressed.
- Evidence exists that religious needs have been assessed and addressed
- There is evidence of referral to specialist spiritual support services according to identified need

The specialist here would be the chaplain.

This last standard seems very broad and begs the question as to how such things can be evidenced. It is a question that can and should be asked of any standards. In this case the answers are found in the detailed Self Assessment Tool that accompanies the standards, a tool that forms the basis of the peer review visit by NHS QIS which highlights the strengths and challenges arising from the self-assessment and visit, and decides whether standards are met or not met.

Evidencing the assessment and addressing of spiritual needs is enabled by the following audit question:

> *How do you ensure that patients and those important to them have had the opportunity for their spiritual needs to be assessed and addressed (see examples below)?*
>
> - *exploring the individual's sense of meaning and purpose in life;*
> - *exploring attitudes, beliefs, ideas, values and concerns around life and death issues;*
> - *affirming life and worth by enabling reminiscing about the past;*
> - *exploring the individual's hopes and fears regarding the present and future for themselves and their families/carers;*
> - *exploring the 'WHY' questions in relation to life, death and suffering.*
>
> (CSBS 2002, 7.10.1.)

To be able to answer the audit question chaplains need to record their *therapeutic interventions* in the patient information systems (notes and/or electronic records) and by doing so they also contribute to standard 5 on inter-professional communication, an example of the integration within standards.

The impact of the Standards

Although the first round of visits by NHS QIS was completed in August 2003 with the public reports due early in 2004, there is already anecdotal evidence that the standards are having a profound influence on practice, with specialist palliative care units (hospices) and hospital support teams embracing the spirit of the standards and striving to meet them.

Hospice chaplains report that where no chapel/prayer room was available plans are now in place to create them, and the multi-faith nature of their use is being embraced. Within palliative care units chaplains are included in the core multidisciplinary team and attend regular multidisciplinary team meetings. They also record their interventions in the patient records and in this the standards have proven to be a useful tool in expressing their interventions. Chaplains are not trained in note-writing and the issue of confidentiality has long been a struggle.

Although the standards will inevitably be revised following the completion of the first round of peer review visits, it is clear they have been embraced. Their integrated format is welcomed and understood and has the potential to be a positive influence on the provision of Specialist Palliative Care Services which includes spiritual care, religious care, and chaplaincy.

Standards for Hospice and Palliative Care Chaplaincy

Where the clinical standards for specialist palliative care set standards within this specialist area of healthcare, the Association of Hospice and Palliative Care Chaplains Standards for Hospice and Palliative Care Chaplaincy seek to take the next step of setting standards within the profession of hospice and palliative care chaplaincy (AHPCC 2003).

It is no accident that the standards follow the format of the CSBS clinical standards. Given that the clinical standards are mandatory in Scotland, it was common sense to follow a format that works and to include the relevant clinical standards within these professional standards. This enables chaplains working in Scotland to have both consistency and continuity within their clinical and professional standards, and offers an example of good practice that can be shared in the United Kingdom as a whole.

There are seven standards identifying the core elements of a chaplaincy service. While the introduction supports the view that all healthcare professionals can provide spiritual care the standards give a description of the specialist expertise that defines chaplaincy.

Access to Chaplaincy Services (1)

The first standard seeks to evidence the information available to patients and their families/carers about local chaplaincy services and how they can be contacted. It also states that there should be a written protocol for referral to chaplaincy services: The actual system may be a verbal one, but it is necessary that the process (protocol) should be written down.

Spiritual & Religious Care (2)

In this standard the wording of the CSBS standards in is reflected with regard to spiritual needs and assessment. However, an addition here is the inclusion of the element of protection for patients from unwanted visits from spiritual or religious groups or representatives. The standard supports the position that the patient has the right to see their relevant spiritual or religious representative and also has the right to decline a visit. All referrals to other agencies should be with the patient's consent. The standard also draws on the clear definition of spiritual care and religious care as it appears in the NHS Scotland Guidelines (NHS HDL 2002):

Religious Care is given in the context of the shared beliefs, values, liturgies and lifestyle of a faith community.

Spiritual Care is usually given in a one to one relationship and is completely person centred and makes no assumptions about personal conviction or life orientation. Spiritual Care is not necessarily religious. Religious Care, at its best, should always be spiritual.

Multidisciplinary Teamworking (3)

The criteria section of this standard sets out the essentials of multidisciplinary team working including: attending and contributing to team meetings, responding to referrals and referring on to other team members, and the recording of relevant information in patient information systems (notes and /or electronic). There is at present considerable debate in the NHS, in England & Wales in particular, around data protection and the whether or not chaplains should have access to patient records. These standards adopt a common sense approach, they assume that if chaplains are recognised members of the care team and contribute to team meetings there is no issue over access to patient records, indeed not to have access would leave chaplains unable to meet these professional standards and the clinical standards. This view is supported by hospices e.g. Marie Curie Cancer Care is producing a patient information leaflet for use in their hospices. The leaflet makes clear that spiritual care is part of the holistic approach of palliative care and that chaplains are members of the core multidisciplinary team and all members of the team have access to patient notes (MCCC 2003 b).

Staff Support (4)

Following on from teamwork the importance of good working relationships is stressed. The confidentiality of the chaplaincy relationship with staff and volunteers is developed with chaplaincy offering personal and professional, spiritual and religious support to all staff and volunteers and the multidisciplinary team in particular.

Education & Training (5)

This standard addresses the need to raise awareness among other healthcare professionals about the provision of spiritual and religious care through staff induction, in-service training and a programme of education for all healthcare professionals. It stresses that the chaplain's remit is not only to provide the specialist input to spiritual care but also to encourage others to develop their skills in a holistic approach to care.

Resources (6)

Here the resources required for chaplaincy to function are described are drawn together including the elements contained in the clinical standards: e.g. access to a chapel/prayer room, quite private areas, patient records, sufficient hours. It also introduces personnel issues such as regular appraisal, professional development, and external professional supervision.

Taking into account the need for a multi-faith approach to spiritual care and chaplaincy, the criteria for chaplaincy appointments is not faith or ordination specific e.g. Minister, Rabbi, Imam etc. Rather the focus is on the individual with the criteria being membership of the Association of Hospice and Palliative Care Chaplains and holding a recognised status within a mainstream faith community.

Chaplaincy to the Unit (7)

The wider aspects of chaplaincy are addressed in this standard including responding to the unexpected and unusual events that impact of staff in particular

but may include patients and their family/carers. E.g. the illness or death of a colleague or a national disaster, anniversary or world event. There is a recognition that in such times there is a need for someone with experience to organise an event that reflects people's feelings and, as a result, seeks to bring meaning and meet their needs

A baseline for chaplaincy.

The standards were warmly embraced at their launch with many chaplains acknowledging they were under pressure locally to develop chaplaincy and spiritual care standards. The publication of professional standards complete with a Self Assessment Tool not only enables palliative care chaplains to be fully engaged with the world of healthcare standards, but they also provide a way of auditing their service and identifying the resources currently being used and those required to move forward to achieve the standards. The Association of Hospice and Palliative Care Chaplains has distributed the standards through Help the Hospices to all its members and all palliative care units in the UK. There is for the first time the potential for a UK wide baseline audit for chaplaincy services in hospices and palliative care.

Although these standards are particular to the specialty of hospice and palliative care chaplaincy, they have the potential to be used as a basis for developing broader healthcare standards for chaplaincy services in other areas of healthcare.

Spiritual & Religious Care Competencies for Specialist Palliative Care

While standards can be used to audit clinical provision and services when it comes to individuals and their professional practice, *competence* is the current healthcare model. Competence levels offer a framework to enable individuals to enhance their skills and to develop professionally. They also provides a tool for those responsible for administering and encouraging their local Personal Performance Review and Development process. Marie Curie Cancer Care has taken forward the work of competence in spiritual and religious care with the development of Spiritual & Religious Care Competencies for Specialist Palliative Care.

The Competencies were prepared by a multi-professional group, and, from the beginning, acknowledge the difficulties of definition and language within Spiritual care in particular. They also acknowledge the difficulty of evidencing an area of care where *awareness* of skill can clearly be evident though hard to measure. The Competencies follow the familiar three column format headed Knowledge, Skills and Actions. There are four levels of competence relating to different aspects of patient & family/carer contact:

Level 1. All staff and volunteers who have casual contact with patients and their families
Level 2. Staff and volunteers whose duties require contact with patients/families
Level 3. Staff and volunteers who are members of the multi-professional team
Level 4. Staff and volunteers whose primary responsibility is for the spiritual and religious care of patients, visitors and staff

The competence each member of staff and volunteer should be able to demonstrate is set out at each level and includes:

- an appropriate understanding of the concept of spirituality at that level,
- an awareness of their own personal spirituality,
- recognition of personal limitations,
- when to refer on,
- documenting perceived, needs, referral and intervention.

Levels 1 to 3 encourage an increasing level of competence through awareness and practice with a protocol for referring on to the professional with expertise in spiritual care: the chaplain. Level 4 gives a competency framework for the chaplain or director of spiritual care which includes: how referrals are responded to and recorded, the depth of intervention, and knowledge of other external spiritual and religious resources. The *actions* column for level 4 also includes acting as a resource for staff support, education and training, and influencing the development of national initiatives. At first reading level 4 seems very detailed and daunting. However, it needs to be borne in mind that competencies should be challenging if they are to encourage the development of personal skills, and, as with standards, they are designed to be aspirational but achievable.

The weakness in the competence framework is measurement. However, the competencies come

with suggestions for audit at each level. There are two key elements for audit with a third at Level 4:

- Reviewing documentation
- Personal Performance Review and Development process (PPRD).
- Review of training and education delivered (Level 4)

Documentation can be used to show referrals are being made and give some measurement of skill. PPRD can be used to discuss competence and identify training needs. The review of training and education is by evidencing evaluation of education and training sessions and showing how evaluation has been used to improve future sessions.

At present Marie Curie Cancer Care is preparing the competencies' document for publication. However, once published its impact within the charity will be profound. There will be a requirement for all staff to meet or be working towards achieving competence in spiritual and religious care. This provision of spiritual care has long been recognised by other healthcare professions, nursing in particular, as an integral part of the caring role. Not only is that provision acknowledged by the development of competencies in Specialist Palliative Care, there is the potential for it to be clarified and evidenced, and for the natural skills of all healthcare professionals to be enhanced and developed.

Conclusion

These three documents have the potential to have a profound impact on the provision of spiritual and religious care in hospices and palliative care teams. The order of publication provides a striking continuity and process to encompass all aspects of spiritual care, including service provision, integration into the care setting, service definition, and individual competence. The *national standards* set service levels and audit process for units; *professional standards* focus on the professional service responsible for the provision of spiritual and religious care; and the *competencies* support and enhance the breadth of spiritual care offered by individual healthcare professionals at all levels, and the expertise of chaplaincy in particular.

A considerable advantage in the ordering of the process has been the integration of the different documents. There is a continuity of format, and the inclusion of self assessment audit tools makes evaluation and comparison achievable. Although the documents readily acknowledge the difficulty of definition and measurability of spiritual care, they offer tools and pointers to allow the process in which audit can at least begin and develop. As the standards and competencies are introduced locally and the process of audit begins, ways will be found to plug the acknowledged gaps in evidencing care and, as a result, there is the potential for a measurable improvement in service provision and care.

There is a danger with the two standards documents in particular there of chaplains becoming disheartened by the fact that they are not able to achieve all the standards at present. Although they set at a level that *should* be achievable, they are by nature aspirational and designed to develop care,. The greatest challenge will be that the standards will raise resource questions, most especially in terms of facilities and time. However, they are also the best argument in support of resources: all healthcare providers should be committed towards achieving standards in care and practice, and that includes chaplaincy and spiritual care.

There is no doubt spiritual care has seen a remarkable development in Scotland since the turn of the millennium. Although growing, the field of specialist palliative care is still comparatively small, and its holistic and multidisciplinary focus positively encourages openness and trust. There is considerable advantage to Scotland having its own Health Department. The country is small enough to allow people to think creatively, to know each other personally, and to encourage working together across traditional boundaries and barriers.

The first three years of the millennium have seem remarkable developments in spiritual care and chaplaincy. As the NHS Guidelines move on to "plans for implementation", as the CSBS and AHPCC standards influence practice and change, and as the competencies engender a broader understanding of spiritual care and how it is practiced by all healthcare professionals and chaplains in particular, there is a real sense of excitement that will carry us into the next few years: How will it all develop?

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CHAPLAINS PERCEPTIONS OF SUPERVISION

Andrew Moore, Chris Levison

Abstract: Several professional groups have effectively incorporated supervision into their everyday practice. Chaplains as a 'caring' profession cannot be immune from the personal effects of engaging in pastoral relationships with patients, carers and staff. Clearly, Chaplains require adequate support to prevent 'burnout' and stress. This paper explores Chaplains perceptions of supervision using a focus group methodology. The emerging themes from the findings provide a valuable insight into the perceptions and attitudes of chaplains towards the concept of supervision. In particular, Chaplains view supervision as a necessary part of their professional practice.

Key Words: chaplains, supervision, focus group

Background

Supervision has been defined as *an intensive, interpersonally focused, one–to-one relationship in which one person is designated to facilitate the therapeutic competence in another person* (Loganbill et al 1982). Proctor (1988) describes the multiple interactive functions of supervision as *formative, restorative and normative*. This clearly emphasises that effective supervision should demonstrate supportive, educative and managerial elements, which ultimately is to the benefit of the patient or client.

Several professional groups have effectively incorporated supervision into their every day practice (Hawkins and Shohet, 2000). Professions such as nursing, social work, counselling and psychotherapy have used different models of supervision, each of which have emphasised a different primary focus. For example, within social work, supervision has been viewed as being managerial in nature (Brashears, 1995).

Supervision has clear benefits. For instance, within nursing, clinical supervision, if implemented effectively, will bring positive benefits such as reduction in stress levels (Butterworth et al, 1997), increased skills and knowledge (Butcher, 1995) and even a reduction in complaints (Butterworth et al, 1997). However, Wosley and Leach (1997) offer words of caution arguing that clinical supervision has yet to demonstrate its efficacy in improving outcomes for patients.

Supervision and Healthcare Chaplaincy

Chaplains cannot be immune from the personal effects of pastoral relationships with patients, carers and staff. Engaging with people in depth on a daily basis, offering support and 'being there' for them will inevitably take its toll on the chaplain. The Chaplain has a unique calling for where the 'pain' is greatest. As Speck (1988) emphasises 'they (chaplains) may be unaware of the extent to which serving others can be a way of meeting unconscious needs of their own, which in turn can lead them to be quite hard on themselves as well as being troubled about whether the have done enough'. Without adequate support, the Chaplain's family life and social interests outside of work may suffer (Eadie, 1975).

Chaplains as *helping* professionals require support and supervision to reduce stress levels and prevent *burnout* (Hawkins and Shohet, 2000; Orchard, 2000). In many cases Chaplains have few opportunities for accessing informal support as many work part-time, alone or in small teams (Speck, 1988).

Study

Aim

The study aimed to explore chaplain's perceptions of supervision and specifically to examine what is meant by supervision and its effect on chaplaincy practice.

Methodology

As the aim of this explorative study was to elicit the opinions of Chaplains regarding supervision, a qualitative approach using a focus group interview was chosen.

Focus groups have their origins in sociology, but much of the knowledge comes from the field of market research (Morgan, 1988; Krueger, 1994). This interview technique was developed because decisions made by individuals take place within a social context, and these decisions often grow out of discussion with other individuals (Patton, 1990). The increased acceptability of qualitative research methods has generated interest in the use of focus groups (Morgan, 1988; Patton 1990; Robinson, 1999).

Krueger (1994) states that focus groups are valid if used appropriately, following established procedures. Typically focus groups have high face validity because of the credibility of comments from the participants who open up and share insights with each other.

Sampling

Purposive sampling was undertaken with participants drawn from across Chaplaincy in Scotland representing a broad range of experience. Ten Chaplains agreed to participate and were drawn from the acute, primary care and hospice sectors. The Church of Scotland, Scottish Episcopal and Roman Catholic denominations were represented. Nine of the participants were full time chaplains, with one employed on a part- time basis.

Data Collection

Participants were told the purpose of the study and were informed that the focus group was being audio taped. It was emphasised that participants were free to withdraw from the study or have the tape stopped at any point. The focus group was moderated by one of the investigators.

As suggested by Kreugar (1988), the interview questions were constructed according to the following categories: opening, introductory, transition, key, and ending. The schedule of questions is outlined in Appendix 1.

Data Analysis

All audio taped focus group data were transcribed verbatim. Analysis followed the recommendations of Kruegar (1994) beginning with open coding of the data that, after some refinement, resulted in major categories, or themes. The two investigators independently coded each transcript, using a line-by-line approach. These results were jointly reviewed and refined until consensus was reached regarding major themes.

Credibility, Transferability and Limitations

The researcher included participants in the data analysis process to assist with the objective validation of themes identified from the data gained from the focus group (Lincoln and Guba 1985). Field notes also assisted in adding some credibility to the data from focus group (Taylor 2001). These combined processes will assist in ensuring credibility of the research findings.

The nature of the purposive chosen sample will limit the transferability of the findings to the Chaplains chosen for the research only. But clearly the study method has been deliberately chosen to explore a phenomenon that has not been extensively researched. For this reason credibility of rich and meaningful research findings are more important than transferability. As only one focus group was facilitated data saturation will not have been reached, and therefore not all the perceptions, beliefs or values of the study population explored.

Findings

Main themes and sub-themes identified within the transcript from the focus group (in no order of frequency of occurrence or priority)

Theme 1 Defining supervision

Participants indicated that the word 'supervision' could be interpreted in numerous ways. There is evidently more than one type of supervision, which can take place on various levels. It may be under-

taken on an individual basis or as part of a group. Supervision is clearly a dynamic process that is both re-active and proactive in nature.

Participants felt that supervision is an important tool for supporting Chaplains to reflect on their professional practice in perhaps a relatively informal manner or setting. However, supervision may also have a management and professional function that can be used to assess practice in a more formal way. Participants were less in favour of the latter as an approach:
It is about best practice and improving what we are doing. It includes management or support that hopefully helps chaplains not to get to the point of burnout. We should have a clearer understanding of what we are doing, be able to see where we are going because we are reflecting on what we are doing.

Theme 2 The role and development of Chaplaincy within the healthcare system

Participants stressed the importance and need for a clear and unambiguous definition of the role of Chaplain and the qualities that someone from a recognised faith community can bring to the role. This is a time of uncertainty and transition for Chaplains and the respondents expressed a need for other healthcare professionals and indeed Chaplains themselves to clearly understand their role within today's healthcare system:
Can we say you need to be drawing your chaplains from a religious vocational background because they can offer this, and that, including to the non-religious people rather than just saying, well its all because up until now a pool of pastorally trained people have only been available from religious bodies. The philosophy of why it should be us in the future is not clear at the moment.

The participants agreed that there might be some advantages to the professionalisation of Healthcare Chaplaincy. These included increased credibility and promotion of integration with other professionals within the healthcare environment. Participants felt strongly that as other health care professionals have systems of regulation and registration that Chaplaincy may benefit from a similar system.

Participants also stated that some role conflict exists between their responsibilities to their own faith community and to the employing Trust. Lines of accountability are cloudy and confused. The current systems of appointing part-time and whole time Chaplains from different faith communities and methods of evaluation were of concern to some participants.
Chaplains, because of this dual responsibility business are a bit like people who have feet in 2 boats which maybe moving apart.

If supervision has the effect of helping chaplains to come to *a clearer understanding of what we are doing*, and *to see where we are going because we are reflecting on what we are doing* then it may well be the case that at a time of rapid change within chaplaincy, when issues such as the above are the focus of debate, supervision is a development whose time has come. Through supervision, chaplains would hope to be both affirmed and challenged, as well as supported amid all the current uncertainties. They would also be encouraged in the discipline of reflection upon practice, which will become more than ever necessary as the chaplaincy service develops.

Theme 3 The effect of supervision on Chaplaincy practice

All participants reinforced the stressful and challenging nature of their role and viewed supervision as a positive step for Chaplaincy. It was also felt that supervision could be a useful method of reflecting on practice within a safe and secure environment. Other positive benefits stated by participants included allowing difficult issues to be raised, practice to be challenged, regular support to be provided and ultimately improved standards of practice:
Things that started out as problems can become quite liberating insights.

Participants stated that other healthcare professionals would view Chaplaincy more favourably if supervision were introduced. Clearly, supervision is a process of professional practice and this would assist in integrating Chaplaincy within the multidisciplinary team:
To been seen as a co profession amongst the professionals we have to have supervision.

Also on the positive side, supervision was identified as a way of helping chaplains to achieve 'closure', in other words, to be able to 'let go' of the many people and situations which they encounter in the hospital, the sometimes fleeting but nevertheless meaningful pastoral encounters which can threaten

at times to overwhelm, if they are not laid aside as the chaplain moves on. As one participant put it: *you don't want to be carrying around too many ghosts.*

Some concerns were however raised by participants regarding supervision. While supervision can be used as a method of monitoring standards of practice, respondents strongly stated that separate systems for management on the one hand, and support on the other, would be of more benefit to Chaplains. Supervision should not be understood as a formal means by which management could identify bad practice, but rather as a means of support through which chaplains would have *the freedom to discuss their practice in an open way*. Some anxieties were also voiced regarding the maintenance of confidentiality within supervision.

Theme 4 The provision of supervision

Participants stated that considerable resources are required to implement and support a system of supervision. Supervision was viewed as intrinsic to the professional service offered by Chaplains and therefore employing bodies have an obligation to adequately resource this support. One or two participants stated that supervision should be compulsory:
There needs to be agreement between the church and the NHS. Once supervision is deemed to be necessary, it will need to be funded by the NHS.

Several participants wished supervision to be externally provided, however they realised that the funding of supervision may only happen if it is work place based and professional in nature. Participants intimated that resources would only be available if clear evidence of the effectiveness of supervision could be provided:
We need to have some sort of research or evidence that chaplaincy is not only doing a good job but if you train them properly chaplains will do a better job.

Other barriers preventing supervision raised by respondents included current workloads being too great, replacement or travel costs for attending supervision sessions, who should be the supervisor (internal versus external) and a real concern that the funding of supervision may decrease service provision.

Participants clearly felt that while the profile of Chaplaincy is raised every opportunity should be taken to promote the provision of supervision as integral to the practice of Chaplains. Participants also feel that long term planning is required:
We have no training budget at the moment and many hospitals don't. Long term planning will be needed to build in supervision – 2 or 3 years down the line.

Conclusion

This study highlights that Chaplains view supervision as a necessary part of their professional practice. Yet, no formal infrastructure has been established by the employers, resulting in Chaplains having to search for their own supervision, whether formally or informally. Many Chaplains receive no supervision at all. These findings reflect those reported by Orchard (2000) and demonstrate that the provision of supervision is an emerging employment issue that has considerable resource implications.

Chaplains wish supervision to contain supportive and educative elements. However, they realise that a managerial component is necessary, especially if Chaplaincy is to be perceived as a healthcare profession. As part of the continued professional development process, a number of supervision methodologies could be used to support Chaplains and these may include clinical pastoral education and reflective theological learning.

Chaplains openly wish improved clarification of their role as a valued profession within the healthcare team. The provision of a robust system of supervision will be integral to a more formal professional approach to Chaplaincy practice. The lack of published literature emphasises the need for further research to demonstrate the positive impact that supervision has on chaplaincy practice. It is hoped that this study will prompt further investigation and debate.

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CONFERENCE REPORT - 'CHAPLAINCY FOR TOMORROW'

Georgina Nelson

Introduction

Between March 25th and 27th of this year, just over eighty participants gathered at Crieff, having been invited to attend the above conference. 'Chaplaincy for Tomorrow' was the fruit of long planning and preparation on the part of the Church of Scotland's Board of National Mission, and in his opening address, convener Rev. Jim Gibson expressed the hope that it would prove to be 'a school for listening and learning together'. Its stated aims were, to provide an opportunity for those involved in every aspect of chaplaincy to meet together; to address issues concerning chaplaincy; to assist the church to address the opportunities and challenges of chaplaincy in the 21st century; to explore ways in which chaplains might be better supported in their frontier task.

The phrase 'frontier task' has a vaguely heroic ring to it. I hadn't thought of my daily journey to St. John's hospital as an expedition to the frontier. To me, it is home; a familiar place where I find a good measure of welcome and acceptance. But, light heartedness aside, 'frontier task' is an interesting way for a board of the church to describe chaplaincy. Working at the frontier implies distance from the centre, from the place where committees consult and policy is devised. Frontier work suggests innovation, difference, creativity, constant engagement with what is new and challenging; negatively, it may also carry with it the sense of apartness, the threat of isolation, the blurring of role and purpose – and, to quote a phrase which cropped up at the conference- the danger of 'going native'. Echoes of all these things could be heard in the discussions at Crieff, as frontiersmen and women, and representatives of 'the centre' (if 121 George Street can be so described, in all Christian love), listened to each other and, hopefully, learned together.

Themes in common

Preparation began before we arrived at Crieff. In order to prepare the ground for the meeting of chaplains from diverse fields, participants were sent a series of brief and illuminating papers summarizing the philosophy and work of chaplains in healthcare, prison, university, the armed forces, the police force, school and industry. I came to the conference with a sense of at least some of the differences that exist; for example, chaplaincy to the armed forces is perhaps the most structured, the most closely defined in terms of its role, while chaplaincy within the workplace is much more in a position to carve out its own niche and discover its own relevance to the particular setting; healthcare chaplaincy is long established and generally accepted, if not always entirely understood, while chaplaincy within the police force is at a much earlier stage in its development., and in the eyes of some, still in the process of proving its worth.

And yet, many themes, it seemed to me, were held in common, and this sense was reinforced in the course of the conference itself, as speakers from various branches of chaplaincy gave us their insights, and representatives from the areas in which we serve, notably Hector Mackenzie, head of patient focus and quality at SEHD, Sir John Arbuthnott, Chairman of Greater Glasgow NHS board, Professor Bernard King, Principal of Abertay University, and Colin Mitchell, head teacher of Dumfries High School, told of their expectations of and valuing of chaplains. Themes in common include: the building of relationships in whatever setting in which the chaplain works; affirmation of the worth of the individual; contributing to the life and ethos of a community; symbolizing, helping promote, instilling certain values, alongside colleagues of other disciplines; being available to all, regardless of rank, status or standing; modelling teamwork, ecumenical and multi-faith relations; being 'a safe space'; having a concern for justice; and not least, accompanying others on a journey, whether it be the prison chaplain who offers accompaniment ' to those prepared to make the painful journey away from that which is false towards that which is true', or the forces chaplain who accompanies servicemen and

women in their emotional and physical preparations for war, or indeed the hospital chaplain who accompanies the patient on his journey through that strange and sometimes terrifying terrain of illness and hospitalisation. In our various settings, part of the chaplain's task is connected with 'promoting operational effectiveness', and yet the paper produced on behalf of the Royal Air force Chaplains' Branch surely speaks for all when it explains that 'the guiding principles of the Pastoral and Spiritual Care Policy are to be most clearly seen in the outworking of the kingdom of God'

Exploring Issues

As is usual in a successful conference, much of the work of exploring of issues went on in the course of lively and animated discussions outwith the formal sessions. Within the conference proper, one plenary session and a session of group discussion was devoted to an analysis of a questionnaire which participants had filled in beforehand. This questionnaire was described as a 'snapshot' piece of research, and invited us to identify among other things key issues, problems and frustrations in our chaplaincy, our views on supervision, training and career structure, our suggestions as to how the church might best affirm and support chaplains, and our vision for the future. Results were analysed and presented to us by Dr. Iain Barclay. I was interested in the sense that emerged that many working in chaplaincy feel a kind of liberty and release from the structures and expectations of the institutional church and its parish ministry, as we work alongside those of many faiths or none. There is a perception of lack of understanding and support from a church which still views parish ministry as the norm and the gold standard, as it were.(Dr Barclay posed the question as to how the board of ministry would react to someone with a definite call *not* to the parish but to chaplaincy.) Interesting too is the demand among chaplains for training in management, perhaps more especially training in managing change.

For healthcare chaplains, much hope for the future is invested in change arising from the publication of the NHS Guidelines, and a vision emerges of a chaplaincy service which is ecumenical, person centred, professional, and staffed, trained and funded adequately. Issues highlighted include on call commitment, whether we should be employed by Trust or by the Church, and how we are to develop as a profession.

Responding to Issues: points for action

The final morning of the conference was devoted to further exploration and response. This was led by conference reporters Dr Alison Elliot and Sir Neil Mackintosh, who gave us their overall impressions of all that they had heard, and distilled its essence into several 'points for action'. Dr Elliot commented that the Board had 'loitered creatively' as it were, but that 'loitering has to become leadership, as the church articulates where it is going.'

The points for action are six in number, and I reproduce them below. To each of them representatives of the board made preliminary response at the time, and pledged to pursue them in further discussion and consultation.

- That the board should reflect upon this conference and look for ways of building upon the connections made here.
- That the board should address inconsistencies in the treatment of Chaplains and other ministers
- That the board should facilitate close working and joint development of all varieties of Ministry within the Church
- That the Church should ensure that Chaplains are equipped to do a professional job
- That the Board should undertake developmental word to assess training needs and how they can best be addressed
- That Chaplains should have the opportunity and encouragement to make available to others, in the Church and in the community, the skills and insights they develop in their work.

Highlights and Memories

The above makes no pretence to being an exhaustive report of what was a stimulating but intense conference. Other highlights included the opportunity given to participants to visit areas of chaplaincy outwith our own; venues included RAF Leuchars, Polmont Young Offenders Institution, Ninewells hospital, Lintrathen water treatment Plant and Dundee City Council. John Swinton provided us with some challenging thoughts on the identity and pro-

fessionalism of chaplains. Ivan Middleton, who may have felt, if he will excuse the biblical allusion, a little like a lion in a den of Daniels, gave us a valuable humanist perspective on the proceedings. Gilleasbuig Macmillan led our worship inspiringly, and left us with the humbling but strangely comforting thought that perhaps our identity consists more in how we are perceived than in how we perceive ourselves. David Wilkes, Deputy Chaplain General to the army, related to us Studdart Kennedy's advice to Theodore Baillie Hardy, i.e. 'Work in the frontline, and they will listen to you' and 'take fags in your rucksack' (adherence to the latter would increase the cred of the healthcare chaplain no end in some quarters, but in others a dim view might be taken – but the point is still well made!). We sang the 23rd psalm unaccompanied, to the tune 'Stracathro'. Bill Speirs sang to *us* (not a psalm, I hasten to add, but ' The Scottish Breakaway') And, for those struggling at this very moment with the ramifications of HDL(2002)76, Sir John Arbuthnott explained to us that in some quarters HDL is said to stand for Hell, Damnation and Lamentation. What more can life hold?

The Board of National Mission intends to produce its own report for participants, to which I refer any who would like a fuller overview.

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Note:
Dr. Alison Elliot is preparing a conference report which will be circulated to all participants.

Dr. Elliot has also been engaged in producing a booklet called, provisionally, 'Frontier Spirit'. This is to be published by Scottish Christian press, and hopefully will be ready in time to be launched at the forthcoming conference 'A Seamless Transition' organised by the Scottish Executive. The latter will be held on November 26th, at the Inchyra Hotel. Polmont.

Readers might also be interested to see the chapter entitled 'On Other People's Territory : Chaplaincy', which she contributed to 'Inside Verdict' edited by Steve Mallon, Scottish Christian press, 2003.

HOLY PLOT OR COMMON GROUND?

A HUMANIST REFLECTS

Ivan Middleton

Abstract: Writing from a humanist perspective, the author argues that the right of the patient to receive spiritual care from someone who shares the same philosophy of life must be respected. The 'religious' chaplain should no longer be expected to act as 'jack of all trades'. The task of the chaplaincy is not to bring people to God, but to help them find comfort or meaning. The author welcomes the fact that the NHS HDL (2002)76 Guidelines suggest no bar to humanists undergoing training as hospital chaplains.

Key Words: humanist; chaplaincy; spirituality; spiritual care.

A little while ago I was invited to join a group of Chaplains, former Chaplains and faith representatives to review existing guidance and to produce new guidance on the Chaplaincy service. As a Humanist I was immediately confronted by two fairly significant problems.

Firstly I did not care for the term "Spirituality" and secondly I did not think that the term "Chaplaincy" did justice to the service on offer. To my surprise others on the group held similar views, if not for entirely similar reasons. Was this some form of "holy plot?"

Well, they were all sympathetic and I think everyone agreed that neither of these words really conveyed what they should. However, none of us, in the end, could come up with any better alternatives.

My conclusion was that "spirituality" is to me the feeling of awe and wonder when, in the presence of beauty, in the countryside, great painting or art, music, poetry or prose; when face to face with death or birth.

I had been invited in my capacity as Secretary of the Humanist Society of Scotland, not really a post likely to make one an expert in Chaplaincy services. A career in Social Work, during which I had been responsible, for a few years, for hospital based Social Work services in Edinburgh and the Lothians, gave me some inkling. My other credentials included talking with nursing staff in the Edinburgh Sick Kids about working with children who were dying, and their parents. I have also contributed to workshops on bereavement run for staff at the Simpson's Maternity Hospital in Edinburgh. Lastly I have become in the last 5 years, an experienced Celebrant for the Humanist Society of Scotland, having performed 19 Namings over 100 Funerals and 78 weddings. (I appreciate that a conscientious and energetic Church of Scotland Minister would probably manage to do this, and more, during Assembly Week!).

Another perspective was provided when, as a young man (and a Humanist), I needed to enter hospital in my native Northern Ireland. Everything was fine until we came to the question of my religion. Naively I suggested that "none" had a nice ring to it. In response two fairly large ward sisters folded their arms aggressively and told me this would not do. I began to understand what victims of the Spanish Inquisition must have felt like in the first few minutes of their ordeal. Fortunately my grilling did not develop into a "roasting"! When, with temerity, I asked what lay behind this question I was told that it was in order to identify which chaplain should visit me "if things went wrong." Despite the implied threat in this statement, I stuck to my guns, stating that an "Ulster Protestant" Chaplain in such circumstances would be the last person I would want to see.

This experience gave me insight into just how vulnerable people feel when delivering their body into the hands of the medical and nursing professions. In extremis, a Humanist, like a Christian or Muslim, would want to discuss his fears with someone whom he trusts and feels he shares a common life stance with.

I am aware that the majority of staff and patients do not have anything which could even loosely be described as a "live religious connection." Those who do have that connection will be pleased to receive the attention of an overtly religious Chaplain. He or she can either minister to their needs directly or act as a conduit to obtain the services of an appropriate religious leader.

The opposite seems to be the case for those without a faith. They are unlikely to want contact with someone who perhaps, even evangelically, believes something, which they do not. Patients are likely to be feeling at their most vulnerable and need some evidence to assuage their fears that they may not receive objective advice and counselling. It cannot be tenable to offer a service to "believers" only.

I became very aware of how much the Chaplaincy movement owes the Church of Scotland (CofS). However, I think the time has come to make available practitioners of whatever stance the member of staff or patient identifies. We need to move on from the model of the Church of Scotland Minister trying to be seen as a "Jack of all Trades," whilst patently being seen by most others as merely the servant of one Master.

As we all know, the majority of the populace have no live connection with any faith group. It will often be that it is only when faced with their own or another's death that they will feel moved to make a choice. Humanists, over the last few years have been improving the ceremonies which they can offer to non-believers. Earlier the Unitarians and individual liberal clerics were left to cater to this need. Following a training event completed in April 2001 added another 14 successful trainees to our register, also giving much better geographical coverage. We now have over 30 active celebrants throughout Scotland. We began to keep accurate figures in 1998. In 1998 we conducted 3 Naming ceremonies, in 2002 that had risen to 38. Weddings increased from 20 to 110 and Funerals from 142 to 729. The trend is still upwards and will be enhanced with the availability of more celebrants. It is interesting to note that literally anyone can conduct a funeral ceremony.

Apparently many chaplains and religious leaders have acted as "Humanists", for instance in performing non-religious funerals and weddings. I think the compromises thus demanded of them and the recipients of their services would be better avoided by calling upon Humanists to help. Historically there was, I appreciate, little alternative. Now though there are over 30 trained and registered Humanist Celebrants throughout Scotland. Under no circumstances would any of us do a "pretend" Christian ceremony.

However, to our chagrin we are not able to provide a legally recognised marriage. This is still the case despite our Petition to the Scottish Parliament. We do carry out training, keep a register and have a complaints system. The couples who have sought us out are almost always sincere and thoughtful people. Society should surely be glad that couples want to make a commitment to each other in front of their families and friends. However, instead society tells them that, unlike those with a professed religion, they will need to have not one ceremony, but two. We have argued that this is discrimination under the European Human Rights legislation. So far to no avail.

Returning to Chaplaincy we have to ask how many of these Humanist volunteer celebrants would be able or willing to tend to those wishing to avail themselves of Humanist solace? The answer to that question is unknown. Just as the answer to how the Churches will respond to the dramatic decrease in their ordained religious leaders over the next 5 to 10 years is unclear.

What exactly is Chaplaincy? Everyone agreed with what it is not. It is not "social work," as we know it, neither is it Counselling. Undoubtedly it contains elements of both. I was surprised to learn that the sacramental aspects of the job have long been recognised as a justifiable call upon the taxpayer. This possibly owes more to the 19th than to the 21st century. It cannot be tenable to continue to offer a service to believers but ignore the others.

I was brought face to face with the issue of a Humanist approach to the death and dying of children

when I was invited to discuss my approach with the nurses of the Sick Kids in Edinburgh. The unnatural nightmare of children dying is faced everyday by these nurses. At the time I reflected: *This is not a time for proselytising, but a time for supporting children and parents by helping them to identify and then build upon any beliefs they may have. I think it is crucial to respect the views and beliefs of children and their parents, if they have made a clear choice.*

The Guidance has now been issued and I am pleased that it is means that applications can be made by Humanists, as Training in Chaplaincy will be the main essential, as opposed to the holding of a belief in a recognised religious faith. The tasks of worship and other religious rituals can be performed by the religious leader of a patient's own choice.

As a follow up I was invited to attend and participate in a Conference entitled "Chaplaincy for Tomorrow." Throughout the meetings of this Chaplaincy Group I have learned a great deal about the dedication and the open-mindedness of many Chaplains. I trust we can all move forward and offer support to patients and their families, as well as staff.

I was asked to address the conference. Positively I have been pleased that several Chaplains have approached us for Humanist information and brochures for their hospital's Sanctuary. Two of the Humanist Funerals I have conducted were held in Churches (both CofS). The clergy and lay staff involved were very helpful and had responded to the requests of the families involved.

Negatively I have twice found Families requests turned down, both again CofS. The more concerning of these was in the case of an infant who had died in the most distressing of circumstances. His parents wished a burial. The nearest large enough building was an adjacent church. However, this was refused after the minister consulted his "Elders". We had that ceremony in a hall in the Botanic Gardens where that little baby had played. Some of the mourners did say to me that with an attitude like that it was little wonder that Churches were emptying. Perhaps consistency is too much to hope for but I would ask the Church to decide whether or not their buildings are to be made available to their "Communities" in time of need.

I also commented on the vocabulary often used. Patronising and negative phrases are used, people with *no faith, non-believers, non-attenders*. What's wrong with seeing us as human beings with a different *life stance*? I also reminded my audience that many people have told their families before they die that they do not want a minister to conduct their funeral. As the Rev I.M. Jolly cannot take all the blame for this it is an issue that needs to be addressed.

I have observed that Chaplains act as role models for people in hospital, displaying integrity, having the time to listen and offer support. I noted that some Chaplains were aware of financial pressures. Examples were bringing weddings and the expenditure associated into the universities, others trying to demonstrate shorter times in hospital beds.

In a small group discussion I certainly found myself in agreement that within the NHS it would not seem consistent to have Chaplains supported through the Board of "Mission". I also was struck by descriptions of how Chaplains are often expected to hold the tensions within their place of work or to act as the conscience of their host organisation. I was impressed with the warning that Chaplains must guard against attempts being made to turn them into the image of their host.

In conclusion I commented that I did not see the role as expressed by the Industrial Chaplains as "bringing people to God". Rather I am of the view that as well as referring patients to someone of their own life stance that Chaplains can help people to find comfort or meaning in their travails. Humans usually have, within themselves resources and answers. Perhaps the Chaplain is uniquely placed to help them to find these resources and answers, to help them to help themselves.

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HEALTHCARE CHAPLAINCY IN BULGARIA:

TRADITIONS AND PROBLEMS

Jordan Vuchkov

Abstract: In this article the author seeks answers to many questions about the past and the future of Healthcare Chaplaincy in Bulgaria. The Church has no official input into hospitals, but patients, their relatives, medical staff, and the whole of society needs pastoral care and spiritual support during times of suffering. Nowadays the treatment of patients in hospital is a complex and responsible process. It demands the combined efforts of the therapeutic team, and the valuing of human life and human dignity at the highest level. An empirical study, investigating the attitude of staff and patients to the necessity of Healthcare Chaplaincy, shows that the problem is important and its solution must be found as a top priority.

Keywords: patients, medical staff, traditions, social transition, pastoral care.

Introduction

Nowadays Bulgarian social life is beset by a great number of moral problems. This marks the transition from totalitarianism and warlike atheism to spiritual renewal and a restoration of real, universal spiritual values. Among the most important problems is that which relates to the restoration of centuries-old Bulgarian traditions in pastoral care for the sick. The importance of this problem is heightened by the development of modern science. The remarkable progress in all scientific areas leads on the one hand to the obliteration of the margins between different scientific disciplines and, on the other hand, to the building of permanent relations between them. In addition, the mark of modern scientific thinking is its interdisciplinary character. At a time when humanity is at the centre of all scientific research, there is a natural aspiration that the investigations range over a large number of problems about human existence and spirit. For that reason it is easy to explain the increased interest in the theme of pastoral care within healthcare, not only from the side of theologians and religious workers, but also from the side of physicians and scientists in medical ethics.

Today, the hospital treatment of patients is a complex and responsible process, which demands the common efforts of the therapeutic team: highly qualified and motivated physicians, nurses and other staff, who place the highest value on human life and dignity. However, the therapeutic team is confronted with numerous tensions in those for whom they care - physical, mental, spiritual and social stress. The pressure on individual members of the team to look beyond their own specialism is therefore very high. Often, in spite of their scientific, technical competence, and therapeutic abilities, the members of the team are unable to stabilize the patients psychologically and thus to give them faith and hope.

There exist in the milieu of the modern hospital many therapeutic and ethical problems, whose solution requires a holistic approach to the patient's personality. Yet the reality is that at present not one single chaplain serves in any Bulgarian hospital. There is only one right way forward ; we all - society, church and state - must discover again (after 50 years) the place of the chaplain in the Bulgarian hospital and his responsibility for the treatment of patients.

Healthcare Chaplaincy Traditions in Bulgaria

The Bulgarian tradition of pastoral care dates back a thousand years to 865 when St. Boris the First accepted Christianity as the official state religion. Immediately we must emphasize the great achievement of Eastern Orthodoxy in the creation and development of monastery hospitals. At the beginning stands St. Wasili, who in 369 founded the first Christian hospital in Caesarea. In Bulgaria, the church, as the basic social and religious institution, was the first institution which successfully organized humane relations towards our own suffering brothers and sisters (Mutafov & Shosheva 2000). In addition, in the Middle Ages a number of Bulgarian religious leaders were also great physicians - St. Boris The First, St. Kliment, St. Kiril (Constantine Philosoph), St. John Ekzarh, St. Iwan Rilski Miraclemaker, Wasili Wrach. These practitioners in theology, philosophy, medicine and pharmacology wrote many scientific medical books in the Bulgarian language. These books have been utilised from the Atlantic Ocean to Asia Minor and helped to underpin the European Renaissance. The biggest monastery hospitals in Bulgaria were founded at the the Monastery of Rila, the Monastery of Bachkovo, the Monastery of Trojan, and the Monastery of Kuklen. All these facts confirm the importance in Bulgarian history of an approach to healing in which the scientific and the spiritual were interrelated and interdependent. (Vasilev 1985)

Unfortunately, such traditions have been destroyed. After 1947, the communist government limited the charitable activities of the Bulgarian Orthodox Church (CPA f. 146). The Bulgarian Orthodox Church *has been removed from the sphere of family, school, hospital and army. Its activity is reduced only to liturgies in the churches* (Zaphirov 2001). This critical period is far from finished.

Yet, out of the barren soil of 50 years of state atheism, a real contribution to European theology has been produced by the books of two theologians, minister George Glogov (1943) and professor Christo Dimitrov (1957). Both scholars are unequivocal in their emphasis on the importance of pastoral care, - as significant, contemporary, relevant and powerful as ever - the care for the soul, in the absence of which the church cannot remain and renew itself.

The authors make their case in these terms: two people play the most important roles in a human life, in the bad times of suffering and anxiety.. These people are the doctor for the body and the doctor for the soul. Having said this, the soul doctor, in the person of the chaplain, needs adequate education and training (Dimitrov 1957); he must make sacrifices of time, resources, convenience (Glogov 1943), as must the medical doctor. The real spiritual visitations and conversations with the patients are the most important methods for pastoral care. Together with the relatives, the chaplain must direct all his own efforts to save the little part of spiritual power (Dimitrov 1957), remaining in the sick person.

Both authors underline that *real spiritual care for patients is a special kind of art and it demands physical and spiritual power, fine personal qualities and Christian virtues from the chaplain* (Glogov 1943).

Problems and peculiarities of the Bulgarian social model (1944-2002)

The development of the Bulgarian State during the second half of the last century demonstrate that Bulgarian totalitarianism was much more the 'ideal' model than in the other communist countries. Bulgaria was in greater isolation from the democratic world than Hungary, Poland or the Czech Republic for example. The traditions and the values of European civilization were destroyed. The most telling social consequence, and, at the same time, the deepest and most difficult to overcome, is the dehumanization of social, public and human relations, as well as the demoralization of the Bulgarian population. The causes are multiple, but one of them is *a fracturing of the continuity and coherence hitherto provided by the basic regulators of the social order - law (jurisprudence), traditions, religion (it was denied and replaced by atheism)* (Zlatkov 1998).

Ermenov(1998) argues that for the past fourteen years Bulgarian society has been undergoing a painful transition towards a new and worthwhile social order. The most important characteristic of this transition is the sudden reinforcement of destructive processes in all public spheres (economic, political, cultural), and a high degree of social tension. Most affected are the intelligentsia in the fields of technology, education and health, in other words, the sections of society which can contribute most sig-

nificantly to the new order in Bulgaria. If we are to achieve a successful transition to democracy, we must change the Bulgarian educational system on every level. It is important to begin with education in social skills. Such an approach to education would mean a balance between the modern and the traditional, the universal and the specific, the theoretical and the practical. The methodological foundation of training in social skills presupposes a lively training process, which makes for enjoyment of communication and which encourages self-realization and creativity (Vuchkova 2002).

One of the possible outcomes of this critical ferment in Bulgaria (Georgieva 1998) is to give the patients, their relatives, the staff and the whole of the Healthcare institution a little more hope and power. But only the involvement of the Church can achieve this. Only the contribution of highly motivated and well-trained chaplains, who, at the same time, need support and help from the whole of society.

We consider that the necessity of the restoration of Bulgarian traditions through the joint responsibility of physician and chaplain for the treatment of sick people is both obvious and imperative.

Empirical study

Aims of the research

- To examine the attitude of physicians, nurses and other medical specialists regarding the necessity of pastoral care in Bulgarian hospitals.
- To examine the attitude of patients about the necessity of pastoral care in Bulgarian hospitals.

Method

The aims determined the use of the following methods:

- Documental - official normative acts and decrees;
- Sociological method - individual anonymous inquiry;
- Statistical method - χ^2, coefficient of contingency.

Prompted by the desire to investigate a facet of the ethical problems in modern Bulgarian Healthcare between 1999 and 2000, we initially interviewed 400 physicians, nurses and other medical specialists working in the University Hospital to the Trachian University - Stara Zagora. The second group interviewed were 100 critically ill patients, treated in the Department of Anesthesiology and Intensive care to the University Hospital - Stara Zagora. Both groups were asked to comment upon three aspects of pastoral care :- the perceived need for chaplaincy contact with patients; the need for such contact with patients' relatives; the need for the involvement of chaplains alongside physicians and others as part of the healthcare team.

To identify the staff we used following personal characteristics: Occupation, Sex, Age, Education, and Religion. For the patients we used additional information on social status.

Sample

Fig. 1 and fig. 2 present the frequency distribution of the subjects in accordance with identification characteristics.

Fig. 1. Staff - personal characteristics	
Occupation	Physician - 55% Nurse - 25% Clinical laboratory assistant/manual therapist - 7% Hospital attendant - 13%
Sex	Male - 27% Female - 73%
Age	20-30 yr. - 20% 30-40 yr. - 40% 40-50 yr. - 25% over 50 yr. - 15%
Education	Med. university - 59% Med. college - 32% Other - 9%
Religion	Bulgarian Orthodox - 90% Muslim - 4% Other - 6%

In the first inquiry (staff) we offered only 3 possible answers regarding religious affiliation: Bulgarian Orthodox - 90%, Muslim - 4%, Other - 6%. But in the patients' inquiry we offered 6 possibilities: Bulgarian Orthodox - 90%, Muslim - 6%, Catholic - 0%, Evangelical - 3%, Other religion - 0%, Atheist - 1%. We think that the latter is much better and we will use this in our further studies.

Fig.2. Patients - personal characteristics	
Social status	Employed - 18% Unemployed - 24% Student - 7% Pensioner - 51%
Sex	Male - 56% Female - 44%
Age	20-30 years - 5% 30-40 years - 14% 40-50 years - 23% over 50 years – 48%
Education	University - 8% College - 47% Other - 45%
Religion	Bulgarian Orthodox - 90% Muslim - 6% Catholic - 0% Evangelical - 3% Other - 0% Atheist - 1%

The professional mix of the staff who took part consisted of Physicians (55%); other specialists (45%) of which Nurses formed 25%, Clinical laboratory assistant/Manual therapist 7%, Hospital attendant 13%. We consider that the opinion of clinical laboratory assistants, manual therapists and hospital attendants is as important as the opinion of doctors and nurses.

Results from the empirical study

Of the 400 staff questioned the responses to chaplaincy were positive. When asked if contact between the patients and chaplain was deemed necessary, 64% answered yes, 30% said no, and 6% offered no opinion. The figures for contact between chaplains and patients' relatives were slightly less, with 55% answering yes, 36% no, and 9% with no opinion. The response of staff to the issue of teamwork which included physician and chaplain was also positive with 63% stating that physician/chaplaincy teamwork had a positive influence on patients' treatment. (28% said no and 9% offered no opinion).

When the same questions were put to patients the results were similarly in favour of chaplaincy involvement and teamwork, however the numbers expressing no opinion were greater than those answering in the negative. While 62% saw contact between patient and chaplain as positive 15% said no and 21% offered no opinion. Interestingly while the staff had placed less emphasis on contact with the patients' relatives, the patients themselves rated this of more importance than contact with themselves, with 68% saying yes to contact with their relatives, 9% saying no, and 23% offering no opinion. The patients' perception of the positive influence of teamwork by the physician/chaplain was also significant with 67% responding yes, 6% no and 27% with no opinion.

Discussion of Results

'Is there a need for contact between the chaplain and patients' relatives?'

Staff responses

The type of the hospital (private or public) does not determine the staff's perceptions of the need for contact between patients' relatives and the chaplain - there is no statistically significant difference. The answers are distributed in 2 groups, according to the coefficients of contingency. In the first group there are relatively higher coefficients in relation with age, education and occupation. Such coefficients in the second group (religion and sex) are relatively lower. The analysis shows: The proportion of women, hospital attendants, and persons with lower education who think that the contact between patients' relatives and chaplain is unnecessary is bigger. The oldest and the youngest members of the staff on the other hand , respond very positively to this question, as do clinical laboratory assistants and manual therapists .

Patient responses

The patients' perception of the same question is affected by the sex, religion and education of the respondents. The highest coefficient of contingency is in relation to religion. We can show the following peculiarities: women, patients with lower education and Bulgarian orthodox patients assess the need for contact between the chaplain and the relatives much more positively than do men, and patients with higher education.

'Is teamwork which includes both chaplain and physician necessary for the treatment of patients?'

Staff responses

The age of the respondents has no effect on the distribution of answers. The other personal characteristics likewise show low coefficients of contingency,

the lowest being the coefficient by sex. There is no statistically significant difference in the negative answers, although a higher percentage of men than women considered such teamwork unnecessary. Those with higher education tended to have a less positive response to this question, and in fact those staff members who had both a higher education and a positive response to this question formed the smallest group. It is interesting that nurses have also a negative perception of teamwork (which included physician and chaplain) in hospitals.

Patient responses
The inquiry with the patients shows a statistically significant relation between answers to the same question and the sex of the persons - coefficient of contingency by this personal characteristic is the highest. The percentage of women with a positive response, and the percentage of men who express no opinion is relatively larger.

'Is contact between patient and chaplain necessary?'

Staff responses
We find a statistically similar pattern to the previous one. There is a statistically significant relationship between the way in which staff answered this question, and the sum of their personal characteristics, excluding religion. An increasing age and educational profile increases the likelihood of a positive perception of the need for chaplaincy involvement with patients. We have noted with interest that a larger proportion of women, nurses and hospital attendants have a negative response to this question.. The heads of departments have a much more positive perception than the other physicians.

Patient responses
Among patients we found the following characteristics to be statistically significant: sex, religion and education. Women, and patients with less education respond more positively to this question.

The future of Chaplaincy in Bulgaria

Analysis and enquiry show the importance of researching the place of the chaplain in Bulgarian hospitals. Age old Bulgarian traditions have been destroyed. It is necessary, therefore, to develop a modern model of joint responsibility for the patient's treatment, shared by both physician and chaplain.

The study highlights that one aspect of the problem which faces hospitals in Bulgaria is concerned with spiritual care of patients, relatives and staff. The contemporary situation has arisen a result of a conflict between the Bulgarian orthodox traditions, the totalitarian past and our young democracy. The piece of research outlined above focuses upon patients in ICU and medical staff - physicians, nurses, clinical laboratory assistants, manual therapists and hospital attendants. The studied problem is new for Bulgaria, delicate and difficult to interpret and resolve, because it is related to the core values of each person in hospital - patient, relative and staff member.

The building of a modern model of effective healthcare chaplaincy in Bulgarian hospitals is important not only for the development of the Bulgarian Healthcare system but also for the development of the whole of Bulgarian society.

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MINISTRY BEHIND A MASK – A CHAPLAIN REFLECTS UPON SARS

Bruce Pierce

Abstract: The outbreak of Severe Acute Respiratory Syndrome (SARS) which occurred in Canada, notably Toronto, in spring 2003 gave rise to two responses which together have profoundly affected the healthcare environment:_ stringent infection control measures, and fear of an unknown enemy. From his perspective as chaplain resident at Toronto General Hospital, the author describes the chaplaincy response to the 'new normal' in hospital life. He identifies the problems created, and stresses the need to adapt to a new healthcare environment 'behind the mask'.

Key words:SARS; chaplaincy; healthcare; infection control.

Introduction

In attending to a patient, hospital chaplains have only themselves to bring to the encounter. Our training as hospital chaplains focuses on communication as encapsulated in the art of pastoral conversation. This enables us to engage in a dialogue at many levels with a patient. To move this encounter forward appropriately and effectively, we rely on our professional training and intuitive skills.

There are no tools other than the self for the chaplain in such a conversation – no props, no cue cards and no comfort blankets. In addition to the articulated word non-verbal communication is crucial and this is a two way process with patients. Appropriate facial expression, eye contact and speech tone blend with posture, gesture and distance to facilitate patient - chaplain communication. Anything that hinders this interaction can add to the complexity of such conversations.

From the first week of April to the time of writing, chaplaincy practice has changed and has had to be adapted within all Toronto hospitals. Since SARS (Severe Acute Respiratory Syndrome) first appeared, it has created a new framework within which we have to engage in pastoral conversation. It has led to a process of continual adaptation for all healthcare professionals, including chaplains who now must minister always aware of the needs for infection control. In the words of the Ontario Chief Medical Officer of Health, Dr. Colin D'Chunha *we're learning as we're travelling the road*.

Severe Acute Respiratory Syndrome is an infectious disease that was first recognized in south East Asia in late February 2003 (Zambon & Nicholson 2003). It was first identified in Canada in early March 2003. In the first study in Canada the first 10 cases were of patients who ranged from 24 – 78 years (Poutenan 2003). The most common presenting symptoms were fever, and malaise followed by non-productive cough and shortness of breath associated with infiltrates on chest radiography. It was noted that of this group, half required intensive care support including mechanical ventilation. At the time of writing, early May, the current Ontario death total is 23. Most of the fatalities reported occurred in patients with underlying illness.

Current evidence suggests that respiratory droplets are the primary means of transmission and require close contact with a case of SARS. Close contact means having cared for, lived with or had face to face (within one meter) contact with, or direct contact with respiratory secretions and/or body fluids of a person with SARS. In Ontario, the majority of cases can be traced directly to specific transmission settings, such as household, hospital or community exposure.

Fear and recognition of the unknown has contributed to the rapid reaction to SARS. It has an associated morbidity and mortality but its origins are still tentative. The presence of an insidious and non-specific onset incubation period of up to 10 – 11 days has meant that SARS may be transmitted unwittingly in community. It also has a poorly defined pathogenesis, with a current absence of laboratory diagnostic testing and there is the failure of known antimicrobial treatment. Scientists have identified a previously unknown virus in the coronavirus family as the primary cause of SARS. Such viruses often infect animals and formerly only had minimal effect upon humans. The current strain is different. However it has been noted that as many as 40% of Canadian SARS patients did not test positive for coronavirus.

Fear is quite apparent – has the virus mutated sufficiently into multiple strains to avoid detection? As noted by Zambon the optimism of the 1960's and 1970's has given way to a mature realism that the relationship between human beings and microbes is neither completely predictable nor biased in favour of humans (BMJ 2003).

The rapidity of the spread of the disease and the morbidity indicate an agent that is infectious and virulent which requires strict control measures for droplet and contact transmission by healthcare workers, a vigilant healthcare profession and most crucially public education. SARS has challenged the healthcare system and it has crossed traditional healthcare boundaries and the new emperor is infection control. Despite stringent infection control measures hospitals have become places to be feared rather than places of healing. This may apply to staff too.

How chaplaincy adapted to SARS?

In the early days in many hospitals, chaplaincy services were deemed as non-essential as the various hospitals instigated policies of zero risk. This classification has raised concerns for the perceived role of the chaplain in a crisis situation. Within my own institution, as many of us are chaplaincy residents, we initially followed the governmental directive of the withdrawal of all resident hospital programs.

After two days there was a limited return of chaplaincy but it was into a new world. Hospital services had been drastically reduced with no surgery, minimal staff, no visitors and limited admissions. The normally busy concourse of the hospital was deserted – the few staff present wore facemasks and other protective gear. Chaplaincy developed a phone orientated ministry acting as link people for patients who had become isolated from their families due to an embargo on visitors, unless the patient was a child or terminally ill. The sense of loneliness on the part of patients was palpable. Many patients who were immigrants to Canada experienced the segregation of a language barrier in the absence of their family. The chaplain's role was at times to liase between the gathered family at the hospital entrance, the staff and the isolated in-patient. In these times of uncertainty and fear, this sense of patient isolation was increased as all staff were dressed in complete isolation protective wear. The precautions reached a level where even sitting in the chaplain's office required us to wear facemasks.

As the days passed more staff returned but we were returning to what was called the 'new normal' situation. To minimize possible infection, staff used only one entrance and the few visitors allowed in used another. To date, on reaching the only accessible entrance to the hospital, staff must first show their photo ID badge to hospital staff that are fully gowned with full-face protective helmets and gloves. Hands are outstretched then and liberally covered in antiseptic lotion. A check list must be completed and checked to show where entering staff have been, how they feel and where they will be in the hospital. Next temperature is taken and if it exceeds 38 there is a referral to occupational health. If all these stages are negotiated successful then one can come into the hospital after a further washing of hands.

Though some strict controls have eased a little in the last few days chaplains encountering patients still wear gowns, gloves and facemasks. After each visit the gowns and gloves must be changed. For those chaplains whose practice is to visit all patients in a ward, a new and more infection control approach is mandatory. After every encounter hands must be washed or antiseptic solution applied.

The presence of SARS raises particular challenges for faith traditions liturgically. As no meetings were allowed in the hospital, Easter services were can-

celled and continue to be on hold. In Toronto, radical changes came into worship with both the Anglican and Roman Catholic traditions dispensing with both the common cup at communion and the sharing of the peace. Some patients have needed to explore the challenge that has come to their view that items associated with faith practice somehow had an inherent protection for the faithful.

Frontline healthcare staff have become both physically and emotionally stretched and chaplains have had a major role in staff support. The physical demands of having to gown up repeatedly have taken its toll. Chaplains have also assisted with the many frustrations that such pressures have raised. Staff have also been helped to embrace a new mindset for the caring professions whereby the belief that 'we will to work no matter how ill we are', has now become a more appropriate practice that says the correct response is to stay home.

Concern also was expressed as to where the boundary was between self-care and patient care. Some raised the ethical issues about the expectation placed upon staff and how far care should be proffered in the face of personal risk. The approach of visiting without considering the infection implications has gone forever.

New procedures and practices may well remain within the hospital as the 'new normal' moves to acceptance as the norm. With ongoing reductions in visiting there may be the need to restructure working hours for those services that connect in with families such as social work and chaplaincy. The restriction on visitors has also applied to local clergy, who in Toronto are actively involved in patient visitation. In their absence greater demands have been placed on the chaplains through increased referrals.

Conclusion

In summary, SARS has, initially at least, unsettled our comfortable thinking and total confidence in the power of antibiotics and that that science has all the answers in this 21st Century. At the same time SARS has demonstrated the calibre of a city and its ability to adapt, comprehensively, swiftly and appropriately, to such a major challenge. As chaplains we need to continue to adapt as we engage in pastoral conversation, often from behind our masks,

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CLINICAL PASTORAL EDUCATION (CPE): A REFLECTION

Valerie Duff

Abstract: Clinical Pastoral Education (CPE) is a widely used educational programme in many parts of the world. This article is a reflection on the author's personal experience of CPE, together with some very brief historical data, and approved quotes from the reflections of a small group of participants in a CPE module held in Scotland in the Autumn of 2002. It is offered to stir interest in CPE, rather than to give a deeply informative description of the process.

Keywords : clinical pastoral education; pastoral care; supervision; verbatim; living human document.

A Very Personal Experience

I sat at a table around which were gathered seven other people. These were not people I knew well, in fact, we had only met as a group twice before. On the first occasion, we were instructed on what would be expected of us. The second time was when two others in the group had done what I was about to do. I had no other previous experience to draw upon, and frankly I was scared. My normal pattern in a group situation had been to sit still and to listen. The only times I could remember presenting anything to a group had been excruciatingly painful experiences for me and not something to be welcomed. I was expected in this time allotted to me to present a conversation I had recently had with a patient on my ward, and to share my reflections on what had occurred. Not only was I expected to share with this group of virtual strangers what the patient had said to me, but also what I had said to him; not only what I observed was happening with him, but also how I had felt during the conversation; not only what I thought he might have gained from the experience, but also, and maybe more importantly, what I had learned. I was expected to lay before this group an example of my ability in pastoral ministry, to which they would respond. This made me anxious.

The group was made up of students like myself, and one supervisor. My worry was that I would somehow 'lose face'; that I would be revealed as unworthy of the job I was attempting to do, and that the supervisor would see my inadequacy most clearly. After all, as a deaconess ministering in the Church of Scotland I had long been aware of difficulties I was having in the area of pastoral care, and of the inadequacies which I felt. But then, that was why I was here, in the United States of America, seeking training in CPE.

I presented my first 'verbatim'. What happened next was most unexpected. It was as if up to that point in my ministry I had been marching through heavy sand, and at last I had come upon a spring in the desert.

CPE : Historical Beginnings

Clinical Pastoral Education, or CPE, began in the USA, and arose partly as a reaction against traditional theological education as it was taught at the beginning of the 20th century, and partly out of the attraction towards medical psychology. Traditional theological education happened in the classroom where theological problems were studied by reading books and listening to lectures. CPE on the other hand brought students face to face with problems, through the study of the 'living human documents'(Powell 1975).

The generally accepted founders of CPE are William S. Keller, Richard C. Cabot, and Anton T. Boisen.

Keller began teaching courses in pastoral, medical and social work experience with supervision, in Cincinnati in 1923. His programmes included two of the basics of CPE, ie supervised clinical case studies (the forerunner to the verbatim) and the sense of

'process'. The outbreak of world war two ended this programme.

Richard C. Cabot of Boston made history by introducing social workers to Massachusetts General Hospital in 1905, and twenty years later, he confronted theological educators with his case for the introduction of a clinical year in theological studies. Cabot's creed was that the only absolute need of the human soul is the need to grow, and to that end he urged educators to develop what he called clinical theology, ie a theology brought into the situation of suffering. Cabot pleaded for a professional model of theological education – competence in pastoral work and training in pastoral theology. He was the teacher of Anton Boisen.

Anton T. Boisen, a Presbyterian minister, is generally recognised as the father of the modern CPE movement. Between 1889 and 1935 he experienced no less than six psychotic episodes, which involved three hospitalisations. Personally engaged in a struggle to make sense of his own illness, he functioned professionally as a mental health chaplain, as a researcher, and as an organiser of clinical training for theological students. During his time as chaplain to the Elgin State Hospital near Chicago, he organised the Chicago Council for the Clinical Training of Theology Students. In his work as researcher, he sought to construct a clinical theology with the help of 'living human documents', while at the same time relentlessly pursuing his search for the meaning of religious experiences, especially the relationship between religious experience and mental disorder. He pursued special studies in the essentials of case records for teaching purposes.

Boisen started off in 1925 with five theological students. This marked the beginning of modern CPE and the rest, as they say, is history. Today, there are CPE centers throughout the USA and Canada, and on every other continent.

What is CPE?

I have often been asked to explain CPE and have not found it easy to do so. CPE is an experience and a process, and like many experiences, understanding comes with experiencing the process, not with reading or hearing about it. CPE is, as its name suggests, primarily education, education which is to a large degree dependent upon an experiential process whereby the student is asked to reflect upon his or her own practice of ministry. It encourages the student to engage with the study material – the pastoral conversation – and then to reflect upon the experience, allowing him or herself to be taught by the live situation and to integrate the learning. It is education directed towards enabling the student to come to a fuller understanding of the pastoral office By integrating the formal theological learning s/he has engaged in with the practical situations s/he faces in ministry the student comes to a deeper understanding of self and profession.

It may be helpful to describe a fairly typical CPE programme as it would occur in the United States. One full unit or 'quarter' of CPE consists of 400 hours of supervised experience in a defined clinical setting such as hospital, prison, congregation or parish. It normally takes place over a ten week period. A typical CPE week would comprise of daily supervised seminars, morning or afternoon, with the rest of the day given over to clinical work. It is based upon a medical model, and so students would be expected to take responsibility for in house on call rotations. Each night, at least one student chaplain would remain in the hospital overnight and be on hand to respond to all pastoral calls.

There are three levels: Basic (internships), Advanced (residencies) and Supervisors in Training. In my own experience of CPE at the Tri Hospital CPE centre in Atlanta, the supervised seminars occurred in the morning. When we arrived at the hospital there was time for us to come together as a group to hear the daily report which would let us know of anything which had happened the previous night. We then had time to check in with the staff in the areas we covered and to deal with any urgent situations. Around mid morning we would again gather as a group. On Mondays the chaplains who had been on call on Sunday would present the worship service which they had prepared and delivered. They would be expected to explain their reasoning for doing what they did, and to reflect theologically with the group. On Tuesday and Thursday mornings we would gather for a verbatim seminar when at least two of the group would present a pastoral conversation. On Wednesday we took part in what is called the 'Interpersonal Relationships' seminar. This was an open group meeting at which some matters of housekeeping, e.g. course structure, would be addressed, and the rest of the time would be given over

to the expression of any problems which participants were encountering with any aspect of the course. Friday morning seminars would be more didactic, and would often involve someone from the hospital staff coming along to teach us about different disciplines in the hospital, or perhaps one of the more experienced students or chaplains teaching about an aspect of pastoral care. Once a week I met with the supervisor for a personal supervision session during which I was expected to present a verbatim for supervision purposes.

Scotland – 2002

In the autumn of 2002, four chaplains (two full and two part time) from different parts of the country took part in an extended basic unit of CPE, that is, 200 supervised hours. They were supervised by myself. We met together on one morning per week for twelve weeks. Each chaplain was expected to be doing at least twelve hours of pastoral work either in a hospital or in a parish setting. The weekly meetings included verbatim presentations, some didactic material, worship and reflection upon worship and some free group time. In addition, each group member was required to participate in personal supervision once per fortnight. At the end of the twelve weeks, each wrote an in-depth evaluation of their process.

As I indicated earlier, CPE is based on a process, and I hope it would be true to say that the process worked. It required a definite commitment from the participants, and each took their responsibility seriously. At no time was the course in danger because of lack of interest! Although it was a fairly intense process, it did in fact lack the intensity which is possible when the work is carried out on site and in the context of a group which meets for a shorter period but more often. It seems to me that the comments of the participants speak for themselves. Members of the group wrote in their evaluations :

I wanted to listen and to be listened to, so that I could hear myself and know myself better, and help others to do the same. I think that has been achieved…..I have been reminded of the habit of reflective practice and will try to continue it. I also have become aware of the need for some form of continuing supervision…I think I have a renewed sense of the value, the complexity and the hidden depth of the everyday pastoral encounter, and so, a refreshed sense of the worth of pastoral ministry.

I suppose at base I was hoping for quick solutions – hope to do hospital chaplaincy and pastoral ministry in ten easy stages! So perhaps my main learning psychologically was accepting what I already know in a sense – that understanding is rarely instant, but is an ever continuing process. Although I have long understood and accepted the need for attentive listening, I think the course has really underlined this for me, helping me to be much more aware of the quality of my listening and responses…

In signing up…I set myself the goal of learning more about reflection, and hoped to experience something of supervision. During the course I have learned that everything matters and that in 'being there' pastorally for another requires of us attention, concentration and thought…I have tools within me to do the job but they need to be looked after, nurtured and developed.

I have become more aware that one of my motivations in this ministry was to 'fix it' for people…the course has helped me to accept the value of just listening…I'm not sure whether it's as a direct result of the course but I am now looking at things in a different way. When I first became a chaplain, I was anxious that the badge would mean that people would expect me to have answers. Now I am aware that it's a constant process of learning dependent on God. The phrase 'let go and let God' is important to me….

We hope to offer more courses of this type in the coming years with the possibility that we may also offer a full basic unit during the summer months. I trust this is a good beginning which can be built upon.

Conclusion

When I sat at that table and presented my first verbatim, my worry was that I would be 'found out'; that in opening myself up in this way it would be discovered that I was a fraud as far as chaplaincy was concerned. The reality was that I was affirmed in who I was and what I was doing. This is not to say that there were not times in my CPE experience when I was challenged to look at my own issues and to come to a deeper understanding of both myself

and the task in hand. I have no hesitation in recommending CPE as one of the ways in which we as pastors and carers can enhance our knowledge of self, and our competence in the work that we do.

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DEALING WITH FAILURE IN PALLIATIVE CARE

Fiona Downs

Abstract: In this article failure is considered from general, political and financial perspectives, Technological failure is discussed and educational, organizational and communicational failures are identified. In a Hospice setting, corporate staff failures are explored and the more painful personal and spiritual failures at the patient/carer interface are examined.

Key words: failure, palliative care, death, patient, carer

Introduction

Confronting Failure in Palliative Care is a challenging, daunting and uncomfortable experience. It involves "sounding soul depths" but there are significant rewards. In Palliative Care, our starting point is failure. We tend to inherit the clinical failures of others. Perhaps the motto of Mary Queen of Scots - "My end is my beginning" - could be corrupted to - "*Their* end is *our* beginning".

But what is failure?

- To fail is to fall short or be lacking in
- To fall away, to dwindle,
- To die (so Death is a failure)
- To prove deficient under trial or examination or pressure
- Not to achieve
- To be disappointed or baffled
- Not to be sufficient for
- To leave undone or to omit
- To deceive
- Failure is omission or lack of success

To be fallible is to be capable of making mistakes or liable to error. Failure comes from the Latin fallere - to deceive (This is not too far from the Latin *palliare* - to cloak from which palliative care is derived and so perhaps we should not be too surprised to experience failure in Palliative Care!).

If failure is lack of success, we ought also to define success. To succeed is to obtain one's wish or to accomplish what is attempted, to come after, to follow, to come into another's place. Success is prosperous progress, achievement, termination (which is not too far from ending, death, failure). Therefore perhaps success and failure are more closely linked than we imagine and we can conclude with J.M. Barrie that *We are all failures - at least all the best of us are* (Maxwell 2000).

The big picture

We do fail, we all fail but we find it difficult to acknowledge and confront failure and so we look for circumstances or others to blame. Don't we?

Isn't it comforting to have politicians and Health Ministers to blame for the *Big Problems* of resource allocation? We tend to look after cancer patients with Palliative Care needs and cancer has been high on the political agenda but shouldn't patients with non-malignant diagnoses also receive palliative care? Shouldn't Palliative Care be available to all who need it? Isn't it a Governmental responsibility to provide resources? We are currently in an age of expecting that everything that can be done for patients should be done with regard to surgery, chemotherapy etc. but we are already facing a crisis of resources. So who will make decisions regarding the sharing of resources, including:

- Palliative Care resources, in the future?
- Will the decisions be equitable?
- Who will advise the decision makers?
- What can we do?

Perhaps our role is, firstly, to provide evidence, (though characteristically we have been poor at pro-

viding an evidence base for what we do) to demonstrate by Needs Assessment exercises that patients with e.g. Neurological diagnoses like Multiple Sclerosis and Motor Neurone Disease, who could benefit, are being denied access to appropriate care.

Secondly, we need to educate the politicians and the Scottish Office through agencies such as the Clinical Standards Board for Scotland and the Scottish Partnership for Palliative Care.

Thirdly, we need to attract significant individuals to the cause, e.g. J.K. Rowling, who have an interest or personal experience, to increase the profile of previously neglected patients. We must be sure of this - we fail if we do nothing at a national level to highlight the plight of patients with non-malignant diagnoses and their need for Palliative Care.

We can also fail patients with Palliative Care needs, whatever their diagnoses, at a Regional level if there is no organized referral system or a lack of knowledge of basic Palliative Care and communication skills.

The influence of the Scottish Partnership for Palliative Care (SPPC 2001), the Clinical Standards Board for Scotland (CSBS 2002), the Scottish Intercollegiate Guidelines Network guidelines (SIGN 2000) and emerging Managed Clinical Networks (MCN) will help greatly but in our own regions we have responsibilities -

1. To ensure the Primary Health Care Teams (PHCT) and hospital staff at all levels are educated in pain and symptom control and communication skills and that a referral system is in place for those with Specialist Palliative Care needs.
2. Jointly to produce local standards, guidelines and protocols, thereby constantly improving quality of care.
3. To improve communication by letter/ telephone/ e mail to achieve seamless care.

Dealing with failure in a hospice setting

Within our own organizations we have even greater responsibilities. My experience is in Hospice care but I believe this can be extrapolated to other situations, as Hospices do not have a monopoly on death and dying.

The Inpatient Unit

Great changes have taken place in Palliative Care since I started work at St. Columba's Hospice 18 years ago. Life was simpler then but Hospices have become more sophisticated and some people are beginning to ask if we now fail our patients by over-investigating, over-medicalising or over-physicalising death. The number of investigations (blood tests, microbiology, radiology) we perform has risen exponentially, particularly in the last 5years (Forth Valley Health Board, 2000) but there are situations we can improve dramatically - for example by treating hypercalcaemia, by commencing, discontinuing or altering the dose of drugs or by arranging a single fraction of radiotherapy to painful bony metastases - and, increasingly, we might be seen to be negligent if we do not attempt improvement.

What we must do is ensure that we discuss with patients and relatives the risks and benefits of each course of action and listen to what their wishes are. Hospices are not immune to Hospital infection problems and we have had serious difficulties associated with MRSA and Clostridium Difficile infections but by routinely isolating patients to avoid cross infection we are in danger of failing our patients and making them feel like lepers. We are bound by NHS guidelines (Health Advisory Group on Infection 1998) with regard to infection control and do adhere to them but we need to be innovative in our ways of dealing with the problem.

Could we be accused of failing by excluding relatives - by not permitting them to care for their loved ones within the hospice setting? Do we consider the Adults with Incapacity (Scotland) Act 2000 and the implications for involving relatives? We constantly need to ascertain their wishes and their understanding.

Are there symptoms we fail to deal with? Do we pay attention to the detail of pain and symptom control? Do we use the SIGN guidelines? Do we know our limitations and when to ask for help?

Isn't failing to ask for help a failure? Have we developed clinical and corporate governance? Do we do everything we can to minimize risk?

With regard to the timing of death, do we fail to have the relatives present if they wish to be there? Do we ensure up-to-date contact numbers at all times?

Day Care

If our patients are well, volunteer drivers collect them but if their physical conditions deteriorate they are transported by private companies for a fee. Should we be negotiating with the Health Board or Lottery for funding for a neglected area?

Day care is a therapeutic, social environment but do we fail our patients by "missing something" amongst the buzz? We've all had doorstep conversations regarding issues which patients would be reluctant to broach in a social group or for which they would even be reluctant to request a private chat. Are we able to provide "natural" regular one to one slots and private facilities to allow verbalization of deep feelings but prevent embarrassment or stigmatization?

Home Care

We may fail here by lack of availability - i.e. not providing a 24 hour, seven day a week service or we may fail by doing too much. We may be seen as "the Cavalry" coming in and deskilling or disempowering others - District Nurses, relatives, clergy. Do we fail by not having an in-patient bed or equipment available when required? Do we fail by not keeping abreast of new developments, drug regimes, lifting and handling techniques?

Are we victims of our own success? If we pull out all the stops in one situation do we unrealistically raise expectations of professionals or families in another? These thoughts may be familiar but we can still blame the organization, the management, the system for these failures.

Failure at the patient/carer interface

At Strathcarron Hospice we have a room called the Holly room. It is a family room and we place patients with young families there because it has a double bed and extra equipment. Our memories of patients we have cared for in that room are often coloured by feelings of failure. This is unlikely to have anything to do with the name Holly, though we are aware of associations with eternal life, pagan gods and prickly leaves! Sifting through the case sheets of patients who have died in Holly allows some common strands to be identified in relation to the theme of failure:

Patients' responses to failure

The transition from physical health to sickness and dependency brings many non-somatic consequences (Thomson 1976, Vanstone 1982). Patients progressively lose the ability to exercise power and influence in the ways used by physically healthy people but may develop alternative means of exerting power: A patient may report symptoms (e.g. pain, insomnia, infection) but refuse medication ("poisons"). Even if care is accepted it may not be validated as effective.

Physical disease may be accompanied by "malignant alienation", manifested when a patient is "out of sorts" with everything – self, world, God, family, carers. The carers can consequently become apprehensive of the patient and afraid to approach him. The patient then becomes more powerfully manipulative and selectively alienating, causing staff schisms.

The patient may subject the actions and attitudes of carers (both professional and family) to analysis and scrutiny, thereby potentially giving rise to mutual suspicion, defensiveness and hostility. Tensions may arise if the patient and family have different perspectives on treatment ("let illness take its course" vs "do everything possible to extend life"). Patient and relatives may differ in their respective standpoints in relation to faith, belief, and alternative therapies.

Failure and carers

When confronted with these manifestations of patient power, carers can be subject to feelings of failure. Exceptionally long involvements or exceptionally short involvements are familiar stressors. Other stressors for carers include:

- Young patients with dependent family members
- Synchronous life-threatening illnesses in the same patient
- Criticism of care, particularly if unjust
- Unanswerable spiritual issues
- Quest for therapy outwith our resources e.g. "healing" or "wholeness" by alternative/complementary/unorthodox means

- Refusal of mediation in intractable family tension.

Corporate failures can be corporately admitted but at our deepest levels as carers we all have personal failures which we are reluctant to admit even to ourselves. We may make gaffes. We may fail to respond to cues when we feel out of our depth, unable to cope or when we fear our intervention may worsen a situation, perhaps especially in the spiritual or psychosocial realms. In addition, our own personal (professional/domestic) baggage may impact negatively on our ability to deliver effective care and the asset of sensitivity may degenerate into the liability of hypersensitivity. The conscientious worker may become the workaholic, unwittingly demeaning other colleagues. Little is known about the impact on individuals of a life-time career in Palliative Care, this being the first generation which has worked solely in this area of medicine but perhaps the key is in how we deal with our own vulnerability. *I will be forced to pay attention to my own suffering and need if I am to be of service to anyone else* (Campbell 1986).

The discipline of pastoral theology has rightly highlighted the theme of the "Wounded Healer", (Campbell 1986). *The wounded healer heals because he or she is able to convey both an awareness and a transcendence of loss*. (Church Times 1997). Henri Nouwen (1972) relates this, not only to the experience of disability, but also, and possibly more importantly, to the task of care-giving. So professionals who seek to deliver care in the face of apparent failure can draw on spiritual resources and also on principles closely related to professional caring:

- Acknowledge patient autonomy
- "Come into another's place" or "wear another's shoes" – see from another's perspective, possibly with the help of fellow-professionals to re-evaluate both failure and success, and what these may actually mean to patients.
- Be realistic, acknowledging that we fail because we are human.
- Promote mutual support within the caring team – foster realism about our own personal and professional strengths and weaknesses.
- Ensure appropriate peer support networks exist to prevent "natural" failures progressing to burn out or serious mental/physical illness.
- Set limits - demarcate boundaries for professional activity and personal leisure and recreation.

Palliative care purports to offer comfort, reassurance and hope where there is apparent failure (life-threatening illness) and those who deliver Palliative Care are confronted by failure both in and around them. By enabling patients and carers to identify and utilise their own personal and spiritual resources, failures can be challenged. As good palliation can offset the adverse effects of illness, so the personal and spiritual resources of carers and patients can extenuate feelings of failure.

Death

With the prospect of impending death as the outcome of life-threatening illnesses, patients and their carers may reflect on the question of what death might mean. For some death is soothing, welcome, an adventure but for many death is a failure, feared because of its inevitability, the uncertainty both of its timing and what lies beyond it and the variation in its quality. The acceptance by past generations of dying as "God's will" is no longer a satisfactory explanation to many but, as the illness advances, there can be a shift in perspective whereby the final outcome comes to be regarded as a friend, bringing ultimate release from pain, dependency and disease and even by some as "the final healing".

The ideal, frequently but by no means universally achieved in specialist palliative care, would be to provide opportunities in the ending of life for forgiveness, reconciliation, hope, and the expression of deep emotions. The pursuit of these issues may well involve reflections by patients, family and staff on perceived failures in their lives which could become overwhelming but, by acknowledging and confronting failure, perhaps we can all better understand it, learn from it and begin to "fail forward" (Maxwell 2000) thereby achieving a measure of success.

A final thought

Antonio Machado beautifully describes failure transformed:
'Last night I dreamed-
-blessed illusion-
that I had a beehive here
in my heart
and that

the golden bees were making
white combs and sweet honey
from my old failures.'
(translated by Robert Bly) (O'Donohue 2000).

Acknowledgement

I would like to thank the Rev. Stuart Coates, Hospice Chaplain, Strathcarron Hospice for inviting me to consider the concept of Failure in Palliative Care and for his advice and helpful comments on the manuscript.

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Fiona Downs is consultant in palliative medicine at Strathcarron Hospice, Denny.

Editorial Note

'Dr. Downs' article is adapted from a talk which she originally prepared for a conference organised by the College of Health Care Chaplains, but which, due to unforeseen circumstances, she was unable to deliver.

BOOK REVIEWS

The editors would like to express their thanks to the staff of Strathcarron Hospice, Denny for their considerable contribution to this issue's Book Review section.

The Sacred Art of Listening
Forty reflections for cultivating a spiritual practice
Lindahl K
ISBN 1-901557-65-0
Wild Goose Publications

I was eager to pick up this attractive book and to begin the daily discipline of reading and reflection on individual parts of the listening process. I found the book helpful in gaining new insights into listening and understanding the 'between the lines' communication that we are often so aware of but unsure of how to respond to.

Each reflection built upon the previous one but sometimes the daily portion was too short for me and I often wanted to carry on and read the next day's as well. The illustrations are designed to help the reader focus onto his or her own heart while thinking about each reading. I found them beautiful on their own but strangely distracting to focus on, as they were so intricate and busy, and did not help me personally to be still and reflect.

This book is identified as being in the category of 'Spirituality and Self help'. This is spirituality in the general sense and not specifically Christian. This was difficult for me in certain parts of the book where being open to the spirit was being encouraged as a way of listening to people; this being the universal spirit, not the Holy Spirit. Chapter 9 on 'Common values/Listening for Connectedness 'seems to have an underlying assumption that because of our common humanity we can assume a common core of spirituality and unity. Identification of, and respect for our differences is an equally important part of listening.

This is a book that helps us to slowly reflect on our own skills and understanding of the place and value of listening. It also challenges some of the personal values that we somehow find ourselves holding and not quite knowing how we got them in the first place. It would be of help to anyone who was attempting to grow in knowledge of themselves or others.

Dora Bennett, Clinical Nurse Specialist, Palliative Care (community),West Lothian H/C NHS Trust.

Primary Palliative Care – dying, death and bereavement in the community
Rodger Charlton (ed)
ISBN 1- 85775573 -1
Radcliffe Medical Press

This book comprehensively illustrates the complex issues involved in delivering palliative care to patients with malignant and non-malignant illnesses in the community by the Primary Heath Care Team (PHCT). The authors explore the primary-specialist interface and clarify the roles of primary care and specialist practitioners. Chapters 1-16 are stand-alone, clearly written and well referenced. The reader is directed to useful further reading and websites.

Excellent chapters are offered on core topics in palliative care including pain and symptom control, ethics at the end of life and spiritual care. The challenges of providing out of hours palliative care and managing emergencies are explored well.
Carer strain is highlighted with useful information that the professional can use to facilitate effective coping.

The chapter on bereavement outlines grief responses and refers briefly to grief theory. Assessment and support of the bereaved person is succinct, however it fails to provide the professional with in-depth guidelines on how to conduct the bereavement assessment.

The book acknowledges the importance of continuing professional development and offers practical advice on developing significant event audit and professional development plans in order to improve and change practice. The importance of effective

teamwork is acknowledged. I would like to have seen discussion on the difficulties experienced at the primary care – specialist care interface and ways of addressing these.

The final chapter provides the reader with insight into one lady's lived experience of having cancer and the care she received. Her account is moving and emphasises aspects of care which could be improved.

I would recommend this book to anyone interested in palliative care. It will be of particular interest to healthcare professionals and allied healthcare professionals practising in primary care, hospices, community hospitals and nursing homes.

Elaine McManus, Lecturer in Palliative Care at Strathcarron Hospice, Denny

Speaking of Healing
Gower C.
ISBN 0-281-05539-4
SPCK

This book refle3cts on the challenge to preachers who seek to make links between the Gospel narratives of healing and contemporary experiences of illness. It addresses the miraculous as it is manifested in the encounters between Jesus and sick people, and offers guidance as to how this material may be addressed from the pulpit today.

Christopher Gower is well qualified to address this theme; he is rector of Marylebone Parish Church, which for years has sought to incarnate the partnership between religion and medicine. His professional interest in preaching has found its outworking in his completing pioneering MTh in preaching (the basis, we are told, of the current book).

Gower reviews themes relating to healing and wholeness, addressing them from his own pastoral experience. His references are almost entirely from very recent literature – although "demythologising" is mentioned, Rudolph Bultmann is not.

He then reviews four apparently disparate methodologies whereby preachers might address the Gospel material, which he entitles as follows: literal, liberal, metaphorical/spiritual, social/community. He gives examples of mindsets whereby the miracles might be expounded with reference to the four, apparently mutually exclusive, methodologies. In an exciting, engaging and attractive conclusion, he suggests that a lot of the apparent antipathy between the four methodologies might actually be false, and that a truly holistic sense concern should take each of the four equally seriously. Probably belatedly, we are introduced to the eschatological dimension, where we are rightly told that "we do not start to fully live until we have also faced up to death"(p.107). Might this perspective have been better woven into one of the four categories to which we have been earlier introduced (Possibly metaphorical/spiritual)? Might it not be helpful to regard the miracles of Jesus as a foreshadowing of God's kingdom in its ultimate fullness – in the hereafter?

I warm to this book which contends that clergy should be more is ideologically flexible in the way we think and preach. The Church's ministry to sick and disabled people has been diminished by an oversegmented approach to healing. The Gospel accounts surely demand that we regain the holistic approach which is the hallmark of the ministry of Jesus. How better to achieve this than to take seriously the perspectives of different theological approaches – and indeed of the caring disciplines – in order that we may faithfully represent God's purpose for the making of his whole creation, as Gower rightly pleads.

Stuart Coates, Chaplain, Strathcarron Hospice, Denny.

Problem Drinking: A Person-Centred Dialogue.
Richard Bryant-Jefferies
ISBN 1-85775-929-X
Radcliffe Medical Press

I liked this book and the way it addresses three different themes. The person centred approach, problematic alcohol use and supervision. Bryant-Jefferies approaches the subject in an unusual way with the case study of a fictitious client. He uses dialogue to explore in some detail 12 counselling and 4 supervision sessions. As the book is read the process of the counselling unfolds with the reader readily becoming involved in the story, as with a novel, wondering what may have developed by the next week's session. The dialogue is supported with discussion and the theory relating to the issues raised. For the novice counsellor particularly this

detailed exploration of the counselling process is enlightening. At the end of each chapter questions and discussion topics are posed that are of relevance to both the novice and the experienced practitioner.
Throughout the book Bryant-Jeffries skilfully demonstrates the breath and depth of the person centred approach while at the same time the issues of alcohol use are explored. The person centred approach is not usually associated with problematic alcohol use. This book clearly demonstrates the possibilities.
As the work with this client progresses the place of supervision is introduced giving valuable insights into the significance of personal factors, boundaries and support. I found it liberating the way supervision is integrated into the counselling process.
This book will be of value to a variety of people; person centred counsellors, those working with alcohol issues in a whole variety of settings and even the clients themselves. The book is easy to read and at the same time provides a wealth of information and the exploration of complex subjects.

Val Smith, Lecturer in Palliative Care/ Person Centred Counsellor Starathcarron Hospice, Denny.

Caring for the Dying at Home: Companions on the Journey
Thomas Keri
ISBN 1-85775-946-X
Radcliffe Medical Press

This book is based on the Gold Standards Framework developed by Keri Thomas who is a Macmillan GP Facilitator in Warwick, England. Dr Thomas also juggles working as a GP with five children and being a clergy wife! The framework consists of 'seven C's: 'communication, coordination of care, control of symptoms, continuity – out of hours, continued leaning, carer support and care in the dying phase'. The framework arose out of Dr Thomas' desire to improve community palliative care by working with a multi-disciplinary group of both generalists and specialists. The tenet of the framework encourages better communication amongst team members in order to improve the care of patients and their families.

The book is a resource book which is best used as a dip in text rather than reading from start to finish. It is aimed at, and is best used, by practitioners working in the community. Furthermore, it is an essential text for those wishing to implement the Gold Standards Framework into their practice. However, other professionals, including chaplains, may find the book useful as a resource text regarding community palliative care.
The book is divided into three parts. Parts one and two are a resource for anyone with a general interest in, and a desire to, improve palliative care in the community, particularly those working in primary health care teams. The first chapter emphasises the importance of improving community palliative care and offers a framework for doing so. The second chapter proposes a sociological perspective, by exploring a modern way of dying, and putting community palliative care in context. The third chapter investigates living with dying at home by exploring the current state of primary palliative care. The next two chapters explore the concepts, and issues of, needs based and evidenced based care, Chapter 6, on the other hand, explores the political and contextual changes affecting community palliative care. The next two chapters are clinically focused and are written by a consultant in palliative care. They explore the key features of palliative care for patients with common cancers and common symptoms and problems in palliative care. There follows a short chapter on bereavement. Part two is creatively and usefully concluded with a few pages entitled 'sources of help and wisdom' with resources and 3 short poems to sum up from the viewpoint of the person who is dying.

Part three is a handbook for those involved in the Macmillan Gold Standards Framework programme.

I enjoyed reading this book and recommend it to readers of this journal. It contains some interesting and thoughtful nuggets of information. However, it is primarily a community resource and some will find issues such as bereavement and psychological, social and indeed spiritual issues dealt with too succinctly in the resource section. They are however, included in the gold standards framework in part three.

Dr Bridget Johnston, Lecturer in Palliative Care, Strathcarron Hospice

Using Research in Primary Care: a workbook for health professionals
Alan Gillies
ISBN I-85775-936-2
Radcliffe Medical Press
This is primarily a workbook designed for health professionals. It covers 20 topics at the heart of the research agenda in the NHS. Each topic is assigned a chapter.

Each chapter contains an introduction, a small section of key information, practical activities and online resources available for the topic, and finally key points written as learning outcomes. Icons throughout the book guide you towards relevant online resources, including documents, useful links and downloadable templates. The book, therefore, requires the reader to do some work. Indeed, it is not possible to complete learning of the various topics without carrying out the various online and practical activities and background reading. Although, the workbook is not designed to be assessed, and does not contain answers as such, the reader will in my view still probably learn more about, and gain a greater benefit, of research, than simply by reading an 'ordinary' text book.

Its is an excellent source for those chaplains who wish to improve their knowledge of research as well as improving their IT and other study skills.

Dr Bridget Johnston, Lecturer in Palliative Care, Strathcarron Hospice

Consent in Clinical Practice.
Margaret Mayberry with John Mayberry
ISBN 1-85775-804-8
Radcliffe Medical Press, 2003
With 'Our Nations' increasing Americanisation in the ever growing blame and sue culture and the advent of tighter legislation, such as the Data Protection Act 1998, clinical practitioners should be aware of ways to minimise their own personal risk and that of their employers to litigation. The Mayberry's book aims to give clinical staff a "concise, practical guide" to one area where risk could be minimised, that of informed patient consent.

The main areas the book deals with are that of the ethical concepts underlying consent, who is competent to give consent, the need for information, and the government and relevant professional organisations viewpoints.

The book quotes from a vast quantity of legal cases and research, with the legislative perspective of the book being solely from English and Welsh law. There is very little real and practical advice given to the practitioner who may be reading this book in an effort to further develop their knowledge and understanding of this complex area, and who wishes to put this into practice.

For me the promises of the back cover are not fulfilled in the content.

Alison Cowie, Regional Information Analyst, Marie Curie Cancer Care.

Growing Up With God
Cooks N
ISBN 1-901557-74-X
Wild Goose Publications
This little book is a gem for the chaplain who spends time with children or does occasional pulpit supply and needs a source for children's addresses.

The book is in three substantial parts. Part one explores the understanding of the story telling model, examines the themes of the Christian faith, moves on to listening to children, praying in response to stories and concludes with ways in which the material can be used. The focus is on helping children begin a *spiritual life* rather than a more restrictive focus on *faith*. It looks at the complexities of story telling with a wide ranging age group, the questions that arise from different age groups hearing the same story and offers sound advice e.g. let the younger children ask their questions first lest the older questions overwhelm them. One wonderful example is of the six year old child who asks "when did God die?" He'd heard that people go to heaven when they die and that God lives in heaven. Simple logic?

Part two is the story selection and each story comes with a detailed faith theme, life situation and the feelings to be explored. The story is read, there are some notes to guide the story teller to reflect and talk about the story, and a guide to praying after the story. Fergie the Frog comes to life when you realise he likes fly loaf and you produce a fruit slice from ASDA (a fly cemetery) and invite the children

to taste Fergie's favourite cake. The first story tackles bullying, fear, courage, and having a friend in Jesus.

Part three includes a detailed and very useful selection of indexes to the stories including faith themes, life themes, feelings, and biblical references. The indexes are followed by a comprehensive resources index pointing to other books. Not only do you get the book list, you get an introductory paragraph to explain its content and use.

The story section alone makes this book a worthwhile buy, however the introduction gives a great insight into what is a specialised area that comes naturally to some but which the rest of us would do well to learn.

David Mitchell, chaplain, Marie Curie Centre, Hunters Hill, Glasgow

ORERE SOURCE

Abstracts for the Pastoral Care and Other Health Care Journals

Some Thoughts About Speaking for Ourselves

The best known firm in the U.S. for working with hospitals to help them measure patient satisfaction, and plan for improvement of patient care services is Press Ganey. This past summer they published an article by Harold G. Koenig M.D. It can be accessed on their website. (www.pressganey.com and type the name "Koenig" in the search feature.)

Koenig is an associate professor of psychiatry and internal medicine at Duke University Medical Center, and has been one of the U.S.'s leading medical proponents of the idea that doctors should take account of the spiritual needs of their patients. To date he has published over 100 articles in peer-reviewed journals concerning different aspects of health, religion and spirituality. For Press Ganey's publication Satisfaction Monitor (July/August 2003) he wrote a review piece titled "*Meeting the spiritual needs of patients*." In it he describes the spiritual needs of patients, looks at the data concerning the frequency of such needs, and how often they are addressed, describes the consequences of unmet spiritual needs (quoting his own work and that of Kenneth Pargament) and concludes with some suggestions about how to address patients' spiritual needs. He offers five questions that he suggests all health professionals should be trained to ask:

- Do your religious or spiritual beliefs provide comfort and support or do they cause stress?
- How would these beliefs influence your medical decisions if you became really sick?
- Do you have any beliefs that might interfere or conflict with your medical care?
- Are you a member of a religious or spiritual community and is it supportive?
- Do you have any spiritual needs that someone should address?

He concludes by stating that once spiritual needs have been discovered, the health professional "must orchestrate the meeting of those needs. This may involved referral to chaplain services, providing access to inspirational readings or directions to the hospital chapel; notifying the patient's clergy or friends at church; praying with or simply listening and trying to understand." The article also announced that at Press Ganey's National Conference in November 2003 Koenig would present a session titled: "Religion, spirituality and health: meeting the spiritual needs of patients."

In a few days, news of Koenig's article and of his conference session reached a large group of on-line chaplains, which, though based in the U.S. also has participants in the United Kingdom. (Any chaplain may join by going to www.yahoo.com, selecting Groups, and signing up for the "pastoralcare" group.) From the reactions in the correspondence that followed, it was clear that a lot of oxes had been gored. Surely it was not appropriate that a physician, rather than a spiritual care specialist such as a chaplain should be the one making such a presentation!! What gave him the legitimacy necessary to be presenting outside his field of expertise? Gored indeed!

So what does make him a legitimate presenter outside the field of his professional training? I was still pondering the question when the July-August issue of Holistic Nursing Practice arrived (Vol. 17 # 4). It contains three articles which focus on "spirituality in nursing interventions". The first article is "*Examining the ethics of praying with patients*" by Winslow and Winslow. In it, they establish an ethical basis for nurses upon which they can offer prayer as part of their respectful care for patients, and at the same time maintain their own integrity. They present and discuss five guidelines for doing so.

The second article is "*Prayer's clinical issues and implications*" by Elizabeth Johnston Taylor. Her key question is: How shall nurses incorporate prayer in nursing practice? It was this paper that made me weep, not because it is a bad paper. Quite the contrary, it is an excellent paper. I wept because it was a paper which should (and could) have been written by a chaplain. Taylor approaches the subject of prayer with patients with the greatest

possible care, and making use of all that has been discovered and described in the pastoral, nursing and psychological literature. She has done her homework, even locating one of the very early articles on prayer and the dying patient in a long-forgotten gem of a book from the mid-1970s. (Bane, Kutscher, Neale and Reeves (eds) Death and Ministry (1975) U.S. publisher - Seabury.)

Consider the matter of *how* to pray. She quotes several pieces of research (all done in the U.S.) which have indicated that most adults pray conversationally (as opposed to meditatively or ritually). She also quotes a a small Australian study which showed that a person's style of prayer changes as their health status changes. Taylor's point is that a nurse's (and chaplain's ?) approach to making prayers needs to match the situation, personality as well as the current physical and spiritual status of the person.

She discusses the matter of assessing if and how one should pray with a patient. She suggests two questions that can be used. However, she also notes that assessment questions may not be necessary if the nurse has been listening carefully to the person's story. "Prayer can take the form of listening for what individuals would have said if they were in touch with their real feelings and needs."

Taylor looks at the research experience which has considered how illness affects patient's prayers, and addresses the spiritual conflicts that patients may be experiencing. She also lifts up the difficult matter of how to help a person address questions or doubts about prayer. "I can't concentrate, so how can I pray?" ""How do I pray when I am too sick?" "Am I praying he right way?" "Why is God silent? Is God there?"

There are additional matters which Taylor addresses e.g. supporting a person without praying with or for them ("I am hearing your doubts about whether God is answering your prayers. I know that must be disturbing. I sense that it would be helpful for you to have someone more experienced than I to talk with you. May I call the chaplain or someone you prefer?")

Then there is the patient for whom prayer is harmful. Taylor helpfully describes a short process for engaging the patient who believes, for example that prayer will be more efficacious than treatment and refuses the latter. Throughout her paper, she is making use of the reported wisdom of many care-providers, and presenting it in a manner which will undoubtedly educate nurses, and may hold insights even for experienced chaplains.

So what makes Taylor (and Koenig) legitimate presenters? They have done their homework and have spent the time and effort it takes to gather the insights of others - and their own - into an accessible and useful vehicle for helping others to learn. And that is how it will continue until we chaplains tackle the challenging task of representing our ministry, and different aspects of that ministry to those colleagues outside our field of training, and also to our own junior colleagues.

Right after the brouhaha following Koenig's temerity to be a spokesperson for spiritual care, a woman chaplain who has been challenging her colleagues to do research and to write about spirituality did so again, calling on someone to contribute to Press Ganey's readers from within the profession. As I write these words, no one from among the 350+ chaplains in the pastoralcare group has offered to do so.

(A copy of Taylor's article may be obtained by contacting oreresource@rocketmail.com)

Rev. W. Noel Brown, Chaplain and ACPE Supervisor, North-western Memorial Hospital, Chicago, and editor of the ORERE SOURCE, a bi-monthly compendium of his abstracts from the pastoral care and healthcare literature. Contact: oreresource@rocketmail.com

Homer U. Ashby
Being forgiven: toward a thicker description of forgiveness
J of Pastoral Care & Counseling
Vol. 57 # 2 (Summer 2003) pp. 143-152
The last decade has seen a significant increase in interest in the general topic of forgiveness, leading to the appearance of several major books on different aspects of the subject. (McCullough, Pargament, & Thoresen (eds) Forgiveness: Theory, Research, Practice (2000) Guilford Press. Worthington (ed) Dimensions of Forgiveness: Psychological Research and Theological Perspectives. (1998) Templeton Foundation Press.)
Ashby has noted that a less commonly studied aspect of this subject is seeking forgiveness from others. He describes both the process of seeking forgiveness, and then being-forgiven process, before giving examples. He concludes by examining the specific steps of being forgiven, which he presents as a four-step process. (8 refs)

Lyndsay S. Baines, John T. Joseph, Rahul M. Jindal
Emotional issues after kidney transplantation: a prospective psychotherapeutic study
Clinical Transplantation
Vol. 16 # 6 (Dec 2002) pp. 455-460
When a kidney transplant proceeds uneventfully, as they now routinely do, the patient's hospital course may not (from an emotional perspective) reflect how the person will cope in the months following.
This study, done in Scotland and still on-going, is being conducted to examine the relative benefits of psychotherapy (individual versus group versus none) for persons who have received their first cadaver transplant.
Of interest to the chaplain will be their findings concerning the emotional states of such patients. Negative emotional states appear to be the single most influential factor in determining the quality of life after a medically successful kidney transplant. The primary emotional concern for these patients appears to be their wish to "return to normal," with "normal" often being defined with reference to their former life perspectives, before the onset of their renal disease. Consequently, much of the help needed by these patients is to assist them in redefining normality, to be understood in terms of daily (social, relational, vocational, recreational) lifestyle. The person who is unable to do this experiences ongoing frustration, a sense of failure, and low mood.
The paper has a rather rich description of what the inner world of these persons can be like.

The CHA Theology and Ethics Department
Genetics and confidentiality
Health Progress
Vol. 84 # 1 (Jan/Feb 2003) pp. 24-25
The first of six ethics cases which will appear in this journal.
This case involves genetic testing and issues of confidentiality. The case involves a man in his late 20s who tests positive for early-onset Alzheimers Disease, and who is subsequently denied employment on the basis of this information.
Following the case, there are discussion questions for sponsors and board members of a hospital, for executive teams, and for ethics committees. There are also brief highlights of guiding ethical principles drawn from Roman Catholic moral tradition. A side-bar lists several resource articles.

B. Casey, A. Long
Meanings of madness: a literature review
J of Psychiatric and Mental Health Nursing
Vol. 10 # 1 (Jan 2003) pp. 89-99
How people make meaning for themselves when they are sick is of great importance for chaplains. When a person is mentally ill, in addition to the normal complexity of the process which is grounded in our human nature, there is another layer of complexity associated with the illness itself for the chaplain to work with.
This paper examines how people make sense of the experience of mental illness. They are influenced by the contexts of their environments, available cultural explanations, and the nature of their mental states.
The authors suggest that when a person experiences a psychological trauma, they attempt to regain a sense of order by imposing a narrative structure on the trauma they are experiencing. And when such personal stories are shared, the meanings they began with are shaped and refined through talking and over the passage of time.

Richard Chartres
Healthy living: healthy dying
http://www.Kingsfund.org.uk/
Vol. Downloaded 07/25/2003 pp. 1-6
The Kings Fund is an English independent charitable trust whose purpose is to improve health, espe-

cially in London, England. This paper is the annual lecture for 2003 by the Fund's President, the Reverend and Right Honorable Richard Chartres, Bishop (Anglican) of London. He describes how Western society today seems to be unable to see life and death holistically. Because of our strong Western medical model, no integrated view can develop of the person who is sick. Nor can a vision be created of the culture from which sick persons come.
However, he does not limit his criticism to the medical profession. "The Western Churches have a confession to make here. They have played a part in casting into shadow the social and relational aspects of healthy living and healthy dying by sometimes narrowing their discussion of what constitutes salvation to focus on mental assents and dispositions. The word used in the New Testament for "salvation" and the verb "to save" both include the idea of restoration of physical well-being and healing and do not simply point to some supposed spiritual part of ourselves. "Salvation in the Christian tradition was originally a holistic notion which was bound up with building a health giving community." (p. 3)
He also speaks out against thinking of health as a commodity, that there be a "truce" in reorganizing health care organizations; and that the culture of blame in health care be more and more discouraged.

Linda Ganzini, Elizabeth R. Goy, Lois L. Miller, Theresa A. Harvath, Ann Jackson,
Nurses' experiences with hospice patients who refuse food and fluids to hasten death
New England J of Medicine
Vol. 349 # 4 (24 Jul 2003) pp. 359-365
There are well-known barriers preventing patients from being assisted in ending their life (euthanasia, physician-assisted suicide). However, the choice to stop eating and drinking is legal throughout the US, is an option for competent patients, and does not necessarily require the participation of a physician.
The authors of this paper, who are from Oregon where physician-assisted suicide is an option available to residents, decided to find out whether persons do in fact choose to end their lives by ceasing to eat and drink. They asked nurses in hospice programs whether they knew of persons who had done so, and also about persons who had asked for physician-assisted suicide, so that they could compare and contrast the two groups. One hundred and two nurses (33%) reported that they had cared for at least one patient who had hastened their death by stopping all food and liquid intake.
The nurses reported that persons had done so because they were ready to die, saw their continuing existence as pointless, and considered their quality of life poor. The nurses reported that 85% of the patients died within 15 days of having stopped the food and fluids, and on a 0 - 10 (very bad - very good) scale, the median rating for the quality of these deaths was 8.
While there are ethical issues that need to be considered, the authors suggest that there should be further discussions about the choice to hasten death by refusing food/fluids, and about standards for evaluating and caring for patients who make this choice. (24 refs)

Fiona Haas
Bereavement care: seeing the body
Nursing Standard
Vol. 17 # 28 (26 Mar 2003) pp. 33-37
What evidence is there to support the commonly accepted belief that it is helpful to the subsequent grieving process for family members to view the body at the time of death?
Haas looks at reports from a variety of different settings, mainly disasters, and concludes that, generally speaking, it is beneficial for people to see the body of the deceased, even if the body has been damaged. There are strong emotional reactions at first, but the grieving process appears to resolve itself more beneficially when the deceased has been seen.
However, Haas has also found some reports which suggest that seeing the deceased can be traumatic, and make it difficult for the person. She describes these findings.
In summary: it is natural to want to view the body and relatives should be encouraged to do so; if they wish, children can view the body, they may need support; children benefit from being treated with honesty and are helped by being involved and not isolated; if the body has been damaged, the family should be prepared, but not prevented from viewing if that is their wish; relatives may need time and privacy to be with the deceased; more research is needed concerning mother's reactions to stillbirths; the wishes of those who do not wish to view the body should be respected.

Keith Hawton, Sue Simkin
Helping people bereaved by suicide
British Medical J
Vol. 327 # 7408 (26 Jul 2003) pp. 177-178
Does bereavement by suicide differ from bereavement resulting from some other form of sudden death? Not necessarily, according to this paper. However, certain themes or features in the grieving process may be more prominent. These are: stigmatization, shame and guilt, and a sense of rejection. The authors also point out some of the social and environmental factors which affect the course of the grief process.
The article includes contact details for 5 organizations in the U.K. They also name two useful books: A Special Scar by A. Wertheimer (2001) Brunner-Routledge; and, The Bereavement Information Pack for those bereaved by suicide or other sudden death, from the Royal College of Psychiatrists in London.

Christine Kennedy, Sharon E. Cheston
Spiritual distress at life's end: finding meaning in the maelstrom
J of Pastoral Care & Counseling
Vol. 57 # 2 (Summer 2003) pp. 131-141
What is a spiritual emergency? How would you define spiritual distress? Hospice chaplains are very familiar with patients who are distressed, but who, when they are provided with standard psychotropic medications fail to respond and continue in their distressed state. Kennedy and Cheston suggest that acute distress that has no organic etiology (and is therefore unresponsive to pharmacologic intervention) is most likely a manifestation of spiritual distress.
In their paper, they suggest there is an urgent need for continuing dialogue across all disciplines in hospice care in order to more certainly identify spiritual distress so that spiritual distress can be appropriately responded to. They report anecdotal evidence from four hospice professionals of differing backgrounds who each describe their work in identifying and responding to this kind of distress. (25 refs)

Daniel E. Lee
Physician-assisted suicide: a conservative critique of intervention
Hastings Center Report
Vol. 33 # 1 (Jan/Feb 2003) pp. 17-19
Lee is unambiguously opposed to physician-assisted suicide. He agrees with Karl Barth: "it is for God and God alone to make an end of human life." (Church Dogmatics Vol III: The Doctrine of Creation, Part 4 (1961) 404, 425.) He has been active in his opposition.
However, he says he has begun to struggle with the question whether "those of us with deep moral reservations about the morality of physician-assisted suicide have any business using the coercive power of government to try to prevent those who disagree with us from doing what they believe is right?" He has come to the position, based on ideas spelled out in On Liberty by John Stuart Mill, and Joel Feinberg's more recent commentary (Social Philosophy (1973) 49-51) that it is more important to truly discover what a person's choice is concerning his present and future medical situation.
He adds that Oregon's Death with Dignity Act has not created a slippery-slope situation as he and many of his like-minded colleagues had feared.
"Those of us opposed to physician-assisted suicide would do well to focus our efforts on helping others discover the meaning and hope that are possible in life, even in the midst of suffering. We can accomplish far more by reaching out in a loving, caring manner to those experiencing great suffering, instead of sitting around moralizing about what they should or should not do and threatening physicians with legal penalties if they act in ways at odds with the values we hold dear." (7 refs)

Julia Neuberger
A healthy view of dying
British Medical J
Vol. 327 # 7408 (26 Jul 2003) pp. 207-208
Neuberger, a rabbi in London, urges society to adopt a new approach to dying, one that will allow persons to have a good and healthy death. She believes that insufficient attention is often given to the overall world of the person in the care that is provided for them as they are dying; that psychosocial and spiritual care is essential for a good death; that the curative model of care does not fit for chronic conditions that may lead to death; and that hospices have the right approach to good death, but largely for patients with cancer, AIDS, or motor neurone disease, a fact that leaves many terminally ill people untouched by good care as they die.

Michele Le D. Sakurai
The challenge and heart of chaplaincy
Health Progress
Vol. 84 # 1 (Jan/Feb 2003) pp. 26-28, 56

Sakurai describes the many recent changes in health care in the U.S. which have, in turn, brought changes to the roles of hospital chaplains. They are now expected to have expertise in areas such as risk assessment, crisis intervention, advocacy, cultural and religious diversity, ethics, the ability to integrate the patient's story into a larger faith perspective, create and enact ritual support, be able to discuss end-of-life issues, and bereavement and grief.
It is an excellent resource article which will help chaplains interpret chaplaincy to community clergy and the institutional religious community.

Yolande Saunders, J.R. Ross, J. Riley
Planning for a good death: responding to unexpected events
British Medical J
Vol. 327 # 7408 (26 Jul 2003) pp. 204-206
When a terminally ill patient develops an acute problem, risky emergency treatment may seem futile to the medical staff. But sometimes patients are not ready to die. What is a good death in such circumstances, and how can the health care team achieve it?
In this case, authors describe the medical choice points that they reached. The patient was a 19-year-old man with cancer of the prostate, lung metastases and bone marrow disease. He was in a hospice unit. He began to bleed at a catastrophic rate. The question became: what to do? He was "fully alert and fully oriented."
The paper describes how the doctors proceeded from that point. It is an excellent, albeit tragic ethics discussion case. (14 refs)

Nancy Scheper-Hughes
Keeping an eye on the global traffic in human organs
The Lancet
Vol. 361 # 9369 (10 May 2003) pp. 1645-1648
"The ideal conditions of economic globalization have put into circulation mortally sick bodies travelling in one direction and healthy organs (encased in their human packages) in another, creating a bizarre kula ring of international trade in bodies. The emergence of the organs markets, excess capital, renegade surgeons, and local kidney hunters with links to organized crime, have stimulated the growth of a spectacularly lucrative international tourism, much of it illegal and clandestine. In all, these new transplant transactions are a blend of altruism and commerce; of consent and coercion; of gifts and theft; of care and invisible sacrifice." (p. 1645)
In 1999, Scheper-Hughes and Lawrence Cohen, another medical anthropologist founded OrgansWatch. This essay is essentially the fieldwork done around the world by Scheper-Hughes, supplemented by the reporting of her research assistants in different countries. The medical problems of donors are numerous, not to mention their subsequent social and psychological problems. In today's market, an Indian or African kidney will fetch as little as $1000, a Philippino kidney can get $1300, a Romanian or a Moldavian kidney yields $2700, but a Turkish or an urban Peruvian kidney can command $10,000 or more. Sellers in the U.S. can receive up to $30,000.
A truly frightening article.

Robert W. Stuford
The spiritual journey of an organ transplant patient
J of Pastoral Care & Counseling
Vol. 57 # 2 (Summer 2003) pp. 191-196
This article is a hospital chaplain's detailed description of the psychological, emotional and spiritual dynamics of an organ transplant patient, the recipient of a liver transplant. A man in his early 60s, a former fireman, he had been at death's door a number of times before he received his transplanted organ. We are told how his life, and that of his two daughters has been affected by his illness and how it continues to be even today because of the post-surgery routines.

Donald Thurn
What "big picture" should inform professional chaplaincy? - editorial
J of Pastoral Care & Counseling
Vol. 56 # 2 (Summer 2002) pp. 105-108
According to Thurn, chaplaincy faces the question: "How much can I assimilate into the culture before I lose my identity?" His ideas have been inspired by the thoughts of Huston Smith in his book Why Religion Matters: The Fate of the Human Spirit in the Age of Disbelief (San-Francisco CA: Harper San Francisco, 2001) where Smith argues that "scientism" has developed a cosmology which has people believing that science is the only way to understand all of existence. But where, he asks, does that leave "art, religion, love and the bulk of life we directly live?"

Thurn is concerned that chaplains need a centre for their professional identity that is not reliant on the recent research which has been linking religion/spirituality and health care. "As chaplains we need to understand the contradiction in which we live and work." (p. 107) He offers several suggestions as to how we might function within that contradiction.

Rachel Y. Zisk
Our youngest patients' pain - from disbelief to belief?
Pain Management Nursing
Vol. 4 # 1 (Mar 2003) pp. 40-51

Effective relief for the pain of surgery has been available only since the mid- nineteenth century, and for much of the period since that time, children have been denied pain relief, partly because it was believed that the very young could not experience pain, but mostly because they could no articulate the fact they were hurting.

This article reviews the development of knowledge and attitudes regarding pain in young persons, and suggests why and how changes have occurred. According to Zisk, modern pain prevention began in Chicago in Oct 1846 when William Thomas Green Morton, a dentist extracted a tooth with the patient having been given ether. (This appears to be factually wrong, most records show that Morton provided ether to a man at Massachusetts General Hospital on 30 September 1846.)

Zisk describes how in the 1990s there has been a great change in the treatment of pain in young patients, though she maintains that there is more progress needing to be made.

The paper chronicles some of the fascinating beliefs held in the medical profession which slowed the acceptance of pain control. It was believed that the rich and educated, for example, felt more pain than those who were not. There are also horror stories from the modern era. A relatively recent one involves the belief that boys did not need any pain relief as they were circumcised.

Scottish Association of Chaplains in Healthcare (SACH)

The Association seeks

- To be a professional body representing the interests of chaplains in Healthcare
- To promote, set and maintain high standards of chaplaincy and provide a Code of Practice to further them
- To provide support and fellowship
- To provide training and educational opportunities
- To develop and promote special interest groups
- To promote theological reflection
- To establish and promote good working relationships with religious and other organisations concerned with the promotion of healthcare
- To keep and publish a list of members

Further details of the Association are available from the SACH website:

www.sach.org.uk

Request for articles

The Editorial Board are currently considering papers for Volume 7 (2004). We are interested in a variety of articles including: research based articles, papers from academic study, conference presentations, and more general papers from all aspects of healthcare.

The Editors are keen to support authors who may be new to writing papers, or are unsure of the process and format of writing. We will be pleased to discuss your ideas prior to submission, offer advice, and can offer constructive criticism on a first draft.

Full *Instructions for Authors* are contained on the page opposite.

The Journal of Health Care Chaplains

The editors acknowledge the *College of Healthcare Chaplains (CHCC) Journal* which seeks to promote relevant issues concerning chaplaincy and spiritual care among chaplains in the wider healthcare community and would encourage the readership of both journals in our efforts to extend the influence and growing respect and professionalism of the journals.